

The View from Here: Perspectives on Rural & Northern Psychology

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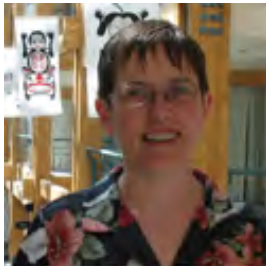
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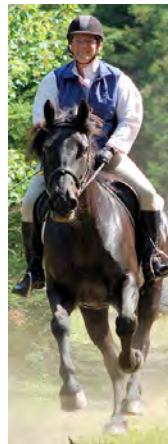
Dr. Judi Malone: Chair



Dr. Cindy Hardy: Chair Elect



Dr. Karen Dyck: Past Chair



Dr. Shelley Goodwin: Secretary-
Treasurer



Laura Armstrong
(Resident): Newsletter
Editor

Jeffrey Ansloos (Resident): Student
Representative





Greetings to our section members. This is my first column as chair and I want to begin by thanking the membership for this opportunity to serve you. I am a longstanding member of the Rural & Northern Section of CPA & am enthusiastic about rural & northern practice issues within the larger scope of Canadian psychology.

As a regular contributor to The View from Here, many of you already know me as a rural practitioner, university educator, and researcher in rural practice, professional ethics, and collaboration both in Canada and in Australia (I call north eastern Alberta home).

This term has been active and rewarding for our new executive which includes Cindy Hardy (Chair-Elect), Karen Dyck (past-Chair), Shelley Goodwin (Secretary/Treasurer), & Jeffrey Ansloos (Student Rep) in addition to Laura Armstrong, our newsletter editor. A primary task for this year has been the establishment of an Ad Hoc Student Representative Committee & we are working with Jeffrey, your student representative, to complete this objective. Other key collaborations have included:

- Preparing scenarios for an evidence based treatment from a rural & northern perspective.
- Preparing a formal response to the Ethics Committee of CPA in relation to their revision of the Code of Ethics for psychologists.

- Collaborating with the CEO, Practice Directorate, & Government Relations officers of CPA to advocate for the inclusion of psychologists in the federal loan waiver program (CanLearn) for medical professionals.
- Identifying & planning for an ideal section keynote speaker, section business meeting, & reception for CPA 2013 in Quebec city – I look forward to seeing you there.
- Beginning collaborations & communication with the Counselling & Community Psychology Sections for future invited section speakers.
- Working with CPA to enhance our listserv capabilities & institute technological improvements.
- Completing two fact sheet reviews by collating feedback from our members.

Thank you all for responding to requests for participation on our listserv. We have been active as a group & the ongoing contributions of each of you do well to represent our section.

Look for an update on our advocacy efforts in the winter edition of Psynopsis as there are plans to publish the response we received from the Honorable Leona Aglukkaq Minister of Health and Minister of the Canadian Northern Economic Development Agency. Together we can ensure that psychology is seen as a key aspect of health, particularly for rural & northern populations.

Stay in touch and stay active. We are here to represent your needs within CPA.

Dr. Judi L Malone
Registered Psychologist (AB, AUS)
Chair, Rural & Northern Section



A few months back the news media saturated us with stories about hunger strikes, alleged financial mismanagement, and Idle No More gatherings. Since then, four important legal decisions concerning Aboriginal people's¹ rights in Canada were released and received surprisingly little media attention. As a result of the media's selective attention, many good people remain poorly informed and perhaps blissfully unaware of the ongoing injustices perpetrated against the Aboriginal people of Canada. As psychologists working and living in rural and northern Canada, we can play a role in furthering social justice, but only if we ourselves are well-informed. To that end, this article summarizes recent legal decisions that you might not have heard about in the media. These decisions highlight the federal government's substandard treatment of the Aboriginal people of Canada over the last 150 years.

