Researching Health in Ontario Communities (RHOC)

Findings from our First Communities: Port Colborne and Welland

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Executive Summary

Mental health, substance use, and violence problems are important public health concerns that impose considerable economic, health and social costs on individuals, families, communities, and societies.

In order to improve understanding, prevention and treatment of mental health, substance use and violence problems in Ontario, a multi-disciplinary team of researchers from the Centre for Addiction and Mental Health (CAMH) developed the research program, Researching Health in Ontario Communities (RHOC). Working closely with community and provincial partners, RHOC uses a mobile research laboratory to bring research to diverse Ontario communities, including rural, remote, Northern, urban, and First Nations communities. The project is funded by the Canadian Institutes of Health Research (CIHR).

In the spring of 2011, RHOC investigators launched the research project in Port Colborne and Welland. Following Welland, research was completed in Windsor and Leamington. As of the fall of 2012, the project is ongoing at Kettle and Stoney Point First Nation, and it will be starting in the Sudbury area in 2013. This is the first community report from the project. In it we describe the findings from the research conducted in Port Colborne and Welland.

In Port Colborne and Welland, we conducted four pilot studies to examine mental health, substance use, and/or violence problems:

1. Consumer Journey Study
2. Intimate Partner Communication and Conflict Study
3. Stress and Mental Health Study
4. Evaluation of Health States Study.

In addition to completing a pilot study, all participants were asked to complete a computerized questionnaire which included standard questions regarding service utilization, stress, mental health, substance use and experiences of violence. Participants in the four pilot studies were also asked to provide biological samples – hair, to examine stress cortisol, and saliva, to examine genetic vulnerabilities to mental health and substance use problems.

This report provides a description of the overall RHOC project (Chapter 1) and outlines methods and results for the Consumer Journey Study (Chapter 2), the Intimate Partner Communication and Conflict Study (Chapter 3), and the Stress and Mental Health Study (Chapter 4). The report also describes service utilization patterns and unmet need for all study participants, with comparisons drawn across studies (Chapter 5). Because the Evaluation of Health States Study was designed mainly for statistical purposes (i.e., the improvement of measures of population health), we do not devote a chapter to this study in the present report. Methods for this study are outlined in Appendix A. Detailed results from the questionnaire data for the four pilot studies are presented in Appendices B (Port Colborne) and C (Welland), respectively. Analyses of biological samples are still underway and are not presented in this report.

Consumer Journey Study

The Consumer Journey Study involved interviews with individuals who currently have or previously had mental health and/or substance use problems and who have sought help for these problems ("consumers"). Family members of consumers were also interviewed. The goal of this study was to document individuals' experiences seeking and receiving care and to identify the major barriers and facilitators associated with consumers' journeys through the local system.

As described in Chapter 2, participants in the Consumer Journey study in both Port Colborne and Welland had complex stories to tell that shed light on the strengths and weaknesses of local services. Participants commonly felt that their problems with mental health originated in childhood and that substance abuse was a coping mechanism used to deal with either childhood trauma or stressors associated with their mental health problems. Most individuals experienced co-occurring problems and

had struggled to find care that adequately addressed the complexity of their needs. Participants felt that the Niagara region was underserved in terms of both primary and specialized care for mental health and addictions. Transportation and financial barriers were identified as major impediments to accessing needed care. Lack of affordable counselling was also a major concern, as were long waitlists and stigma. Participants also indicated that physicians and psychiatrists who do not show empathy and/or do not spend sufficient time with them was a key barrier to improvement.

Many participants had experienced elements of success in their journey, and felt that certain local services (especially Port Cares, Hope Centre, and methadone services) were especially helpful. In addition, family members served a very important supportive role and often helped consumers obtain care.

Participants' recommendations for improving services included: more local services and more local health care professionals (including family physicians, more local specialized care for mental health and addictions, and care for concurrent disorders), more affordable counselling, assistance with transportation, and more help navigating the system.

Intimate Partner Communication and Conflict Study

This study (described in Chapter 3) sought to better understand intimate partner violence among young adults by examining a broad range of aggressive incidents, including physical and non-physical aggression.

Because general population studies have been limited by the difficulty of recruiting young adults, especially men, the first focus of the study was to test new approaches to participant recruitment. We found that Respondent Driven Sampling was effective for recruiting women in Port Colborne but not men. Therefore, we tried a different approach in Welland involving recruiting people in the appropriate age group from the mall for immediate participation. This method proved more effective but in neither community was it possible to recruit a fully representative sample of young adults.

The study also sought to develop a measure of perceived contributing factors to incidents of aggression and violence. Such information can provide critical insight for developing effective preventive and remedial interventions for partner aggression and violence among youth. The final version of the measure contained about 160 questions grouped under 16 themes (e.g., communication, stress). An important finding was that participants saw different factors contributing to their partner's aggression compared to their own aggression. In particular, they saw their partner's aggression as being influenced by their aggressive or controlling personality and a desire to make the participant feel bad, whereas they saw their own aggression as being a reaction to feeling disrespected and an attempt to end the fight.

Although the Respondent Driven Sampling recruitment method did not result in representative samples, the diverse participants recruited in the two communities provided rich and detailed descriptions of aggressive incidents and the factors that were perceived to have influenced these incidents. Based on these descriptions, we were able to extend previous distinctions of intimate partner violence, which divides aggression into "intimate terrorism" and "situational violence," to include a third category – aggression related to a troubled or unhealthy relationship. Troubled/unhealthy relationships were commonly related to: mental health problems of one or both partners; substance use or addiction by one or both partners; and trust/jealousy issues. Identification of this third group has important implications for prevention efforts and service planning. Of course, prevention of and services for intimate terrorism is of highest priority. However, incidents of aggression that occur in unhealthy relationships can also have detrimental psychological and physical consequences. As such, services are needed addressing these relationship problems as well.

Stress and Mental Health Study

This study tested a "random walk" (door to door) approach to recruiting a random population sample in Port Colborne, and examined various measures of stress, depression, substance use, the impact of other people's drinking on participants' lives, social support and coping. As described in Chapter 4, the "random walk" approach produced a reasonably good response rate of about 50% (number of participants = 92), which is comparable to recent telephone survey response rates.

Results from the study revealed that common sources of stress were financial and work-related problems (e.g., being demoted at work or having to change to a worse job). Women were more likely than men to experience stress. Thirteen percent of respondents reported symptoms of a major depressive episode in the previous 12 months, with notably high levels of depression among men (15% of male respondents, compared to 11% of females). Daily use of tobacco was high compared with the general population of Ontario (35% of the current sample, compared to 15% of the Ontario population in 2009). Similarly, heavy episodic drinking (i.e., 5 or more drinks on a single occasion at least once a week) and hazardous drinking were high, particularly among men, with 39% of male respondents reporting harmful levels of drinking, compared to 10% of female respondents. Comparatively, 19% of men and 8% of women in the Ontario population in 2009 reported hazardous or harmful drinking. Many respondents reported being negatively affected in various ways by another person's drinking, including people in their personal lives as well as strangers.

Participants reported that they received a great deal of social support from friends and family. For example, 91% of respondents said that they have a friend or relative whose opinions they trust. When dealing with stress, respondents commonly used strategies such as trying to look on the bright side of things (90%) or talking to others (82% of female respondents and 58% of males). However, some respondents reported using substances in order to feel better. For instance, 27% of the sample said that they deal with stress by smoking cigarettes more than usual, while 18% said they try to make themselves feel better by drinking alcohol.

Service Utilization and Unmet Need

Chapter 5 examines service utilization and unmet need for emotional/mental health problems, substance use and violence problems. Family doctors were found to be a common point of contact for people seeking help for these types of problems. The internet was also used a great deal when people were seeking help, suggesting that the internet may be an important place to provide information regarding local supports for emotional/mental health problems, substance use and violence problems.

