Despite its many challenges, rural psychiatry can be particularly rewarding because it allows an opportunity to provide much-needed care and the ability to be at the forefront of helping to close gaps in health care disparities. The privilege of being a true community resource and the ability to improve overall community mental health give meaningful purpose to the work of a rural psychiatrist.

Psychiatrists who choose to practice in rural areas are faced with many challenges, including impoverished populations, stigmatization of mental health conditions, reduced access to treatment, and provider shortages. In addition, they are confronted with issues such as increased rates of suicide and binge drinking and nonmedical use of prescription medication among adolescents. Moreover, societal issues, such as homelessness, that have important implications for mental health appear to have patterns and solutions in rural areas that are different from those in urban areas. For example, in rural areas, homelessness can be a direct consequence of economic changes within the community, and it is more likely to affect women and children.

Geographical isolation and the small size of rural communities can contribute to specific ethical dilemmas that arise involving confidentiality, patients’ rights, patient-provider relationships, and distribution of limited resources. However, the ability to offer a reliable source of mental health care and the opportunities to become involved in community solutions mean that the rewards of rural psychiatry can far outweigh any challenges.

Challenges and obstacles
Accessibility of mental health care in rural areas continues to be an ongoing concern. Poverty, reduced rates of health insurance, long travel distances, and a shortage of public transportation create potential obstacles. Availability of a range of health care options is another limitation in rural areas. For example, when seeking treatment for depression, rural residents are more likely than their urban counterparts to receive medication only; it is likely that this is because there are fewer therapists in rural communities.

Other evidence-based treatment options, such as psychosocial rehabilitation, are also less commonly found in rural regions. Moreover, options for substance use treatment are likely to be limited. Many rural communities do not have detoxification services, and if they are available, they are less likely to offer medical monitoring in addition to social models of substance use treatment. Because of these disparities, rural providers are more likely to report that the lack of access to referral resources is a major challenge in providing care. Telehealth improves access to specialty services. Initiatives such as Project ECHO (Extension for Community Healthcare Outcomes) out of the University of New Mexico use technology to create knowledge networks and communication between rural health care providers and university partners. Telehealth can also be used in SBIRT (screening, brief intervention, and referral to treatment) initiatives to expand access to substance use treatment in rural communities.

Patient concerns about the acceptability of mental health care may also influence the experiences of rural psychiatrists. It is not uncommon to hear patients describe their reluctance to attend appointments “because people will see my car in the parking lot.” Qualitative studies on the manifestation of stigma around mental health in rural communities describe the importance of “rural gossip networks” and the impact of increased “social visibility” in small communities. Surveys conducted among rural residents also suggest that the perceived effectiveness of mental health treatment can influence the acceptability and the likelihood of help-seeking and that individuals in rural communities are less likely to view mental health treatment as helpful. Certainly, these systemic issues are not the only ones found in rural areas. Other commonly encountered clinical situations are explored and discussed in the case vignettes that follow.
systematic challenges and rewards that are unique to this subspecialty. This information can be useful to psychiatrists who practice in rural communities and to colleagues in urban areas who collaborate with them.

**What are the implications for psychiatric practice?**

This article uses case-based examples to provide an updated, in-depth look at frequently encountered situations in rural psychiatry, and it challenges the reader to use a critical problem-solving approach. The many rewards of rural psychiatry practice are highlighted.

**Telemedicine as a strategy to provide privacy**

Telemedicine can be an effective means for people to communicate sensitive issues within a rural area. Telepsychiatry improves access to mental health care and supports a range of models, including direct patient care, collaborative care models, and consultations between providers. Videoconferencing equipment allows a connection to a distant psychiatrist who can conduct an assessment, deliver therapy, and potentially prescribe and monitor medication treatment.

**CASE VIGNETTE**

Dr V is an inpatient psychiatrist currently practicing in rural Texas. Her husband is an engineer with a large oil company who has been offered a consulting position in Alaska. At the end of the summer, Dr V and her husband relocate to Fairbanks. Dr V’s new job at the local hospital’s outpatient clinic offers many opportunities for professional exchange of information. She frequently consults with primary care colleagues and the few psychiatrists in town on complex cases. However, as winter approaches and the daylight gets significantly shorter, Dr V finds herself suffering from seasonal affective disorder.

Since Dr V works closely with the other psychiatrists and therapists in town, what are her options in terms of seeking mental health care? Is this an example of the stigma that can occur when accessing mental health care? Dr V can visit her local primary care physician; however, given that she is well connected to other physicians within the relatively small community, she may wish to seek care from a distant provider to allow herself more privacy. Telemedicine allows Dr V to obtain confidential care from a mental health provider not in her area. Although this might be an example of Dr V’s concern regarding stigmatization of mental health care, more simply put, it is an example of one’s right to privacy and anonymity.

When establishing direct telepsychiatry services, it is especially important to anticipate issues around safety, potential emergencies, documentation, confidentiality, communication, and transmittal of prescriptions. There are a number of practical resources available to providers and agencies. The American Telemedicine Association has recently issued practice guidelines for the use of telemental health. In addition, the University of Colorado at Denver has developed a helpful Web site, The Telemental Health Guide. This site provides practical tips and advice for clinicians, administrators, community members, and policymakers on the development and use of telemental health.

**Rural professional isolation and practicing within one’s scope**

Telehealth is also increasingly being used in primary care settings to facilitate access to psychiatric consultation for patients and providers. Co-location of the telebehavioral health service within a primary care clinic can provide an additional layer of privacy. In general, attitudes toward telemedicine are positive among individuals who are seeking care. Individuals with mental health conditions who reside in rural areas are especially likely to report positive attitudes toward telehealth because of the benefit of reduced travel time to mental health clinics.