On Jan. 8, 2013, a trial judge in Federal Court of Canada ruled that Métis and non-status Indians are "Indians" under s.91 (24) of the *Constitution Act of 1867*. This means the federal government has exclusive legislative authority and settles the debate over the level of government (federal or provincial) that has legislative authority for Métis and non-status Indians. In their claim, the plaintiffs wrote "because of the federal government's refusal to recognize Métis and non-status Indians as Indians..., they have suffered deprivations and discrimination in the nature of: lack of access to health care, education and other benefits available to status Indians; lack of access to material and cultural benefits; being subjected to criminal prosecutions for exercising Aboriginal rights to hunt, trap, fish and gather on public lands; and being deprived of federal government negotiations on matters of Aboriginal rights and agreements." The trial judge did not decide two additional questions having to do with the federal government's fiduciary duty to Métis and non-status Indians and their right to consultation and negotiation, leaving those questions for future debate. <http://cas-ncr-nter03.cas-satj.gc.ca/rss/T-2172->

[99%20reasons%20jan-8-2013%20ENG.pdf; http://www.metisnation.ca/wp-content/uploads/2013/02/Daniels-Plainspeak-FINAL-REVISED.pdf](http://www.metisnation.ca/wp-content/uploads/2013/02/Daniels-Plainspeak-FINAL-REVISED.pdf)

On March 8, 2013, the Supreme Court of Canada ruled that Canada had not upheld promises made to the Métis people in the Manitoba Act of 1870 and had not acted in accordance with "the honour of the crown" in its implementation of land grant provisions of the Act. <http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/12888/index.do>

On March 11, 2013, the Federal Court of Appeal ruled against the federal government's argument that a case against it should be thrown out. The case is brought against Canada by the First Nations Child and Family Caring Society, the Assembly of First Nations, Chiefs of Ontario, and Amnesty International. The complainants allege that the Canadian government has discriminated against First Nations children living on reserve by underfunding child welfare services provided on reserve. The Federal Court of Appeal found that the federal government cannot hide behind a technicality; with this decision the human rights case will now be heard by the federal human rights tribunal. The hearings are being live-streamed; see <http://aptn.ca/pages/news/tag/kids-in-care/>. See also <http://ccla.org/2013/03/11/federal-court-of-appeal-rules-in-favour-of-allowing-human-rights-complaint-to-proceed/>; <http://www.fncaringsociety.ca/i-am-witness>

On April 4, 2013, the Federal Court of Canada ruled that Canada must adhere to Jordan's Principle in respect to the care of Aboriginal children living on reserve. Jordan was a child who died in hospital at age 5 years, never having lived at home with his family, while the federal government argued with the province of Manitoba about who should pay for his health care. In 2007, the House of Parliament voted in favour of adhering to Jordan's Principle, which states that the government of first contact should provide services so children and families

do not suffer while governments fight over who is responsible for paying for services. In the current case, the government of Canada argued that it would not reimburse the Pictou Landing Band for the costs of caring for Jeremy, a severely disabled teen who had been cared for by his mother until she developed her own health problems. After Jeremy's mother became ill, the band paid for the care Jeremy needed and subsequently sought reimbursement from the federal government. Canada refused to pay for those services, even though the services would have been provided to other children in Nova Scotia. Canada's position was that Jeremy should be placed in institutional care, far away from his home and at much greater cost than in-home care. With the court's ruling of April 2013, the federal government is being told it must adhere to Jordan's Principle.

<http://www.fncaringsociety.com/sites/default/files/Ruling-%20Fed%20Court%20Beadle%20and%20Pictou%20Landing%20FN.pdf>;
<http://www.afn.ca/index.php/en/news-media/latest-news/afn-welcomes-fed-court-decision-on-application-of-jordans-principle>

You might be wondering how this relates to our work as psychologists. To me, the connections are obvious. In my practice, classes, and research I meet people who have experienced the realities of growing up "Indian" in Canada. I have also met the oppressor, the colonizer. As psychologists we must strive to recognize the ways in which we can oppress people (for example, by labeling or marginalizing). Think about our code of ethics. We hold the principle of autonomy as a core ethical value, yet many of us accept without questioning the fact that our government limits the rights of individuals to identify as belonging to a particular family, clan, band, or piece of land as their ancestors have done for thousands of years. On ethical grounds alone, psychologists should be taking action to end the injustice and promote autonomy for all Canadians.

Here are some meaningful actions we can take as individuals, ranging from easy to hard:

- Become informed. Learn about the issues.
- Start discussions about the issues and encourage others to become informed.
- Challenge myths and prejudices when you hear them espoused by others.
- Be an active witness - if you see injustice, name it.