Community Stakeholder Comments

The findings from this report were presented at a community forum held in Welland on October 3, 2012. This event provided an opportunity for the project's advisory committee members and other community stakeholders to discuss the findings and to share insights gained through their own knowledge of and experience with the community. Attendees at the forum, the majority of whom worked in social service professions or within agencies addressing mental health, substance use, or violence problems, generally felt that the results corroborated their experiences working within the community. Specific comments from forum attendees for each study can be found in the respective chapters. Because Chapters 4 and 5 were presented together at the forum, discussion surrounding both chapters is presented at the end of Chapter 5.

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Chapter 1: Introduction

Background

Mental health, substance use, and violence problems are important public health concerns that impose considerable economic, health and social costs on individuals, families, communities, and societies. The annual costs associated with treatment for mental illness in Canada have been estimated at $6.3 billion. Indirect costs due to lost productivity associated with mental health problems have been estimated at approximately $8.1 billion (Stephens & Joubert, 2001). In 2002 alone, Canadian health care costs related to alcohol, tobacco and illicit drug use were estimated at $8.8 billion (Rehm et al., 2006). A recent study suggests that violence against women costs the country another $6.9 billion (Varcoe et al., 2011). Aside from these economic costs, the personal and social burden associated with mental health, substance use, and violence problems is enormous.

Importantly, research indicates that mental health and substance use problems commonly co-occur, and that these problems, as well as their co-occurrence, are strongly associated with violence. Mental health, substance use, and violence have complex aetiologies involving both individual-level factors (such as stress in a person's live) as well as community-level influences (such as community safety) that may act independently and interactively to affect community members' well-being. In order to better understand mental health, substance use and violence problems and develop initiatives to address these problems in local communities, a multi-disciplinary program of research is required that addresses a wide range of biological, behavioral, and social factors operating at the individual and community levels.

Researching Health in Ontario Communities (RHOC) is a research initiative led by a multidisciplinary team of investigators from the Centre for Addiction and Mental Health (CAMH) that seeks to improve understanding, prevention and treatment of co-occurring mental health, substance use and violence problems in Ontario. RHOC is funded by the Canadian Institutes of Health Research (CIHR) under its team grant program. With a team of experts from the biological, social and behavioural sciences, RHOC is able to examine the complex interplay among a diverse range of factors that contribute to mental health, substance use and violence problems. By conducting the research at the community level, RHOC is able to provide Ontario communities with data that are often unavailable from larger provincial or national surveys.

The RHOC project involves close collaboration with community stakeholders throughout the research process, including representatives from local and regional health agencies focusing on prevention and treatment of mental health, substance use, and/or violence problems. This collaboration ensures that the research is relevant and meaningful to the community and facilitates use of the findings in local efforts to improve the well-being of community members.

RHOC's Objectives and Research Plan

The objectives of the RHOC project are to:

- better understand individual-level and community-level factors associated with mental health, substance use and violence problems
- evaluate the extent of unmet need related to mental health, substance use and violence problems in Ontario communities
- use research knowledge to inform strategies for the prevention and treatment of mental health, substance use and violence problems and to improve the capacity of community services to respond to community members' unmet needs

- establish a protocol for working with local community partners in the development, implementation and application of research
- develop a database of indicators for participating Ontario communities with information on mental health, substance use, violence, stress, and service utilization within the community, among other factors, to be used in ongoing research and in community planning.

Structured around these objectives, RHOC's research plan consists of five key components. First, a mobile research laboratory is used for all data collection. Second, pilot studies are initially conducted to develop research protocols and provide preliminary findings; this pilot work forms the basis for developing larger studies. Third, a common set of variables related to key individual-level measures of mental health, substance use, violence are collected in all studies (the RHOC "core measures"). Fourth, in the long term, RHOC investigators will develop a community indicator database for participating communities. The fifth key component of the RHOC project is involvement of community stakeholders in the planning, implementation, and interpretation phases of the research. These five components of the project are briefly described below in turn.

Bringing Research to Local Communities with the CAMH Mobile Research Lab

All studies conducted as part of the RHOC project use the CAMH mobile research lab to collect data in Ontario communities. Funded by the Canada Foundation for Innovation, the mobile lab is a 34-foot specially outfitted trailer consisting of interview rooms, computers and equipment for extracting and storing biological samples. The mobile lab is wheelchair accessible.

The mobile lab allows CAMH researchers to conduct research "on the ground" in diverse communities across the province of Ontario, including rural, remote, Northern, urban and Aboriginal communities. The lab permits high-quality research to be conducted in a standardized way across all of these varied settings. It also allows for research to reach smaller communities that are often missed in larger provincial or national studies, thereby providing local data to communities that might not otherwise have such information. In each community, local staff are hired and trained to collect data. In this way, the RHOC project provides a unique learning opportunity for local communities, allowing students and trainees to participate in a multidisciplinary team research setting where they can obtain hands-on research experience in the areas of mental health, substance use and violence.

Pilot Studies

The RHOC project consists of a series of pilot studies that are led by different investigators on the RHOC team. In these pilot studies, researchers investigate important topics relating to mental health, substance use and violence problems. They also design and evaluate new data collection methods and survey instruments for use in subsequent research studies. All pilot studies aim to provide a better understanding of mental health, substance use and violence problems in Ontario communities and are used to inform the development of larger projects on these topics.

Four pilot studies were conducted in Port Colborne and Welland: the Consumer Journey Study; the Stress and Mental Health Study; the Intimate Partner Communication and Conflict Study; and the Evaluation of Health States Study. The Stress and Mental Health Study was conducted in Port Colborne only, while the other three studies were conducted in both Port Colborne and Welland.

The CAMH mobile research lab in Port Colborne, April 2011

The Consumer Journey Study, led by Samantha Wells, Andrea Flynn and Nick Kates, examined barriers and facilitators to care among persons with mental health and substance use problems through interviews with both treatment consumers who have one or both of these types of problems and family members of consumers with these problems. This qualitative study sheds light on the lived experiences of individuals with mental health and substance use problems, with an emphasis on concurrent disorders, and thus uncovers details that can illuminate avenues for service improvement. Methodological details and results for this study are presented in Chapter 2.

Led by Kathryn Graham, the Intimate Partner Communication and Conflict Study examined young adults' experiences of aggression (both non-physical and physical) in intimate relationships and their perceptions of why aggressive incidents happen, with the goal of uncovering how different perceived motives relate to aggression severity and determining the extent to which perceived motives can serve as a basis for differentiating minor intimate partner aggression from aggression leading to emotional or physical harms. Methodological details and results for this study are presented in Chapter 3.

Led by Samantha Wells, Andrea Flynn and Paul Tremblay, the Stress and Mental Health Study tested a "random walk" technique for recruiting participants for a study focusing on biological, social, and epidemiological measurement of mental health, stress, substance use and violence. In addition, participants were asked about the impact of other people's drinking. Participants were recruited using a random household sampling strategy and invited to visit the mobile lab for completion of a computerized questionnaire and provision of hair and saliva samples (see "core measures" below). Methodological details and results for this study are presented in Chapter 4.

Led by Jürgen Rehm, the Evaluation of Health States Study examined people's evaluations of the disabling effects of different health conditions, including both physical and mental health problems. The study also examined the association between individuals' own health status, including depression and drinking problems, and their evaluations of disability. The goal of this study was to improve measurement of population health. See Appendix A for more information about this study.

In the following chapters, the Consumer Journey Study, the Stress and Mental Health Study, and the Intimate Partner Communication and Conflict Study are each described in more detail and corresponding results are presented. Because the Evaluation of Health States Study was designed mainly for scientific purposes (i.e., the improvement of statistical measurement of population health), we do not devote a chapter to this study. Descriptive data from this pilot study relating to demographics of participants, alcohol use, substance use, and mental health are presented in Appendices B (Port Colborne) and C (Welland).

