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Mental health care in rural and isolated areas: Lessons from northern British Columbia

Knowledgeable people are needed to provide therapeutic interventions for psychiatric problems common in the North, including posttraumatic stress disorder and depression.

ABSTRACT: Access to mental health care in northern, rural, and isolated areas of British Columbia is problematic from numerous perspectives, including cultural issues, lack of expertise, travel, residential school syndrome, alcoholism, family violence, and poor collaboration between mental health professionals and family physicians. Solutions offered hinge on productive collaboration in the form of teleconferencing and workshops.

For nearly 20 years I worked at regular intervals in the far northwestern part of British Columbia—first as a family physician and then as a psychotherapist focusing especially on "trauma-spectrum disorders."

During the early 1990s I was the medical director of the clinic at Dease Lake for the BC College of Family Physicians. In that role, I undertook an overall assessment of how health care was delivered and I interviewed many interested parties—school principals, social workers, band office leaders, church leaders, and the RCMP.

Without exception, all the parties identified mental health care as the most underserviced aspect of professional health care in non-urban areas. And it is a huge area—about the size of France. The nearest psychiatric unit is in Terrace, at Mills Memorial Hospital, 6 hours from Dease Lake by road on a good day.

Visits from a psychiatrist were, and still are, few and far between. When psychiatrists come, everybody knows that it will be many weeks (and usually months) before they return. It's pretty hard to give good continuity of care under such conditions. Also, adults often need different expertise than children or adolescents do, and many professionals are reluctant to cross those boundaries.

Often the school counselor is left trying to make up for the lack of continuity, and he or she already has a full caseload of those who don't need a psychiatrist but do need a lot of good, solid counseling.

Dr Hunter was a family physician in West Vancouver from 1972–1989. At that time, her work with clinical hypnosis and trauma disorders, especially dissociative disorders, threatened to overtake her family practice so she diverted into full-time psychotherapy work, focusing on trauma-spectrum problems. She is a past president of the BC College of Family Physicians, the American Society of Clinical Hypnosis, the Canadian Society of Clinical Hypnosis (BC Division), The International Society for the Study of Dissociation, and a past National Co-Chair of the Canadian Society for Studies in Trauma and Dissociation. She had been an assistant clinical professor in the Department of Family Medicine for many years before moving to Victoria in 1999. She is currently the director of the Labyrinth-Victoria Centre for Dissociation.

What are the common problems?

Posttraumatic stress disorder

Various forms of posttraumatic stress disorder rank high on the list of problems. As underlying causes, "residential school syndrome" and cross-generational family violence, often associated with alcohol abuse and sexual assault, are probably the most common.

It is now acknowledged that taking young children from their homes, communities, and cultures and forcing them to stay in residential schools—often for years and at times with no visits to or from family allowed—was unconscionable. Virtually all churches now admit to that; governments, however, have been slower to do so, or to provide the counseling or psychotherapy needed to help the person understand what happened, come to terms with it, and heal emotionally. It is not enough to say "That was a long time ago: get over it." Knowledgeable therapy is required. But who is going to provide it? Or pay for it?

It is also crucial to include culture-specific approaches to healing, which many First Nations communities are now doing. Good collaboration between the indigenous and the non-First Nations counselors, trained from different perspectives and therefore with different therapeutic agendas (and, of course, different cultural backgrounds) is essential but often hard to come by.

Because the children were taken from their culture at such an early age, they often feel disconnected from both cultures. They are often extremely alexithymic—they literally have no words to express how they feel, either in the language of their origin or in the language of those who took them away. Such complications do not foster recuperation.

The inter-family and intra-family violence, which is itself another aspect of posttraumatic stress, causes heartbreak and long-lasting sequelae in the forms of sexual assault, inappropriate behavior, anger management (nonexistent in many cases), family disruption and disintegration, and incestuous complexity.

Although we may wish to attribute these problems to the First Nations peoples alone, such is not the case. The very fact of living in isolated areas can spawn the same sorts of reactions and similar types of posttraumatic responses in people of all backgrounds. Family disruption due to separation because of work, schooling, financial insecurity, or other causes creates emotional trauma. The fallout can be devastating.

However, that fallout could be minimized by making good professional help available and affordable. Too often, it is neither.

Depression

Depression and the anxiety disorders that often go along with it are common. In northern areas, depression can be exacerbated by months of very short days and long nights. As well as being associated with seasonal affective disorder (SAD), depression can be associated with missing family and friends, as may be the case, for example, with people who are used to living and working in more populated areas. But it is often more insidious than that.

Alcohol and drug abuse interlaces with every other diagnosis and situation. Substance abuse is a source of major concern in schools and the community.

When groups of teenagers make "suicide pacts," as has occurred several times over the past decade in the North, then something is wrong in the community and the intervention of a good community mental health team is badly needed. Where to find such help? It simply isn't there, and has not been available in areas where I have worked in the past 20 years.

The money saved by providing such services—more collaboration of expertise, less time lost from work because of timely treatment, fewer legal problems, less court time, less crime in the community, fewer addiction problems, improved family function—would more than compensate for the cost, to say nothing about the cost of young lives.

Medication will help, of course, but not cure. The real answer is *people,* knowledgeable people who can help by providing education and therapeutic interventions; then, perhaps,

social changes will begin to occur and that in turn will promote further change.

Substance abuse

Alcohol and drug abuse interlaces with every other diagnosis and situation. Substance abuse is a source of major concern in schools and the community. Crime increases because desperate individuals need money to buy drugs and alcohol, and because irresponsible, sometimes violent and criminal, behavior often follows the use of such substances. This does not help a community to find its way through adversity; instead it exacerbates it.

