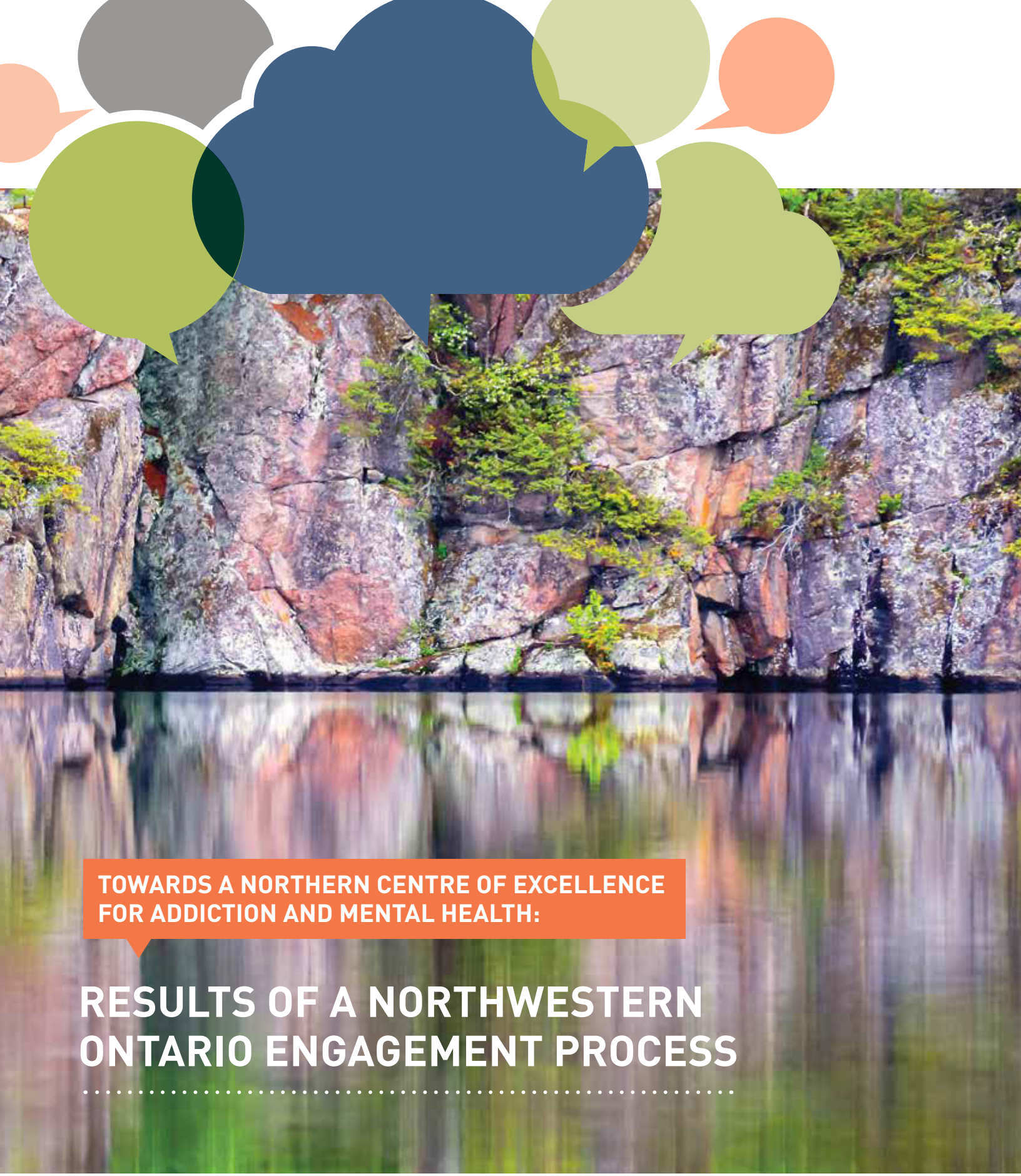

TOWARDS A NORTHERN CENTRE OF EXCELLENCE FOR ADDICTION AND MENTAL HEALTH:

RESULTS OF A NORTHWESTERN ONTARIO ENGAGEMENT PROCESS

MAY 2018

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ACKNOWLEDGEMENTS

This engagement with citizens of Northwestern Ontario's urban, rural and remote communities could not have been possible without the assistance of many people. First and foremost, the TBDS and CRaNHR would like to acknowledge the group of individuals who began this project with discussions and submission of a funding proposal to the Ontario Ministry of Health and Long-Term Care in 2013-14: Dr. David Williams (formerly Medical Officer of Health and CEO for the Thunder Bay District Health Unit and currently the Chief Medical Officer of Health, Ontario Ministry of Health and Long-term Care), Ms. Lynda Roberts (Director of Health Promotion, Thunder Bay District Health Unit), Ms. Cynthia Olsen (Coordinator, Thunder Bay Drug Strategy), Ms. Nancy Black (Director, Concurrent Disorders Services, St. Joseph's Care Group), Ms. Aimee Juan (Manager, Addiction Services, Thunder Bay Counselling Centre), Mr. Brent Maranzan (Senior Planning and Integration Consultant, Mental Health, North West LHIN), Dr. Paul Multzer (Psychiatrist, St. Joseph's Care Group), Dr. J. Bruce Minore (former Director of the Centre for Rural and Northern Health Research), Dr. Pamela Wakewich (Director, Centre for Rural and Northern Health Research), Dr. Christopher Mushquash (Associate Professor, Lakehead University) and Dr. Mary Ellen Hill (Senior Researcher, Centre for Rural and Northern Health Research).

