Current Status of Out-Reach Rehabilitation in Canada

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The present research examined the structure and function of out-reach rehabilitation programs in Canada. Using a survey methodology, 17 out-reach programs were identified, most of which have been established within the past decade. Out-reach programs were classified either as Institution-Based or Network System programs. Institution-based programs typically consisted of teams of rehabilitation specialists who travelled from urban rehabilitation institutions to rural communities. Network system programs were not based in urban institutions, but functioned primarily by coordinating the delivery regionally-based and urban-based specialized rehabilitation services. Assessment and consultation comprised the largest proportion of clinical services offered by both types of out-reach programs. Most respondents noted that the primary responsibility for treatment provision remained at the community level. Disabilities related to brain injury were the groups most often seen by institution-based programs, and disabilities involving sensory or communication difficulties were the groups most often seen by network system programs. Survey respondents indicated a need to expand both the types of services offered and the number of communities served by out-reach programs. The most commonly voiced concern was the potential threat of fiscal cutbacks on the future of out-reach services.

Statistics indicate that approximately 13% of the Canadian population is disabled (Social Trends Directorate, 1986; Statistics Canada, 1988). There are also indications that the prevalence of disability is higher in rural areas (15%) than in urban areas (12%); Social Trends Analysis Directorate, 1986). It has been suggested that factors related to the distribution of the aged population, the lack of adequate primary health care services, poor health education, and the lack of health promotion and illness prevention services likely contribute to higher disability rates in rural communities (Burns, Batavia, Smith, & Dejong, 1990; Warren, Cockerill, Paterson, & Patterson, 1986).

Despite higher prevalence rates of disability, there are relatively few rehabilitation resources available in rural communities. In Canada, rehabilitation institutions are based in large urban centres, and although these institutions are capable of providing high level care and a wide range of expertise, they are relatively inaccessible to the disabled persons from rural communities. Problems related to referral difficulties, long distance travel, and a general reluctance to be treated for extended periods away from home have been major obstacles to rehabilitation care confronting persons with disabilities in rural Canada.

In addition to problems of accessibility, questions have been raised about the suitability of urban rehabilitation centres in the treatment of disabled individuals from rural communities. It has been argued that institutional care and treatment often bear little relation to the actual rehabilitation needs of disabled persons from rural communities (Peat, 1989; WHO, 1981). Rehabilitation professionals within urban centres often have minimal information about the physical or psychosocial demands of the rural environment. From a rehabilitation perspective, treatment interventions applied with limited knowledge of an individual's environment are likely to meet with limited success.

Over the past decade, several out-reach rehabilitation programs have been established to provide rehabilitation services to rural communities. Typically consisting of travelling teams of rehabilitation specialists, the goal of out-reach programs is to provide rural communities with rehabilitation services that would otherwise only be available in urban institutions. Given the difficulties that have been experienced in attracting rehabilitation professionals to rural communities, out-reach programs have been discussed as a viable means of interfacing the resources of urban centres with the rehabilitation needs of
rural communities (Gersten & Ostwald, 1978; Sullivan, Ware, Giustini, Lascelles, & Dehoux, 1990).

We conducted a pilot study in 1990 to identify the different out-reach rehabilitation programs currently operating in Canada (Lascelles, Sullivan, Cappon, & Ware, 1991). We saw the identification of existing programs as a first and necessary step in efforts to examine the current status of out-reach service delivery. We proceeded by mailing letters of enquiry to Directors of Rehabilitation Centres, Schools of Occupational Therapy, Physiotherapy, and Rehabilitation Medicine, general hospitals, and various organizations providing services to disabled populations. From the responses obtained, it appeared that there may be as many as 20 out-reach rehabilitation programs operating in Canada.

