When proper health care is far, far away

JUNE 4, 2012

As health-care workers who deal with psychiatric emergency cases, we see patients from Quebec's remote northern regions who are transferred south to Montreal for treatment. A striking difference between these patients and the rest of the Quebec population is the dearth of health services in their home communities.

This was the case of one man in his late 20s who initially arrived inebriated at a hospital in Nunavik, with thoughts of suicide and homicide. In order to receive the necessary and appropriate psychiatric care, he then had to travel 1,100 kilometres to a Montreal hospital.

When interviewed by our psychiatric emergency team, he was reluctant to speak to us, and maintained that he only had these ideas because of his intoxication. He expressed a desire to stop drinking but added that he had refused the help that was available to him back home due to concern about confidentiality. All too often therapists and patients know each other socially in small remote communities.

After several days in the emergency room and then in a Montreal crisis centre, the man was discharged back to his home in Nunavik. A few weeks later, he killed a man and then committed suicide.

This came as an immense shock to the entire medical team involved in his care. Many of us were left with a similar thought: "This probably would not have happened if he had been from another region of Quebec with easier access to appropriate care."

There are many reasons for lack of access to health care among remote populations, including issues involving logistics, resources, political will and history. One important variable linked to all these reasons is money. Healthcare spending on aboriginals under the Non-Insured Health Benefits program is $1,215 per capita, compared with per-capita health-care spending of $5,096 for residents of Quebec and $5,614 for other Canadians.

The NIHB program covers First Nations and Inuit people in Canada who have recognized bureaucratic status as aboriginal persons, which by no means includes all aboriginals. The largest areas covered under the NIHB are pharmacy (42.9 per cent of spending), dentistry (21 per cent) and medical transportation (30.3 per cent). The "Other Health Care" category is mainly short-term crisis intervention and mental-health counselling, which has undergone a funding decrease of 3.5 per cent over the past fiscal year.

Some communities receive additional treaty money for health care, money that is used to cover the costs of running a hospital. Many community-based health projects, including counselling for public health, detoxification centres and suicide prevention, are funded by grants or other agencies such as the National Aboriginal Health Organization, which has had its funding cut completely and will close down this summer. The Assembly of First Nations, which provides support to other organizations for health-care provision, saw transfers from Health Canada decline 40 per cent this year.

There are no easy solutions when it comes to delivering appropriate mental-health care in remote communities. Nonetheless, examples of successful interventions exist, and guidelines can also be borrowed from the humanitarian sector. For example, the World Health Organization suggests an intervention pyramid with a broad base of basic security and social services. Building up from that base, the WHO recommends strengthening community and social networks and non-specialized supports – and then after that, working to develop more specialized services. A successful example is a program in New South Wales, Australia, that trains and employs aboriginal people to work as care providers.

In a parallel vein, today's communications technology could be used for the development of tele-health programs, by which mental-health patients and care providers could be linked across distances and specialized care be made more affordable and accessible. Tele-health may be one solution to the problem of health-care access in Quebec's northern remote regions – and more specifically to the problem of confidentiality.

Our patient's story was, sadly, not unique. Immediate action is needed to improve the delivery of mental-health services in remote communities. As we have been profoundly sad to discover, there is too much potential for human tragedy when access to these services is not available

The authors:Julia Dornik, Nisrine Masrouha, Katerina Nikolitch, Melissa Pickles and Lorin J. Young are resident physicians at the McGill University Health Centre and members of the Montreal chapter of Physicians for Human Rights (physiciansforhumanrights.org).