Throughout the engagement process, Cynthia Olsen, Coordinator, Thunder Bay Drug Strategy, and Drs. Mary Ellen Hill, Pamela Wakewich, and Christopher Mushquash, Centre for Rural and Northern Health Research, Lakehead University, served as principal partners. They worked closely with our 10-person Advisory Committee, who played a key role in guiding the implementation of the engagement. The Advisory Committee participated in monthly meetings, identified stakeholders, and provided various in-kind supports for the engagement sessions. They also offered continuing advice throughout the project, answering our many inquiries with patience and good humour.

Above all, we would like to thank the front-line workers and managers, planners, decision makers, and people with lived experience in Northwestern Ontario who took part in the engagement activities. Although we cannot acknowledge them by name, we greatly appreciate the time, effort and thoughtfulness that they showed during the engagement sessions. It is our hope that the information shared in this report will assist rural and northern communities in providing more effective care for people with addiction and mental health challenges.

The engagement and dissemination activities were supported through a knowledge exchange grant from the Ontario Ministry of Health and Long-Term Care. No official endorsement by the Ministry, however, is intended or should be inferred. Opinions expressed in this report are those of the individuals who took part in the engagement; any conclusions drawn are those of the authors alone and any responsibility for errors in fact or interpretation rests with them.

MAIN MESSAGES

Mental health and addiction issues are disproportionately high in Northwestern Ontario and clients have increasingly complex needs (often dual diagnosis of addiction and mental health). For many, fundamental needs such as food security, safe and secure housing and access to basic health care are not being met. The landscape of substance use is also constantly changing with synthetic drug and polysubstance use making effective interventions more challenging.

Current mental health and addiction services are oversubscribed and there are serious service gaps across Northwestern Ontario with few or no specialized programs for youth, seniors, women, Indigenous, Francophone and LBGTQ2S populations. Lengthy waitlists, lack of detox, counselling and supportive programming, shortages of adequately trained personnel, poor coordination of care and unclear care pathways negatively impact both clients and care providers. Prevention and wellness programming and long-term addiction and mental health recovery supports are lacking.

Community-based programs, and Indigenous mental health and addiction programs are chronically under-funded and under-staffed and burnout and turnover are high creating constant staffing deficits. Limited access to programming leads to a revolving cycle of crisis with high levels of law enforcement and emergency services involvement overloading those systems as well.

The Northwestern Ontario engagement identified overwhelming support (95%) for a Northern Centre of Excellence for Addiction and Mental Health. Participants endorsed a blended model which would combine face-to-face and virtual interaction.

A Northern Centre of Excellence could serve as an advocate for addiction and mental health issues in the north, building local capacity through specialized training and education, connecting service providers, community partners and those with lived experience, researching gaps in service, and developing and sharing educational programming and best practices made in and for the North, with particular attention to cultural sensitivity and the need for respectful and holistic care for Indigenous people.

INTRODUCTION

The Thunder Bay Drug Strategy (TBDS) was developed in response to increasing substance use and related harms and the recognition that such a significant problem required a community-based collaborative response. More than 350 people were involved in the development of the strategy over a two-year period. The strategy contains 112 wide-ranging recommendations related to the causes and harms associated with substance use and recognizes that the issue of substance use must be addressed both at the municipal and regional level. In 2011, Thunder Bay City Council ratified the TBDS, accepting it as the official plan to reduce the harms associated with substance use.

REASONS FOR ENGAGEMENT

Across the North West Local Health Integration Network (LHIN), addiction to opiates and other substances represents a public health crisis that carries an enormous social, economic and health burden in cities, towns, rural areas, and First Nations communities. Moreover, unmet needs for care are significant, as evidenced by Emergency Department utilization rates for mental health and substance use that continue to remain, respectively, two times higher and four times higher than provincial rates.

Given the dispersion of Northwestern Ontario's population across vast geographical distances, there is need to support communities in developing local, effective, and sustainable approaches to wellness. There are gaps in the information available about addiction and mental health issues and challenges in collecting, analyzing and applying data and research evidence. With a growing Indigenous population, the region also requires diverse, culturally safe and contextually relevant treatment options for Indigenous peoples.

Recognizing these needs, the Provincial Expert Working Group on Narcotic Addiction (2012) recommended that further planning and development be undertaken to improve capacity in northern, rural and First Nations communities to address these issues. Specifically, the report recommended the development of a strong foundation of system supports and commitment to strengthen local resources through evidence-based interventions, monitoring, evaluation, surveillance, research, and the promotion of sharing of knowledge, lessons learned, and best practices.

Recognizing the need for system improvement in the substance use and mental health sector and tailored-to-the-North long-term solutions, the Thunder Bay Drug Strategy Implementation Panel and the Thunder Bay District Board of Health jointly recommended the development of a Centre of Excellence for Addiction and Mental Health in Northwestern Ontario and invited the Centre for Rural and Northern Health Research at Lakehead University to partner in a regional engagement process exploring key stakeholder and consumer views around the potential development of such a centre.

In January 2017, the Ontario Ministry of Health and Long Term Care awarded a knowledge translation project grant to support the engagement process. The resulting year-long engagement process succeeded in documenting the priorities, experiences and opinions of 216 front-line service providers and managers, planners and policy makers, and people with lived experience.

Representing the views of those who live and work in 34 different communities, the engagement revealed widespread support across the North West LHIN for the development of a Northern Centre of Excellence for Addiction and Mental Health, where northern research, evaluation, education, and collaboration, would improve the quality of care in northern urban, rural and remote communities.

ENGAGEMENT PROCESS

The engagement, start to finish, took approximately 15 months. During the initial three months, the Centre for Rural and Northern Health Research undertook an extensive scan of the literature with a view to creating an agenda for the engagement sessions. The first phase examined Centre of Excellence models used in Canada and internationally to improve services for rural, northern and Indigenous populations; the second phase examined what is known and not known about mental health and addiction in rural and northern settings, with emphasis on vulnerable populations living rurally, specifically, older adults, youth, women, Indigenous people, and those identifying as LBGTQ2S.