The results of the pilot study also suggested that there were different models of out-reach service delivery. Some programs were extensions of existing services based in urban rehabilitation institutions, while other programs functioned autonomously, without structural or administrative ties to rehabilitation institutions. Institution-based programs typically consisted of teams of specialized rehabilitation professionals travelling from urban rehabilitation institutions to rural communities. Programs that were not based in urban institutions appeared to function primarily by coordinating the delivery of specialized rehabilitation services to rural communities. We referred to the latter as network system programs. A third model of out-reach service was termed out-reach treatment teams. Out-reach treatment teams appeared to consist of small groups of rehabilitation professionals, primarily physiotherapists and occupational therapists, travelling to local health care settings or patients’ homes to provide rehabilitation treatment.

Although encouraging, the findings of the pilot study left many questions unanswered. Only minimal information was obtained about the structure and functional characteristics of the different programs. Issues related to the nature of clinical services provided, the range of rehabilitation disciplines involved, and the target populations of out-reach programs were not addressed by the pilot study. A more in-depth analysis of identified programs was necessary to obtain a clearer profile of Canadian out-reach rehabilitation programs.

The primary aim of the current research was to provide a detailed analysis of the structure and function of out-reach rehabilitation programs in Canada. Emphasis was placed on examining the range of rehabilitation services offered by different out-reach programs, models of service delivery, the mechanisms by which services could be accessed, and the disability groups most likely to make use of these services. A survey methodology was used where questionnaires were mailed to representatives of different out-reach programs. Questionnaire responses and a follow-up telephone interview were the primary data on which this paper is based.

**METHOD**

**Sample**

The initial survey sample consisted of 22 out-reach programs that were identified through the pilot study. Out-reach programs were defined as continuously operating services that had a clear, but not necessarily exclusive, mandate for the provision of rehabilitation services to rural communities. The survey sample does not include community-based programs, nor does it include public or private rehabilitation services that are provided informally or on a ‘special needs’ basis.

Some out-reach programs identified in the pilot study are not described in this paper because they did not have the resources necessary to compile statistics on various aspects of their operation. We also acknowledge the possibility that our search may not have identified every out-reach rehabilitation program in Canada.

**Procedure**

All out-reach programs identified through the pilot study were contacted by telephone and the objectives of the survey were explained. Respondents were told that a survey questionnaire would be mailed to them requesting information about the structure, function, and operation of their programs. Respondents were also told that they would be contacted by telephone to answer additional questions.
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The survey questionnaire contained several questions about specific aspects of the out-reach programs including: 1) the disciplines involved in the program (e.g., physiotherapy, social work), 2) the different types of services provided (e.g., consultation, treatment), and 3) their target populations (e.g., stroke, amputee). The survey questionnaire also contained several open-ended questions where respondents were asked to describe the geographical area serviced by their program, their perceptions of the rehabilitation needs that were not being met by their program, and the types of resources that would facilitate meeting these needs.

The questions for the telephone interview focused primarily on process-related issues such as the mandate of the program, the referral and screening process, program coordination, and service delivery model. Discussion of the program’s mandate provided information relevant to the inclusion criteria.

RESULTS

The results of the survey are discussed within a modified multiple case study framework and are presented under four main subheadings, 1) Description of Programs, 2) Clinical Services, 3) Target Populations, and 4) Future Directions.

Description of Programs

The present research identified a total of 17 out-reach rehabilitation programs currently operating in Canada. Out-reach programs were distributed widely across the country, with the highest concentration in Ontario. The programs identified in the survey were classified either as institution-based programs or network system programs. The primary distinguishing characteristic between these types of programs was whether or not they were based in urban rehabilitation institutions.

From the results of the pilot study, it appeared that there were several small programs consisting of teams of rehabilitation professionals providing rehabilitation treatment in local hospitals or patients’ homes. In the pilot study, these were referred to as out-reach treatment teams. Upon closer examination however, these programs could not be clearly distinguished from rural community-based programs. Most of the programs that focused primarily on treatment provision, as opposed to assessment or consultation, were based within the communities or regions they served. In the description of programs below, the Extra-Mural Hospital is described as an example of a rural community-based program.

