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Psychiatric Outreach to Underserviced Communities in British Columbia

SUMMARY

The author describes the maldistribution of psychiatric physicians in British Columbia, speculates on the causes of that phenomenon, and summarizes the response to the problem provided by the Psychiatric Outreach Program, a project sponsored jointly by the Ministry of Health and the University of British Columbia. (*Can Fam Physician* 1987; 33:1655–1657.)

RÉSUMÉ

L'auteur décrit la mauvaise distribution des médecins psychiatres en Colombie-Britannique, discute les causes de ce phénomène et résume la réponse à ce problème offerte par le Programme d'accès à la psychiatrie, projet subventionné conjointement par le Ministère de la santé et l'Université de Colombie-Britannique.

Key words: psychiatric physicians, outreach program

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ALTHOUGH THE TOTAL number of psychiatrists in British Columbia yields a ratio of about one clinician per 10,000 persons, a value generally agreed to be appropriate in terms of the provision of services, maldistribution creates a serious problem. The overwhelming majority of psychiatrists live and work in the two major centres of population, greater Vancouver and greater Victoria. A much smaller number are located in a few other medium-sized cities elsewhere in the province, and less than a handful are in solo practice in small communities.

Consequently there are many smaller towns and rural areas in this vast area that are chronically underserviced by fully trained psychiatrists. The provision of medical care for psychiatric patients in these communities accordingly becomes the responsibility of the family physicians who, without doubt, perform a great amount of primary psychiatric care in their practices. This care is often of very high quality in terms of psychotherapy and of chemotherapeutic management where indicated.

Among these patients psychiatric intervention by specialists tends to occur later rather than earlier in the course of a given episode of illness. Referral to a psychiatric specialist may involve arranging to transfer the patient to a larger centre when out-patient management in the community is ineffective or insufficient. In a large urban community such as Vancouver, a family physician may diagnose depression and immediately refer the patient to a private psychiatrist or community mental health centre. In remote areas, however, the family physician would likely elect to treat the depression with medication, counselling, or both, and would refer the patient only if these initial efforts were unsuccessful or if the patient became acutely suicidal. Similar situations arise in other branches of medicine, of course, and it is common knowledge that the range of skills employed by rural and small-town family physicians is usually broader than that of their urban colleagues.

Why is there such a maldistribution of psychiatrists? There are a number of reasons which tend to promote the advantages of urban psychiatric practice and the disadvantages of working in smaller communities.[1]

The presence of psychiatric colleagues in larger communities means that one may readily share concerns about management of individual patients. Second opinions are easy to obtain. If the psychiatrist is hospital-based, the on-call schedule is rotated among a group of practitioners. There is usually a host of community resources in the allied health professions, such as specialized substance-abuse teams; social workers with special skills relating to issues such as child abuse and marital conflict; public health nurses; and persons trained in the skills of psychological testing, not to mention all of the other types of medical specialist.

A solo psychiatrist practising alone in a smaller community cannot consult so readily with colleagues as can a psychiatrist in urban practice. Smaller-community resources are fewer and less specialized, and being on call is continuous rather than intermittent. Furthermore, arranging to leave the

community to attend courses and meetings, and to take holidays complicates management when no replacement is readily available, and specialists find it difficult to secure locums.

Apart from the obvious logistic problems cited above, psychiatrists find additional difficulty associated with what might be called the "goldfish bowl" type of social existence in smaller communities. Of course, this is true for all physicians, as well as for clergy and other professionals, in these communities, but the level of intimacy attained in psychiatric interviewing can be intense and often involves sexual and family matters. The small-community psychiatrist always has a guard up, so to speak, remaining circumspect and protecting the confidentiality of the personal lives of daily associates. In addition, she or he must be exemplary in terms of personal conduct. A restaurant meal may, in consequence, be coloured by reflection on the vicissitudes of incest in the family of the waitress. Ordering a glass of beer may be inhibited by the presence of a fellow at the next table with whom one has just concluded a session of alcohol counselling. The anonymity conferred by residing in a larger population centre allows the clinician to separate his or her professional life more easily from social existence.

To be sure, there are a handful of psychiatrists in the province who cherish the advantages of working in smaller communities. For them the disadvantages just mentioned do not amount to a significant deterrent. It would seem, however, that the great majority of my colleagues prefer the benefits and amenities of an urban practice, and, in consequence, the smaller communities and rural areas have been and remain seriously underserviced in psychiatric medicine.

Some suggestion has been made that the present Government of British Columbia may try to redress this problem by restricting billing numbers, thus preventing doctors from working in the community of their choice. Such restriction represents a very controversial and heavy-handed political approach to a complex problem, and one which has caused much resentment and litigation. How the future will unfold in regard to this issue remains to be seen.

