Community Needs **ASSESSMENT** Summary Report

2019

DETAILED REPORT OF FINDINGS:
Mental Health and Addictions

Health and Social Services
Haldimand and Norfolk

Report prepared by Quality, Planning, Accountability and Performance (QPAP)

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The following reports outlines results of the Haldimand Norfolk Health and Social Services (HNHSS) Community Needs Assessment (CNA) 2019. This section of the report includes detailed results and conclusions about mental health and addictions in the communities.

Community Profile

Mental Health

- Nationally, about 62% of Canadians reported a somewhat strong or very strong sense of belonging to their local community. In Ontario, about 70% of the population reported a somewhat strong or very strong sense of belonging to their local community. Local data are not available for Haldimand and Norfolk counties.
- Nationally, about 86% of Canadians reported being satisfied or very satisfied with their life. In Ontario, about 93% of the population reported being satisfied or very satisfied with their life. Locally, 93% of residents in Haldimand and Norfolk reported being satisfied or very satisfied with their life.
- In 2016 there were 11 suicides reported in Haldimand and Norfolk counties, compared to 20 in 2015, and 19 in 2014.
- The rate of emergency department visits for intentional self-harm was 142.2 (117.1-167.2) cases per 100,000 population in Haldimand and Norfolk counties, compared to 154.9 (152.6-157.1) cases per 100,000 population in Ontario. Further, the rate of hospital admissions for intentional self-harm was 91.3 (71.5-111.2) cases per 100,000 population in Haldimand and Norfolk Counties, compared to 71.1 (69.6-72.6) cases per 100,000 population in Ontario.
- 73% of residents in Haldimand and Norfolk reported that their mental health is very good or excellent compared to 71% in Ontario.
- 23% of Haldimand and Norfolk residents reported that their life stress is quite or extremely stressful compared to 22% in Ontario.
- The self-reported prevalence of anxiety disorders in Haldimand and Norfolk counties was 9.5%, compared to 8.6% in Ontario.
- The self-reported prevalence of mood-disorders in Haldimand and Norfolk counties was 10.2%, compared to 8.7% in Ontario.
- There are no registered psychiatrists or psychologists in Haldimand or Norfolk counties.

Substance Use and Addictions

- In Haldimand and Norfolk counties, the self-reported rate of exceeding the Low Risk Drinking Guidelines was 52% (45.9-58.2%), which was significantly higher than in Ontario (44%, 43.4-45.4%).
- The self-reported adult current smoking rate in Haldimand and Norfolk is 19.5% (15.0-24.1%) compared to 18.1% (17.3-18.8%) in Ontario.
- There were 67.9 cases per 100,000 population opioid related emergency department visits (n=76) in Haldimand and Norfolk, compared to 63.4 cases per 100,000 population in Ontario.

- There were 23.2 cases per 100,000 population opioid related hospital admissions visits (n=26) in Haldimand and Norfolk, compared to 14.6 cases per 100,000 population in Ontario.
- There were 9.8 cases per 100,000 population opioid related deaths (n=10) in Haldimand and Norfolk, compared to 10.2 cases per 100,000 population in Ontario.
- 12% of mothers reported smoking during pregnancy compared to 7% of Ontario mothers.
- 2.9% of mothers reported using alcohol during pregnancy compared to 2.4% of Ontario mothers.

Community Survey Results

Mental Health

- 12% (n=47) of survey respondents reported feeling socially isolated where they live. Further, 12% (n=50) of survey respondents reported that they felt they had no or little social support network.
- 77% (n=248) of survey respondents agreed or strongly agreed that Haldimand and Norfolk was a safe place to be their true self.
- 45% (n=183) of survey respondents reported experiencing depression and/or anxiety.
- 18% (n=72) of survey respondents reported experiencing other, non-depression, mental health difficulties, such as post-traumatic stress.
- In the past 12 months, 9% (n=28) of survey respondents reported experiencing a mental health emergency or crisis.

- The most commonly identified places people went during crisis were a family's home (49%, n=145), a friend's home (44%, n=131), or a doctor's office (29%, n=86).

