

BEYOND THE PILOT STUDIES: COGNITIVE BEHAVIORAL THERAPY IN A REMOTE ABORIGINAL COMMUNITY

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Introduction

In this talk, I want to describe to you to development of mental health care by means of TeleHealth utilizing several professions across several rural and remote communities. By the end of the talk, I would like to highlight what I believe to be the development of a model of appropriate mental health care in such communities.

In May of 2006, Chris Clement of Vancouver Coastal Health and the co-author of this presentation asked me to begin provision of TeleHealth outreach psychiatric services to the Heiltsuk community of Bella Bella (Waglisla). This is a community of approximately 1500 people, 90% of whom are Heiltsuk. It is the remaining central community of more than 50 Heiltsuk sites, many of which were seasonal. R.W. Large Memorial Hospital, the Bella Bella Medical Clinic and the Hailika'as Heiltsuk Health Centre provide health care services. I was very familiar with the community and facilities as I had provided in person outreach psychiatric services on a regular monthly basis from 1992 to 2003. My last trip into the community was in February 2004. No other psychiatrist has visited since that last trip. Cost per trip was approximately \$500 airfare plus \$200 for housing and the cost of food. I usually traveled in on a Wednesday and out on a Friday. While there, I would see approximately 12 patients. Due to pent-up demand, that count reached 20 throughout most of 1993. Over the years, I have seen more than 300 Heiltsuk patients or 20% of the community population.

Traveling into Bella Bella from Vancouver is possible only by aircraft or water. Travel is from the South terminal at YVR to Port Hardy for refueling and then on to Bella Bella. Airtime is about 95 minutes while block time, or time from arrival at the airport to arrival at the destination, is about twice that. Travel time to the airport was an additional hour. The "office" I used in Bella Bella was the storage room for the laboratory at the hospital. There was no window, soundproofing was less than adequate and the decor was storage room modern.

The TeleHealth room in Bella Bella is a conference room in the hospital while the TeleHealth room in North Vancouver is a conference room in the BC Rail building. Travel time from my office, on foot, is approximately 5 minutes. Soundproofing and decor are still not ideal, but access is immensely easier. I "travel" to Bella Bella on a Wednesday afternoon twice a month and see five or six patients each time. Usually I see two or three new patients for consultations and two or more patients for follow-up CBT psychotherapy.

Diagnostic Epidemiology

Reserve communities are not at all similar to any of the large Canadian cities. Remote and rural reserve communities are even more different. The death rate from all causes is much higher, the suicide rate is much higher and the morbidity rate is even higher. In my experience, 90% of the women and 40% of the men have a history of sexual abuse or assault. A majority of the men have a history of physical assault. Obesity and diabetes are epidemic. Drug and alcohol abuse is widespread. Education, but not intelligence, is limited. Traditional skills and knowledge are poorly transmitted from generation to generation.

The major diagnoses of schizophrenia and bipolar disorder are rare. In Bella Bella, there are only two people with an established diagnosis of schizophrenia. In a similar-sized mainstream community, there would be 15. Only this fall have I actually diagnosed bipolar disorder in two First Nations families.

The major diagnoses seen in remote and rural reserve communities are those of posttraumatic stress disorder, depression and anxiety disorders. For all three of these disorders, suicide is a continuing concern. For all three of these disorders, the most appropriate treatment is psychotherapy. In particular, cognitive behavioral therapy (CBT) has been shown to be effective.

Service Needs

Psychiatrists providing outreach to rural and remote (R&R) communities usually are able to provide a reasonable diagnosis, suggest medication and perhaps recommend psychotherapy such as CBT. However, most fly-in psychiatrists are not in the community frequently enough or long enough to provide psychotherapy. The training of most psychiatrists also does not include training in cognitive behavioral therapy (CBT). CBT is taught by psychologists to psychologists and is practiced by psychologists. Psychiatrists are funded by the healthcare system; psychologists are not. Thus, although CBT is widely recognized as an effective treatment for the disorders most prevalent in R&R communities, it is very rarely available to them.

