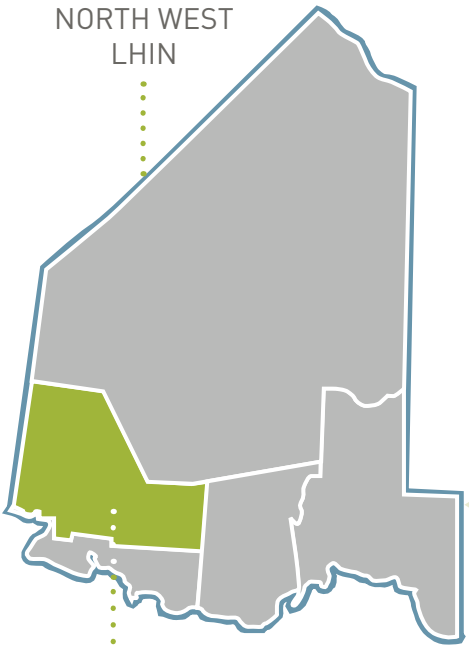
Towards a Northern Centre of Excellence for Addiction and Mental Health

Engagement Results for: **KENORA DISTRICT**

Northwestern Ontario Engagement Nov 2017 - Mar 2018 | Kenora District Engagement Sessions



KENORA DISTRICT

42 042 people | **54 108** km²

54% rural
29% Aboriginal* Identity

3 major towns, 13 First Nations

Kenora to Thunder Bay:
5.5 hours drive

(Source: Statistics Canada, 2016 Census)
*"Aboriginal" is used to reflect census terminology

1 **FACE-TO-FACE SESSION**
Kenora: Dec 2017

2 **TELECONFERENCE SESSIONS**
Rural and Remote First Nations: Dec 2017

Rural Communities: Mar 2018

2 **VIDEOCONFERENCE SESSIONS**
Northwestern Ontario WEST:
Jan 2018

Northwestern Ontario WEST 2:
Mar 2018

33 **PARTICIPANTS FROM 24 ORGANIZATIONS** serving Kenora, Dryden, Ignace, Red Lake, surrounding rural communities and 13 First Nations.

Of these, 9 participants were affiliated with Indigenous organizations and organizations serving Indigenous people

SECTORS
Addiction, Mental Health, Social Services, Housing, Education, Public Health, Health Administration, Hospital, Justice, Peer Support

ROLES
Front-line workers and Managers in Indigenous-specific and non-Indigenous organizations, including Social Workers, Police, Counsellors, School Guidance Counsellors, Community Leaders, Outreach Workers, People with Lived Experience, Policy Makers

INSIDE:

- What are the mental health and addiction priorities in Kenora District?
- How could a Northern Centre of Excellence for Addiction and Mental Health help?
- What should a Centre of Excellence for Northwestern Ontario look like?

A Priority Mental Health & Addiction Issues -- Kenora District

1. EMERGING TRENDS

- **Opioid** use has declined compared to 5 years ago; however, Red Lake has had few new people and Kenora has seen an increase
- **Alcohol** continues to be main issue in most places but more using alcohol with other drugs (e.g. **crystal methamphetamine**, **cannabis**, or **cocaine**)
- **Dual diagnosis** seen in up to 50% of clients; more developmental delays and fetal alcohol spectrum disorders; assessment **waitlist** up to 18 months
- High prevalence of **anxiety** among **children and youth**; more young girls "**cutting** as a coping tool"
- **Suicides** have increased significantly in some places; links seen between suicides, multigenerational addiction, family breakdowns and **unemployment**

2. LIMITED LOCAL ADDICTION AND MENTAL HEALTH SERVICES

- **Physician shortages** mean that referrals are difficult; "without physician, you can wait up to 12 hours for prescription refill in emergency room"
- Few inpatient detox or mental health beds available **locally**; if unavailable, must refer to Thunder Bay; if transportation delay, bed may be closed
- No **family-oriented** addiction treatment centre; barrier for women with children, who must arrange for **childcare**
- Specialist care via videoconference is difficult to access because internet is unavailable or unreliable
- **Waitlists** long: for counselling, 12 months; for residential treatment, 7 months; "services need to be available when people are ready or they may not go"
- Consequences can be serious: "this morning... an individual passed on because there was no **access** to primary care to get him into addiction treatment"

3. POOR COORDINATION OF CARE AND UNCLEAR CARE PATHWAYS

- Barriers in system prevent provision of **quality care**, as focus is on crises, not on prevention or recovery: clients "need services across the continuum"
- Complicated referral and intake processes; takes up to 2 years for staff to learn the **complex pathways of care**
- **Service silos**, reflected in separation between mental health and addiction services, causes discontinuity: multiple intakes, referrals, and consents required

4. WORKFORCE ISSUES

- **Recruitment** and **retention** issues, hard to find qualified staff to fill positions in north where cost of living is higher and salaries not competitive
- **Training** opportunities are limited; only basic mental health and addiction training is available online (e.g. CAMH)
- Training staff outside the community is **expensive**: organizations don't have the budgets to send staff to Toronto for specialized training, nor the funds to pay for replacement workers when staff are away
- Work-life balance is difficult; increased caseloads and more complex demands cause ongoing **staff stress**