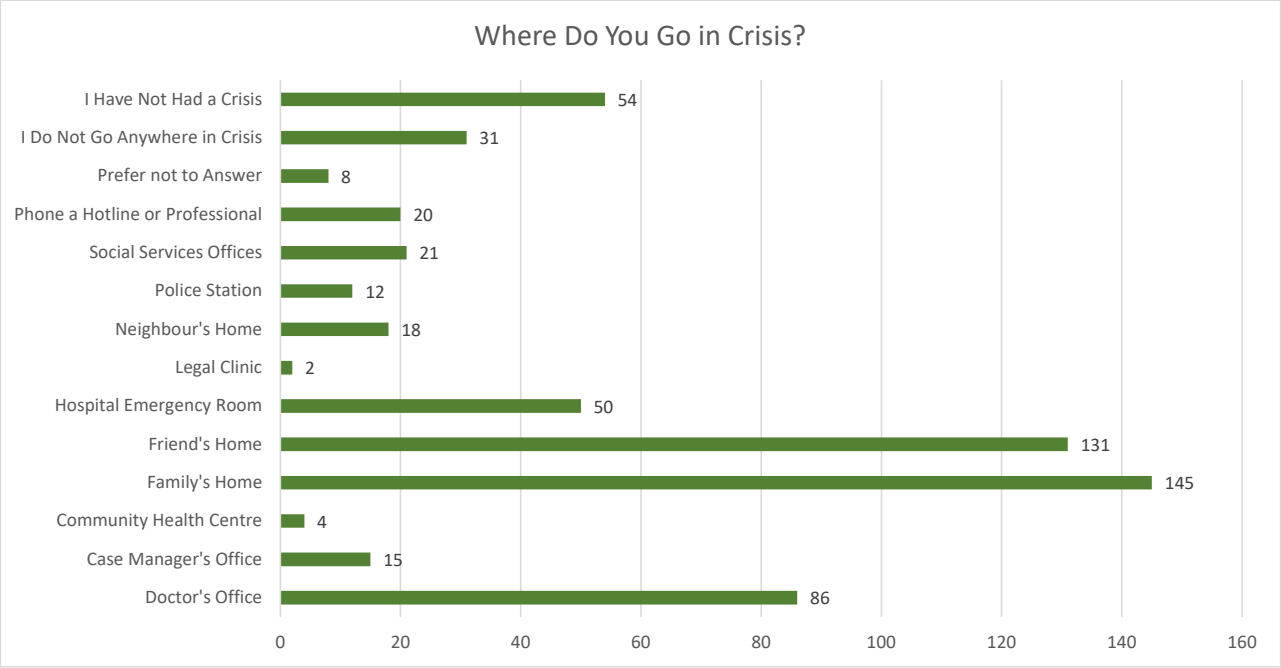

Figure 1. Locations that survey respondents report going to or attending when in crisis.

- 10% (n=30) of survey respondents reported that a psychiatrist was one of their primary healthcare providers and 4% (n=12) of survey respondents reported that a psychologist was one of their primary healthcare providers. Further, 8% (n=24) of survey respondents listed a psychiatrist as one of their primary social supports and 3% (n=9) listed a psychologist as one of their primary social supports.

Substance Use and Addictions

- 3% (n=14) of survey respondents reported an addiction to alcohol. However, 9% (n=27) of survey respondents reported having one or more drinks most days.
- 13% (n=53) of survey respondents reported an addiction to tobacco. However, 19% (n=58) of survey respondents reported using cigarettes or tobacco daily.
- 3% (n=12) of survey respondents reported an addiction to elicit drugs.
- 1% (n=6) of survey respondents reported an addiction to both alcohol and illicit drugs.
- In the past 12 months, 23% (n=71) of survey respondents reported being exposed to second-hand smoke while indoors.
- 36% (n=111) of survey respondents reported an awareness of the Low Risk Drinking Guidelines.
- In the past 12 months, 26% (n=79) of survey respondents reported using marijuana or cannabis products.
- In the past 12 months, 7% (n=21) of survey respondents reported using vaping products or e-cigarettes.
- In the past 12 months, 6% (n=19) of survey respondents reported using alcohol before or during driving; however, in the same period, no survey respondents reported using cannabis before or during driving.