Core Measures

All study participants who came to the mobile lab to participate in a pilot study were asked to complete a computerized questionnaire consisting of a standard set of measures relating to:

- service utilization (including formal and informal services and supports) for mental health, substance use, and violence problems
- stress
- social support
- mental health problems (depression, anxiety)
- disability/daily functioning
- substance use and problems, including tobacco, alcohol, prescription drugs, and illicit drugs
- partner and non-partner violence

Additionally, to assess biological vulnerabilities to mental health, substance use and violence problems, participants were asked to provide a sample of their hair (to detect cortisol levels as a measure of chronic

stress) and a sample of their saliva (to examine genetic factors that are hypothesized to be involved in mental health and substance use problems). The results for the core questionnaire data are provided in Appendix B (for Port Colborne) and Appendix C (for Welland). Results for biological samples are not presented in this report. Genetic analyses require a large volume of data and at this stage interpretation of results for individual communities is not possible. The analysis of hair to examine stress is a relatively new field of study and investigators are currently working toward refining interpretation of data.

Community Indicator Database

An important long-term goal of the RHOC project is to develop a community indicator database with data for participating RHOC communities. This database will be created using existing statistics from Statistics Canada (e.g., Census data, Canadian Community Health Surveys) to create economic indicators relating to income, educational attainment, labor force activity (participation, unemployment rate, industry), and dwellings owned versus rented, as well as indicators of social capital (e.g., engagement in community activities, volunteering, etc.), health service utilization, access to health care, and satisfaction with the health care system. The RHOC community indicator database will also include variables from RHOC's core questionnaire aggregated to the community level (for example, community rates of alcohol use, partner and non-partner violence, co-occurring mental health and substance use problems and disability rates due to such problems, etc.). Additionally, variables unique to specific projects will be aggregated to the community level wherever possible, producing, for example, prevalence estimates of stress among young adults. The community indicator database will occur in later years of the RHOC project.

Community Involvement

During the planning and development of the research the RHOC team works closely with a community advisory committee, which included representatives from local and regional health and social service agencies. These individuals meet with the RHOC team on a regular basis and provide input throughout the research process to ensure that the research team understands community needs and concerns and the research is appropriate to the community setting.

Community Selection

Communities are selected for the RHOC project based on both research considerations and community support. The goal of the RHOC project is to explore a a wide range of communities, including communities that are at high risk of experiencing mental health, substance use and violence problems as well as communities that are representative of the Ontario population on key indicators such as median income, unemployment rate, proportion of dwellings rented (rather than owned), and proportion of families headed by a single parent. Using these data and applying Geographical Information Systems, these indicators were graphed to map differences in indicators across the province, allowing for informed selection of a diverse range of communities. From here, we consulted with community experts and stakeholders to determine the level of community interest in being involved in the pilot phase of the RHOC project. Due to the overwhelming support that the project received from the communities of Port Colborne and Welland, these two communities were selected as the initial sites for the research.

Ethical Considerations

All data collection procedures and instruments were reviewed and approved by the Research Ethics Board (REB) at CAMH. Additionally, the mobile lab and corresponding research in the lab underwent a Privacy and Impact Assessment conducted by the CAMH Privacy Office which incorporates privacy documents developed by the office of the Information Privacy Commissioner of Ontario (IPCO).

Cautionary Note – Data Considerations

Given that the RHOC project in Port Colborne and Welland involved pilot work, caution should be used when interpreting the data. In particular, the data are not designed for making community comparisons (that is, comparing statistics for Port Colborne to those in Welland). Additionally, prevalence data (i.e., rates of depression or hazardous drinking) should be interpreted only in reference to the specific study sample for which the data were collected. For example, the Consumer Journey sample was collected using posters and advertisements and therefore may not be generalizable to all people in Port Colborne and Welland who have sought help for mental health and substance use problems. The random walk sample (i.e., Stress and Mental Health study) is a random sample generated from the general population and therefore is the only data that might be considered generalizable to the population of Port Colborne. However, as discussed in Chapter 4, the sample size for this study is small (92 cases), making it difficult to conclude that the findings necessarily represent the entire population of Port Colborne.

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Chapter 2: Consumer Journey Study

The main aim of the Consumer Journey Study was to better understand the experiences of seeking and receiving care for people who have mental health and substance use problems. In this research we placed particular emphasis on co-occurring problems and also took into consideration experiences of violence among individuals who have mental health and substance use problems. In order to provide an in-depth examination of the experience of seeking and receiving care for mental health and substance use problems in Port Colborne and Welland, this study employed a qualitative research approach involving interviews with both consumers of mental health and substance use treatment services and family members of treatment consumers. Consumers' lived experiences can shed light on the treatment barriers that individuals find most difficult to overcome as well as the factors that facilitate their journey toward stability or recovery. Family members are also uniquely positioned to offer key insights into the consumer journey given that they often assist their loved ones in the effort to obtain care or act as a source of support or assistance in times of need. Importantly, best practice guidelines indicate that both consumers and consumers' family members should be meaningfully involved in health planning and system development activities (Health Canada, 2002; see also Grella et al., 2009; Harris & Edlund, 2005; Havassy et al., 2009). As such, the present research provides a starting point for further discussion of strengths and weaknesses of the local system and ways in which care for people with mental health and substance use problems can be improved, incorporating the views of those with first-hand experience seeking help within the system.

Methods

A total of 59 consumers (28 interviewed in Port Colborne, 31 in Welland) and 25 family members (10 interviewed in Port Colborne,[1] 15 in Welland) participated in interviews and completed RHOC core measures. In Port Colborne, both focus group interviews and one-on-one interviews were conducted with consumers. It was expected that some consumers would not feel comfortable participating in a group interview while others might welcome the opportunity to share their experiences with other consumers; as such, when participants called in for eligibility screening, they were afforded the opportunity to participate in a either a group or a private interview. It was initially decided that only focus group interviews would be conducted with family members of consumers and that one-on-one interviews would not be needed for this participant group; the rationale for this decision was the presumption that family members would be comfortable in a group setting (i.e., have fewer privacy concerns than consumers) and that the group would enhance insights about the system based on shared discussion of experiences. However, after conducting a few focus group interviews (4 groups with consumers – a total of 17 participants, and 2 with family members – 7 participants) it was discovered that many family members and consumers were not comfortable sharing their stories in a group setting, while others felt that the focus group did not afford them the opportunity to fully explain their experiences. Therefore, remaining data collection consisted only of one-on-one interviews with consumers and family members. This approach eased individuals' comfort level in the interview and further allowed for collection of very rich data.

During the interviews, participants were asked to discuss their own (consumer participants) or their family member's (family member participants) experiences with the mental health and addiction treatment systems in the Niagara region. The interviews covered six main topic areas, including access to the treatment system, experiences in the treatment system, barriers and facilitators to receiving care, transition out of the treatment system, relapse, and recommendations for service improvement. As the

[1] An additional three individuals (from the same family) interviewed in Port Colborne were residents of Wainfleet but expressed a great desire to be included in the research and to have their opinions heard. As such, they were included in the interview component of the Consumer Journey study but did not complete the core measures due to eligibility criteria relating to residence. Findings for this family did not differ from other interviews; as such, for privacy reasons, any findings reported in this chapter resulting specifically from the interview with the Wainfleet family are presented as part of the Port Colborne data.

study evolved it became apparent that both violence and stigma were issues faced by many participants; as such, additional questions were added to the interview partway through the study to address individuals' experiences with violence (partner and non-partner violence) as well as with stigma for receiving treatment.

The focus group sessions consisted of 2 to 6 individuals. Each focus group session took between 30 and 60 minutes and was audio-recorded. A structured focus group approach was used in which the moderator controlled both the direction of the discussion and group dynamics in order to ensure participation from all members of the group and coverage of all topics of interest. The one-on-one interviews also ranged from approximately 30 to 60 minutes in length and were audio-recorded. These interviews were largely unstructured and open-ended, designed to afford individuals the opportunity to express their views about their problems, treatment needs, and experiences in the system. Participants were guided in this discussion by a skilled interviewer in order to ensure that the conversation addressed the main topic areas of interest. The interviews were conducted by a researcher who was not a resident of Port Colborne or Welland in order to ensure participants' privacy. Recordings were transcribed (also by a staff member who did not reside in Port Colborne or Welland) and transcripts were analyzed for recurring and consistent themes.