Institution-Based Programs. The survey identified 11 institution-based out-reach rehabilitation programs. Institution-based programs consisted of teams of rehabilitation specialists who were based in urban rehabilitation institutions, and travelled to rural communities to provide services. Six of the institution-based programs focused on child rehabilitation, and 5 focused on adult rehabilitation.

(1) The Travelling Clinics Program of the Children’s Rehabilitation Centre (St. John’s, Newfoundland) was established in 1970 with the goal of providing rehabilitation services to children in rural Newfoundland and Labrador. The services offered by the Travelling Clinics include medical consultation, physiotherapy, orthotics, nursing, cognitive retraining, occupational therapy, speech therapy, and family counselling. The team travels to designated sites 8 times per year. Most patients are seen in local hospitals or schools. The Out-Reach Therapy Program is a community-based component of the Travelling Clinics that was established in 1978 to better service the treatment needs of the target populations (Crosbie, Murphy, & Squires, 1993).

(2) The Community Follow-up and Liaison Service of the G.F. Strong Centre (Vancouver, British Columbia) was established in 1978 with the goal of providing rehabilitation follow-up services to patients discharged from the G.F. Strong Centre. The Service is staffed primarily by rehabilitation generalists and the focus is primarily on outcome assessment, resource provision, and education. Community visits are held in 20 different regions of British Columbia. Most patients are seen in their homes.

(3) The Terry Fox Mobile Clinic of The Rehabilitation Centre (Ottawa, Ontario) was established in 1982 with the goal of providing rehabilitation services to disabled persons in rural communities of north-eastern Ontario and western Quebec. The services offered by the Mobile Clinic...
include medical consultation, physiotherapy, occupational therapy, speech therapy, nursing, psychology, social work, orthotics, and seating. The team provides services to 14 designated sites and most patients are seen in local hospitals (Greene, 1993).

(4) The Outreach Rehabilitation Services for Children were established by the Rotary Children’s Centre (Sault Ste. Marie, Ontario) in 1984. The program provides rehabilitation services for disabled children in the Algoma district of northwestern Ontario. Services offered by the program include physiotherapy, occupational therapy, and speech/language therapy. Approximately 11 trips are made to various locations each year. Most patients are seen in local hospitals or schools.

(5) The Preschool Out-Reach Program of The Grandview Rehabilitation Centre (Oshawa, Ontario) was established in 1985 to provide rehabilitation services to preschool children in eastern regions of central Ontario. The services provided include speech therapy, physiotherapy, occupational therapy, and audiology. Patients are seen primarily in preschool settings.

(6) The Children’s Out-Reach Service was established in 1985 by the Wascana Rehabilitation Centre (Regina, Saskatchewan) to provide rehabilitation services to disabled children in southern Saskatchewan. The clinical services provided by the Children’s Out-Reach Service include physiotherapy, occupational therapy, speech therapy, and conditioning therapy. The team provides services to 10 designated communities. Most patients are seen in local hospitals and schools.

(7) The Mobile Therapy Resources Program was established by in 1987 by the School Therapy Services Department of the Rehabilitation Centre for Children in Winnipeg. The Mobile Therapy Resources program provides rehabilitation services to disabled children in southern and central portions of Manitoba. The team consists primarily of occupational therapists and physiotherapists who travel to designated sites. Most patients are seen in schools (Wirt, 1993).

(8) The South Central Regional Rehabilitation Services were established in 1987 by the Morden Hospital (Winnipeg, Manitoba). The program provides rehabilitation services primarily to disabled adults in south central Manitoba. The services provided by the program include physiotherapy, occupational therapy, and speech/language therapy. Most patients are seen within local hospitals.

(9) The Mobile Seating Clinic of the I.W.K. Children’s Hospital (Halifax, Nova Scotia) was established in 1991 to provide seating services to disabled children in rural communities of Nova Scotia. Services focus primarily on seating with a team consisting of occupational therapists and seating technicians. The team provides services to 6 designated sites. Most patients are seen in local hospitals.