Services

- Half (50%, n=158) of survey respondents reported that more mental health services were a top three need to keep their family safe. Further, 85% (n=249) of survey respondents agreed or strongly agreed that Haldimand and Norfolk counties need more mental health support services and counselling.
- 9% (n= 29) of survey respondents ranked tobacco cessation support as a top three service need for their family to be healthy. Further, 70% (n=203) of survey respondents agreed or strongly agreed that Haldimand and Norfolk counties need more resources to support individuals who want to quit smoking.
- 28% (n=88) of survey respondents reported that more services for substance misuse were a top three need to keep their family safe; whereas 21% (n=66) of survey respondents reported that more opioid misuse rehabilitation services were a top three need to keep their family safe. Further, 75% (n=219) of survey respondents agreed or strongly agreed that Haldimand and Norfolk counties need more resources to support individuals who misuse alcohol and drugs.
- When ranking their top education needs, nearly half (48%, n=152) of survey respondents ranked more accessible mental health services in their top three, and 22% (n=69) of survey respondents ranked more accessible services for substance misuse in their top three. 13% of survey respondents reported wanting more education or information about alcohol and other drugs.

- When listing their top three mental health supports needs for a healthy family, survey respondents ranked general mental health supports among their top three most often (54%, n=163).

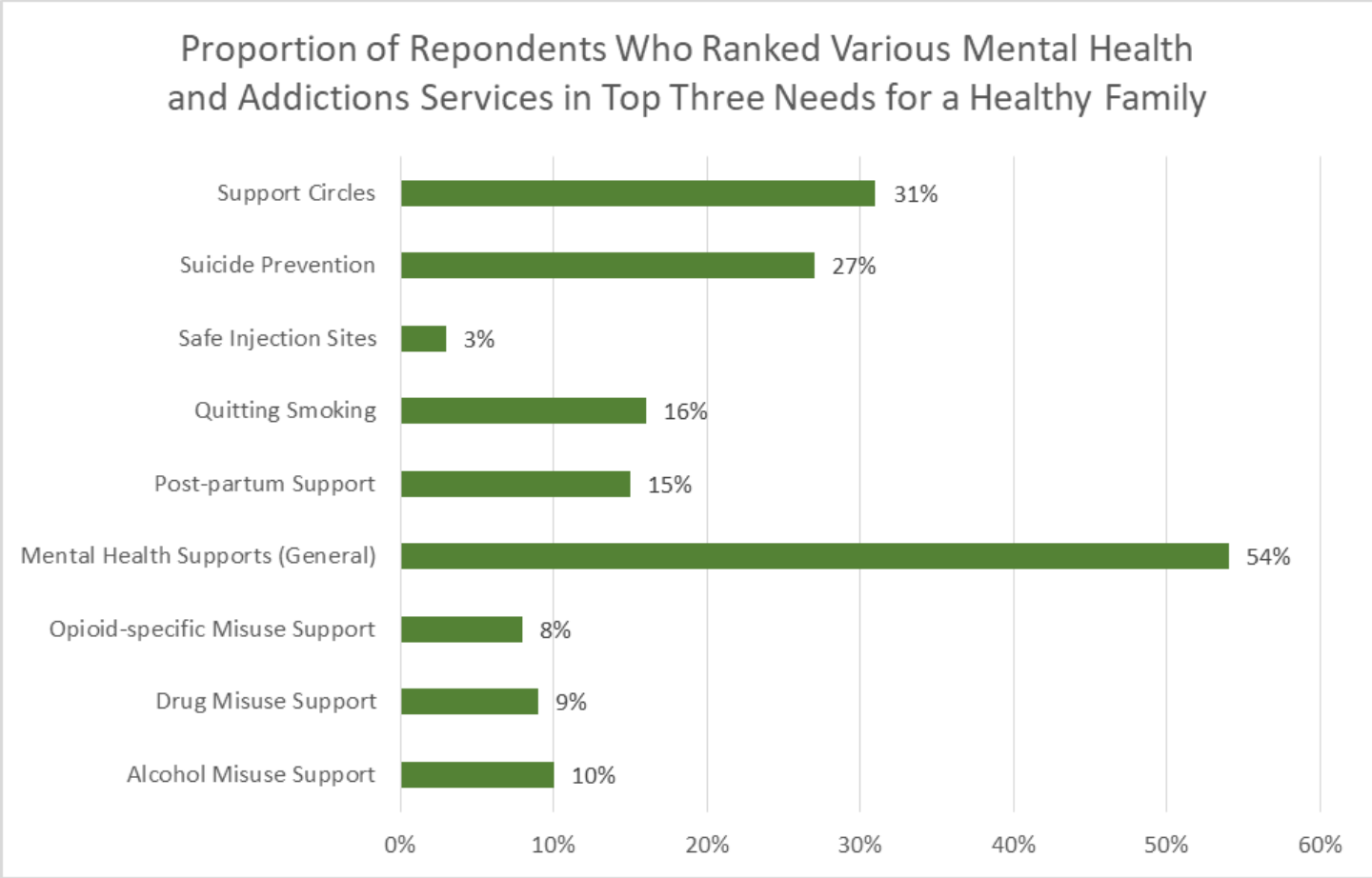

Figure 2. Proportion of respondents who ranked various types of mental and social services in their top three needs for a healthy family.

- Stress management (47%, n=141) and mental health and depression (44%, n=131) were the most commonly listed mental health and addictions topics that survey respondents wanted more education about.