Recruitment of consumers

This project was originally conceptualized to study co-occurring mental health and substance use problems. This population is particularly difficult to treat and is most vulnerable to falling through gaps in the treatment system due to a general lack of integrated services and coordinated care (Brouselle et al., 2010; Havassy et al., 2009; Health Canada, 2002; Watkins et al., 2001). Therefore, in Port Colborne, adults (aged 18 and over) who had co-occurring mental health and substance use problems and had sought treatment for either type of problem (or both) in the Niagara Region in the past 5 years were recruited through posters placed in local treatment agencies and other community settings, including laundromats, grocery stores, and food banks. Family members of consumers with co-occurring mental health and substance use problems were similarly recruited through posters placed in treatment agencies in Port Colborne/Welland and in various public locations within the communities. Word of mouth also generated interest in the study, resulting in individuals dropping by the lab and ultimately participating in the study if they met eligibility criteria. In Welland, we expanded the study's focus to include individuals who had one type of problem (mental health or substance use) as well as those who had co-occurring problems. This was done to allow for comparisons between people who have single disorders and people who have concurrent disorders in terms of their experiences accessing and receiving services. Nevertheless, the majority of study participants from Welland had experienced both types of problems. The same recruitment methods employed in Port Colborne were implemented in Welland. In order to be eligible, consumers and family members also had to be residents of the community being studied (Port Colborne for the duration that the lab was in that community; Welland for the study's duration in that community).

Individuals interested in participating contacted the local project coordinator who screened them for eligibility. For those deemed eligible, an appointment was scheduled for an interview session. Callers who were not eligible to participate were asked if they would be interested in picking up or being mailed a resource package containing information on services for mental health and addictions within the Niagara region.

Core measures

All study participants were also asked to complete the RHOC core questionnaire and provide hair and saliva samples (discussed in Chapter 1).

Consent and compensation

Before all interviews, participants were asked to read an information sheet and sign a consent form. If needed, assistance reading the information sheet was provided. Following data collection, participants were compensated $25 in the form of gift cards for completing the interview and an additional $25 in gift cards for completing the core measures (questionnaire, provision of hair and/or saliva samples). All study participants were given a resource package with pamphlets and information regarding local and regional services for mental health and addictions.

Results

Demographics

Port Colborne

In Port Colborne, the sample consisted of 28 consumers and 10 family members (plus 3 family members from Wainfleet who did not complete the core measures and thus are not included in these demographic results). The consumer sample consisted of 15 males and 13 females, and included a large proportion of people aged 30 and over (74%), with a mean age of 38. It also included a relatively small proportion of married people (11%) and a large proportion who were never married (36%) and separated (21%). This sample also included a wide range of levels of education, including 32% who had some high school, 25% who had completed high school, and 29% who had completed college or technical school. The sample consisted of very few employed people (4% working for pay, 4% self employed) and a large proportion that was unemployed (26%) or on long-term illness or disability (48%). A large percentage had personal (83%) and household (73%) incomes of less than $20,000.

The 8 male and 2 female family member participants in Port Colborne had a mean age of 43 and a range of educational attainment, including having completed high school (3 participants), some college/technical school (2 participants), completed college or technical school (3 participants), or completed university (2 participants). More than half of family member participants (6 participants) were working for pay and another 2 were self-employed. Only 1 family member participant had a family income of less than $20,000 while 8 had a household income of $50,000 or more.

Welland

In Welland, the sample consisted of 31 consumers and 15 family members. The consumer sample included 15 males and 16 females, and consisted of a large proportion of people aged 30 and over (81%) with a mean age of 39. This sample included a range of marital status groups, including 27% who were married, 23% who were living with a partner, and 23% who were never married. This sample also included a wide range of levels of education, including 36% who had completed high school, 19% who had some college/technical school, and 20% who had completed college/technical school. Many participants were on long-term illness or disability (42%), while 19% were working for pay and another 16% were unemployed. A large percentage had personal (69%) and household (60%) incomes of less than $20,000.

Family member participants in Welland (11 females and 4 males) had a mean age of 46. This group included a wide range of levels of education – 7 of the 15 participants had completed college/technical school; 3 had completed high school and another 3 had completed some college/technical school. Five were working for pay, 3 were going to school, another 3 were retired, 2 were on long-term illness or disability, and another 2 were unemployed. A large proportion (67%) had a household income of less than $20,000.

Mental Health and Substance Use

In Port Colborne, 74% of consumers (64% of male participants, 85% of female participants) met criteria for depression. Forty-three percent of consumers (40% of males, 46% of females) met criteria for harmful or hazardous drinking. A total of 86% of participants (87% of males, 85% of females) reported smoking daily, while 74% (71% of male participants, 77% of females) reported using illicit drugs in the past 12 months. These and other results from the core questionnaire relating to consumers' mental health and substance use for Port Colborne participants are presented in Appendix B.

In Welland, 77% of consumers (85% of male participants, 69% of female participants) met criteria for depression. Fifty percent of consumers (53% of males, 47% of females) met criteria for harmful or hazardous drinking. Fifty percent (47% of males, 53% of females) reported smoking daily, while 63% (73% of male participants, 53% of females) reported using illicit drugs in the past 12 months. These and other results from the core questionnaire regarding consumers' mental health and substance use for Welland participants are presented in Appendix C.

Thematic Analysis

Interviews with consumers in Port Colborne and Welland revealed very consistent experiences in both communities. When the project was initially conceptualized, it was expected that family members would provide a unique perspective on barriers and facilitators to care, given that family members commonly take on responsibility for individuals with co-occurring mental health and addiction problems and often assist their loved ones in times of crisis. However, while the interviews revealed that family members often did serve an important role in caregiving, both consumers and family members reported very similar stories about the consumer experience. Therefore, the results below are not presented separately for consumers and family members.

In the results below, all names of consumers, family members, and individual physicians or health care professionals are pseudonyms. Names of agencies are retained. In some cases, identifying details not affecting the interpretation of findings have been changed to protect the privacy of participants.

Results are presented according to the following major topics: 1) mental health problems or trauma in childhood leading to substance use; 2) complex problems and difficulties finding appropriate care; 3) common modes of entry into the system; 4) experiences seeking and receiving care, including both positive experiences and facilitators as well as negative experiences and barriers; and 5) suggestions for improvement. These topics are discussed in turn.

Mental Health Problems or Trauma in Childhood Leading to Substance Use

Many participants viewed their mental health problems as originating in childhood and preceding their substance use problems. Participants consistently reported that substance abuse emerged as a coping mechanism for their mental health problems:

> *"What happens is we got mental problems in the first place from childhood and then we turn to drugs*" [male consumer, Port Colborne]
>
> …
>
> *"Addiction is caused by mental health problems in the first place and then we turn to the drugs and figure it out on our own and eventually go beg our family doctors for help or there is a crisis"* [female consumer, Port Colborne]
>
> …

"Mental health was the catalyst for the addiction" [male consumer, Welland]

…

"[My partner] smokes marijuana, that's it now, there used to be a lot more, he used to do coke he used to do meth, yeah. Coke and meth and all of that kind of stuff too. It was a means for him to escape. It was that high that lasted you know for, for a few hours there or whatever it was however long it lasted that he felt normal, he didn't feel like he was the outcast [because of his mental health problems]" [female family member participant]

Many participants attributed their current mental health or substance use problems to childhood exposure to parental mental health and/or substance use problems or to other traumatic childhood experiences. Several participants reported that one of their parents had committed suicide while others reported being abandoned or neglected. Many consumers also experienced or witnessed extensive family violence as a child, often in combination with parental alcohol and drug abuse:

"I got home and [my mother] was gone, the place was empty…I think that was the catalyst for everything else…so I went to my dad's…at my dad's it was just, just abuse, verbal, mental, physical on a constant basis...[male consumer, Port Colborne]

…

"You know, I grew up watching [my father] walk around all coked out and beating the crap out of women and slinging drugs and in and out of prison and, you know, that's where I learned from…I still have nightmares from the stuff that happened when I was a kid" [male consumer, Welland]

Importantly, although they felt their problems had initially emerged in childhood, many participants did not seek help until later in their lives:

"I knew I had issues when I was a child. I never said nothing to my parents because I always thought, well, if they think about this they will think I am nuts. That's what I thought as a kid" [male consumer, Port Colborne, speaking about his depression]

Given that many participants located their current mental health and substance use problems in childhood, they were commonly frustrated that health care professionals did not explore the childhood or traumatic roots of their current mental health and substance use problems. This theme is presented in more detail below ("*Negative Experiences and Barriers to Care*").