My own background is that of a registered psychologist in practice prior to returning to medical school and psychiatric training. For many years, I taught at UBC in both the psychiatric residency program and the psychology clinic attached to the department of psychiatry. Nearing retirement from UBC, I established the North Shore Stress and Anxiety Clinic with 10 Ph.D. level psychologists, most of whom had been my former students. It was obvious to me from the beginning of TeleHealth outreach to Bella Bella that I could not provide all the mental health service needs for the community. However, I had a clear idea about who could provide those services. All of the psychologists in my clinic know a great deal about CBT.

The Proposal

I suggested to Chris that CBT would be an appropriate treatment for the major diagnoses seen in Bella Bella. She pursued funding through First Nations and Inuit Health Branch with the assistance of Bo Reid of Hailika'as Heiltsuk Health Centre. Funding was granted for \$25,000, so

in March of 2007 psychologists began to provide cognitive behavioral therapy by means of TeleHealth to Bella Bella. At this point, three psychologists are involved in providing this service.

The Development

RW Large Memorial Hospital in Bella Bella is a United Church hospital. The chief executive officer of that hospital (Glen Timbers) is also the CEO of the Bella Coola Community Hospital in Bella Coola, BC. Bella Coola is a mixed Nuxalk/white reserve and community. A drug and alcohol worker, two intermittently resident counselors and an exceptionally effective clinical social worker (Carole Clark) provide mental health services. Medical care is provided by three doctors resident in the community for a number of years and supplemented by a continual stream of locum physicians. Several psychiatrists have visited the community intermittently over the years. The most recent one was Dr. Rachel Boulding, a child psychiatrist from Prince George. She visited approximately every 3 months, when the planes could land. Bella Coola is situated in the valley of the Bella Coola River and at the end of a long ocean Inlet. High mountains are immediately adjacent. The airstrip is not IFR rated and visual flight rules prevail. If there is cloudy weather, as often happens on the BC coast, airplanes do not fly into Bella Coola.

I suggested to Glen Timbers (CEO) that perhaps Bella Coola would be interested in TeleHealth psychiatry. That offer was immediately accepted and in November of 2006, I began videoconference psychiatric contact with the community. I see Bella Coola patients on alternate Wednesdays, usually seeing 6 or 7 each Wednesday afternoon. As in Bella Bella, I usually see two or three new patients and follow-up with psychotherapy the patients seen previously. As of the date of this report, there have now been 128 referrals. Again, I suggested that CBT would be an appropriate treatment for the needs of the community and those psychologists in my clinic could perhaps provide that service. The hospital administrator requested some additional funding to provide for payment to the psychologists and \$39,000 was added to the hospital budget. In September of 2007, 3 psychologists from my clinic began providing CBT services to that community. The hospital also requested funding for me to visit the community 4 times a year and

that was also granted under the Northern & Isolation Travel Assistance Outreach Program (NITAOP). I have now visited the community twice.

On the last visit, September 19-21, 2007, I spoke with a locum physician from Hazelton, BC. Hazelton is a community in Gitksan territory and also has a United Church hospital. That physician said that there were no psychiatric services in Hazelton and that the extended communities of the Gitksan were experiencing four or five completed suicides each month. I was later to quote him in speaking to Noninsured Health Benefits (NIHB) with regard to travel costs for a Hazelton patient to visit my North Vancouver clinic. Shortly after that discussion, I received a call from the Executive Health Director of the Gitksan Health Society (Neil Belanger). He corrected my report of the suicide rate to NIHB. He said there had been only four or five completed suicides so far this year (September 2007). At his invitation, I described our work in Bella Bella and Bella Coola. I also agreed that it would be appropriate for us to extend our services into Gitksan territory.

Chris Clement and Juliana Tancre have almost immediately resolved the connectivity difficulties and Neil is now approaching First Nations and Inuit Health Branch (FNIHB) about funding for the services.

