MENTAL HEALTH ISSUES ARE NOT BOUND BY GEOGRAPHICAL LOCATION: Consider working in a rural community

By: Kristen D’ornellas and Jennifer Drummond

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Dear Colleagues and New Graduates,

It is an exciting time for us as newly graduated occupational therapists (OTs). It seems as though the world is at our fingertips with so many career paths made available with this degree. We would like to tell you about one exciting option that may not be highly publicized but is in desperate need for clinicians with our skills and expertise - mental health in rural communities. This letter is meant to inform you of everything you will need to know in considering this practice setting, including both the challenges associated with working in rural communities and some very appealing advantages. We hope to raise your awareness of the current state of mental health services in rural communities, provide some insight into the difficulties of rural practice, including those of professional isolation and boundaries and yet guide you to the realization that as a new grad you are equipped with a unique skill set that could make you a leader in this field.

Approximately 30% of Canada’s population resides in rural and remote areas of our country with 6% of that total population occupying Northern Ontario (Canadian Mental Health Association [CMHA], 2009; Health Canada, 2008). The gap in Canada’s health care system is unmistakable as reports indicate that Canadians’ health worsens the further they live from an urban setting (CMHA, 2009; Haggarty, Ryan-Nicholls & Jarva, 2010). This trend is demonstrated by a lower life expectancy, higher rates of disability, violence, suicide, accidental deaths and more mental and physical health issues in rural settings (Haggarty, Ryan-Nicholls & Jarva, 2010).

In 2002, rural Canadians self-reported higher rates of depression and ‘fair’ or ‘poor’ mental health in comparison with their fellow Canadians (Statistics Canada, 2004). In addition, rural Canadians have been reported more likely to suffer a major depressive episode or be hospitalized for emotional problems (Rost, Adams, Xu & Dong, 2007). Furthermore, over the past two decades rural suicide rates have surpassed those of their urban counterparts (Weiss Roberts, Battaglia & Epstein, 1999).
Although mental health needs are evident, Ontario’s often fragmented health care delivery system generates numerous barriers that prevent rural community residents from receiving timely, adequate and quality mental health care, resulting in reduced access to resources for those in need (CMHA, 2009; Haggarty, Ryan-Nicholls & Jarva, 2010; Weiss Roberts, Battaglia & Epstein, 1999). This means that poor organization and lack of continuity occurs between hospital admission, discharge planning and follow up. Due to the insufficient number of primary care providers the emergency room has become the primary contact point for many clients with mental health needs, in fact in 2004-2005 the use of emergency rooms for psychiatric needs in northern Ontario was twice that the average (CMHA, 2009).

Even if efforts are made to implement continuity of care, it is not always effective if there are not enough services or those willing to provide for clients with mental health issues (CMHA, 2009). Dr. Drummond personally experienced this poignant issue. One night while working at the emergency department of the Perth and Smiths Falls District Hospital, a distressed woman presented herself to the emergency department with suicidal ideations but could not receive a psychiatric evaluation for 12 hours due to bed shortages. Unfortunately, the emergency department was unequipped to manage her needs as she attempted to die by suicide while she waited in the emergency department.

Although, Ontario’s Northern region receives more per capita funding for community health; this funding is insufficient as major barriers continue to limit access to available services, largely due to shortages of health care professionals (CMHA, 2009; Weiss Roberts, Battaglia & Epstein, 1999). High turnover rates each year, limited access to emergency psychiatric services, weak or non-existent relationships with larger mental health facilities, with specialists, and fewer community supports contribute to the decrease in quality of mental health care (CMHA, 2009; Haggarty, Ryan-Nicholls & Jarva, 2010; Weiss Roberts, Battaglia & Epstein, 1999). In addition, it has been
suggested that many family physicians screen out clients with complex mental health issues, forcing them to travel long distances, leaving behind their social supports, to receive health care (CMHA, 2009). Travel within a rural community can also become costly as many remote areas do not have public transportation and therefore clients must rely on taxicabs or volunteer drivers to attend medical appointments (CMHA 2009).

As I’m sure you can see my friend - there is a problem. Various service delivery approaches are currently being applied to resolve these issues. The Assertive Community Treatment (ACT) approach provides a full range of services by sharing a caseload amongst a multiprofessional team to address mental health needs (Meyers & Morrissey, 2007). ACT teams have had successful results in urban settings and they would appear to be the perfect match for rural communities as they provide door-to-door services, which would eliminate travel costs.