(10) The Head Injury Community Outreach Program was established in 1991 by the Niagara Rehab Centre (St Catherines, Ontario). The program provides rehabilitation services to individuals who have sustained head injuries. The services offered by the program include physiotherapy, occupational therapy, speech therapy, and cognitive retraining. The program provides services to 12 municipalities in the Niagara region. Most patients are seen in local hospitals.

(11) The Regional Brain Injury Outpatient Services were established in 1991 by the Kingston General Hospital (Kingston, Ontario). The clinical services offered by the program include physiotherapy, occupational therapy, speech therapy, psychotherapy, and cognitive retraining. The program provides services to 5 counties in eastern Ontario. Most patients are seen in their homes or in community facilities.

Network System Programs. The survey identified 6 network system rehabilitation programs. Network system programs were not based in urban institutions but functioned primarily by coordinating the delivery of regionally-based or urban-based specialized rehabilitation services. Service coordination is achieved either by accessing program-specific resources or community-based resources. All but one of the network system programs focused primarily on child rehabilitation.

(1) The Arthritis Society of British Columbia and Yukon coordinates an elaborate network of out-
reach and community-based rehabilitation services for disabled adults in rural regions of British Columbia and the Yukon. Examples of services include the Travelling Occupational Therapy Service which was established in 1958 and currently consists of a team of 5 occupational therapists. The Travelling Consultation Service was established in 1968 to provide rheumatology services to designated rural communities. Several additional programs focus on providing education, information services, assisting in self-management, and monitoring service provision (Toupin & Denford-Nelson, 1993).

(2) The Five Counties Children’s Centre was established in 1975 to provide rehabilitation services to disabled children in central Ontario. The clinical services offered by the Five Counties Children’s Centre include medical consultation, physiotherapy, occupational therapy, speech therapy, family counselling, recreation, and pediatrics. Patients are seen in their own homes, local hospitals or schools.

(3) The Rural Preschool Program was established in 1987 by the Society for Manitobans with Disabilities. The program provides rehabilitation services to disabled children in rural communities of Manitoba. The clinical services offered by the Preschool Program include social work, childhood education, physiotherapy, occupational therapy, and speech therapy. Specialized medical rehabilitation services are accessed through the Rural Diagnostic and Review Clinic which is also operated by the Society for Manitobans with Disabilities.

(4) The Northern Clinics Program of the Easter Seals Society was established to provide rehabilitation services to disabled children and young adults in northern Ontario. Clinical services include nursing, family counselling, and medical rehabilitation and consultation. Emphasis is placed on education with the aim of developing rehabilitation resources at the community level. Rehabilitation nurses function as point-of-entry personnel assessing referral suitability, and rehabilitation needs. Rehabilitation nurses also coordinate service delivery.

(5) The Integrated Services for Northern Children (ISCN) was established in 1989 to provide rehabilitation services to children in northern Ontario. The program structure combines features of community-based and out-reach service delivery models. At the community level, the ISCN employs Satellite Workers who are rehabilitation generalists and function as the “point-of-entry” personnel. Satellite Workers coordinate the delivery of rehabilitation services provided by Resource Groups comprising professionals from different rehabilitation specialties. The clinical services provided by the ISCN include physiotherapy, psychotherapy, vocational counselling, occupational therapy, prosthetics, speech therapy, and family counselling. Most patients are seen in ISCN offices or schools (Shea, Salhani, Lewko, Boschen, Flynn, & Volpe, 1993).

(6) The Technical Aids Mobile Services was established by the Saskatchewan Abilities Council in 1991 to provide technical aids for disabled individuals (primarily children) living in rural communities of Saskatchewan. The service provides assessment, consultation, and coordinates the prescription and delivery of technical assistive devices. The program consists of a team/case manager and 2 rehabilitation technologists. Most patients are seen in schools.