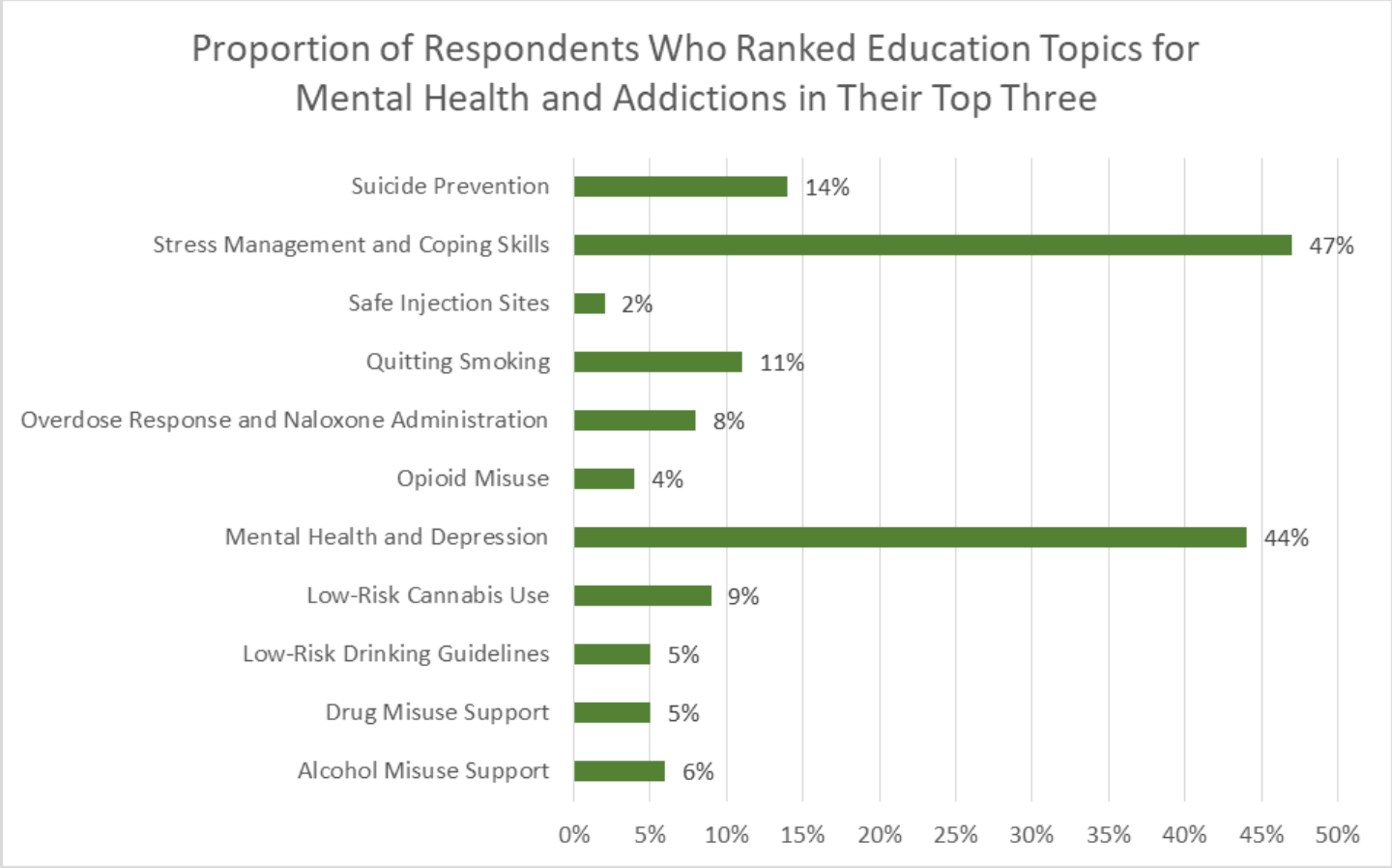

Figure 3. Proportion of respondents who ranked mental health and addictions topics in their top three education requests.

- In the past month, 2% of survey respondents attended Quit Clinics for help to quit smoking. However, no other client-facing services for mental health or addictions are currently provided by the HNHSS.

Focus Groups and Interviews

Seven major themes emerged from the qualitative data collected via focus group discussions and interviews: (i) Mental Health and Addictions; (ii) Physical Health; (iii) Poverty; (iv) Housing; (v) Rurality; (vi) Availability of Products and Services; and (vii) Organizational Structures.

This chapter on Mental Health and Addictions discusses the key themes associated with this topic.

Mental Health and Addictions

The most commonly discussed health need in focus group discussions and interviews was mental health and addictions support. Nearly every conversation in the data collection process referred to concerns about mental health and addictions in Haldimand and Norfolk counties. Cancer and Other Chronic Diseases

Mental Health Across the Lifespan

Mental health concerns were described across the lifespan. For example, one participant (KI70) discussed how mental health concerns among children and youth were increasing, sharing that, "Some of the contributing factors that we encounter are: learners that are homeschooled, interrupted education and undiagnosed learning disabilities/challenges. Many of our learners as a result of the aforementioned, also deal with addiction, mental illness and poverty." Another participant (KI21) reiterated this idea by saying,

"The only other thing that I feel has changed in the last little bit is the mental health component with youth. So our screening tools we use for our consent forms see a lot more anxiety and depression and those sorts of things are being captured as medical history. So mental health from where I sit looking in is a big one. And that specific age group looking at the 10 to 16 year age group we are seeing more of that."

