Interest in rural training experiences in Canadian psychiatry residency training

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Objectives

1. List 3 barriers to rural psychiatry training in postgraduate training programs.

2. Identify 2 strengths and 2 weakness of rural training sites for psychiatric training

3. Outline the consequences of urban centered training.

Background – rural communities

- Compose 18% of Canada[1]
- Reduced access to care – fewer than 8% of physicians[1]
- Typically older, lower SES with more comorbidities[1]
- Higher prevalence of substance use and mental health concerns[2,3]

Background – distribution of psychiatrists

- 10.6 psychiatrist per 100 000 in Alberta (national average 13.1)[4]
- Rural has less access (3.8 in North zone; 6.85 in central zone)[4,5]
- Rural psychiatrist have higher density in select communities (Grande Prairie, Red Deer, Ponoka, Fort McMurray, St.Paul, Claresholm; Lethbridge, Medicine Hat)
- Difficulty maintaining practice given underlying stigma and at times closed societies.

Background – Psychiatry training

- PGY1 focused on basic clinical training – currently no opportunities for completing any of these rotations in rural communities [6]
- PGY2 to PGY5 – psychiatry focused rotations[6]
- Limited exposure to rural training and novel care modalities
- U of A and Royal college mandate to meet needs of diverse populations to promote equity in care access. [7]

Methods

Survey distributed during 2020-2021 training year to all current psychiatry residents at the University of Alberta by redcap.

Focus on demographics, baseline exposure and interest in rural communities.

Data anonymized and exported into MS Excel

Quantitative analyzed by t test and chi square

Qualitative analysis of narrative responses for perceived barriers and resident ideas for training.

Demographics results

- 36 of 48 residents participated (75% response rate)
- Higher completion among female residents (61.1 22/36)
- Most were married (55%)
- Participated in rural training for ≥8 weeks (36.1%); more females (61%), and mostly under age 30 (91.6%)

Quantitative results

Interested in enhanced rural psychiatric training (30.5%)

More junior residents interested in enhanced rural training (64%)

Enhance or maintain their ranking of the program (40%)

Worsen program ranking higher among senior residents (67%)

Those with medical school rural exposure would improve their ranking of the program (59%)

Quantitative results – future rural interest

Interested in future rural practice (33%) – most had significant rural exposure during medical school (50%)

Most residents who were not interested in rural practice had minimal rural exposure

Interest in telepsychiatry training (94.4%)

High interest in combinations of telepsychiatry and intermittent rural clinics (66.7%) or brief integrated blocks (41.7%)

Qualitative results – challenges

- Financial costs – transportation and accommodation
- High service burden
- Limited support
- Isolation from resident colleagues
- Community integration
- Continuity of care
- Rural conservatism

Curriculum suggestions

REALITIES OF RURAL PRACTICE

CULTURALLY RELEVANT CARE

TELEPSYCHIATRY TRAINING

COLLABORATIVE CARE MODELS

Discussion

- Family medicine has implemented rural training with increased rural family physicians[1]
- Focus on social accountability and need to address health inequities
- Recent transition to CBD for psychiatry training
- Success in undergraduate training experiences in rural communities

Comparing U of A to other postgraduate training programs

- NOSM and UBC Prince George focused in rural communities
- Dalhousie new mandate to increase rural training to 10% of total training time.
- Quebec programs spend at least 2 blocks in suburban/rural communities
- Some programs have short/integrated or longitudinal exposures (University of Saskatchewan, University of Manitoba)
- Others have no mandatory rural training programs

Implementation of the study

- 2-week suburban/rural PGY1 rotation
- Increased availability of rural electives for senior residents
- Brainstorming options for rural exposure for core training rotations
- Academic curriculum offerings
- New grand round presentations on rural psychiatry
- Exploring partnerships with primary care in rural communities
- Exploring working group collaboration with other psychiatry training programs.
- Ongoing quantitative analysis to determine prevalence, severity and service allocation gaps.

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