The problem of maldistribution of psychiatric and other medical manpower is not unique to British Columbia. Other Canadian provinces, American and Australian states, and countries such as Sweden have experienced similar difficulties.[2–4] A unique aspect of the problem may be the way in which it has been addressed in British Columbia: the Psychiatric Outreach Programme is a combined effort funded by the Ministry of Health and administered by the Department of Psychiatry of the University of British Columbia. For the past 11 years this collaborative program has enabled urban psychiatrists to travel on a regular basis into interior areas of the province as consultants to family physicians.

Each of the four major teaching hospitals in Vancouver is associated with a geographic region in need of this type of service. St. Paul's Hospital, for example, is linked with the Cariboo district of the central interior. There are two major population centres, Williams Lake and Quesnel, each with about 10,000 residents and drawing on districts with about twice that number of people. These communities are centres for the ranching and forestry industries; each is served by a community hospital, a provincial mental health centre, and social service agencies.

Two staff psychiatrists from St. Paul's Hospital visit each of these communities on a monthly basis year-round, taking turns so that each clinician makes six visits yearly. When possible, residents are encouraged to accompany the clinician to broaden the training program and, it is hoped, to tempt someone eventually to seek a career in one of these communities. Travel expenses are fully paid for by the medical services plan, along with travel-time sessional payments and regular consultation fees for the patients assessed.

Referrals from family physicians are co-ordinated by the mental health centres in each community, appointments are booked for patients at the centres, and the visiting psychiatrists usually spend a very busy day engaged in a series of consultations with new patients. Collateral information about the patients' medical and psychiatric history is usually made available in a detailed referral letter from the family physicians, from files in the mental health centre if the patient is already registered there, or from both sources. The purpose of the consultation is diagnostic clarification, review and adjustment of prescribed medication if necessary, identification of psychological factors important in planning counselling and psychotherapy, and suggestions for organizing whatever follow-up is appropriate and available locally.

At times, arrangements must be made to transfer a patient to an in-patient unit at St. Paul's Hospital in Vancouver. In this circumstance, as the Cariboo region is defined as part of the St. Paul's catchment area, admission can be expedited with minimal delay, particularly if the situation is emergent. The government air-ambulance service may be used to convey to Vancouver patients who are judged to be dangerous to themselves or to others and who are in need of psychiatric admission on an "involuntary" basis under the *Mental Health Act*.

If situations requiring immediate consultation or possible admission arise when there is no outreach psychiatrist on the local scene, arrangements are readily made by telephone, for the family physicians in the communities come to know their psychiatric colleagues at St. Paul's Hospital, and telephone consultation about difficult patients is always available 24 hours a day, seven days a week.

When in the communities, outreach psychiatrists usually interview the referred patients at the mental health centre. The staff of each centre includes a psychiatric social worker (MSW), a clinical psychologist (PhD), and a nurse, and sometimes other allied health professionals as well. These support persons are routinely involved with follow-up in the community, both for out-patients and for in-patients, after their discharge from St. Paul's and their return home. They enjoy excellent working relationships with the family physicians in the communities, and are also available for psychiatric assessment when the outreach psychiatrist is not available.

The outreach psychiatrists are granted courtesy-staff privileges at the community hospitals in each location, and thus assessment of patients in the hospital is also part of the service. Other sites of activity are intermediate- and extended-care facilities, psychiatric boarding homes, and the RCMP lock-ups.

One unusual facility is an operating cattle ranch which is a licensed psychiatric boarding home. Young chronic male patients may fit into this setting, following a sojourn at the provincial mental hospital. The ranch is in an idyllic but remote location, and a combination of healthy living, hard work, prescribed medication as required, absence of alcohol and street drugs, supervision by a family physician, and periodic consultation with an outreach psychiatrist has led to some encouraging results in achieving social stability in the face of chronic illness such as schizophrenia. Although problems in management occur at times, such a facility shows promise for providing a model therapeutic community.

In addition to the direct clinical work, the outreach psychiatrists participate in other ways during their visits. Over the years I have been a panelist at a community meeting on depression (with an audience of 200!), prepared teaching tapes on psychopharmacology for mental health workers, spoken to the local Rotary Club on mental health, and on numerous occasions presented a topic at hospital rounds.

Other teaching hospitals associated with the University of British Columbia have similar programs in place, addressing the needs of the North Coast and the Queen Charolotte Islands, the Peace River District,[5] and the Kootenays. As there seems to be little likelihood of psychiatrists electing to live and practice in these areas in the near future, we believe that the present psychiatric outreach program is at least a reasonably successful alternative, since it provides regular psychiatric consultation services to under-serviced regions of this vast province.

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