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APERCEVOIR: THE PEOPLE OF CHILD AND ADOLESCENT PSYCHIATRY

Dr. Pippa Moss Interviewed by Dr. Alice Charach

Dr. Philippa ("Pippa") Moss is a child and adolescent psychiatrist based in Nova Scotia. She is an assistant professor in the Department of Psychiatry at Dalhousie University and a consultant to Colchester East Hants, Cumberland, Pictou and Cape Breton Health Districts within Nova Scotia

Alice Charach (AC): I remember a conversation with you from many years ago at a CACAP annual meeting. And when Lind Grant-Oyeye, editor for JAACAP, suggested interviewing a rural psychiatrist for this column, I thought of you. So, I would like to find out more about your story, how you decided to go into psychiatry, particularly child and adolescent psychiatry, and of working in rural Nova Scotia.

Pippa Moss (PM): I don't know where to start. I guess my story starts in childhood. I had the odd experience of growing up all around the world; I had to learn to fit into different cultures, as my family moved a lot due to my father's career as a naval officer. When my parents moved to Scotland, I went off to an all-girls boarding school at age 13, as the Scottish school system was incompatible with British examinations that I would have to take at 16. I had decided to be a family doctor, so I tried to go to medical school, but I required more sciences, as these were not exactly encouraged at a girl's school. So, I completed extra courses in the equivalent of grade 11 and 12 in one year, as the only girl at an all-boys school run by monks in Gibraltar, where my family had moved.

I got into medical school at University College London and did a couple of general practice placements. I then realized that what I really wanted to do was to work with children and families where the children had developmental delays, or what we used to call mental handicap. I started my general psychiatry training at St. Thomas' Hospital, London, England. I met my husband. And his family came to Canada and kept asking us when we were going to join them. So, as I didn't believe in divorce, I agreed to join my husband and his family in Nova Scotia. I agreed to 5 years and now we have been here 40. After I arrived, I was told quite firmly that developmental delays were considered a psychosocial difficulty here, rather than a medical problem, and that I had to retrain in psychiatry at Dalhousie University in Halifax. I chose child psychiatry as the best match as I wanted to work with families and in the community, rather than seeing individual patients in my office. Working with children with developmental delays, there was an emphasis on building inter-disciplinary teams and building resources in the community. At the time, in the 1980s, everyone was working hard to get children with handicaps and older people out of large institutions.

AC: What is it like to practice in rural Nova Scotia, what drew you to this area of practice?

PM: That was where the need, and my husband, was. The lovely thing about rural psychiatry is there is nobody there, so you get to develop a service from the ground up. Originally, I was 'it,' along with one psychologist. And then we got a second psychologist. Child psychiatry was a bit of a quantum phenomenon, either you had one, or you didn't. One of the early things we did was get together with Dr. de Boer in the northern zone, and we tried to pull together a regional service and share our resources to improve access. There was this situation where if a child lived on the wrong side of the street, due to zone boundaries, they couldn't get the service. My attitude was always let's see what we can do to get the job done for the problem in front of us.

AC: So, from the early days, you were a program developer, service planner, and pulling resources together. What about now?

PM: Fast forward to 2022. So that is what one does as a rural psychiatrist, building programs and pulling together services. Now I spend some time seeing patients individually, a lot of time in case conferences, a lot of indirect care, and team building. For example, these days I am working a lot with school services and family doctors to develop services for children with uncomplicated ADHD.

AC: Knowing what you know now, if you were mentoring a younger version of yourself, what advice or cautions would you give yourself?

PM: Be more patient. Just because you can see what is the best thing to do, doesn't mean it is going to happen. You have to start thinking in decades, not years. My desire to see things fixed got me into difficulty, as I would take on more and get swamped. Then I would have to step back. Now I can often deputize. I now am thinking about how you handover at the end, so that the work you have done doesn't disappear. I have to make it so it is not a "Pippa approach" but a well-functioning team that can be there without me. How do I now transition so others can take over and the team can keep going. This is not always good for your ego. But it works. It is kinda nice, they don't need me anymore.

AC: What advice do you have for the more recent you?

PM: The more recent me. I have experienced quite a lot of changes in the past year. Last year, my husband got ill and I had to take time off. This gave me time when I had to stop and think. It worked out really well for me, as I had time to reflect on how I was going to deal with my next stage of life. I came back to work part-time.

AC: How did the team do in your absence?

PM: They did fine. I am so lucky. I work with an incredible interdisciplinary team, a wonderful psychologist and excellent social workers, and a really good team of colleagues, child psychiatrists in the northern zone of Nova Scotia. I have their back and they have my back.

AC: Tell me a bit more about your clinical experience in Canada and working in rural areas.

PM: Early on, I spent my time explaining what I do, that they needed me to see children, not adults. Not at all unusual, at the time, for other physicians to wonder why on earth would a child need a psychiatrist? So, I realized there was a different understanding here than in Britain where I first trained.

AC: How did you continue to diminish barriers, to encourage more colleagues to join you?

PM: Not so much as how to persuade others to join me, but having to persuade the powers that be, that they really need child psychiatrists not just adult psychiatrists. You decrease the barriers as you explain what you do.