**CASE VIGNETTE**

Dr A has recently completed his residency and has started working as a general psychiatrist in a rural community mental health center. He feels well prepared for this practice by his broad and comprehensive general psychiatry residency training. However, this week the local family physician referred a 15-year-old with behavioral issues and his adoptive parents to Dr A. Other than a premature birth, not much is known about the developmental or family history of this adolescent. The parents report that their son has been “zoning out” at the dinner table and that there have been acts of verbal aggression toward grandparents when they visit. He has violent, loud, destructive outbursts in the middle of the night. Despite an individualized educational plan, the adolescent’s school performance has been rapidly declining, and he no longer attends athletic events at school.

What are some of the ethical dilemmas of this adolescent’s presentation to Dr A as a new patient? Should Dr A make a diagnosis and treat this child? If so, how would Dr A proceed? A primary ethical
The challenge that arises in the presentation of this patient revolves around Dr A’s training and ability to deliver treatment as a general psychiatrist, not a child/adolescent psychiatrist. However, Dr A is the only psychiatrist in this small town, which is located more than 100 miles from the next urban center with a psychiatrist. Keeping in mind the ultimate goal of safety for the adolescent and others involved in his daily activities, Dr A proceeds with the most accurate diagnosis and treatment plan that is within his scope as a general psychiatrist. Although he does not specialize in child and adolescent psychiatry, he is more likely to diagnose prodromal psychosis than is a primary care physician.

What are resource options in a rural community for a general psychiatrist treating children with complex presentations? Dr A may find it beneficial to request that the community mental health center allow him built-in supervision and consultation time during which he can access senior psychiatry colleagues or board-certified child/adolescent psychiatrists via telephone or videoconferencing. Maintaining these professional networks can be very helpful in keeping up-to-date and stimulating curiosity around relatively rare conditions.

To maintain continuity of care and to monitor progress and adherence, Dr A can consider obtaining permission to provide updates to the other key figures involved in this adolescent’s care (e.g., educators, family members, case managers, natural supports, paraprofessionals, and the patient’s primary care team). Telehealth can be a helpful modality to connect all the team members who may be located at considerable distances from each other. By cultivating relationships with other psychiatrists as well as other professionals, the sense of isolation can be reduced.

**Duality of relationships and ethical problem solving**

The following case presents the common issue of duality of relationships for a provider in a rural area. Dr R is the only psychiatrist in town, and he must carefully determine next steps in approaching a situation involving his daughter and a patient’s son. Furthermore, the community is rural and close-knit, and it is likely that news of any issues at school will quickly spread throughout the community.

**CASE VIGNETTE**

Dr R has a well-respected general psychiatry practice in the Midwest that includes psychotherapy and medication management. Dr R’s 8-year-old daughter is developmentally delayed and has behavioral difficulties. She is enrolled in the only school in town and attends classes with the help of a one-on-one aid. One of her schoolmates is the son of Mrs W, a patient whom Dr R is treating for recalcitrant depression and anxiety. Last week, Dr R’s daughter was involved in a physical altercation with Mrs W’s son.

What are the ethical dilemmas of this rural psychiatrist? Working as a rural psychiatrist presents rewards and challenges—namely, being able to be close enough to the community to see the big picture, but also being part of the community and, therefore, part of the picture. Dr R’s role and continued respect as a psychiatrist within the community depends on how he handles this duality of his relationship as a father and as a psychiatrist. He has several resources, including the American Psychiatric Association’s Ethics Resources and Standards. In addition, it may be helpful for Dr R to discuss this case with a colleague who lives outside the community. This consultation can be conducted over the telephone, or perhaps he can use telehealth technology to connect with an ethics consultation service at a local university or other health system. In this case, Dr R reached out to one of his colleagues from residency.

As he reflected on the situation, he weighed the options of referring Mrs W to a primary care provider versus continuing to provide care for her. Through this process, he chose to address the situation directly during his next appointment with Mrs W. He provided the space to describe their multiple roles and relationships outside the office. Then, through a process of shared decision making, both Mrs W and Dr R chose to continue the therapeutic relationship and agreed to separate their roles as parents from their clinical relationship.

**Conclusions**

Despite its many challenges, rural psychiatry can be particularly rewarding because it allows an opportunity to provide much-needed care and the ability to be at the forefront of helping to close gaps in health care disparities. For psychiatrists who reside in urban areas but are interested in rural health, telehealth offers an alternative way of providing services to rural communities. By making themselves available for case consultations and discussions with their rural colleagues, they provide essential support and networking opportunities.

Patients in rural areas may have any range of previous psychiatric care—from none to continuous—and have a wide variety of illnesses—from straightforward to complicated.
psychiatrists can find professional satisfaction and confidence by providing all aspects of psychiatric care in a rural area. The rural psychiatrist can also be engaged at every level of psychiatric care that includes both psychotherapy and psychopharmacology. Compared with urban providers, rural providers are more likely to tailor treatment to their patients and to integrate other community resources, such as schools, churches, and law enforcement. These adaptations add to the rewards and the ongoing opportunities for learning that are available for all psychiatrists interested in rural health. Although the multiple relationships with community members can sometimes be challenging to navigate, when conducted thoughtfully, these relationships contribute to the rewards of rural psychiatry. The privilege of being a true community resource and the ability to improve overall community mental health give meaningful purpose to the work of a rural psychiatrist.

Disclosures:
Dr Lynm is a PGY-4 resident in the department of psychiatry at the University of New Mexico and a participant in the UNM Rural Psychiatry Track. Dr Bonham is Director at the Center for Rural and Community Behavioral Health in the department of psychiatry at the University of New Mexico. The authors report no conflicts of interest concerning the subject matter of this article.

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