Finally, this is a call for collective action. As psychologists living and working in rural and northern Canada, we must take a stand against the injustice perpetrated against the Aboriginal people of Canada and work towards ending it. In South Africa, psychologists worked against the oppressive influence of apartheid. It is time to do something similar here in Canada, to work collectively against the oppression of Aboriginal people. If you have ideas for individual or collective action against injustice, please contact me, cindy.hardy@unbc.ca. I will collate any ideas that come forward and update everyone in the next newsletter.

Footnote:

¹ Aboriginal people is a collective term used to refer to all indigenous people of Canada, including status and non-status First Nations, Inuit, and Métis people.





I completed my pre-doctoral internship in clinical psychology with the Department of Clinical Health Psychology, Faculty of Medicine, University of Manitoba in August 2012. I was in the Northern stream of the program thus I completed the last six months of residency in Thompson, Manitoba. I was part of the Northern Regional Health Authority (NRHA) Mental Health Consultation Team. Overall, I would describe my Northern resident experience as enriching and valuable as it contributed immensely to my development as a professional and human being in general.

One of the most important professional experiences I had in Thompson was learning to work within a clinical model where consultation with other health professionals was the norm. I worked closely with members from diverse disciplines (e.g., community mental health workers, nursing) to assist with client care. Our working relationships were open and collaborative, and learning was bidirectional. I soon realized that a large part of my professional role was learning to connect with front-line health professionals who worked therapeutically with clients, and strategized with them how best to address clients' presenting problems and/or work through challenges that arise during our own clinical work.

I also appreciated the importance of practicing within a generalist framework (although I was aware of that requirement prior to arriving in Thompson, it was much different seeing oneself in practice). In light of the small number of clinical psychologists in the region who could provide services to address the mental health needs of Northern residents, it was essential to have foundational knowledge and skills in core areas of clinical practice (e.g., assessment, therapy), as well as flexibility, to work therapeutically with clients across the life span (i.e., children, adolescents and their families, and adults) who were from diverse cultural backgrounds and who struggled with a range of mental health and psychosocial issues. I was experiencing a constant cognitive shift. I was accessing learned material and skills from my first half of residency, transferring knowledge and skills learned in one area to another, and accessing professional connections I had developed in Winnipeg (e.g., clinical supervisors) to help me navigate within specialized areas of practice. I found these experiences both challenging and rewarding. Neither my supervisor nor I had the unrealistic expectation that I needed to know everything. In fact, taking initiative by learning where to access the necessary information and building on your knowledge, as well as consulting with your colleagues were key aspects of the clinical work.

Moreover, I had the opportunity to travel to an outside Northern community, following their invitation to have people from the NRHA come to the reserve, to provide mental health education. Although we were unable to deliver this educational session upon our arrival (due to a scheduling error), we were taken around the community and had the opportunity to converse with a community member about the

strengths and struggles of their community. Not only was I learning about the history, resilience and current needs of the community, but I also saw our connection as a step to future collaboration between our communities. In fact, I had a telephone conversation with the same community member, a few weeks before my residency ended, about the possibility of us returning to their community to deliver a mental health presentation.

Focusing on the quality of my professional relationships in Thompson, members of the mental health team were approachable, supportive, and receptive to my ideas. Thus, I felt welcomed and part of the team. I often encountered team members (and clients) outside the workplace, which it was a small adjustment for me as I perceived my work and personal lives intermingling. At the beginning, I was slightly concerned about how to be professional “at all times” and set reasonable boundaries. I started feeling more comfortable about being myself outside the workplace upon discussing my initial concern with my supervisor and interacting with team members in the community. It was important for me to understand and appreciate the interconnectedness of the community, as it was part of the Northern experience.

Lastly, there were times, particularly in the first couple of months, I felt somewhat isolated in Thompson. But, I was able to establish valuable interpersonal connections over time and engage in social activities I enjoyed in the past (e.g., taking zumba classes). I also visited different lakes and parks in the surrounding areas, which were beautiful and breathtaking. I enjoyed the peacefulness of fishing and caught my first fish at Paint Lake! My partner and I also went hiking and swimming in the lake. So,

although it was initially challenging to feel connected to the community, I was able to build social relationships and appreciate the beauty of the North.