In Antigonish, where I came every couple of weeks, I asked for nurses to help. To begin with they offered nurses with backgrounds in ICU. I had to explain that Mental Health is a specialized area of expertise and educate people to refer the right patients to me for care. I spent half of my time taking children off ADHD meds, and explaining why they were not ADHD, and discussing Autism Spectrum Disorder, and Anxiety. And that is why you have to build links with community physicians, as well as links within the teams. Sometimes they called themselves a multi-disciplinary team but in actuality what might happen is that all are in a row of offices at one site, each practicing like independent practitioners. It can be hard work to build a team. Part of that is providing support (such as chocolate), and part is the political aspects; developing the personal relationships, and respecting their expertise and their disciplines as well.

AC: So you have mentioned several important points for someone starting a rural practice: be patient with explaining what is needed, attend to the political, build personal links, find like-minded people, and educate others about what you do.

PM: Yes. Leadership is quietly leading from behind and within, not running out in front with a flag to be followed.

AC: Thank you, that sounds like excellent advice. Now can you tell me about the work you were doing, and for which you were given awards, the Queen's Diamond Jubilee Medal for humanitarian work and the Rural Physician of the Year?

PM: You mean my work in Kenya?

AC: Yes, please tell me about that. Is that related to the awards?

PM: I am most honoured to have received these. The Diamond Jubilee Medal, I believe, I received as I was active in the scouting movement, and in a community group that supported our schools, and I was also involved as an early founding member of a charity, the Fundy Peace Foundation which supports the process of peace and peacebuilding in some difficult areas of the world. And for my charity work in Kenya.

AC: Tell me about your work in Kenya.

PM: I first had contact with people in Kenya in a three-month medical experience, just before doing my final exams. I spent time in Kenya at a mission hospital and that brought it home to me how privileged we are. At that time,

I sponsored a child, and each time I got a pay raise, I sponsored another child. Anyway, later I went out to visit the first student I had sponsored. At that time, when you drove around in Kenya, you would see children's homes, not schools. This was in the late 80s. I asked the person I was with about this, and he told me these homes were for the AIDS babies. That was what brought it home for me.

We set up a family for AIDS orphans and abandoned kids. Then we started a project to support girls to stay in school in Masai Mara; we supported the top students to go elsewhere for their education. And as a retirement project I am building a school.

The home and family for children with AIDS was specifically for kids with complex medical needs, such as mild CP, autism, and post -cardiac surgery, all are children who have needed extra help. I have people in Canada who volunteer to be aunties and uncles and to support these children by sending them money every month. One of the young men I originally sponsored, (when I was a teenager and he was a kid), is the father and his wife is the mother. They foster and adopt these children with complex needs.

AC: Isn't that lovely. You see the work's success over generations.

PM: The project supporting schools in Masai Mara began when we discovered that the little ones do not go to school. Instead, it is the boys, who are older and bigger, aged about 10 to 12 years and able to walk the distance, who may go. These boys sit at the back of the "baby class", as the Kenyans call the 4- and 5-year old's grade, to get their basic education. We realized the boys then returned home and were teaching the little ones under the trees.

Any girls stopped attending school as soon as their periods started because there were no sanitary towels, or toilets, and walking those distances to school they were at risk of being raped. We raised money to provide sanitary products and toilets. And we started raising money to support the top students, particularly the top girls, to further their education (beyond elementary school). And in the last few years, I have spent time building a school in an isolated area. Now, the first student we supported has completed his training, qualified as an elementary teacher, and hopefully he will work in this new school.

AC: And the award for Rural Physician of the year, 2017.

PM: I have always tried to be an integral part of the medical staff association as well as the psychiatry group in my area. I have taken on executive tasks for the medical associations and various psychiatric associations at all levels. I could not do what I do if I did not have a relationship with the many other physicians, who are the backbone of the health system, so really need the relationships with all the physicians in the area. I would suggest that if there is not a medical association in a rural area, start to build one.

AC: What keeps you going each day?

PM: I get a lot more joy out of what I do than I put in, in terms of effort. It is lovely to be a part of a well functioning team. Not long ago, I was in Canadian Tire, a mother came rushing up to me asking, "Is that Dr. Moss? I must introduce you to my son." I had seen the child at age 8 and then again as a teenager. She was so proud of him. "I never thought he would get his grade 12" she said. So, to see a family, like this mother in Canadian Tire, and hear that I had been helpful was much appreciated. I think there are loads of kids whom we see with a briefer intervention, and we do make a difference, but don't always get to know it. That is worth getting out of bed for. My mom always said that hopefully when you are about to leave this world, you know you have left the world a slightly better place.

AC: Are there any other comments you would like to make, any other points that you would like to make regarding the field of child and adolescent psychiatry? Any comments about training?

PM: I really think we have psychiatric services divided into the wrong age groups. We need young adult psychiatrists, treating from about age 15 to about age 25, maybe 30; a time when we see the development of more serious disorders, such as schizophrenia. We have a whole generation of youth falling through cracks in the system between services for youth and those for adults. This would help for covering emergency services. For younger children, we could have fewer people doing call, making more use of telephone consults. And 'young adult psychiatrists' could assist with adult call which tends to be more demanding.

However, just because something makes sense doesn't mean it happens. We keep setting up beautiful pilot projects but there is no money to keep them going. I am looking forward to the new multi-system service centers for youth promised in Nova Scotia.

The way we train is so much better now than in the past. I love the competency-based approach to education. And I would advise all trainees to take every opportunity they can to try out many different ways to practice. Find where your heart is. They are now sending students and resident out to rural areas, so that it can be familiar and not so scary to try as a new psychiatrist. Rural medicine is itself like a subspecialty, and a great one.