In addition to discussions about how rurality is a major driver of mental health issues among youth (see below), participants also described bullying as a driver of mental health concerns among youth. For example, a participant (KI7) shared, "Well there could be bullying issues in the school. There could be self-esteem, bullying." Many participants described how mental health for youth was a priority issue to address with solutions-oriented focuses. One participant (KI46) described the need by saying, "We need to really focus on wellness for youth and strategies for good health and being connected with their community." However, another participant (KI46) worried that current youth programming was not a sufficient remedy to the mental health issues youth were experiencing,

"Well, I think if we start with youth, there are lots of programs. But I worry that sometimes our programming is only putting Band-Aids on what the issues are. And we need to step back and see how we can be proactive and start with our youth to provide them with opportunities to be connected. We live in a world of being connected by technology. But we need people, especially youth, to be social and be connected."

Moreover, conversations about mental health among youth also touched on addictions and substance use experimentation issues. In particular, participants discussed how experimentation with substances was beginning earlier and earlier, and how this dramatically impacted programming at HNHSS. Participants typically suggested the cause for this shift was boredom caused by being a rural community and mental health concerns. One participant (KI36) explained,

"Youth vaping! A lot of our schools are connecting with us with concerns. Actually, last night actually I got an email form, I guess is a school in Caledonia Elementary School. Grade fives and sixes. We know what's wrong. My son's in grade five and one of his friends trying to be. So it is starting younger. But vaping is definitely becoming a need expressively in our community, more so from the youth prevention side of it."

Some participants also shared that a major concern with regards to youth substance use was related to the accessibility of substances. For example, one person (KI36) shared, "The accessibility is a real issue for when it comes to tobacco, vaping, and alcohol."