Complex Problems and Difficulties Finding Appropriate Care

Interviews clearly revealed that consumers who participated in this study had very complex problems and had experienced major struggles finding appropriate care. For the most part, consumers had suffered longstanding problems and were still on a journey to achieve stability. While many participants reported a degree of success in overcoming some of their problems and reported encountering professionals along the way that had helped them greatly, many others were frustrated by their efforts to obtain help for mental health and addictions in the Niagara region and had not found the care that they felt was needed.

The following case examples are typical of the consumer experience that emerged from the interviews. These stories help illustrate the complexity of problems that most participants faced and the associated difficulties they experienced in trying to find care to address all their needs:

Miranda, a consumer from Port Colborne, suffers from depression and anxiety as well as attention deficit disorder, and has a long history of substance use, including tobacco, marijuana, oxycontin, heroin and percocets. She has an immediate family history of mental health problems, with both her mother and sibling experiencing severe illnesses.*

*All names of participants and healthcare professionals are pseudonyms

She consulted a doctor about her mental health as an adolescent but was told that she could not go on antidepressants while she was using recreational drugs. In her early twenties she began dating a man who used drugs daily; this prompted her to start using drugs (oxycontin) daily herself to feel "normal." She has been on many different antidepressant medications as an adult but experiences negative side effects and feels that medications have not truly helped resolve her mental health problems. She has received some counselling, attended several residential treatment facilities in different cities for her addictions, and is presently enrolled in a methadone program. Her current boyfriend is her main source of comfort and support and Miranda views him as her main facilitator to receiving care.

Diane, a consumer from Welland, believes that her mental health problems (including anxiety, depression, and obsessive compulsive disorder) stem from her childhood. She grew up in a "dysfunctional family" and experienced physical abuse at the hands of her parents for many years. She ran away from home as an adolescent and found herself unable to maintain a job, abusing alcohol, and getting into trouble with the police. After drinking on a regular basis to the point where she felt she was going to die, she resolved that she did not want to end up like her father and decided to seek help. She reached out to the Salvation Army (having seen their advertisements on TV), from where she was referred to the YWCA and subsequently to CMHA, where she received counselling and was referred to a psychiatrist. This psychiatrist moved and she felt that the subsequent psychiatrist to whom she was referred had a "poor bedside manner," leading her to discontinue receiving psychiatric care. She currently does not have a family doctor. As such, she no longer takes medication for her mental health problems despite the fact that medications helped to alleviate her symptoms. She lives in low income housing and is exposed to on-going drug and alcohol abuse and violence in her neighbourhood, leading her to isolate herself from her neighbours to avoid violent encounters. Many of her neighbours also suffer from mental illness. Her current main source of support is her church, where she is involved in many activities. She wishes there were more local health care professionals with whom she could talk about her experiences with mental health problems and violence, and would like to see more services available for people who are experiencing or have experienced violence other than partner abuse.

Tim, from Port Colborne, has an extensive family history of mental health and addiction issues. His parents consumed alcohol and used drugs extensively during his childhood. His mother committed suicide when he was a teenager and his father died of health consequences associated with chronic alcohol use. Following his parents' death, Tim began using drugs (marijuana) to the extent that his grandparents sent him to a treatment facility in another city. This treatment did not resolve his issues, and he reports "switching" his addictions from marijuana to sex, then to food, and finally back to drugs. He has been on many different antidepressants to help resolve his mental health issues but reports experiencing negative side effects. He has been arrested for assault and spent time in a corrections facility, where he received some rehabilitation treatment for drug abuse. He has also received care from several residential treatment centers for his drug addictions. Currently, he is enrolled in a methadone program. He also attends Narcotics Anonymous meetings but does not feel comfortable disclosing his methadone use in this setting given the group's emphasis on abstinence. He finds that speaking with counsellors and people that can personally relate to his life with drug addictions is very helpful.

Joanne, from Welland, reports that her daughter Mary was addicted to crack cocaine for 3 years. Joanne partly attributes Mary's drug use to the fact that Mary's biological father abused drugs and alcohol. Joanne also suspects that Mary's stepfather physically abused Mary as a child, and that this trauma prompted her to start using drugs. After realizing that her addiction could lead her to lose her children, Mary sought treatment in Toronto but left without completing the program. Eventually, FACS removed her two children from her

home, which triggered a newfound commitment to fight for recovery. Mary thus returned to treatment and managed to stop using drugs through residential programming and Narcotics Anonymous. She is currently drug-free, living with a partner that she loves, is working part-time, and has a new child. According to Joanne, Mary's biological father has also recovered from his substance abuse problems and is a source of support to Mary.

As these case examples illustrate, consumers in both Port Colborne and Welland exhibited very complex life histories relating to mental health and substance use and their problems had negatively affected many aspects of their lives. Most consumers had suffered from multiple mental health problems for much of their life, reported using many different types of substances, and had often been involved with violence either as a victim or a perpetrator, including abuse by parents as well as partner and non-partner violence.

The complexity of consumers' mental health and substance use problems were sometimes complicated by physical health problems, making it difficult to disentangle the effects of these various issues on their lives and the lives of those around them. For example, one female family member participant from Welland reported that her husband had long suffered physical and emotional effects associated with severe childhood abuse by his father and a traumatic childhood accident. He currently suffers from depression and anxiety and struggles to maintain his sobriety after his former addiction to narcotics. He resents having to take pain medication for his physical health problems and is fearful of taking them because of his addiction history so sometimes chooses to drink alcohol or smoke marijuana instead in an effort to manage the pain. For his wife, his past and present mental health, substance use, violence, and physical health issues intertwine and cannot be separated, complicating his path to seek care: *"…is it mental? Is it physical? Is it drug abuse? It's all a blend."*

Similarly, other consumers reported extreme stress relating to the challenges of obtaining care to address their complex problems. For some individuals, this manifested in their resistance to seeking or complying with treatment. For example, a male participant from Welland reported hesitation at taking drugs for his depression, anxiety, and bipolar disorder because he is a recovered drug addict and feels that taking psychiatric medications would pose a risk to his sobriety. Other participants reported anguish over their challenges and frustration at their seemingly endless search to find care to address their multiple problems:

> *"Your pain, or my pain, never goes away. It's like a piece of clothing that you wear constantly…it's just so damn difficult though, to change the shirt…"* [male consumer, Port Colborne]
>
> …
>
> *"You know I've seen counsellors and psychiatrists, psychologists and even demon possession deliverers and things…endless searching…and the reality is that suffering from a mental health issue especially when it's tied to addiction…it's an endless search"* [male consumer, Port Colborne]

Common Modes of Entry into the System

Many participants' first source of contact for services, particularly for mental health, was their primary care physician. For some, their physician was helpful and represented an important resource in their effort to receive care, most notably relating to provision of medication for mental health problems. However, most participants commented that it was difficult to get a family doctor in the area, leaving those without a doctor in a particularly challenging position, often resulting in a lack of continuity in their care:

"Trying to find a doctor was terrible. I didn't have a physician. I was going back and forth to the walk-in clinic here in Port, seeing different doctors there every time, everyone was prescribing something different…" [male consumer, Port Colborne]

…

"We have a lot of people here in town that just don't have a physician, we had a couple of doctors that either retired or passed on, and everybody scrambled trying to get their records and get accepted at another doctor" [male consumer, Port Colborne]

Those who did have a family doctor commented that their physicians typically only prescribed medications and occasionally made referrals to psychiatrists. For the most part, primary care physicians were not seen as providing sufficient care for mental health or substance use problems. This issue is discussed more below (see "*Negative Experiences and Barriers to Care*").

