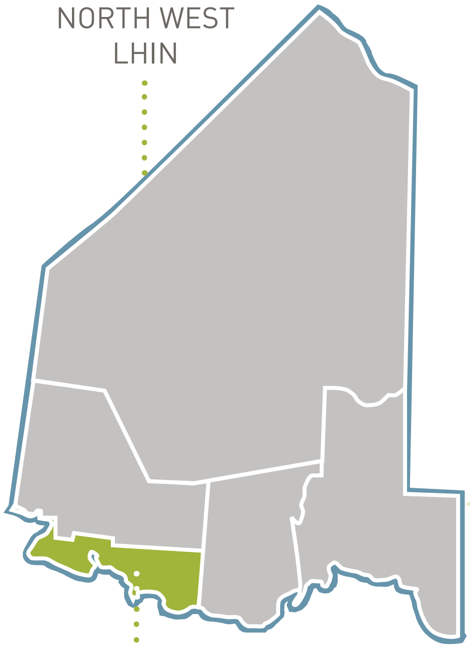
Towards a Northern Centre of Excellence for Addiction and Mental Health

Engagement Results for: **RAINY RIVER DISTRICT**

Northwestern Ontario Engagement Nov 2017 - Mar 2018 | Rainy River District Engagement Sessions



RAINY RIVER DISTRICT

20 110 people | **15 474** km^2

42% rural
2% Francophone**
27% Aboriginal* Identity
17% adults over age 65
30% children and youth 0-24 years

4 major towns, 10 First Nations

Fort Frances to Thunder Bay: 4 hours drive

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

2 **FACE-TO-FACE SESSIONS**
Fort Frances 1: Jan 2018
Fort Frances 2: Jan 2018

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

Northwestern Ontario WEST 2: March 2018

23 **PARTICIPANTS FROM 15 ORGANIZATIONS** serving Fort Frances, Atikokan, Emo, Rainy River, surrounding rural communities, and 10 First Nations

Of these, 5 participants were affiliated with Indigenous organizations and organizations serving Indigenous people

SECTORS
Addiction, Mental Health, Hospital, Emergency Medical Services, Primary Health Care, Public Health, Tribal Health Authority, Social Services, Education, Health Administration

ROLES
Front-line workers and Managers in Indigenous-specific and non-Indigenous organizations, including Nurse, Paramedic, Policy Maker, Social Worker, Counsellor, Volunteer Coordinator, Superintendent, Director, People with Lived Experience

INSIDE:

- What are the mental health and addiction priorities in Rainy River 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 -- Rainy River District

1. EMERGING TRENDS

- Rainy River District has a **history of collaboration** - among organizations, and between Indigenous and non-Indigenous populations
- **Local capacity** for mental health and addiction care has been increasing (e.g. the new detox beds just approved)
- Substances use trends are shifting: **crystal methamphetamines** use has increased dramatically and being combined with **alcohol; Desomorphine** is becoming more common
- Decreasing resources and increasing numbers of people who need them
- Lack of **psychology and psychiatry supports** across the province
- Increase in long-term care residents who are on **methadone**
- Increase in youth with **anxiety; drugs** becoming more common in schools; **suicide** is becoming more common among 12-13 year olds

2. LIMITED LOCAL ADDICTION AND MENTAL HEALTH SERVICES

- People go to jail because that is the only way they can **access** treatment
- Overall lack of services means staff struggle with where to send clients who are actively suicidal, psychotic e.g. Paramedics (EMS) have nowhere to bring someone other than Emergency Room (ER), and that person is released the next day: "It's a **hand off game** – EMS hands that person off to a doctor, the doctor hands them off to someone else, and they do not get the help they need."
- **Rigid criteria** for treatment programs make them inaccessible for some e.g. CMHA is compliance-based, so non-compliant clients do not get services they need
- **Lack of childcare** makes it difficult for clients with children to access treatment
- Extremely long **wait lists** for treatment centres

3. LIMITED AFTERCARE AVAILABLE LOCALLY

- Because the only Assertive Community Treatment (ACT) Team is in Kenora and serves two districts, Rainy River providers need to find other ways to support clients in the community
- Lack of local, regular psychiatric care: "OTN (Ontario Telemedicine Network) isn't the answer. Technology is great, but not everyone can access it"
- Services need to be provided "close to home" so that clients do not need to leave their communities
- **Distances** are a huge issue; even if the services are available elsewhere, clients have no way to get to them
- Staff must **travel** long distances to serve district communities, and constantly need to be creative to "make things work"

4. MEETING THE NEEDS OF INDIGENOUS CLIENTS

- A need to build capacity in **Indigenous** organizations and communities to deliver care to people living on and off reserve: "We want to look after our own people"

5. POOR COORDINATION OF CARE AND UNCLEAR CARE PATHWAYS

- Issues weaning clients off **methadone/Suboxone;** prescribing doctors have authority over dosages; service providers are unable to help their clients **taper off**
- Following up with clients sent away for treatment is complicated and they often get **lost in the system**
- Staff may be **unaware** of available services, so clients don't get the services they need