Further, others discussed how mental health concerns among seniors were also increasing. For seniors in the community, there was a general discussion of increasing needs for mental health supports. For seniors in care, one participant (KI69) explained that, "Mental health issues are not only issues for the young," later adding that there was, "an increased demand for mental health services for the elderly," and adding that in care, "the secure unit has higher acuity than before," referring to increasing prevalence of and intensity of mental health needs among seniors than a decade earlier in their career.

Despite the discussions of mental health across the lifespan, the majority of conversations about mental health and addictions were still focused on adults in the general population, typically referring to adults aged 19-64 years.

Prevalence and Severity of Mental Health and Addictions Concerns

Participants working with agencies frequently commented on changes over time with regards to mental health and addictions. Staff at HNHSS and other agencies referred to an increasing prevalence and severity of mental health issues among their client populations. For example, a participant (KI1) noted, "In terms of vulnerabilities, we are seeing increased prevalence and severity of mental illness, physical disability and addictions." Another participant (KI59) made similar observations of changes in the community, "… we see a lot of mental illnesses. Something that I guess has always been in the population but there are there are definitely more of them." Later a participant (KI1) added that this increasing prevalence and severity was also true of addictions, "And in that time, the prevalence and severity of addiction, it is just, grown, so much. And at such a dangerous, life-threatening level for people."

Further, participants shared how these changes impacted the ways that services must be provided to clients and the need for a trauma-informed lens in care of patients struggling with mental health and/or addictions issues. One participant (KI33) explained how these changes shifted the types of services that clients needed as well,

"Our community in general is changing. Like Dunnville as a community, we see more addiction, more crime on the rise, our caseloads are becoming more of the vulnerable people with multiple barriers rather than the in between jobs people who are coming on and exiting really quickly. Those sort of like just need a hand to strive from one job till the next. We get a few, but our caseloads are primarily like longer term clients."

While most concerns about changes over time were about adults, some also reflected children and youth as well. One participant (KI7) described school-based observations of change, "…one principal said to me when we met with him with the carrot plans that they are seeing more and more children with what is the word, regulation issues. The children are having a greater difficulty regulating themselves."

Despite the increasing prevalence and severity of mental health and addictions issues, some participants felt it was harder to have these needs considered a disability. One participant (KI1) described that, "The province has also changed the definition of a person with a disability for the purposes of [Ontario Disability Support Program]." This was described as a further complication to providing services for clients who may have previously been serviced through another program.

Stigma

Participants with both lived-experiences and those at agencies working with clients experiencing mental health and addictions concerns also described concerns about stigma frequently. One participant (KI4) described the realities of mental health and addictions issues and the stigma that individuals were facing from the community by saying,

"Addiction is a vicious disease where that is the primary focus. So you see people who are so focused on getting high that other thing are not important to them- their family, their children, their housing, their income become less important to a point where they neglect it. And these are things that people wouldn't normally neglect. This is a bad disease. Nobody says 'I'm going to choose heroine over my children'. It just shows you how detrimental it can be, how dangerous it is. It is beyond that person's capability. … So, it's just basically working of the stigma of it, because people want to villainize addicts…"

Other participants described how stigma might be so palpable in some cases that individuals would entirely avoid the services that they could be using in the communities. This was regularly described as being associated with rurality and the small-town feel of the communities. For example, a participant (KI30) explained,

"I don't feel comfortable going to it because of whatever kind of relation problems. I think there's also the fact that it is stigmatized. It's a very stigmatized. Or even accessing it. It's like, well, my aunt works at that clinic. Right. It's very small. And so there's the perception that will if I go to that, the rest of the community is going to hear about it downtown."

Poverty

In context of mental health and addictions, poverty was often described as a cause, such as how poverty may lead to or exacerbate mental health concerns, and as an outcome, such as how mental health concerns may make it difficult to seek employment. For example, one participant (KI7) stated,

"I would say poverty is a huge issue and I would say mental health. Poverty, mental health, and I would say supports because parents don't always know to ask, and don't have anybody to ask when they have a question, and so they feel alone, so that makes mental health even more worse and everything costs a lot. Financially it makes it hard as well. I think it's a vicious circle for them."