Another common mode of entry into the system was the Emergency Department. Consumer and family member participants noted that a crisis often landed consumers in Emergency and prompted their search for further care. For some participants, the Emergency Department became the preferred route to obtaining care because they received help much faster than they otherwise would have received or because it was a way to escape their struggles in the real world:

"I had a little bit of a mental breakdown and I ended up in Welland hospital to see the crisis nurse, in which case it was probably the best thing because I was able to get in to see a psychiatrist within 3 days" [male consumer, Port Colborne]

…

"I been to the hospital when I can't, when I find that my, I can't handle anything anymore. I was taking overdoses before, but not really to kill myself, just to reach out to people to let them know how depressed I was and they put me at Two South at the Welland hospital, and a couple of times I admitted myself because I just had to get away" [female consumer, Welland]

…

"I've signed myself in [to Emergency] a few times…I've been to Welland, St. Catharines, Niagara Falls, all over the place…there's been times when I was going through battles with addiction even when I wasn't using where that's my way out, that's how I felt I could deal with it" [male consumer, Welland]

…

Many consumers, particularly male participants, obtained help as a result of an encounter with the criminal justice system. For some participants this was their first point of entry into the system. In some cases, an encounter with the law made individuals realize the extent to which their substance use was affecting their lives. One participant, for instance, realized that his alcohol abuse was out of control when he was charged with driving while intoxicated, which prompted him to seek out residential treatment for addictions. More often, however, consumers entered the criminal justice system for being involved in violent assaults or drug possession/trafficking. Some of these participants lamented the fact that help for either mental health or addictions did not seem to be available until a crime had been committed:

"If you do a crime you will get help in a minute but if you go beg for help [they say] you don't need help because you are not as far gone as they think you should be, it's almost like they set a limit and if you don't cross this limit then you don't need help" [male consumer, Port Colborne]

…

"Through the years [my brother's] had a number of [mental health] crises…Whenever we attempted to get assistance from the police, from the hospitals, from whomever we've always

been told he's got to break a laws before anything will happen" [male family member participant, Port Colborne]

Experiences Seeking and Receiving Care

In the same way that individuals' life histories, problems, and entry into the system were complex, so too were their experiences within the system. Many participants reported having some elements of care that were positive and some that were negative, and accordingly experienced both facilitators and barriers to care.

Positive Experiences and Facilitators to Care

Figure 2.1 outlines the major facilitators to care that emerged in participants' discussion of their experiences with the system. These facilitators reflected individuals' positive experiences in seeking and receiving care. Indeed, despite the fact that the majority of consumers in this study were still experiencing ongoing problems with mental health or substance use, many had experienced elements of success or improvement of symptoms as a result of their use of local services and due to facilitators aiding them in their efforts to obtain care.

Figure 2.1: Facilitators to Care

- Family (for emotional or practical support)
- Helpful/caring professionals, having supportive people to talk to
- Church/pastor or friends to talk to
- Desire for treatment/personal motivation
- Transportation (owning a car; transportation provided by family, friends, or services)
- Services with flexible/evening hours
- Having employment benefits that cover services

Many health care professionals and agencies were viewed as extremely helpful in assisting consumers overcome or manage their problems. The following family member participant, for instance, reported that her husband had greatly improved his anger management skills through Pathways to Peace:

> **Interviewer:** *[Your husband is] now in anger management for the aggressive behavior…is it helping?*
>
> **Participant:** *Yeah, it's helping, it helped a lot, he hardly ever gets angry now, because he is using what they said, and when he does [get angry] I try to get him to talk it out.*

The Hope Centre was also identified as a helpful agency for participants experiencing mental health problems:

> *"The Hope Centre is one of the best organizations, I wish there was more things like that for mental [health] patients"* [male consumer, Welland]

Some individuals found that self-help groups (AA and NA) were very useful and inspirational:

> *"[AA] definitely not only encouraged me but you see people that have been sober for all these years and you want what they have, right. Not only the peace and serenity part but*

financially, everything starts coming together once you start putting your mind to things" [male consumer, Welland]

Many participants commented that methadone services in particular were excellent in the region and that this form of care was an important factor in their stability:

"The methadone clinic -- they have just been great, the staff is top notch, the doctors, nurses everyone there was great" [male consumer, Welland]

…

"The doctor I see now for methadone…I'm in a good place right now so it's nice and right now I'm in the process of getting off methadone and for the first time in 6 years I don't think of pain killers anymore, and it used to be all I thought about, you know it's been very very tough but I'm in a pretty good place now and he's been a pretty big help" [male consumer, Welland]

Participants who had received counselling commented that it was especially helpful for them, in some instances because it taught them behavioural techniques that helped them manage their mental health problems, and in other instances because it gave them a supportive person to talk to about their problems:

"The one that helped me the best would have been the psychotherapist because she without really saying anything she would just open up the floor and deal with problems. And once I was finished telling her what I was feeling, what I was going through then she would offer up either some feedback on ways that I can change how I am going through it or she would also do exercises, some of them were on different breathing techniques and everything else and they really do help, they really do help" [male consumer, Port Colborne]

…

"I think [the counseling] is what helped me through the dark times. It was very helpful, I got some things off my chest that I wasn't able to get off my chest for years" [female consumer, Welland]

…

"[My addictions counsellor] has been extremely instrumental in my life…I can't even say that this guy really said a whole lot to me that really sunk in but it was somebody that was willing to be there, he was really there to listen. At one point he took me out to lunch, he took me out to lunch every single Sunday and he would just sit there and listen to me talk" [male consumer, Welland]

Participants expressed relief when they found a health care professional who afforded them the opportunity to explore possible longstanding factors contributing to their problems:

"[The mental health counsellor] said the word that gets left out all the time when people go to counsellors or doctors or whatever, is the main root cause which is trauma, and that was such a relief in her acknowledging that" [male consumer, Port Colborne, who was abandoned by his mother at a young age and experienced extensive physical and mental abuse as a child at the hands of his father]

In some instances, formal therapy had not been received, but other individuals, such as a pastor or a sponsor from AA/NA, provided informal counselling that had been of great help to consumers:

"I have a sponsor…it was about the only time that I really felt like there was somebody there that was really willing to work through that…actually trying to help me actually deal with a lot of the underlying issues" [male consumer, Welland]

In many cases, family members acted as a main source of emotional support and also facilitated entry into the system:

> *"My family is hugely helpful…my mom is always there for me no matter what, which is nice because that way if I ever feel emotional or depressed or whatever at least I can call my parents"* [female consumer, Welland]
>
> …
>
> *"It was a smooth road and I think the only reason why it was a smooth road was probably my wife calling the crisis nurse and starting the ball rolling because without it I don't know what steps I would have taken to get to this point"* [male consumer, Welland]

Personal resolve and a desire to get help were also viewed as key facilitators. Some consumers noted that help was available if you sought it out and that service availability aside, personal resolve to get better was critical:

> *"If I had the opportunity, pretty much the only thing that is stopping me is me"* [female consumer, Welland]
>
> …
>
> *"Nobody is going to help you unless you try to get up on your own first"* [male consumer, Port Colborne]

For some participants, especially women but also men, their resolve to get better related to the desire to regain custody of their children or prevent loss of custody. In the following focus group discussion among consumers, two participants agreed that their children were a motivating factor for seeking help:

> **Male consumer:** *Actually, I have being doing well, treatment has been very well, I have no complaints.*
>
> **Interviewer:** *What is your secret then?*
>
> **Male consumer:** *My secret is my kids, you know, because I lost my kids.*
>
> **Female consumer:** *That's my motivation...I never lost my kids but when they called FACS on me, that was like, I walked in to ask for help.*

Having treatment coverage through an EAP was also highlighted as an important facilitator by some participants. Individuals with coverage had often received treatment at Homewood in Guelph. This treatment centre was unanimously found to be helpful and was viewed as a facility that should be emulated in other communities – *"I wish there were more Homewoods"* [male family member, Welland].