Altogether, I enjoyed my residency experience in Thompson. I would encourage other clinical psychology trainees to work clinically in Northern communities. The Northern experience will provide trainees with unique professional challenges, with an appreciation for the strengths and needs of Northern communities, as well as with the necessary breadth of training to feel competent in clinical practice.



Driving through Haliburton County's scenic back-roads often inspires a sense of awe from the natural marriage of rock and water, with imposing high vistas providing a bird's eye view of a truly beautiful area of the province, spanning from the northern Kawartha Lakes to the tip of Algonquin Park. Alongside this beautiful aesthetic is a remarkably robust and resilient system of care which reaches out to people in need, from a rural perspective that is both challenging and unique.

In my role as a Short Term Case Manager with the Four County Crisis Program in Haliburton County, I generally provide 10 weeks of support in the community for people who have self-identified as being in a crisis situation. That wide criterion of need brings me into contact with all walks of life; those with serious and persistent mental health conditions, those who are experiencing a situational crisis, and indeed as is very often the case, a blend of both.

Haliburton County is both vast and under-served, at least through the conventional lens of what is typically considered to be an infrastructure of care. While this certainly presents some challenges, I have also witnessed the residents' unique resilience and sense of community, which can often offset some of the more formidable barriers to service. The lack of transportation is often maligned as an impediment to access many of the "local" resources; often, my clients will need to travel 1.5 hours in order to access our nearest Schedule One Mental Health Unit. Methadone treatment is accessed by many individuals in the county, yet we lack a local clinic which often means four hour round-trips to Peterborough, Lindsay or Orillia. Likewise, many court services are offered out of the county which often

complicates an already stressful experience for an individual in crisis.

This isolation puts pressure on our Human Service systems and in turn informs and creates unique solutions. Often, I am helping my clients tap into an elaborate informal network of support; service clubs, church groups, private citizens and charitable organizations. Where this network interfaces with more formal supports such as hospitals, police and probation, and social services, it often does so with less bureaucracy and gate-keeping than I have experienced in larger urban centres. Thus, a "Day in the Life" of this writer can be a very unconventional series of events. I often find myself brokering deals and advocating in ways that I'm quite sure my urban counterparts would find somewhere along the continuum from hilarious to incredulous.

While most of my days begin at my office in Minden, I am frequently called out to schools, hospitals, offices, unheated cabins, luxurious summer homes, tents on Crown Land, winterized trailers, and elegant country farms. Some of my clients have been raised under the cascading effects of poverty and struggle to make ends meet, while others are escaping the frenetic pace of the city and have failed to find the solace that The Cottage had promised them. I also meet clients at my office, which is co-located with Haliburton Highlands Mental Health Services. I feel that this integration between my employer in Peterborough and the local Mental Health provider has provided a flexible and supportive backbone for service which is truly unique and could be seen as a model for collaboration.

The great challenge (and subsequent joy) of this position, is the possibility of creating services where none previously existed. Wrapped up in

the front-line slogging of assessments, advocacy, and the inherent roller-coaster of Crisis, there is a hidden opportunity to practice an intuitive mode of Community Development. Lacking a homeless shelter, I have been able to work with an informal network of seasonal cottage proprietors, motels and private citizens. Lacking public transportation, I look for creative ways to massage systems and create elasticity in the mandates of other organizations, with the understanding of reciprocity. Interpreting our "Poverty of resources" as a potential strength is more than wishful thinking; it is quite simply 'how things get done up here'.



Joining us in Quebec City for the 2013 Convention?

It has been a banner year for submissions and is shaping up to be a great conference in a beautiful location. Here are the section highlights to keep in mind:

Thursday

4:00 – 5:00 pm 201C Centre 40 Hollow SQ

Rural & Northern Section AGM

Everyone is welcome. Join us for our section business meeting, brainstorm ideas for the upcoming year, and meet your executive. We are considering having Skype-Based participation (or another electronic format) for members unable to attend in person. If you are interested, please let me know at judim@athabasca.ca

5:00 – 6:00 Same Room

Rural & Northern Section Reception

Join us for refreshments and excellent company. This is an ideal time to meet your colleagues from across the country. Last year we had terrific fun and know the same will hold true at this year's gathering.