The use of multidisciplinary care benefits the client as they receive care for various needs and it can also reduce professional isolation of the health care workers. However, research suggests that although ACT teams appear to reduce hospitalizations in rural communities they do not have consistent effects on psychosocial outcomes (Meyers & Morrissey, 2007). Some barriers faced by ACT teams include unfavourable recruitment conditions, difficulty servicing low population, low density areas and stigma around mental health issues present in small communities (Meyers & Morrissey, 2007).

As an alternate option, intensive case management (ICM) is also being applied in rural communities. ICM is a sole health professional responsible for individual caseloads and acts predominantly by linking their clients with community resources (Meyers & Morrissey, 2007). This approach limits the effects of staff shortages because a full team is not necessary (Meyers & Morrissey, 2007). However, ICM can only be successful in addressing mental health needs if there
are enough community resources already in place to support the referred client; this is most often not the case (Meyers & Morrissey, 2007).

As you can see, efforts are being made to resolve the issue of limited access to mental health services in rural communities, however there continue to be barriers. We are not suggesting that you, a new OT, can solve all of these issues in this area of practice, however, we strongly believe that you can make a difference. By contributing to the currently limited staff you can bring a unique skill set to clients who are very much in need. The remainder of this letter will address some topics we’d like you to consider when evaluating a career in rural communities.

Traditional thinking is all about "what is"

Future thinking will also need to be about what can be.

Edward de Bono

Embarking on a career path, without a great deal of support when you arrive, can be an alarming thought. Various reports indicate that isolation is a major concern for occupational therapists considering work in rural communities. Concerns about this issue range from geographical location to social loneliness to professional isolation (Soloman, Salvatori & Berry, 2001). It is true that geographical location can create some barriers for rural community professionals however it also promotes problem solving.

Rural community OTs will likely have to travel greater distances to reach their clients in low density communities therefore OTs will have to tap into their planning skills to manage their clients and maximize their time (CMHA, 2009; Soloman, Salvatori & Berry, 2001). Additionally, OTs may face limited resources, in terms of consults with specialists and equipment attainment (Soloman,
Salvatori & Berry, 2001; Weiss Roberts, Battaglia & Epstein, 1999), however we are known for using creativity to manage scarce resources.

As new graduates we have been educated in the advocacy process and have the tools to campaign for more community supports and long distance relationships with specialists. As we mentioned, social isolation is also a common concern and research indicates that most clinicians value family proximity and employment opportunities for their spouse when considering work in a rural community (Soloman, Salvatori & Berry, 2001). As such, selective recruitment and education of candidates from rural communities is an emerging trend (CMHA, 2009; Soloman, Salvatori & Berry, 2001).

Due to the social closeness that is common in rural communities, it is likely that health care professionals will take on dual roles. This will present the challenge of establishing boundaries to prevent the request for health and medical advice during social events. Finally, professional isolation is an issue in rural community health care partly due to recruitment and retention difficulties. Although rural communities often address mental health care through multidisciplinary teams, an OT may have limited interactions with team members and interactions within the OT professional may not even occur (Soloman, Salvatori & Berry, 2001).

Research suggests that this may lead to role ambiguity and pressure to work as a generalist, resulting in frustration in trying to retain the role of an OT (Hughes, 2001). However multidisciplinary teams also provide the opportunity for interprofessional collaboration and the opportunity to use multimodal treatments to reach goals. Literature also suggests that rural OTs feel that they have limited opportunities for professional development and continuing education due to the lack of proximity to other health care institutions (Soloman, Salvatori & Berry, 2001).
Despite these limitations, OTs have begun to adapt by supervising students, who are up to date on current treatment research, and by participating in mentorship programs (Soloman, Salvatori & Berry, 2001). This is increasingly possible with advancing technology and the development of communities of practice.

Communities of practice are one of the emerging trends used to mitigate some difficulties encountered due to geographical and professional isolation. Such communities are supported by computer-mediated communication and foster collaborative learning environments as well as ongoing consults with expert resources (Cassidy, 2001). In becoming part of a community of practice, you are engaging others by promoting effective teams whilst practicing continued learning; promoting core leadership qualities depicted by LEADS’s framework for the public health sector (Leaders for Life, 2010).