Rural Community-Based Programs. There are currently several community-based rehabilitation programs or resources available to disabled individuals in Canada (e.g., home care, public health nursing). A comprehensive discussion of differences between out-reach and community-based services is beyond the scope of this paper, and is discussed in greater detail in Sullivan, Ware, and Bishop (1993) and Peat and Boyce (1993). The Extra-Mural Hospital is described as an example of a rural treatment delivery service, although it is not an out-reach program.

The Extra-Mural Hospital was established in 1983 with the goal of providing rehabilitation services to disabled adults and children in New Brunswick. The program is not restricted to rural service delivery, but provides services within urban communities as well. The delivery of services is achieved through 16 Service Delivery Units dispersed across the province. Each unit may include occupational therapists, physiotherapists, nurses, nutritionists and social workers. Most patients are seen in their own homes (Ferguson, 1993).
Clinical Services

The clinical services offered by the different outreach programs are presented in Figure 1. Assessment and consultation comprised the largest proportion of clinical services offered by both the institution-based (67%) and network system (62%) programs. Network system programs devoted more time to treatment (22%) than institution-based (9%) programs. Institution-based programs reported spending more time providing education (15%) than network system (3%) programs. While most programs participated in home modifications, and the provision of assistive devices, these services comprised a small proportion of total clinical time.

Target Populations

Figure 2 presents a breakdown of the different disability groups seen by institution-based and network system programs. Brain injuries were the most common disability group (51%) seen by the institution-based programs. For programs focusing on adult rehabilitation, this group consisted primarily of individuals with strokes or traumatic head injuries. For programs providing services for children, this group consisted primarily of individuals with cerebral palsy. Disabilities involving sensory and communication difficulties were the problems most often (40%) addressed by the network system programs.

Neurolocomotor disabilities comprised a sizeable proportion of the disability groups seen by both institution-based (13%) and network system (17%) programs. Individuals included in this category had disabilities related to joint replacements, bone/joint injuries, multiple sclerosis, muscular dystrophy, neuropathy, and polio. Chronic pain, chronic metabolic disorders (e.g., cancer, diabetes, renal disease) and amputees represented the smallest proportion of disabilities seen by either the institution-based or the network system programs.

Future Directions

Survey respondents were asked to indicate the limitations of current service delivery, and suggest directions for future development. The need to expand both the types of services offered and the number of communities served, was the issue most frequently addressed by the different programs. Several respondents also noted that in many cases, rehabilitation services were available in local communities, but the absence of a mechanism for coordinating service delivery often made services inaccessible to those in need. Accessible housing and transportation for disabled individuals were also discussed as inadequate in many rural communities. For children’s programs, funding problems for the purchase of assistive aids were frequently addressed. For adult programs, the need for more respite care for caretakers of disabled individuals was noted by several respondents. An emerg-
ing theme was a call for more “wellness” or lifestyle services.

Respondents were asked to discuss issues of concern in the delivery of out-reach services. The most commonly voiced concern was the potential threat of fiscal cutbacks on the future of out-reach services. Some programs noted the difficulties experienced in obtaining funding to provide out-reach services, and still others noted that they were uncertain about continued financial support of their programs.

DISCUSSION

The results of the present survey indicate that Canada’s involvement in out-reach rehabilitation has been long standing. The Arthritis Society of British Columbia and the Yukon began offering services in 1958, and the Travelling Clinics of Newfoundland have been in operation since 1970. Recently, there has been a marked increase in the number of out-reach programs where 12 of the 17 programs identified in the survey have been in operation for less than 10 years. Initiatives launched during the Decade of Disabled Persons have likely played a major role in fostering the interest and support needed to establish and maintain out-reach rehabilitation services in Canada (cf. Francis, Lascelles, Cappon, & Brunelli, 1993).