In April 2017, the Project Principals established an 10-member Advisory Group, representing organizations delivering research, evaluation, education and services to communities across the North West LHIN. The group assisted in implementing the engagement work plan, assisted in the creation of a comprehensive list of stakeholders, including representatives of health care, human services, justice, education and peer support organizations. The Advisory Group also offered guidance on the development of the engagement materials, selection of community locations, and timing of the engagement sessions and invitations to ensure that there would be no conflicts with previously planned events.

In November 2017, the Project Team invited two facilitators, Alice Sabourin and Carol Rowland, to join the team and lead the engagement discussions. Both facilitators had extensive experience in community engagement and had recently been involved in delivering mental health and addiction services to rural, northern and Indigenous communities.

Working collaboratively with researchers, the facilitators delivered 14 face-to-face sessions in Marathon and Longlac (November 2017), Kenora and Sioux Lookout (December 2017), Fort Frances (January 2018), and Thunder Bay (February and March 2018). Between November and March, the facilitators also conducted a series of 12 teleconferenced and videoconferenced sessions for rural towns and remote First Nations who had not been able to take part in face–to-face sessions. With permission of participants, discussions were audiorecorded and documented in written notes.

The sessions were attended by 216 individuals. With 2/3 of participants from small towns, rural areas and First Nations, and 1/3 from Thunder Bay, the engagement achieved its goal of documenting the experiences, opinions and suggestions of providers and recipients of care across Northwestern Ontario. Health care, social services, education, justice, policy and planning, as well as peer organizations, and people with lived experience were represented.

Following each session, discussion documents were transcribed and analysed to identify emerging trends, local mental health and addiction service issues, and coordination of care challenges in delivering complex care to vulnerable populations. Preferences and opinions regarding Centre of Excellence models and what they might do for local communities and citizens were also assessed. At the end of the engagement, a follow-up online survey gave participants another chance to identify priorities and validate their opinions about the proposed Northern Centre of Excellence.

Towards a Northern Centre of Excellence for Addiction and Mental Health:

NORTHWESTERN ONTARIO ENGAGEMENT PROCESS

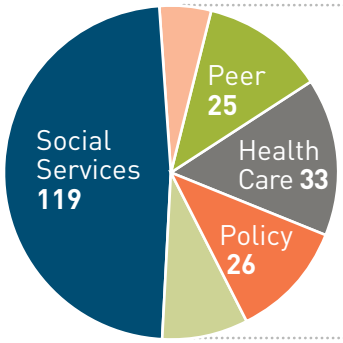
WHO

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



HOW

14 Face-to-Face Engagement Sessions

12 Teleconference and Videoconference Engagement Sessions

1 Follow-Up Survey

WHERE

MODELS FOR A NORTHERN CENTRE OF EXCELLENCE FOR ADDICTION AND MENTAL HEALTH

FACE-TO-FACE MODEL

Research, Training, & Evaluation Services

Face-to-Face Communications

Partner Sites (participating organizations and communities)

Face-to-face knowledge exchange and collaboration (research, training and evaluation) *ie. workshops, presentations, community meetings, education events*

VIRTUAL MODEL

Research, Training, & Evaluation Services

Internet-based and Telephone Communication

Partner Sites (participating organizations and communities)

Virtual knowledge exchange and collaboration (research, training and evaluation) *ie. teleconferences, videoconferences, webinars, Skype, email*

PREFERRED MODEL

Participants in the engagement saw a broad mandate for a Northern Centre of Excellence for Addiction and Mental Health, providing education, evaluation and research to service providers, planners and decision-makers, and people with lived experience, their families and communities. Overall, they were in favour of a blended model which combined "face-to-face" and "virtual" means of communication:

- "Face-to-face" workshops or conferences were viewed as the most effective way of bringing people together to teach them practice skills and knowledge; such interactions encouraged collaboration and networking among organizations and communities
- "Virtual" dissemination of information was seen as the most suitable method for bridging Northwestern Ontario's vast geographical distances; Internet-based information would ensure providers and recipients of care had up-to-date information about services and referral pathways
- At the same time, people recognized that organizations and individuals who served rural and remote communities would need more "low tech" print or audio options for accessing information; in such places, the Internet was unaffordable, unavailable, or unreliable