Telecommunication can also help to resolve ethical dilemmas that may arise and may be too complex for one OT to manage. If a consult with a bioethicist is not possible, or they do not appreciate the subtleties of a small community, it is suggested that you consult with an expert colleague in this area and perform research to understand the ethical process. According to Ontario Telemedicine Network, in 2007, 32000 clinicians used this network for consultations (CMHA, 2009).

It still may seem as though the barriers are endless, however rural community practice is also an ideal opportunity for an OT to assert their autonomy, in fact some research indicates that those who work independently have an increase in job satisfaction (Soloman, Salvatori & Berry, 2001; Weiss Roberts, Battaglia & Epstein, 1999). Independence nurtures innovation and fosters self-reliance skills (Weiss Roberts, Battaglia & Epstein, 1999). Such skills are valuable when working with a diverse caseload and flexible schedule (Soloman, Salvatori & Berry, 2001). Rural communities provide conditions for personal growth and professional development in the face of adversity and a career in this practice setting would reach mental health clients who need OT services.
Many clinicians are attracted to rural practice setting by the lifestyle in small communities, offering diverse recreational activities (Soloman, Salvatori & Berry, 2001). In fact, student placements, in rural communities, are suggested to be long enough to allow them to experience all these places have to offer, in hopes that they will return (Soloman, Salvatori & Berry, 2001). As inviting as a tight knit rural community can be, practicing occupational therapists face the unique challenge of maintaining professional boundaries in a setting with increased visibility of both client and health care professionals (Davis & Roberts, 2009).

The strength of the therapeutic relationship is a reliable predictor of a client’s outcome in the therapeutic process and such an alliance must be maintained in rural settings (McCabe & Priebe, 2004). As we have learned, professional boundaries are essential to promote trust and avoid misuse of power in therapeutic relationships. Boundary violations are thus in conflict with the recovery model, which emphasizes the release of power by the occupational therapist to encourage the client to assume an increased responsibility throughout the recovery process (Jacobson & Greenley, 2001).

We would like to outline several situations that may result in boundary violations and suggest possible strategies to manage these situations that you can later reflect on. As per all clinical experiences, each situation will be unique and we implore you to use your professional judgment and consult COTO’S Standards for Professional Boundaries (COTO, 2009), to be cognizant of and apply professional knowledge to the prevention, setting and management of boundaries.

In rural settings it is not uncommon for health professionals to espouse dual relationships within the community, and feel compelled to provide care to a client who is an acquaintance or friend (Davis & Roberts). This is another situation that conflicts with COTO standard 9, which states “The occupational therapist will avoid non-professional relationships with current clients.” (COTO,
Managing these relationships can be quite complicated because clinicians routinely interact with their clients in non-medical situations.

We would like to stress upon you that as an OT working in mental health, you must always maintain a professional, respectful relationship with the client’s best interest in mind (Soloman, Salvatori & Berry, 2001). It may be prudent to disclose any worries of conflict of interest in documentation, to ensure accountability through transparency (COTO, 2002). If a personal relationship does interfere with clinical judgment, we suggest that you explore alternate care means, through referral to other providers or through use of Telehealth or Skype to gain expert opinions.

Whilst growing up in the small town of Perth Ontario, it became apparent that gifts of gratitude to allied health professionals are considered a normative courtesy. In direct opposition to this practice, is the performance indicator highlighted in COTO’s Standards for Professional Boundaries that states we should “avoid the receipt or exchange of gifts” (COTO, 2009, pp. 8). Nonetheless in some communities this overt refusal may offend the client’s cultural beliefs and potentially harm the therapeutic relationship.

We understand that this potential conflict can be a very uncomfortable encounter for a new clinician and we would suggest you reflect on the context of the gift, the monetary value, the appropriateness of the gift, and what effect your refusal will have on your client. A refusal may be more easily accepted if accompanied by a rationale, as it is in the best interest of the client/therapist relationship (COTO, 2009). Alternatively, the gift could be shared with other members of the team or a donation could be made to a charitable cause to ensure the integrity of the client’s wishes are still intact (Registered Nurses’ Association of Nova Scotia, 1998).

Additionally, stigma around mental health care continues to prevail and can cause many rural community clients to become concerned with confidentiality of their care (Roberts, Battaglia,
& Epstein, 1999). Rural communities have been compared to ‘fishbowls’ (Roberts, et al., 1999), where it is not uncommon for residents to be particularly interested in their neighbours’ health and any trips they may take to mental health services. This lack of anonymity and fear of confidentiality violations may prevent health seeking behavior or collaboration with the health professional for fear of associated the consequences of stigma and social ostracism (Roberts, et al., 1999).