5. MEETING NEEDS OF INDIGENOUS CLIENTS

- Indigenous clients are 40-50% caseload for agencies off-reserve; however, there are few Indigenous organizations delivering services off-reserve
- Indigenous Elders who enter long-term care often find that the experience triggers residential school histories; new strategies are required to address their needs through provision of **culturally supportive care**
- Indigenous youth who leave remote communities to attend high school in towns lack family support; while schools provide counselling, they have care gaps when at home
- Service providers need education about **historical trauma** and generational effects and "how families were destroyed during **opioid crisis**"

6. MEETING THE NEEDS OF YOUTH

- Parents need to know how to identify mental health and addiction issues in their children; challenging when those parents struggle with their own mental health and addiction issues
- **School system** struggles to meet the needs of children with mental health issues; e.g. only one counsellor for 1200 students
- Treatment programs for youth exist only **outside northwestern Ontario**; when they return, no youth-specific follow-up services available in communities

7. MEETING THE NEEDS OF THE AGING POPULATION

- Community services for elderly who have mental health or addiction issues is lacking (e.g. no case management, capacity assessment, long waits)
- **Long-term care** staff are not trained to deal with mental health and addiction issues; once "actively addicted" are admitted, no **access** to detox
- Long wait for psycho-geriatric services and no way of identifying **at-risk elders** in small towns, rural areas or remote First Nations

8. RELUCTANCE TO SEEK ADDICTION AND MENTAL HEALTH SERVICES

- Often, people don't seek care because they feel **stigmatized** having addiction or mental health challenges
- Reluctance to seek care also reflects concerns about **confidentiality** in small communities; in such places, people often won't attend counselling sessions

9. COMPLEX NEEDS

- Access to affordable and safe **housing** is a priority; **homeless** population is at especially high risk; without such supports providers "cannot expect change"
- Front-line providers are seeing more clients requiring complex care: many have mental health and addiction diagnoses, other chronic conditions, and **trauma**
- Transportation issues: limited space on local medical vans; long distances mean high travel costs, hard to pay "up front" for **travel** (travel grants reimburse costs after travel)

10. FUNDING ISSUES

- Funding for mental health has not increased over the past six years and is insufficient, considering demands: "We can't continue to do the work"
- Per capita **funding formula**, reflecting southern Ontario costs of care, not appropriate for the north, where costs of delivering services are higher
- Organizations not funded to do preventive work or community education; without such funding, they are unable to increase awareness of issues

B Considering a Northern Centre of Excellence for Addiction and Mental Health

1. WHAT COULD A NORTHERN CENTRE OF EXCELLENCE DO?

- Advocate by identifying needs and gaps in services: collect local data on services used in crises (e.g., emergency room visits, police calls, incarceration)
- Create "Indigenous-informed" education to support culturally safe care
- Create a "Yellow Pages" containing information about local care pathways and organization mandates
- Document changing community demographics and needs; census data does not accurately reflect current population
- Evaluate mental health and addiction best practices and identify "basket of services to promote mental wellness"
- Examine federal and provincial cross-jurisdictional issues for Indigenous clients; identify strategies to improve coordination of care for people moving into towns
- Function as a training and mentoring space for rural and northern service providers with emphasis on specialized skills
- Network to link front-line staff, other providers, and assist in developing worker debriefing and trauma supports

2. WHAT SHOULD A NORTHERN CENTRE OF EXCELLENCE LOOK LIKE? FACE-TO-FACE, VIRTUAL, OR BLENDED?

- Blended is best because both face-to-face and virtual supports encompass different ways of learning; face-to-face interaction is needed to support collaboration and training (e.g. planning, conferences, workshops)
- Internet-based resources, user-friendly website, are cost-effective ways to deliver education and referral information; however, internet is often unreliable, so "low tech" options such as audio-conferencing, might work better
- Physical space with resource library, evaluation database, and expertise, where service providers could access information, education, and specialized mentoring supports, would ensure sustainability of the centre
- Suggestion that Centre of Excellence "hub" should not be located in Thunder Bay, due to concern that outlying areas will not get resources they need; distributed model, with several "hubs" in smaller towns preferred

BLENDED MODEL

- Research, Training, & Evaluation Services
- Face-to-Face Communication
- Internet-based and Telephone Communication
- Partner Sites (participating organizations and communities)

Northwestern Ontario Engagement: Overall Results

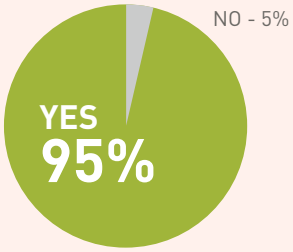
216 participants from 5 engagement areas

35% city of Thunder Bay

65% towns, rural areas and First Nations

65 participants were affiliated with Indigenous organizations and First Nations

SUPPORT
Do you support the development of a Northern Centre of Excellence for Addiction and Mental Health?



Face-to-Face Engagement Sessions **14** | **12** Teleconference and Videoconference Engagement Sessions

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Lakehead UNIVERSITY | Centre for Rural and Northern Health Research

THUNDER BAY Drug Strategy