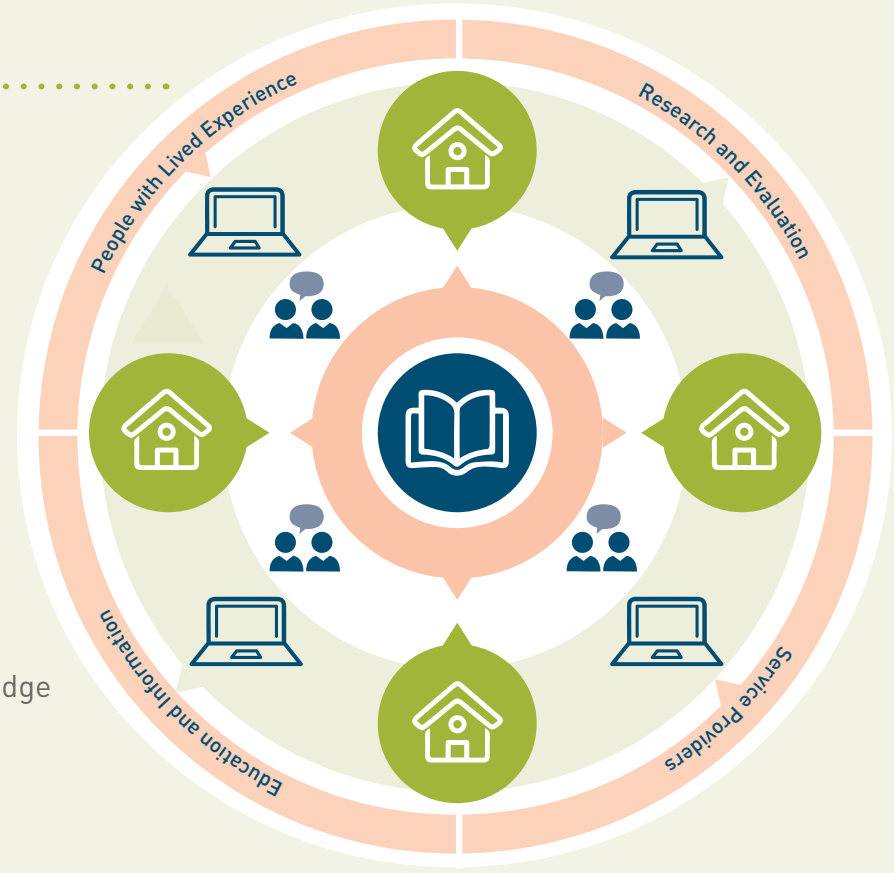
Administratively, there was recognition that a Northern Centre of Excellence for Addiction and Mental Health had to be flexible enough to accommodate the needs and preferences of communities and organizations and promote equitable access to education, evaluation and research across the north. There were, however, differences of opinion about which organizational structure would work best:

- "Distributed model" with "equitable hubs" in Thunder Bay and small towns, was seen as an effective means of building and sustaining local capacity to deliver quality care; it also would support the development of relationships among local communities and organizations
- "Hub and spoke model" with main offices located in Thunder Bay or one of the outlying towns and satellite offices elsewhere could also work well; however, extra services and supports might be required so resources are distributed equitably across the Northwestern Ontario region

BLENDED MODEL

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

Both Face-to-Face and Virtual knowledge exchange and collaboration (research, training and evaluation)



I. FRONT-LINE WORKERS AND MANAGERS

A Priority Mental Health & Addiction Issues

1. EMERGING TRENDS

- Alcohol use continues to be main issue in most communities; cannabis, cocaine, crack, fentanyl, carfentanil, crystal methamphetamine, ecstasy and desomorphine increasing; polysubstance use is common
- Changes in extent of opioid use in different communities; people formerly addicted now being diagnosed with psychoses and other mental health issues
- Dual diagnosis of addiction and mental health in as many as one-half of clients in some agencies; more people with complicated histories, fetal alcohol spectrum disorders, developmental delays, or brain injuries, severe trauma and PTSD; increased self-harm and suicides in some communities
- Increase in synthetic drugs associated with gangs from elsewhere in Canada moving into NWO along the highways

2. LIMITED LOCAL ADDICTION AND MENTAL HEALTH SERVICES

- Access impeded by shortages of primary care physicians, psychologists and psychiatrists; without physician, nearly impossible to get referrals
- Few inpatient detox or mental health beds in small towns; clients can wait up to week for bed elsewhere; by time transportation arranged, bed can be closed
- Gap between mental health and addiction in city, small towns, and remote First Nations; Suboxone and methadone programs not integrated with counselling
- Lack of services for youth, seniors, women, Indigenous, Francophone and LGBTQ2S populations; absence of holistic and family-oriented treatment
- No supportive housing, recovery homes or self-care programs for people discharged from treatment; people go back home to face same issues again
- People in crisis cycle between hospital and police; both acute care and justice systems do not have the resources to respond to these needs
- Prevention and awareness programs, as well as harm reduction, required
- Serious service gaps across Northwestern Ontario: increasing numbers of people seeking addiction and mental health services, but no increases in resources
- Telemedicine difficult to access because internet is unavailable or unreliable in rural and remote areas; some clients dislike telemedicine and refuse to use it
- Waitlists are extremely long: up to one year for counselling, more than 7 months for detox; 4 years for government-funded inpatient treatment centres

3. POOR COORDINATION OF CARE AND UNCLEAR CARE PATHWAYS

- Access for clients requiring addiction, mental health and social services is difficult: clients must access multiple organizations and fill out multiple forms
- Complicated referral, intake and discharge for clients from northern towns, rural and remote First Nations; staff can take up to 2 years to learn the system
- Online addiction assessment tool is time-consuming and creates a backlog; seen as not appropriate for youth or Indigenous clients
- Pathways used in urban areas not a good fit for small towns, rural or remote areas; especially difficult for First Nations who access care federally and provincially
- Preventive and wellness programs lacking; very few community-based programs to provide long-term addiction or mental health recovery supports

4. WORKFORCE ISSUES

- Burnout and compassion fatigue causes high turnover; large caseloads, stress, and low salaries contribute to retention issues in community agencies
- New graduates in health, justice and human services programs often not well prepared for rural and northern work; lack knowledge of determinants of health

- Recruitment issues, hard to find qualified staff in north where cost of living is higher; community organizations cannot offer competitive salaries
- Training opportunities are limited; only basic mental health and addiction training available online; sending staff to Thunder Bay or Toronto expensive
- Work-life balance is difficult when staff are faced with increased caseloads, complex demands and continuing crises