As part of our scope of practice, OT’s have an obligation to gain informed consent that includes disclosing limits to confidentiality and as professional practitioners we must strive to maintain confidentiality by not referencing any clients outside the clinical setting, as identifying characteristics are more evident in rural communities (Roberts, et al., 1999). In all cases, occupational therapists should undertake ongoing self-monitoring and have sound reasoning in support of their professional judgment for practice situations that involve boundary crossings.

We know that you’re probably wondering why we feel that occupational therapists are in a prime position to elicit change in mental health in rural communities. As a new graduate of an occupational therapy program, you are well equipped to deal with the challenges of mental health work in remote and rural communities and promote oneself as a powerful profession.

Today new graduates enter the workforce with emphasized training in working autonomously, applying self-directed learning strategies and utilizing administrative skills (Soloman, Salvatori & Berry, 2001). It is reasonable to say that if we are initially unsure of how to cope with an obstacle faced in a rural community, we have the resource capacities necessary to learn and implement the necessary skills. As new graduates, and scholarly practitioners, we are skilled researchers and
critical appraisers of evidenced based research. We have experience navigating search databases and even from a remote location we would demonstrate proficiency in researching new intervention strategies, so long as this community has Internet access. In addition to developing our research and administrative skills, throughout the program, we have also become experts in enabling occupations.

We feel that expert power obtained through a specialized knowledge base allows OTs to be optimal leaders in rural mental health settings, as literature confirms a positive relationship between occupation and mental health and well-being (Clark, 2010; Rebeiro, Day, Semeniuk, O’Brien, & Wilson, 2000). Engagement in occupation provides a means for a daily routine, promotes skill acquisition, productivity, as well as feelings of purpose (Kelly, Lamont & Brunero, 2010).

We feel that you, as a new graduate OT, can make a difference in the lives of those marginalized clients who are living with a mental illness in a rural environment. You can act as a change agent, a responsibility by means of which we “act on identified opportunities for occupation” and “advocate appropriately for the vulnerable marginalized client to enable participation through occupation” (CAOT, 2007, pp. 12).

As OTs we can look at the congruency of fit in between a person, their occupation and their environment. Currently there is a lack of fit between mental health clients and their rural communities. Acting as a change agent, you have the opportunity to not only impact the lives or individual clients by enabling them to engage in their desired occupations but you have the ability to impact the community as a whole, and perhaps contribute the narrowing of the gap in current mental health care while bettering continuity of care. As occupational therapists we are already embracing a tenant evident in the leadership literature; we have been trained to utilize our wisdom, by utilizing our theoretical models to process and enact change by through a holistic occupational lens (Cockburn & Clark, 2011).
Utilizing our holistic lens we recognize that advocacy should be the responsibility of all health professionals. The profile of Occupational Therapy practice in Canada (2007) demonstrates the importance of advocacy when performing the role of a change agent. There is ample opportunity for advocacy in rural communities, beyond supporting the need for quality mental health care for the individual. As professionals, OTs in rural settings often suffer financial strain as funding for rural health services does not incorporate travel costs for the clinicians (CMHA, 2009). Calling attention to this insufficiency and lobbying for government funding would contribute to overall health in rural communities as it may impact recruitment and retention of quality health care professionals.

Advocacy at a community level is also possible, as OTs, we want to empower our clients to become change agents themselves. Through increased education about mental health issues, OTs have the opportunity to raise awareness within an entire community and reduce stigma, as many people fear the unknown. This awareness could be particularly positive in a small rural community because closeness among members could breed strong support systems for members with mental health issues, once the stigma is removed. Utilizing the community readiness for change model as a frame of reference (McKenzie, Neiger, & Thackeray, 2009), enabling such actions will move a community from stages 2, where there is a slight recognition of a problem but no hope for a solution to a stage 4, where there is clearly identified problem, a leader but no detailed plan. By empowering our clients in such a way, we can help them to design and build an inclusive community with a greater number of supportive resources.

Another opportunity to help build community supports is through action as a practice manager. Practice managers are experts in coordination of resources with those in need. As a rural community OT, you are likely to become familiar with the available resources in surrounding counties and you have the ability to lead rural community members to link with outside services to increase
their supportive network. Examining the small town of Perth, Ontario as an example, we can see how this coordination can impact rural mental health services.