Addictions counseling is desperately needed but, as with all other kinds of therapeutic interventions, is seldom available. When and where it is available, those providing it are almost always on a very short emotional tether themselves.

Dissociative disorders

Dissociative disorders are found all too often in isolated communities where no family counseling services are available and family dysfunction is rampant, residential school syndrome is rampant, sexual assault is rampant, and alcoholism is rampant. Usually we see a somewhat milder form of dissociative disorder NOS (not otherwise specified) but at times we also find dissociative identity disorder (DID).[1-3]

If mental health care is inadequate when it comes to treating general psychological and emotional problems, it is virtually nonexistent when it comes to treating dissociative disorders. The saddest part of all this is that dissociative disorders are treatable. All that is needed is a therapist who understands what will help.

A few years ago, when I was at Mills Memorial Hospital as clinical director of the psychiatry unit, I did a small research project on the level of dissociativity in the inpatient population on the unit (see "Degree of dissociativity in the inpatient population of a hospital in northwestern British Columbia" in this issue). I was not surprised at what I found; it was entirely congruent with what I have outlined above. (In small, rural hospitals, the clinical director of a unit is usually a family physician or general practitioner. The specialists are, of course, the consultants.)

For dissociative disorder patients, it is almost always a long therapeutic journey. This should not be a problem, but it is. If people can get well, don't they deserve all the help available? And therein lies the catch.

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Several years ago, the RCMP brought a young lad into the clinic late at night. He had been rampaging, and his hands were cuffed behind his back. He was 13 years old.

I had seen and diagnosed him about a year before when I was doing another stint at Mills Memorial as clinical director of the psychiatry unit. I knew some of his various ego states, and also knew that with a little calmness, he would be able to switch modes and settle down.

The police were understandably wary of this approach; however, they watched in amazement as I gently worked with him and he began to show a much younger, more frightened aspect of his personality structure. These two wonderful officers were sufficiently impressed with what they saw to drive the patient themselves, when they were off duty, to Terrace.

That is devotion beyond the call, to be sure. But where is such a patient to get continuing care in an isolated area? It is almost impossible—and *that* is inexcusable. It may be that the patient needs to be transferred to a larger community. The expertise is out there. It just needs to be accessed. And funded.

Violence and isolation

Victims of family violence need a safe place to go when desperate and dangerous situations arise. There are a few such safe houses in northern communities—often run by the Band office. The problem is, of course, that everybody knows where they are, and that means that the safe place isn't safe any longer. One does not have the advantage of anonymity that comes with larger centres.

One comment I have heard is, "Well, if they don't like it, why don't

they move?" Such a response is both crass and unrealistic. Most people don't want to move from their homes. And there is something about the North that draws many people to it. Some people like cities; others prefer rural areas. Many like the North—the countryside, the northern lights, the sparkling snow, and the short but hot summers. It is not our place to tell them to move; nor is it right to ignore the need for good mental health care to *all* people in our province.

There is also significant trauma experienced by police, highway workers, conservation officers, and other government employees serving in isolated areas. Not only is there the trauma that goes with the job—accidents, fights, wild animal attacks, bad weather—but also, again, the isolation. These members of the community—even if they are residents for a comparatively short time—are also often in need of psychiatric or psychological help. Of course, in an emergency they can usually be flown out (if the planes are flying, that is, and not weather-bound), but there is still the urgent situation to deal with.

What and where are the answers?

The answers are to be found through collaboration.

There are many routes to collaboration, but among the most important are teleconferencing and workshops given in the North by recognized presenters in the field of mental health for rural and isolated areas.

Teleconferencing is already being used throughout the country, much of it originating from the University of British Columbia. It involves having the proper equipment at both ends of the conference, however, and this is not—so far—easy in the more remote areas.

When it comes to organizing workshops, we have to ask, Who is going to travel, under what auspices, and be paid for by whom? But these barriers should not be seen as insurmountable when such potent and positive outcomes are possible.

The University of Northern BC in Prince George could, and should, be a key player in such innovative directions, offering courses in basic mental health for family medicine students. Obviously this would also require negotiations between the BCMA and the government to create an appropriate fee schedule item for GP psychotherapy, as is found in other provinces. Not getting paid for such time-consuming and demanding work would negatively affect the whole concept.

Most important is good collaboration between general and family practitioners, psychologists, psychiatrists, clinical counselors, and social workers. "Shared care" has been touted in the *Canadian Psychiatric Association Bulletin*[4] and indeed was the focus of an April 2004 theme issue.[5] It is worth a few minutes of every family physician's time to read such articles. More to the point, it should be required reading for those in government, the UBC Medical School (and its branches), and the BCMA.

The newspaper-format periodicals are also attending to these matters. In *Canadian Psychiatry,* for example, there have been recent articles on what is happening in Quebec[6] and broader-based articles on shared care.[7]

The *Canadian Family Physician* is also doing its part by promoting the general collaboration of psychiatrists and family physicians in many areas of mental health, including services or seniors.[8]

The expertise is available. To get it to the places where it is most needed we will need to take a different approach regarding recognition, education, collaboration, and funding. As we have a global health care budget, that may mean that some have to take a slightly smaller slice of the pie—unless the government can allocate new funds for mental health care in northern, rural, and isolated areas.

Every citizen in British Columbia deserves mental health care. Somehow, the ways and means to provide it must be found.

Competing interests

None declared.

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