Related Development

In the process of establishing the use of the psychologists in Bella Bella, the two counselors who are resident in the community also indicated a need for supervision and support on a regular basis. They had been utilizing the services of a fly-in family physician on a monthly basis to discuss the needs of their clientele and their difficulties in meeting those needs. With the easy availability of TeleHealth, I took on those duties on a biweekly basis. This is not only less expensive for their budget but provides greater accessibility as well.

More recently, the nurse for our clinic (and my spouse) who has a special interest in weight management and diabetes prevention has begun to see patients in Bella Coola by means of

TeleHealth. She is attempting to prevent the weight gain often associated with psychiatric medications in providing one-on-one dietary education.

Some Numbers

The NITAOP fee for a traveling specialist to cover time out of office is \$1000. The airfare to either Bella Bella or Bella Coola is approximately \$500. Hotel accommodation for 3 nights is approximately \$350. Meal costs are approximately 45 dollars per day. Patients seen in the community are paid for at standard MSP rates plus 20%. Thus, the cost to the system to send me north to the Central Coast is approximately \$2000 plus my fees. The cost to go to Hazelton is that plus another \$500 extra airfare plus approximately \$200 rental car costs. On an ordinary trip, I would typically see 16 patients.

The cost for one-hour TeleHealth connection is approximately \$75.

In May of 2006, professional mental health services provided to the Central Coast were zero hours per month. That month, I began to provide 7.0 hours of service per month to Bella Bella. In November of 2006, and began to provide the same number of hours psychiatric services to Bella Coola. In March of 2007, that number increased as psychologists began to provide services to Bella Bella. In September of 2007, that number increased again as psychologists began to provide services to Bella Coola as well. In addition, I provide another 6 hours of clinical supervision to the counselors in Bella Bella.

As of the date of this dictation, we are collectively providing 76 hours per month of professional mental health services to the two Central Coast communities. That is almost 5 times the amount of treatment time that could be provided by me individually by flying in on a regular monthly basis. The cost for provision of those 76 hours is \$5,700 plus our fees. As you can tell by following the incremental increases, there is a very high demand for appropriate psychotherapeutic services in these two communities and in R&R communities throughout the North.

Highlighting the Problem

As mentioned earlier, many R&R reserve communities have high levels of sexual abuse and assault, drug and alcohol abuse, physical assault, obesity and diabetes. All of these issues are very much interconnected. Provision of only primary care health care is simply not adequate for most reserve communities. Certainly, care must be shared between specialists and family practitioners in those communities, but it is very unlikely that specialists in mental health are actually going to reside in the community. Therefore, shared care is an absolute necessity. Further, the crisis in psychiatric manpower is not going to be resolved in less than two decades. We simply cannot depend on the medical schools to train enough psychiatrists to provide levels of care that are needed now and will increase each year. Most psychiatrists will not have the appropriate training in CBT and most would like for some of their treatment responsibilities to be seconded to someone with the appropriate training. For these communities, the appropriate service providers are psychologists.

The Model

We think that we have a model that meets some of the urgent needs for mental health care in the North. In our clinic, we have myself as one psychiatrist and we will add a second part-time psychiatrist in December of this year. Both of us have particular interests in anxiety and mood disorders and both of us are familiar with collaboration with psychologists.

We have 12 Ph.D. level psychologists in the clinic, all of whom are familiar with CBT and all of whom have some First Nations interests and experience.

We have one nurse who has a special interest in weight reduction and prevention of obesity and diabetes. She also has some First Nations interests and experience.

Most of us have some experience with videoconferencing and all of us soon will have. Most of us are willing to travel intermittently to remote locations and some have done so on a regular basis.

I suggest that the appropriate model of care is one that utilizes family practitioners, psychiatrists, psychologists and nurses in a collaborative shared care endeavor. All of them need to be

appropriately funded and the results of their interventions monitored. Much of the intervention could and should be by means of videoconferencing on a regular basis. This provides not only quick accessibility to services but also continuity of care.

This model provides relatively quick consultation, real possibilities for education and -- perhaps most importantly -- actual appropriate treatment with continuity of care. The care is shared across professions and locations. So far, it appears to be working well.

30 October 2007