Although Perth has a small-defined population of only 6,000 residents, it is the focal point for health care for 25,000 people in the surrounding region, representing half the total population of Lanark County. Furthermore, its geographic location places it within easy reach (30-40 kms) of the entire county population of 55,000 in the neighbouring communities of Smiths Falls, Lanark, Carleton Place and Almonte. A partnership could be developed between the sole occupational therapist working at Perth and Smiths Falls District Hospital with Lanark Country mental health, a community based mental health organization that serves the community’s mental health needs to enhance the community-based mental health and addiction services. Your roles could be numerous, including consulting with the program managers to help develop the processes and knowledge base for staff to use and maintain and occupational focus. This partnership could result in a community-based, client driven, peer supported group with you as the OT facilitator bringing individuals together who have shared experiences.

In addition to building partnerships with surrounding mental health services, you have the opportunity to collaborate with various clients within the community to not only implement individualized care plans but to you can also promote the development of services within your community. When one is in a position of power, leadership roles in health care delivery can be personified, advocacy is more likely to be successful, along with the securing of necessary resources required for the achievement of community action and goals (Clark, 2010).

Working in a small town, you are more likely afforded more opportunities where power can be exerted to enact change in the delivery of mental health care. Interpersonal relationships outside your work environment can provide alternate avenues for mental health delivery. By involving
yourself in the local community, there is more opportunity for resource development, for example, the attainment of the church basement to run a support group.

Recovery needs to be viewed from this holistic framework whereby goals such as adaptive coping and community reintegration are highlighted throughout the collaborative relationship. Central to the philosophy of the recovery framework is that of developing connections, which underlies personal growth (Mead, & Copeland, 2000). As occupational therapists, you should make use of opportunities to develop innovative practice and collaborative partnerships that are formed between the community, service providers and consumers to promote a consumer’s engagement within the community. In doing so, you are promoting OT’s as powerful profession espousing leadership qualities, as the development of coalitions is a core leadership competency skill described by the LEADS (Leaders for Life, 2010).

A great leader’s courage to fulfill his vision comes from passion, not position. - John Maxwell.

We hope this letter has informed you, friend, of the great need for mental health services in rural communities. Even more than this we hope that we have instilled in you the belief that you have the skills necessary to elicit change and more importantly have a positive impact on the lives of rural community members who are suffering due to a fragmented health care system.

With our warmest regards,

Kristen and Jennifer
References


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Appendix A

Self-Assessment Activities

Reflection questions pre and post

True or False:

- Reports indicate that Canadians’ health worsens the further they live from an urban setting
- In 2002, rural Canadians self-reported higher rates of depression and ‘fair’ or ‘poor’ mental health in comparison with their fellow Canadians
- Rural Canadians have been reported more likely to suffer a major depressive episode
- Availability of support has been identified as the most common factor easing the transition of newly graduated occupational therapists into employment
- In rural settings it is not uncommon for health professionals to espouse dual relationships within the community

Multiple Choice

Rural employment is influenced by?

- Influence of a rural upbringing or previous rural experience
- the perceived appeal of a rural life
- the desire for autonomy and opportunity to develop clinical skills
  - Both B and C
  - All of the above

What factor(s) limit the quality of care received for individuals living with a mental health illness?

- High turnover rates
- Limited access to emergency psychiatric services
- Weak or non-existent relationships with larger mental health facilities and/or specialists
- Fewer community supports
  - All of the above

Which one of these statements is false?

- The Assertive community treatment model uses a multidisciplinary staffed team with shared caseloads to provide a full range of direct services to consumers
- Assertive community treatment teams provide direct services to consumers, thereby reducing the need for additional treatment providers.
Assertive community treatment team case managers broker services by linking and coordinating services for consumers, whereas case managers provide direct services to consumers. Case managers are responsible for individual caseloads, whereas assertive community treatment requires a multidisciplinary team with shared caseloads. ACT teams have had successful results in urban settings and they would appear to be the perfect match for rural communities as they provide door-to-door services, which would eliminate travel costs, however some difficulties have been reported.

Intensive case management involves:

a) Assertive outreach
b) Assessment of consumer need
c) Coordination of care.
d) Both B and C
e) All of the above

Some barriers faced by ACT teams include

a) Recruitment of health professionals
b) Difficulty servicing low population, low density areas
c) Stigma around mental health issues present in small communities
d) Both b and C
e) All of the above

In COTO’s document entitled Principled Occupational Therapy Practice (June 2002) OT’s are responsible for?

a) Ensuring own competence
b) Getting appropriate background information prior to providing service
c) Making appropriate referrals when services not available within own agency or scope of practice
d) Maintaining confidentiality
e) All of the above

Which of these statements about Communities of practice (CoPs) is false?