5. MEETING NEEDS OF VULNERABLE POPULATIONS

A. INDIGENOUS PEOPLES

- Build capacity in organizations and communities to deliver holistic care to Indigenous people; at present, few services available off-reserve
- Improve cultural sensitivity; ensure that Indigenous people with addiction or mental health issues are treated respectfully when they access care
- Jurisdictional barriers need to be addressed; people moving from rural and remote First Nations into towns and cities often lose services when they move
- Recognize that Indigenous cultures are not all the same; cannot take a "one size fits all" approach when developing holistic programs
- Service providers need to understand historical and contemporary trauma and generational effects, including devastating results of recent opioid crisis on Indigenous families
- Youth and elders who travel from remote communities to towns to access services lack family support; new strategies are required to address their needs

B. FRANCOPHONE RESIDENTS

- Although some towns have significant numbers of Francophone residents, very difficult to recruit bilingual service providers
- Francophone-speaking mental health professionals also not available in Thunder Bay; arranging for translation also difficult

C. YOUTH

- Addiction, anxiety, self-harm, serious mental health disorders, and suicide increasing among children and youth; few specialized services to help them
- Parents need education about how to identify mental health and addiction issues in children; however, discussions difficult when parents have addictions
- Schools are struggling to identify and address child and youth mental health needs; do not have capacity; collaboration with community services is needed
- Treatment programs for youth exist only outside the region; when they return, no youth-specific follow-up services locally

D. OLDER ADULTS

- Community services for elderly who have mental health or addiction problems lacking; long waits for assessment and no way of identifying at-risk persons
- Long-term care seeing more people admitted with addiction or on methadone; facilities do not presently have capacity to support such clients

E. WOMEN

- No women-specific community-based or residential treatment, assisted living, or shelters; existing facilities are unsafe for them and lack childcare
- Women with mental health or addiction issues are especially vulnerable to getting involved in drug trafficking or the sex trade

6. RELUCTANCE TO SEEK ADDICTION AND MENTAL HEALTH SERVICES

- Clients are often reluctant to access care due to stigma attached to addiction and mental health; they may not feel comfortable approaching providers
- Confidentiality concerns in small communities can make people disinclined to seek help; some turn to social media for advice or go elsewhere for care
- Cultural insensitivity from service providers discourages Indigenous people from approaching mainstream services; expansion of holistic services recommended
- Parents can be reluctant to seek care for addiction and mental health for fear that their children will be taken into care; lack of childcare is barrier to services
- People who feel that they have not been believed or helped in the past often hesitate about approaching agencies for care; open door programs needed
- High rates of staff turnover contribute to reluctance to seek care; it takes time to build rapport with communities and clients

7. COMPLEX NEEDS

- Basic needs not being met; social assistance allowances insufficient to pay for high cost of rent and food; difficult to help homeless or hungry clients
- Challenge to stay healthy in Northwestern Ontario; rent very expensive, subsidized housing limited, public transportation limited, and food costly
- Few safe spaces in community for people with serious mental health or addiction challenges to go; shelters often full, so high risk of being victimized on streets
- Interconnected physical and mental health issues sometimes missed; clients coming into care with untreated physical health issues
- Navigation supports needed for people who move to Thunder Bay for care; most are unaware of resources available for mental health and addiction

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

1. WHAT COULD A NORTHERN CENTRE OF EXCELLENCE DO?

- Advocate and act as a collective voice for the north, ensure that issues are identified, and innovations and best practices recognized
- Assist with funding applications and proposal writing for organizations and communities; ensure communities are aware of funding opportunities
- Build local capacity by connecting service providers, community partners and people with lived experience to share information about best practices
- Collect cross-jurisdictional data on client needs and gaps in services, including crisis care provided by emergency services, hospital, and law enforcement
- Conduct research on behalf of communities and organizations; ensure that research is culturally safe and Indigenous-informed
- Create regional database to help mental health and addiction organizations with recruiting staff; include links to employers across the region
- Deliver supportive workshops for front-line staff on compassion fatigue, safety, self-care, trauma and debriefing
- Document changing community demographics and needs; census data does not always accurately reflect current population
- Educate workers about culturally safe and sensitive practices, opioid use in pregnancy, mental wellness promotion, and meeting needs of high-risk individuals
- Encourage communities to collaborate and solve coordination of care problems; creation of local care pathways and circles of support would be valuable
- Examine federal and provincial cross-jurisdictional issues affecting Indigenous clients; identify strategies to improve quality and consistency of services
- Function as a training and mentoring space for rural and northern service providers; emphasize building local capacity to deliver specialized care
- Identify gaps in knowledge about services and develop service navigation tools for providers and clients
- Make needs of communities visible; ensure that youth and adults with lived experience are represented and

- Poverty rates are high among those with addiction or mental health issues; applying for Ontario Disability Support Program can take up to 1.5 years
- Some families have 5-8 children; without childcare, often miss appointments
- Transportation issues; few medical vans, clients must use costly taxis or private vehicles to get to appointments; travel costs only reimbursed after appointments
- Whole families need supports if parent has mental health or addiction issues; often grandparents end up parenting; insufficient resources to meet needs

8. FUNDING ISSUES

- Agencies are frustrated with inflexible funding criteria; innovative programs, such as outreach services for homeless and high-risk clients, not sustainable
- Community-based addiction programs using Suboxone not well funded; additional resources needed to ensure counselling and other services available
- Funding allocations based on number of client visits are insufficient to support case management or collaborative care for those requiring complex care
- Indigenous mental health and addiction programs are under-resourced; organizations need more funding to meet needs of growing population
- Law enforcement agencies and emergency services experience significant funding overages due to an increasing number of mental health or addiction calls
- Organizations that provide mental health or addiction services are not funded to do preventive work; community education or awareness programs lacking
- Per capita funding formula does not recognize high levels of need in the north and high costs of delivering services to geographically dispersed areas
- Political responses to northern mental health and addiction crises lacking; representatives have been told about issues, but no response to date

have a voice in shaping programs; surveys to assess needs or videos sharing stories could be useful