The primary goal of out-reach programs is to provide rural communities with rehabilitation services that would otherwise only be available in urban institutions. In relation to this goal, it is useful to compare characteristics of service provision provided by out-reach programs with those of urban rehabilitation institutions. The composition of out-reach rehabilitation programs appears to reflect the range of rehabilitation disciplines found in urban rehabilitation centres. Physiotherapy, occupational therapy, and speech therapy were the most commonly represented disciplines on out-reach programs, suggesting a clinical focus on mobility enhancement, increasing independence in activities of daily living, and facilitating communication. Other health disciplines such as medicine, nursing, seating, orthotics, social work, and psychology were also represented on several out-reach programs. There were no substantive differences between institution-based and network system programs with respect to team composition.

Out-reach programs differed from urban rehabilitation institutions in the nature of clinical services offered. While treatment provision is a major focus of rehabilitation institutions, out-reach programs focused primarily on assessment and consultation. For both institution-based and network system programs, assessment and consultation comprised approximately two thirds of total clinical services. Several programs noted explicitly that a major limitation to providing treatment services was time lost in travel. In addition, it was noted that the infrequency of clinic visits
placed significant restrictions on the nature of treatment services that could be offered.

With respect to target populations, most outreach programs provided services for a broad range of disability groups similar to those seen in rehabilitation institutions. For institution-based programs, disabilities related to brain injury were the groups most frequently seen. The focus on brain injury likely reflects not only the high prevalence of these disability groups, but also the complexity of rehabilitation issues that are associated with brain injury (e.g., ambulation, sensory/communication, cognition, behaviour). There are indications that community-based professionals are able to manage many rehabilitation problems with the resources available at the community level, and request outreach consultation primarily for complex rehabilitation problems (Sullivan et al., 1990).

Disabilities involving sensory and communication difficulties were seen more often by network system programs than by institution-based programs. In interpreting this finding, it is important to note that all but one of the network system programs focused specifically on child rehabilitation, and most children were seen in schools. Due to the demands of school settings, where sensory and communication abilities are important determinants of successful academic performance, rehabilitation efforts directed toward these areas may have the greatest impact on adaptive functioning.

Thus, with respect to team composition, and target populations, outreach programs share many similarities with urban rehabilitation institutions. However, due to the brevity and infrequency of contact, outreach programs have focused primarily on assessment and consultative services, and have minimized their involvement in treatment provision. Most outreach programs indicated that the primary responsibility for treatment provision remained at the local community level. It follows that the potential impact of outreach programs will be limited by the rehabilitation resources available at the community level. Communities with few rehabilitation resources will be less able to benefit from the treatment recommendations made by outreach professionals. Indeed, the absence of community-based rehabilitation resources has been cited as a major reason for lack of adherence to recommendations made by outreach professionals (Sullivan et al., 1990).

The respondents of several outreach programs discussed the importance of maintaining good working relations with community-based clinicians. It was noted that negative attitudes toward 'city professionals' can place significant barriers to effective outreach service delivery. In addition, respondents discussed the need to be sensitive to urban-rural cultural differences in their approach to service provision. Respondents noted that efforts to maximize the impact of outreach programs should go beyond service delivery to include participation in local community activities, frequent telephone contact with community-based professionals and an open forum for feedback on the quality and utility of services provided.

To date, there have been few systematic attempts to evaluate outreach service delivery. However, available evidence suggests that outreach services are perceived as useful both by community-based professionals and by clients receiving these services (Shea et al., 1993; Sullivan et al., 1990). In the present survey, respondents' call for increasing outreach services also speaks favourably about the perceived utility of outreach programs. Flynn and his colleagues provide a detailed analysis of issues related to the evaluation of outreach rehabilitation services (Flynn, Volpe, Boschen, Lewko, Salhani, & Shea, 1993).