As a cause, poverty was described as a major stressor for mental health and addictions issues. Participants described how living in poverty created stress on the client's mind and how this stress often led to mental health issues. For example, one participant (KI10) clarified,

"The three priority areas are sort of linked together. When you don't have housing, live below the poverty line, you can have different forms of mental health and addiction challenges which lead to all of those things combined. Our numbers are just high unfortunately in Haldimand and Norfolk and our stats can demonstrate that."

However, poverty was also described as an outcome of mental health and addictions issues. For example, this same participant (KI10) also shared that, "Homelessness, poverty, challenges with employment and not just retaining employment but maintaining employment and life stabilization are some of the impacts [mental health and addictions] has." Several focus group discussion and interview participants explained that individuals living in poverty are often categorized according to whether they are experiencing mental health and addictions issues, for example describing a stigma that may exacerbate the mental health issues someone is experiencing. A participant (KI17) described,

"Often I think like because it just keeps dividing people into, the poor people and the addicts and the people with addictions. And they're all over here, you know, precariously housed. And they kind of stay over there. And every time they try to jump over the canyon, they're just scrambling to stay over here. And it's very difficult. Seems what it looks like, doesn't it? It's very hard to make the transition. Very difficult and we're over here on this side saying, 'well, you just need to get a job and you just need this, this and this'. Yeah. That kind of thinking has to go out the window."

Rurality

Mental health and addictions issues were discussed in conjunction with rurality in two key ways. First, in context of the isolation in rural communities, and second, in context of the services available for mental health and addictions in rural areas (see next).

Isolation

Similarly to the quantitative data collected in the profile and survey, focus group discussions and interviews often highlighted how rural areas were at increased risk for mental health and addictions problems as a result of isolation. With regards to both adults and youth, participants described isolation in context of loneliness and boredom.

In one focus group (FG3), participants discussed how isolation in rural communities, especially communities without reliable transportation, made people, particularly vulnerable individuals, feel lonely. Interview participants shared similar testaments, where one participant (KI44) suggesting that, "Being socially isolated or with a rural environment poses significant challenges for [agencies]." Another participant echoed this, "I think a lot of people are socially isolated because of the lack of transportation or the inability to navigate the system or know where the resources are and how to get what you need."

Boredom was more commonly discussed in context of youth than any other age group. Participants sometimes described how a lack of recreational and other facilities resulted in bored youth who were more likely to experience mental health

and addictions issues following that. For instance, one participant (KI28) noted,

"A lot of kids are having to lower their expectations with regard to what they have to see here. We are running into that already. 'Where are your pools? Tennis clubs? All those things that we had back in Mississauga'... I just had a conversation on my way here with a resident in [our community] who came from the [City] and operates a business in the city of Toronto. He is divorced but has a young boy here in public school and is going on and on about the fact that there is nothing for his kid to do here other than hockey and soccer."

Further, one participant (KI29) explicitly linked the local youth experience with addictions and boredom and described how it made youth want to leave the area,

"Nothing they say will make them want to stay. It is just like, if you have struggled our whole life and all you see in downtown Simcoe is drugs, why would you want to stay around that for the rest of your lives. There are just so many more opportunities in other communities. There are drugs in other communities; it is not just seen as a crux."

Availability of Products and Services

When discussing mental health and addictions, the issues of availability of services were described as a major concern in most conversations. These issues around availability included lack of available services in the community and distance to reach services, long wait times, and a lack of population-specific resources.

Community Services for Mental Health and Addictions

Participants in both focus groups and interviews repeatedly explained that services for mental health and addictions were not located in their communities or readily accessible to them. The lack of services were described as a gap in provisions in the community, such as when one participant (KI39) said, "There is a big gap here with mental health and addictions. We do have Hope House and they are very good. It's difficult to care for those patients here in the rural setting when we don't have psychiatry."

However, more than just a lack of in-patient centres for mental health and/or addictions, participants also described the lack of available counselling here. One participant (KI20) described, "Counselling is a huge issue as well. The doctor can chat with them briefly. But he doesn't have an hour for everybody because he is here for three hours. We have the CAMH ladies that come by. They are totally helpful but they are not psychologists and they cannot afford a counsellor." The issue of accessing services for mental health and/or addictions in Haldimand and Norfolk was compounded by the lack of available family physicians; one participant (KI42) explained, "Significant mental health needs in community and among clients—no beds in the community, mental health supports are not easy to get. Especially hard for individuals without a family doctor."