- Promote local education and awareness programs, including school-based programs for youth at risk of addiction or mental health problems
- Provide gender- and trauma-informed training on best practices for vulnerable clients across lifespan (e.g., women, youth, older adults, Indigenous, LGBTQ2S)
- Support development of a northern community of practice and ensure local knowledge and expertise is shared widely
- Work with university and college to ensure that health and human services curricula have focus on northern mental health and addiction issues

2. WHAT SHOULD A NORTHERN CENTRE OF EXCELLENCE LOOK LIKE?

- A blended model that combines face-to-face and virtual interaction was preferred; this approach would accommodate different ways of learning and disseminate information; however, internet not always available or reliable in rural areas
- Close relationships with small towns, rural areas and remote First Nations would ensure that Centre planning and operations reflect local needs and priorities
- A distributed model, with "hubs" in Thunder Bay and small towns, was seen as a way of ensuring equity in access and resources; however, varying opinions about where Centre administration should be located
- Indigenous component is necessary to ensure that the Centre is inclusive of First Nations people and respects Indigenous knowledge
- Physical space with resource library, database, and education, evaluation and research expertise, would ensure sustainability of the Centre
- Virtual component needs to be accessible and easy to navigate for service providers, people with lived experience, their families, and communities
- Most participants saw value in a Centre of Excellence; they looked forward to further planning and engagement occurring
- 4 of 216 people attending the sessions, however, felt Centre was unneeded as expertise is already available and resources should be used for services

II. POLICY MAKERS AND PLANNERS

A Priority Mental Health & Addiction Issues

1. EMERGING TRENDS

- Aging population in Northwestern Ontario (NWO); cuts to psychogeriatric services mean very few can access care; families referred to Emergency Room (ER), but no dementia care, so very frustrated
- High risk populations (e.g. people who inject drugs) becoming more reluctant to access care; supervised injection and outreach services needed to overcome barriers to care
- High volume of calls to emergency services and police for issues related to mental health, addiction, and trauma; repeat calls common; some people cycling through justice system
- Service saturation: across NWO, numbers of people in need of crisis care exceeds the number of mental health and detox beds available
- Women with children drawn into human trafficking because of addiction; integrated addiction, mental health, and social services not available for them
- Youth treatment facilities are minimal, only 8 beds available for all NWO; increasing needs for age-specific treatment for non-beverage alcohol, solvents, and other substances

2. COMPLEX NEEDS

- High levels of dysfunction at family, community, and neighbourhood levels; victimization and criminalization of people with mental health and addiction
- Housing and transportation difficulties are major issues; acceptability and affordability challenges across NWO and within communities
- Loss of industry jobs and economic stability across NWO, along with shifts in population, resulting in issues with mental health
- More people presenting with mental health, addiction, and cognitive difficulties due to brain injuries or developmental delays; specialized services not available
- Trauma is common in NWO; early childhood experiences, poverty, mental health issues, and substance use contribute to violence

3. POOR COORDINATION OF CARE AND UNCLEAR CARE PATHWAYS

- Collaboration and communication between Indigenous-specific and non-Indigenous services needs to be strengthened; cultural sensitivity should be enhanced throughout the system
- Evidence-based treatments are not applied across services; more equitable access to services, including addiction medication and mental health assessments are needed
- Jurisdictional differences for First Nations clients present as a challenge in coordinating care; compounded as people move between federal and provincial systems of care
- People with addiction cycle through the system; go through treatment, relapse, go back into treatment multiple times because long-term treatment unavailable
- Planning and other structural decisions often made in isolation; this creates tension within various sectors; need for consistency in service delivery and funding allocations across NWO
- Prevention programs, community awareness, and mental wellness initiatives lacking; providers feel that they are too busy "putting out fires" to plan prevention
- Transient population across communities; people become "lost" as they move from one organization to another (e.g. miscommunications, paper-work problems, follow-ups lost)

4. LIMITED LOCAL ADDICTION AND MENTAL HEALTH SERVICES

- Addiction services seriously overburdened; new system for accessing treatment in place, but no detox beds available anywhere in NWO; waitlists way too long
- Community-based methadone and Suboxone clinics are insufficient to

meet demands for addiction care alone; no counselling or other long-term recovery supports in place

- Lack of psychiatrists and specialized youth and older adult psychologists causing serious delays in assessments; some rural primary care staff have augmented skills to address gaps
- Primary care provider shortages cause people to go to ER for care: highest rates of mental health and addiction visits anywhere in province; need alternative acute services
- Serious recruitment and retention issues in smaller places; organizations often cannot afford to send staff elsewhere for training
- Service saturation: treatment services overburdened; front-line providers experiencing compassion fatigue; contributes to recruitment and retention issues
- Training often "siloed" and not generally accessible; improving skills to deliver trauma-informed practice and community-based Suboxone programs identified as priorities across the system

5. COMPLEX NEEDS

- People are often reluctant to engage with care providers due to discrimination and stigma; need system approach to reduce systemic barriers to care
- People with mental health and addiction often cycle through the justice system; people go back to similar lifestyles when they are released; breach probation, incarcerated again
- Safe and affordable housing limited; supportive housing for people with developmental or cognitive issues limited; homeless population at risk of victimization
- Transportation is an issue; people living in poverty have difficulties getting to appointments; winter weather causes challenges for people with mobility issues
- Women and children coming into shelters have high levels of need; most have complex history of abuse, trauma, violence; many have mental health issues, some have substance use challenges