Negative Experiences and Barriers to Care

Despite these positive experiences and facilitators, consumers faced numerous barriers to receiving the care they needed. Consequently, most consumers had at least some negative experiences in their efforts to receive care for both mental health and substance use problems. Many participants expressed general dissatisfaction with the care that was available in the area, relating specifically to a perceived lack of services and long wait times, intertwined with transportation and financial barriers that arise when care is sought outside of the immediate community. Care not adequately addressing consumer and family member needs for a variety of reasons was also a major concern. Figure 2.2 lists barriers to care reported by consumers and family members in Port Colborne and Welland.

Figure 2.2 Barriers to Care

- Lack of services/health care professionals in the area
- Physician/health care professionals' negative/discriminatory attitudes
- Lack of transportation
- Long waitlists
- Finances (programs that cost money being largely inaccessible)
- Not knowing about available services/how to access services
- Lack of services for concurrent disorders
- Stigma in the general community
- Hours of care (difficult for people who work to access services – most supports available only during working hours)
- Addictions programs requiring abstinence (highlighted as particularly problematic for methadone users)
- Familial/environmental factors (when family/neighbours also have mental health or substance use problems or are violent)

Lack of services

Participants in Port Colborne and Welland, including both consumer and family member participants, consistently reported that there were not enough health professionals or services in the area, including primary care physicians, psychiatrists, and specialized programs for mental health and addictions:

> *"I don't have a family doctor now and I haven't for a lot of time but I know there has been times when I tried to get a family doctor and you know there has been none available"* [male consumer, Welland]
>
> …
>
> *"We've looked around for help for [my partner] and haven't been able to find anything, and we had a CMHA here, for mental health, and now they are closed, they closed it, so any help that I could have got him there is gone. Any help for me to help him gone…I was going to go there and then they closed the door the morning after because then I sat down and thought about it I was like okay I have to take a course and he has to take a course…he needs to know how to deal with himself and I need to know how to deal with him, so that's why I started to look it up and then it was gone, and I was like 'what the heck, where am I supposed to go now?'"* [female family member, Welland]
>
> …
>
> *"Niagara is a sad state, there is nothing out here. You got the odd AA, and most of the people that [my daughter] knows there are from her old crowd so she doesn't want to be around them, and as far as uh any other services out here for any of her problems there really isn't anything. Niagara sucks. The health care out here is so bad, really bad, and especially for someone like [my daughter] that I feel should be still dealing with her mental health issues"* [female family member, Welland]

Primary care physicians were viewed as not having enough time to provide consumers with the help they need:

> *"Family doctor visits, you are lucky if you can get 5 minutes or 10 minutes, so that's just a hi, how are you doing, you got an issue, what is it, you got 3 minutes"* [female family member participant, Welland]
>
> …

> *"With Dr. Smith, he was good, like he would listen but he would only give you a prescription for medication every time you came in. So, I think if he hadn't been so, if he would have had more time to talk to you and help you figure out how to deal with some of these issues that you were dealing with because it seemed to me like he had too many patients. One time he said to me he had like 1,000 patients so you were lucky that you got maybe 5 or 10 minutes with him. So you didn't really have time to discuss the issues, and maybe get some feedback on how to better resolve them"* [female consumer, Welland].

Many participants felt that health care professionals did not care about the problems consumers were experiencing and did not show compassion:

> *"His family doctor is useless, just useless. Doesn't care about him, I mean this is my perception. Often times that we took him there he really did not have much interest in his situation at all. Throw a couple of pills at him and it's the same if we take him to emergency"* [male family member participant, Port Colborne, discussing his brother's mental health problems]

Some participants felt that services for addictions were more readily available than care for mental health problems, leaving individuals with these latter types of challenges particularly underserved:

> *"I think the way they do things in the province, it's horrible for people with mental health…addictions is one thing, you can send people off to a facility anywhere you know to save your jobs and whatever and unions are involved but when it comes to mental health, I don't think it's quick enough getting the people the help they need"* [male family member participant, Welland]

One of the most consistent themes emerging from the interviews pertained to the perceived lack of affordable counselling services. Participants frequently expressed the opinion that the system did not offer enough counselling services and that the counselling that is available is too expensive for most consumers, particularly those with severe problems that interfere with their ability to work and those on disability. Yet, counselling was viewed as necessary to address underlying emotional factors contributing to mental health and substance abuse problems and to help consumers develop strategies to deal with their triggers. This gap in care was expressed by individuals in both Port Colborne and Welland, by males and females, by consumers and family members, and in reference to both mental health and substance use problems:

> *"Well, I love the idea of speaking with a psychologist, but it gets expensive, right?"* [male consumer, Welland]
>
> …
>
> *"I thought I would benefit from some talk therapy…you know before going into prescriptions…just because you know you have an addiction problem…the last thing you want is another addiction, right?"* [male consumer, Port Colborne]
>
> …
>
> *"I don't have that support for my end and he definitely doesn't have the support from his end…You know, his family doctor doesn't know what's going on and his mental doctor just hands him a prescription and sends him on his way, it seems like the world becomes so much, so fast paced, that it's get him in get him out get him in get him out get him in get him out, so there is nobody for him to sit down and actually take the time with him on the days where he really could use somebody to talk to other than family"* [female family member participant, Welland]

Available Services Not Meeting Needs

Nearly all participants identified one or more way in which services that were available did not meet their needs. For some participants, available services were perceived as being too short-term to help resolve both substance abuse and mental health issues:

> **Male Consumer:** *The rehab [New Port] that's here…it's only 18 days.*
> **Interviewer:** *That's not long enough?*
> **Male Consumer:** *It's not really…if you've been an addict your whole life, anyone can stay clean for 18 days when you're locked somewhere.*
>
> …
>
> *"He doesn't want to go to New Port because he feels he needs more than 3 weeks"* [male consumer, Welland, discussing his brother's substance abuse problems]
>
> …
>
> *"He went to the Welland hospital…they just kept him for a couple of days…I don't know if it's a shortage of beds or what but they didn't keep him long and you know like I was pretty scared…he would have days where he would want to […] ram the car into the telephone post and just kill himself. And there would be days that he tried to take a knife and try to cut himself…I was mad because I felt like you know the hospital should have kept him longer"* [female family member discussing her husband, Welland]

Related to the issue described above regarding perceived lack of counselling services, another major concern was that many health care professionals, including primary care physicians, psychiatrists, and hospital staff, often do not address the underlying causes of consumers' issues. This frustration was visible in reference to both mental health and substance abuse problems:

> *"He goes every 3 months to see the psychiatrist...He goes in and sees him and then he gives him another prescription for another 3 months worth of meds but he literally walks through the door, the doctor says 'hi Bob, how are you,' Bob says 'meh, I could be better,' he says 'are you still dizzy?,' Bob says 'yeah.' He says 'do you still have highs and lows?,' Bob says 'yeah.' 'Do you have stable moments?,' 'Hmm maybe twice a week,' 'Okay, here's your prescription' and sends him on his way. He doesn't talk to him. He doesn't, you know, get down to the nitty gritty of it with him or help him try to decide okay in this week this is what really pissed me off or you know this is what triggered it…."* [female family member participant, Welland, discussing her partner who has bipolar disorder]
>
> …
>
> *"…When I was on methadone, I kind I felt like I was sort of like pushed through and sort of given a prescription to something and 'take this'… I didn't really feel like anybody really cared to try to deal with a lot of the underlying issues that maybe had to do with my addictions"* [male consumer, Welland]
>
> …
>
> *"Maybe I was looking for help with the root cause and not necessarily the symptoms…like, treat the disease, not the symptoms"* [male consumer, Port Colborne, in reference to his search for help for his addictions]

This last participant stopped seeking addictions treatment because he felt that the underlying causes of his drug use were not being addressed by any of the health care professionals he consulted.