6. LACK OF SERVICES FOR YOUTH

- More youth are seeking help for mental health and addiction issues, and providers know that working with youth at an early age can help break the cycle of addiction, but there is **nowhere to send them**
- Increasing number of **suicidal youth**, but no child/adolescent services to help them
- Available services for youth are connected to Child and Family Services (CAS), and **parents are afraid** their children will be taken if they seek help for them
- Lack of **safe spaces** for children and youth

7. WORKFORCE ISSUES

- Decreasing resources, increasing need
- **Staff are "maxed"** and do not have the time to give clients what they need; they cannot see clients as often as they would like
- Difficult to **retain staff** who come from out of town
- Need more educated and qualified staff to fill positions; students entering the workforce unprepared
- Staff need a deeper understanding of mental health and addiction issues (social determinants of health, past trauma)
- Severity of some cases are beyond the resources that exist; need **access to specialists** for supervision/ consultation when practicing

- Unqualified staff are expected to provide specialized services because no one else available
- Front-line **staff need support** with stress and trauma they experience on the job: "there is a lot expected of them and they go above and beyond to try to meet the needs of their clients"

8. STIGMA OF MENTAL HEALTH AND ADDICTION

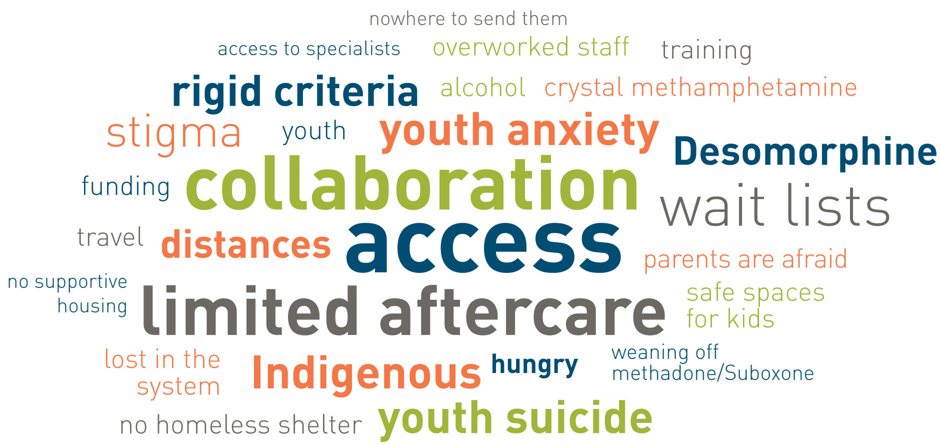
- Clients may be reluctant to seek care **due to stigma**
- Some clients have not been believed or helped adequately in the past, so are reluctant to seek help again
- Some harm reduction services in place, but lack community support

9. COMPLEX ISSUES

- Many individuals have concurrent addiction and mental health issues
- Staff must be creative and "think outside the box" to solve complex issues for their clients
- It is difficult to help **hungry** clients address mental health and addiction issues; staff pay out of pocket or bring food from home to feed clients
- It is difficult to help **homeless** clients address mental health and addiction issues e.g. an address is needed to navigate the mental health and addiction system
- A new gold mine in the area has sparked an **affordable housing crisis**; there is no **homeless shelter** for increasing numbers of "working poor" as well as older adults still working who cannot afford the high costs of rent
- **No supportive housing** means clients cannot leave situations of family violence and domestic abuse because there is nowhere else to go

10. FUNDING ISSUES

- Decrease in **funding** to pay staff
- More funding needed to maintain programs and services



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

1. WHAT COULD A NORTHERN CENTRE OF EXCELLENCE DO?

- Help drive grassroots initiatives and keep them going, write proposals, collect data, and provide training; overworked staff do not have energy or time to put into these much-needed activities that will improve service provision
- Document local knowledge and expertise, and provide a place to house that knowledge
- Bring people together from a variety of service areas so that what is available can be known to all
- Facilitate collaboration and consultation among service providers, organizations and schools in the north
- Coordinate problem-solving between communities, eg. "Fort Frances works on X, Kenora works on Y, etc."
- Allow front-line workers to "be the experts", and share best practices with others across [Northwestern Ontario]: "learn about what people are doing across [Northwestern Ontario] to help address the issues we're all facing"
- Share northern-based research that respects Indigenous knowledge and methodologies
- Provide a space for people with lived experience to share their knowledge and "provide healing and wellness to people in despair"
- Advocate for staff, providing training and support so they can better manage the trauma of the job, e.g. dealing with suicide
- Provide training to front-line workers to strengthen local capacity
- Educate workers about culturally safe and sensitive practices, opioid use in pregnancy, mental health promotion and literacy, etc.
- Facilitate access to specialist support for front-line staff

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

- Must be inclusive of First Nations people and respect Indigenous knowledge
- A blended model would be the most sustainable in NWO; because the internet is not reliable it cannot be completely virtual; face-to-face engagement is important, with a partner site in each community
- The virtual component is important to bridge distances; needs to be accessible and easy to navigate (have a local representative who can coordinate resources and needs)

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

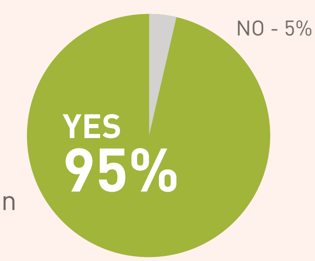
216 participants from 5 engagement areas

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