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

1. WHAT COULD A NORTHERN CENTRE OF EXCELLENCE DO?

- Accessible service database for communities that organizations can update; this would improve knowledge about services that are available and improve referral processes
- Coordinate education across NWO; identify training needs and opportunities, encourage exchange of resources, and support collaboration to improve access to information
- Facilitate networking: connect front-line providers to others in the field, create opportunities for debriefing, case conferencing, and promote sharing of local expertise
- Promote development of competency-based, standardized, and accredited training for northern addiction and mental health organizations; build on expertise available in the region
- Provide information on best practices and ensure that it is accessible to service providers across NWO; resource equity is needed

2. WHAT SHOULD A NORTHERN CENTRE OF EXCELLENCE LOOK LIKE?

- Blended model preferred, combining face-to-face workshops and conferences with virtual components, such as internet and telephone sessions
- Creative and effective use of technology recommended; internet is not widely available and often unreliable in rural and remote areas; print and audio options needed
- "Hub and spoke" model has the potential to work well, but necessary to pay particular attention to building relationships and ensuring that resources are distributed equitably across the region
- Ideally, the Centre should be staffed 24/7 to ensure that information about services, resources, and care pathways at local and regional levels is up-to-date and accessible

III. PEOPLE WITH LIVED EXPERIENCE

A Priority Mental Health & Addiction Issues

1. EMERGING TRENDS

- Gangs from other parts of Ontario have moved into the city and are regularly rotating crews of dealers into neighbourhoods who introduce drugs that are "cheap and dangerous"
- Perception that many drugs, such as crack cocaine and crystal methamphetamine, are being laced with fentanyl; noting that overdoses occur more frequently and multiple doses of naloxone are needed for recovery
- Methadone programs, while reducing harm, do not offer counselling to help people taper off methadone; instead, the perception is "they're always pushing more and more and more"
- New drug, Synthetic U-47700 ("pink heroin"), is less expensive and 8 times stronger than heroin; more people with prescriptions selling Gabapentin, Ritalin, and Wellbutrin on street
- Opinion that people with chronic pain might do better with medical cannabis; however, physicians reluctant to prescribe cannabis for fear of triggering PTSD or psychosis

2. LIMITED LOCAL ADDICTION AND MENTAL HEALTH SERVICES

- Crisis care beds are few and hard to access: waits up to 5 days in the emergency room were reported and, if beds were unavailable, people were discharged after 72 hours
- Culturally sensitive and holistic treatment for addiction is lacking for First Nations; coming to a city for treatment is traumatic "especially when you cannot bring family with you"
- Detox or recovery beds are limited; perception that beds are designed for people coming off alcohol, not opioids, and that comparatively few beds were allocated for women
- Telemedicine was seen as only a partial solution to lack of psychiatrists: there were concerns about assessments and medication being given based on "a 10-minute video conference"
- Treatment centres, recovery or halfway homes have long waitlists, which discourages people from seeking care; the consensus was that "people need to get right into detox and into treatment"

3. POOR COORDINATION OF CARE AND UNCLEAR CARE PATHWAYS

- "Clear, consistent pathways" would improve access to specialized care; people in crisis need navigation assistance because connections to agencies are so complex
- Family physicians are not well-informed about addiction and mental health; suggestion that specialized nurse practitioner or social worker could improve referral process
- While people acknowledge Rapid Access Addiction Medicine Clinics will improve addiction care, similar "walk-in" programs could be used to deliver more timely access to specialized mental health care
- "Overlapping services" causes problems in knowing where to go for care; however, "one stop shopping" was not seen as an answer, especially for "people on the streets"

4. COMPLEX NEEDS

- Housing was a priority; however, insufficient shelter allowances means people can only afford substandard housing in unsafe neighbourhoods, which adds to stress
- Participants reported they "took money out of food budgets" in order to pay for safer accommodations; the consensus was "poor housing leads to poor mental health"
- People living on the streets "without an address" have difficulties obtaining services; those with mental health issues experience discrimination from landlords
- Open discussion and debates would determine best ways to support people with complex issues; recognition that addiction and mental health often leads to involvement with justice system

5. RELUCTANCE TO SEEK CARE

- People with addiction and mental health issues said they felt "hopeless or worthless" about the stigma attached to their conditions; some felt that "they had to lie" to avoid discrimination
- People who were labelled as drug-seeking reported having to make multiple visits to providers to

get prescriptions refilled and get treatment for injuries and infections

- Methadone or Suboxone program clients said the stigma persisted even when they were in recovery: "there's a difference between how I'm going to receive care and somebody else is"
- Indigenous people are discriminated against: as a participant noted "because I'm pale ... I'm going to get treated differently than [someone] who looks Indigenous"
- Youth with mental health issues are stigmatized in schools; programs to give teachers, youth and parents "skills or tools to deal with that kind of thing" were recommended
- Lack of anonymity in small rural communities "where everyone knows everyone's comings and goings..." is a huge barrier to people seeking support
- Those who lived in communities where most people drank, for example, risked being stigmatized if they sought treatment: this was a "cultural barrier" that potentially could "lead to ostracism"

6. FUNDING

- People with lived experience emphasized that government planners and service providers had to ensure patient and family advisers are given a stronger voice in decision-making
- They want "opportunities to engage in things where we're not the token voice of lived experience or added in the aftermath of decisions already made"
- Participants emphasized that small "street-based" programs that offer outreach to high risk individuals perform a valuable service; stable funding would ensure sustainability
- Funding models based on southern Ontario were seen as insufficient, given the extent to which northern cities, rural areas and remote First Nations are affected by mental health and addiction issues
- "Consistent funding ... clear definitions ... policies and procedures" would be the ideal way to improve access to care: people need both a "first door" and a "last door" open to succeed