Friday

12:30 – 1:30 200C QC Convention Centre 700 Theatre

Rural & Northern Section Keynote

Pierrette Desrosiers "Une Psychoch dans le Champ"

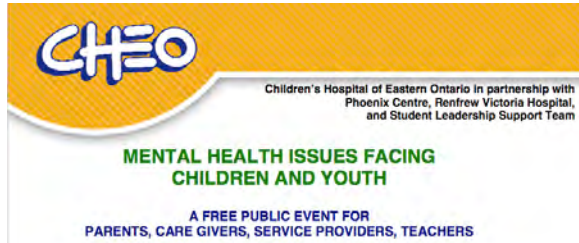
We are lucky to have an imminent rural Canadian psychologist share her story with us as this year's section keynote. Pierrette is a national and international expert and keynote speaker and is Quebécoise. Check out her website at <http://www.pierrettedesrosiers.com/> or in English at http://www.pierrettedesrosiers.com/index_en.html This presentation will be in French.

Although the schedule isn't officially finalized yet we wanted you to be able to pencil in these exciting opportunities. I look forward to seeing you there!

Judi

Section Chair





What is the overall goal of CHEO's mental health information night program in small communities?

I think our goal of reaching out to smaller communities is to recognize that youth and their parents face many of the same challenges that are seen in bigger cities, but may not feel that they have the same resources to deal with them. We're trying to bring some of those resources to them, at least in the form of some information, and acknowledge that they're dealing with some of these same issues. We also hope that by talking about some of these issues, we can head off some of the difficulties by offering suggestions before the issues get to be too great; and in those instances in which families are dealing with significant mental illness, we can work to challenge the stigma that may be there. It might sound hoakie, but we actually believe in it.

How might this information be of particular benefit for the smaller communities in which it is presented, in comparison to larger communities?

In larger communities, they may have had an opportunity to hear this information before, with CHEO having offered a number of similar presentations, either as a group such as our psychology department, or from individuals presenting to parent councils at local schools. But CHEO also is responsible for far more than just the City of Ottawa, and we want to respect that commitment by reaching out to communities that may not get to see us as

often. As mentioned earlier, last year our psychology department presented in Cornwall, CHEO participated in a roundtable discussion on mental health in Pembroke, and this year we're in Renfrew. We also reach out to smaller communities through our telepsychiatry program, but it's nice when we actually get to get out to them in person.

How are specific topics chosen for presentation in a community? Do the mental health topics presented change depending on the community or are the presentations consistent across communities?

Our patients come from cities, towns, and rural areas, as well as the north. Topics chosen are really based on what we've heard parents asking about when their children and youth have been treated as outpatients or admitted, but they tend to be fairly consistent across communities. If we had a specific request from a community, of course we would work to accommodate that.



Group therapy is frequently presented as an empirically sound practice for many disorders. Yet, this research does not suggest how to structure group therapy if you live in a rural and northern area and are in private practice? While there are many resources on how to develop a therapy group, the ones I have researched recommend small group sizes (4-6 clients) and 4 to 8 sessions. Additionally they suggest two clinicians if the group is over 7 clients. These guidelines seem geared to public practice where the need to generate income is not a concern for the salaried psychologist.

I am interested in hearing how other rural psychologists take on this challenge. How do you organize a group? Do you hold the group in the community or in your office? What number do you aim for to allow for sufficient numbers to generate an income for you while making the cost of the group affordable to both those with and without insurance? Do you aim for your hourly rate to fit within the provincially recommended rate? At what number of clients do you have a second therapist? Or maybe the bigger question I am asking is how do you make groups viable in private practice while providing EBT for a reasonable price for the clients and allowing the psychologist to make a living.

Shelley Goodwin Ph.D.

Survey: Practice Variables and Professional Satisfaction of Psychologists in Urban, Rural, Northern, and Remote Canada

Help us understand the nature of Canadian psychological practice. Drs. Karen Dyck (University of Manitoba), Judi Malone (University of Athabasca), and Cindy Hardy (University of Northern British Columbia) are engaged in a national survey exploring professional satisfaction and issues of recruitment and retention. We are looking for psychologists from across Canada and from every area of practice. If you are a licensed/registered psychologist, help us to increase our understanding of practice variables by participating in this online survey co-sponsored by the Canadian Psychological Association.

Survey link:

<http://web2.cpa.ca/membersurveys/index.php?sid=69648&lang=en>