It may be premature at this point to attempt evaluative comparisons of the relative merits of institution-based and network system programs. The most useful discussions may be ones that highlight the particular strengths of each type of program. For example, a number of network system programs noted the advantages of having point-of-entry personnel working directly within the rural communities they served. Respondents explained that the structure of many network system programs seems ideally suited for functions such as the coordination of community-based services, coordinated access to specialized urban resources, as well as direct treatment provision.

In planning future directions, it may prove useful to capitalize on a network system model of outreach service delivery to maximize the im-
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Impact of existing rehabilitation resources. As noted by some respondents, services available at the community level were often inaccessible due to lack of a mechanism for coordinating service delivery. All too often, effective services can become inefficient due to an inadequate access or delivery system.

Respondents from institution-based programs discussed the advantages of having direct ties with urban rehabilitation institutions. It was noted that certain rehabilitation problems may be sufficiently complex that they cannot be effectively managed by community-based treatment services, even with the assistance of out-reach professionals. The ready access to institutional admission was noted as an important option for individuals requiring intensive rehabilitation treatment or high technology services.

With respect to future planning, the impact of institution-based programs may be increased by using urban rehabilitation institutions to build the rehabilitation resources of rural communities. Professional exchange programs may be a cost-effective means of upgrading the rehabilitation skills of rural professionals and familiarizing them with the range of services available through urban institutions. Increasing the skill level of rural professionals in this manner would also address some of the difficulties experienced in attracting specialized rehabilitation professionals to rural communities. Such exchange programs would also be useful in increasing the awareness of urban professionals to the potential resources and cultural characteristics of different rural communities.

As noted earlier, the growth and development of out-reach services in Canada have proceeded with little or no inter-program communication. Several authors have discussed the importance of information sharing in the development and maintenance of effective and efficient forms of health service delivery (Francis et al., 1993; WHO, 1981). We see this paper as contributing to efforts to increase information sharing in the area of out-reach rehabilitation. By describing different models of out-reach service delivery, and examining the advantages and limitations of different approaches, we can begin to develop an information base that will facilitate growth and development, and reduce the likelihood of failure.

To maximize the continued viability of out-reach programs, information sharing must go beyond the academic and clinical arenas. More attempts need to be made to inform consumers of the current status of rehabilitation services and engage consumers in discussions about ways to improve service provision (Poisson, Greene, & Sullivan, 1993). Particularly in the area of rehabilitation, informed consumers can play a significant role in increasing the efficiency of health care service delivery.

We believe that with continued development, out-reach has the potential for becoming a dominant model of health care service delivery that is viable not only at the rural level, but at the urban level as well.

La présente recherche examine la structure et la fonction des programmes mobiles de réadaptation au Canada. Au terme d’une enquête, 17 programmes mobiles — la plupart établis au cours des dix dernières années — ont été répertoriés et classés en deux catégories, selon qu’ils relevaient d’une institution ou constituaient un système de réseau. Les programmes institutionnels typiques reposent sur une équipe itinérante d’agents de réadaptation attachés à des centres urbains et qui parcourent périodiquement les régions rurales. Les programmes constitués en système de réseau ne dépendent d’aucun établissement urbain. Ils fonctionnent principalement en coordonnant la prestation de services de réadaptation spécialisés au niveau régional et urbain. L’évaluation et la consultation forment la majeure partie des services cliniques offerts par les deux types de programmes. La plupart des répondants ont noté que la responsabilité principale de la prestation du traitement se situait au niveau communautaire. Les anciens blessés crâniens forment la plus grosse clientèle des programmes institutionnels, tandis que les personnes porteuses de handicaps impliquant des troubles sensoriels ou problèmes de communication ont surtout recours au système de réseau. Les répondants au sondage indiquent qu’il est nécessaire d’assurer l’expansion des deux types de services et l’augmentation du nombre de communautés bénéficiant des programmes mobiles. Ils expriment le plus souvent leurs inquiétudes au sujet d’éventuelles compressions budgétaires qui pourraient compromettre l’avenir des services mobiles.
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