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

1. WHAT COULD A NORTHERN CENTRE OF EXCELLENCE DO?

- Advocacy, to assess and explore strategies that improve the lives of people with mental health and addiction: public awareness campaigns would "get the information out" and reduce stigma
- Create a northern "community of practice" to help clinicians and people with lived experience strengthen connections and share "practical information" about what works (or not)
- Deliver education and research in a broad sense, ensuring that physicians, nurses and other providers have up-to-date information on addiction harm reduction and risks
- Develop a database of community-based services which would help staff on the front-lines of organizations know how the system works and make better referrals for clients
- Provide age-specific information to help youth with addiction or mental health issues access health and social services, as well as peer supports

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

- Blended model was preferred by most participants, who felt there are advantages and disadvantages to having only a "face-to-face" or "virtual" model
- Face-to-face communication would allow people to see one another and communicate non-verbally; this could not easily be done on the internet where you "cannot emote when typing"
- Virtual communication, if paired with a navigator, would be an effective means of giving people access to information; they could just "call or text and get a more instant response"
- Youth would appreciate virtual means of communication, so they can connect with peers and get information via social media, chat rooms or discussion boards; phone apps could be used
- Rural and remote communities, however, require access to information in other forms, including print or audio information, because internet services are costly or unavailable

FOLLOW-UP SURVEY

After the last Engagement Session was held in March 2018, we delivered an Internet-based survey to all people who had participated in the engagement and shared their email address with us. The survey gave participants another opportunity to indicate their priority addiction and mental health issues, give their opinion on whether a Northern Centre of Excellence for Addiction and Mental Health would help address these issues, indicate which model they preferred, and declare whether or not they would support its development. Results (summarized on the facing page) confirmed that:

- By far the most pressing priority in Northwestern Ontario is developing local strategies for serving clients with complex needs; needs of Indigenous people and youth, as well as determinants of health were also recognized as areas for improvement
- Two-thirds of respondents believed a Northern Centre of Excellence could assist them to address their priorities; the remainder were unsure whether it would be helpful; comments revealed that some were reserving judgment until a firm proposal and plans were in place
- Overall results confirmed the high levels of support for a Northern Centre for Addiction and Mental Health: 95% would support development of a Centre, with strong preference for a blended model that combined "Face-to-Face" and "Virtual" means of knowledge exchange and collaboration

NORTHERN CENTRE OF EXCELLENCE FOR ADDICTION AND MENTAL HEALTH ENGAGEMENT: FOLLOW-UP SURVEY RESULTS

Participation rate **48%** invited: 188* completed: 90

*number of engagement session participants for whom we had a current email address

Issues

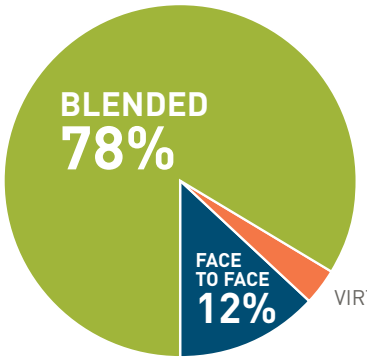
What are the top priority mental health and addiction issues for your community? (people chose up to 3 responses)

Developing local strategies for serving clients with complex addiction and mental health needs	57%
Improving responses to the specific needs of youth	32%
Improving capacity to support the needs of Indigenous communities and clients	28%
Sharing local strategies to address determinants of health (e.g., poverty, housing, food)	28%
Improving coordination of care	27%
Sharing best practices & innovative solutions across Northwestern Ontario	26%
Training and education for staff	26%
Collaboration around access to care issues	22%
Assistance with developing funding proposals	12%
Linking peer support and/or consumer groups across Northwestern Ontario	10%
Linking communities of practice	10%
Evaluation of local programs/projects	3%

% of respondents selecting this priority

Can it help?

Do you think a Northern Centre of Excellence could assist you in addressing these priorities?



Best Centre of Excellence model for Northwestern Ontario?

FACE-TO-FACE
Workshops, Presentations, Community Meetings, Education Events

VIRTUAL
Teleconferences, Videoconferences, Webinars, Skype, Email

BLENDED
Both face-to-face and virtual knowledge exchange and collaboration

Support

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

95% said YES

NEXT STEPS

DISSEMINATION OF FINDINGS

Results were compiled into five sub-regional reports (Thunder Bay City, Thunder Bay District [excluding city], Kenora District, Rainy River District, and Northern District), and an overall report was prepared to summarize common themes and issues, from the points of view of Front-line Staff and Managers, Planners and Policy Makers, and People with Lived Experience. Hard-copy and online versions of these deliverables will be made available to disseminate results broadly across the North West LHIN. Presentations also will be made to regional, provincial and federal policy and decision-makers at a later date.

PROPOSAL

Based on the results of this engagement, the Thunder Bay Drug Strategy has agreed to move forward with the development of a proposal for a Northern Centre of Excellence for Addiction and Mental Health, working in partnership with Northwestern Ontario communities and organizations. The benefits of a Northern Centre of Excellence for Addiction and Mental Health would be:

- Support for a comprehensive and coordinated approach to research, evidence and capacity building to support exchange of best practices and local solutions to care
- More focused attention to the needs and context of Northern communities and optimized ability to come to meaningful, long-term, and sustainable solutions to reduce substance use related harms
- Improved capacity to conduct relevant research spanning the spectrum from prevention and surveillance through to treatment and recovery incorporating cultural and contextual factors
- Increased ability to attract addiction professionals to Northwestern Ontario, building long-term capacity, additional expertise, and drawing new resources through grants and funding
- Capacity building for local wellness and healing solutions among rural, remote, and isolated communities in partnership with service providers and individual and family peer organizations

NORTHERN CENTRE OF EXCELLENCE FOR ADDICTION AND MENTAL HEALTH

ENGAGEMENT PROJECT: 2017-18

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