Wait Times

Wait times were described as an ongoing barrier to accessing services for both mental health and addictions treatments.

Over and over again participants described how the services for mental health had extremely long waitlists. For many,

this seemed to be one of the most substantial barriers to accessing services. Two participants articulated the implications of long waitlists for mental health services very clearly:

(KI44) "Access to certain medical services, counselling waitlists can be very long. Getting psychiatric assessments are very limited around here. If they are able to get in it's usually the skype type ones. And then they usually have to go to Brantford to do those. I think just the fact that it is so much information when they get here too."

(KI4) "Because they are also inundated with high volumes of seeking help, so there is a wait list. And then to get access to a psychologist is another wait list. So this whole system that they have to navigate through feels challenging. It makes people just say forget it, I am not going to do it, I am not going to pursue it any further."

Further, when comparing services in Haldimand and Norfolk counties to local municipalities, one participant (KI14) explained that the difference in lengths of waitlists was quite substantial, "… the waitlist for mental health and for housing there is like nothing compared to what we have here. You are at least probably looking at six to nine months for counselling. Whereas there you were unlucky if it was even three."

When describing the barriers to mental health and addictions services, one participant (KI16) explained why they felt that wait times were the greatest barrier to accessing necessary services,

"The waiting list… There is never any services for people. I have naloxone if you overdose. But I don't have anywhere to send you for the treatment you actually need so you won't use or that you'll reduce the use that you are currently using. It's very frustrating, mental health, the same thing. Psychiatrists are few and far between. There are wait lists for them. There's mental health restrictions so if my client doesn't want to take medication, the psychiatrist will refuse to work with her. She could be on a year wait list, have a 10 minute appointment and never be seen again because she didn't want to take the medication. There is good reason not to take the medication. There are some side effects that make the people uncomfortable. Sometimes you have to form a trusting relationship with a professional before you trust them to take the mediation. So it's just very concerning."

One participant (KI43) explained how long wait times may be dangerous for individuals in crisis, "Counsellors have waitlists of up to 1.5 years; suicidal need help immediately—shameful." Relatedly, with specific reference to addictions treatments, participants explained that waiting for service might be the determining factor as to whether an individual enters services at all. Participants explained that the motivation and willingness for a person struggling with addiction to enter treatment changed as quickly as daily or faster. One participant (KI26) explained this by describing, "…a lot of the times we hear from individuals that the wait time for various services like treatments, detox, you can't necessarily get it that same day when they will be ready or considering it. That is probably pretty high up there as a need." Another participant (KI22) shared a similar experience and described how this impacted other health services, "I find with folks who are higher priority, waiting a week is too long, its simply too long. We hear that when we see return visits to the emergency department because quite frankly, 911 is their instant access to things."

Population-Specific Resources

Mental health services for youth were commonly described as a population-specific service that was lacking in Haldimand and Norfolk. Participants explained how there was limited capacity to deal with mental health concerns for youth

here. One participant (KI5) described how most youth mental health programming was referred to Hamilton, "The mental health impacts right now are getting bigger because there is lack of service within Haldimand and Norfolk and they have to go outside of our region to get the type of service. They can still access Macmaster Children Hospital but the waitlist for the service is a big one." Another participant (KI7) described, "Mental health is such a huge issue out there for parents, for children and how to access services. We have limited services out there. And knowing who to access when and which door to knock on."

Conclusions

Mental health and addictions was described frequently as the greatest need in the communities in Haldimand and Norfolk counties. Both survey respondents and focus group and interview participants ranked this as a major concern again and again. Participants linked the issues of mental health and addictions to all other aspects of their life, such as poverty, and housing. Addressing the mental health and addictions crisis in this region was a priority for participants. Moreover, the lack of available resources was seen as a great barrier to service and the lack of population-specific services, such as for youth, was another major concern. Ideas related to mental health and addictions can be seen throughout most of the other chapters of this report as well.

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