CoP’s groups of people who share a concern, set of problems, or enthusiasm about a topic
CoP’s strengthen their knowledge and expertise about a topic by interacting on an ongoing basis.
The small group learning environment promotes reflective practice
CoP’s promote continued learning
None of the above
## Appendix B

### Reflection questions pre and post

**True or False:**

- Reports indicate that Canadians’ health worsens the further they live from an urban setting
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Intensive case management involves:

f) Assertive outreach

\[ g) \text{Assessment of consumer need} \]

h) Coordination of care.

\[ i) \text{Both B and C} \]

j) All of the above

Some barriers faced by ACT teams include

f) Recruitment of health professionals

\[ g) \text{Difficulty servicing low population, low density areas} \]

h) Stigma around mental health issues present in small communities

\[ i) \text{Both b and C} \]

j) All of the above

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CoP’s strengthen their knowledge and expertise about a topic by interacting on an ongoing basis.

The small group learning environment promotes reflective practice

CoP’s promote continued learning

None of the above
Appendix C

Learning activities

1. Identify three positive aspects of rural health practice and three challenges or difficulties of rural health practice. Which of these would you particularly like, and which would you find most difficult?
2. Consider the differences between rural and urban practice, and how this might affect one’s practice environment
3. If you were moving into rural practice, what would you be looking for in a rural community in terms of the workplace environment and structure
4. Do you think community involvement is an essential part of working in a small town environment? Why or why not? If so, how could you integrate yourself into the local community.
5. How do you feel think about working with limited contact with a health professional team? Would you use any strategies to cope?

Case Scenarios

You are in a small rural town with only one pub. You are out for a social drink after finishing work for the day when you see a client (whom you know to have concurrent mental health issues and history of alcoholism) and whom has previously disclosed that he was in recovery, drinking his fifth beer for the evening. As his treating occupational therapist, what do you do?

You are an occupational therapist in a small town and are doing some Sunday afternoon grocery shopping at the local market. A client approaches you by in one of the aisles tells you about their last job interview that you coordinated. How do you respond?
Self-Reflection on Power

Table 1
Questions to Guide Self-Reflection on Power

It may be helpful for you to focus on taking stock of your sources of power by asking yourself the following questions, which are largely derived and modified from an inventory published by Ponte et al, in 2007.

- How do I define my power?
- Am I comfortable thinking about myself as being powerful?
- What are the power dynamics in the organization in which I work?
- How do other departments and disciplines view occupational therapy's power in my work setting?
- Do I possess self-confidence?
- Am I a powerful occupational therapist? To what extent do I possess reward, coercive, legitimate, referent, and expert power?
- What strategies and tactics can I employ to increase my power?
- What strategies and tactics do my competitors use to diminish my power?
- Are the occupational therapy leaders where I work seen as powerful?
- Does the setting where I work enable me to accomplish my aims without constraints? This sometimes can be determined by asking another set of questions based on an organizational/structural model of empowerment described by Kanter (1993):
  - Am I in the right place on the organizational chart?
  - Do I have access to information and resources I need?
  - Are there opportunities for my advancement?
  - Am I at the table when important decisions are made—especially those that impact OT?
  - Is the will of other professionals often imposed on me? Do I sometimes feel ambushed or like a lamb about to be devoured by a bird of prey?
  - Am I permitted, even encouraged, to do functions beyond my job description?

**Tip Sheet**

When working in a rural community:

- Be aware of local culture, customs and resources
- Use time management skills and planning to address the challenge of traveling long distance

Dealing with Professional Isolation:

- develop relationships with surrounding community mental health services
- take on a student, to tap into their knowledge of current research
- liaise with a mentor a community of practice using telehealth or other electronic communication

Dealing with Professional Boundary Issues:

- clearly communicate professional boundaries (be diligent re: when and where community members can seek your advice
- be aware that client identifying characteristic are more likely to be linked to the client in smaller communities
- be transparent about any conflict of interest when working with those who you have a dual relationship with

Leadership:

- empower the community members to begin to develop their own forms of support networks
- build partnerships with surrounding community health networks
- advocate or better access to well funded mental health facilities