In other instances, participants felt that doctors refused to address their mental health problems when they were using substances. Participants also often felt that their mental health problems wouldn't be taken seriously because of their substance abuse issues:

"[The psychiatrist] rushes me out and I don't even get a chance to talk, he just thinks it's just the drinking that's the problem" [female consumer, Welland]

…

"My thing is they won't even look at mental health because I have substance abuse, so they are not even acknowledging it…they say until you are off drugs you can't really fully know" [female consumer, Port Colborne]

Consumers noted that resolving addictions does not automatically remedy mental health problems, and, as such, felt that care for both problems is needed:

"The alcohol and drugs are gone, so if the alcohol and drugs were the only thing that ever caused it then you think the anxiety would be gone at this point but it's not" [male consumer, Welland]

Some participants indicated that responsibility for seeking help lies mainly with the consumer, who may face challenges trying to navigate the system on their own:

Interviewer: *Have you actually been referred by anybody somewhere?*

Male consumer (Welland): *Uh no, no, I don't think so, um no, the only thing, the methadone doctor has given me, he's shown me the resources, you know, I mean he's got lots of information on everything that is available and uh as long as you pick me up and carry me to one of the places I'm sure it would be great…*

…

"They give you phone numbers…literally ripped out of the phone book and gave it to me and told me to call these support places. Like how are you helping me do anything, so I am doing all the work, you're not helping, what's the point in this…" [male consumer, Port Colborne]

…

"In this town there are lots of people that can benefit from something for mental health, I know so many people that can benefit better just shot under the system, given pills, and told to go on disability and that's it. They are just left in the wind to deal with it themselves and it makes them, for some of them, more depressed than they already were." [female family member, Welland]

For participants, a lack of communication between different health professionals often created gaps in consumers' care:

Female family member participant (Welland): *Half the time people don't know how to deal with [my husband]. His doctor, he can't even, he has side effects from these pills, he can't even talk to his doctor, his family doctor about it because he knows nothing about the pills because the pills are prescribed by the psychiatrist, who he can't see until it's been 3 months [since the last appointment with the psychiatrist].*

Interviewer: *And the psychiatrist and the family doctor never communicate?*

Participant: *No, there is no communication. If we have a problem with the Seroquel we call into the psychiatrist and the psychiatrist doesn't even talk to Joe, he talks to the receptionists because we tell the receptionist, the receptionist tells him, he switches the pills, or adds a different pill in there and that's it.*

Some participants felt that a major issue affecting care was physician attitudes, with psychiatrists in particular highlighted by participants as being insensitive to their problems:

"So then finally I did get a family doctor and he sent me to Dr. White in Welland and Dr. White is actually terrible. He has no bedside manner and he dropped me after 3 times. He literally said I can't do nothing for you, so he sent me to Dr. Jones and he said 'why did Dr. White drop you?,' I said 'I have no idea, he obviously doesn't know what he's doing' and he says 'well, I am not going to help you if he won't,' and so I went back to my [family] doctor…he was very disturbed over that, he was not happy. He couldn't believe it so he said 'I am going to try to get you into Hamilton,' he said, 'I know a couple of good psychiatrists, might take a year because there is a line up, a waiting list, but if you get in it's worth it" [male consumer, Port Colborne]

Other participants expressed general frustration at the larger system in reference to the lack of help for people with mental health problems:

"It seems odd to me that the government, they pay these politicians so much money, they pay them millions of dollars a year but they can't provide people like us as taxpayers or as people with proper mental health care, access to psychologists and psychiatrists and access for places to get help for these things but yet they can spend millions of dollars on these politicians and these recreational centres and stuff…" [female consumer, Welland]

Long Wait Times

Related to the perceived lack of services, both consumers and family member participants identified long wait times as an important barrier, such that individuals were not receiving help when it was needed. This problem was particularly concerning for participants who had mental health problems:

"If I hadn't gotten an appointment with a psychiatrist in Welland through Emerg, they told me that it's up to in excess of 3 months to get an appointment, and you have to get referred to an appointment, so it's just, there would be a big running around game to try to get it done, and I think we need faster action than that. Like when I was down really low in the dumps and your anxiety levels are so high to get told you are going to wait months, that's not fast enough" [male consumer, Port Colborne]

…

"I still see my family doctor but at this point he wants to get me with someone who is more specialized I guess. And I did a kind of interview at the hospital but I am sort of on a waiting list I guess. I don't know what it was actually associated with I hope eventually it's a psychiatrist. I don't know if it's one of those waiting lists like I tried calling them a year ago and the wait list was like 6 months, and at the time I was not doing well so I was like well, 6 months I'll be dead…" [female consumer, Welland]

…

"It takes too long…everything…you can't just make an appointment, locally you can't make an appointment and get in to see anybody for sometimes weeks, sometimes months…I mean for mental health patients a month is a long time. What happens to people who suffer from deep depression or um you know are suicidal?" [male family member participant, Welland, discussing his adult daughter]

While complaints about waitlists were most commonly expressed in reference to mental health treatment, participants did comment that it was also an issue for addictions:

"My biggest thing is now, and I think everybody agrees when you are going through the shit and coming down and whatever or withdrawing or whatever you need help then, there, you don't need to wait two months, three months, a year to get into treatment. You need it right away and sometimes detox is not the answer" [male consumer, Port Colborne]

…

"My sister OD'd and died waiting to get into treatment" [female consumer, Port Colborne]

Lack of Transportation and Financial Barriers

The perceived lack of services in the area was also frequently cited in reference to a lack of transportation and limited finances, which were both viewed as major barriers to getting the right kind of care. These issues were frequently identified by both family members and consumers in Port Colborne and Welland:

"A lot of people don't drive so if there is no resources here but there is resources in St. Catharines, if they are on ODSP or Ontario Works they can't afford the bus to St. Catharines because the bus to St. Catharines is expensive so they can't afford it" [female family member participant, Welland]

…

"I've been to Port Cares, I've been to my doctors, I've been to Toronto to see people and all they want to do is give you drugs and like I've called anger management classes and stuff, it costs money that I don't have…because I am on welfare, nobody covers that stuff for you…apparently there is no funding in Port Colborne, Welland and St. Catharines, there is only funding for Fort Erie and Niagara Falls, again so when they do want me to see somebody I have to get there…I don't know about you but I am pretty sure I will never see you jump on a bike and ride for 2 hours, but I can't afford a bus…" [male consumer, Port Colborne]

…

"You can't be in 3 different cities and expect us at the lower end of poverty to get able to get to these services that we want, desire, because they are too far to be feasible" [male consumer, Port Colborne]

Stigma

Some participants commented that they felt stigmatized by both the general public and health care professionals for their mental health and substance use problems. Importantly, however, the stigma attached to addictions seemed more salient to participants, as, in their minds, their addiction was viewed by others as their own 'fault':

"If you are born with a mental health issue you're looked more highly upon than a person that is doing drugs and eating pills" [male consumer, Port Colborne]

…

"[If you use drugs] they look at you different when you go say for mental health issues. One time I went on a cocaine bender, for a long time injecting everything… I was just at my wit's end and I went in there to get help and they turned me away and said I was a junkie, that I didn't need help [for mental health problems]" [male consumer, Port Colborne]

…

"…Being a drug addict it's hard for me to ask for drugs [for mental health problems] and I never been one of those people who does the doctor shopping thing, you know, so I know I have a real problem with anxiety but I can't go to a doctor and ask for specific pills because I feel like he's looking at me like I'm a drug addict who's sneaking pills" [male consumer, Welland]

Perceived stigma against methadone users by both the general public and health care professionals emerged as a notable finding. Being on methadone was viewed by some participants as key to their stability, but as something for which they were judged negatively, resulting in embarrassment and shame:

> *"In the pharmacy, you get your drink, people that are there are looking at you like you are some kind of low life, scum of the earth crawling up from the floor* [female consumer, Port Colborne]
>
> …
>
> *"There is nothing worse…my son's teacher was there and I am standing in line and you could tell from the look where you are, you are surrounded by…so I walk away pretending I am not getting my drink but he knew, he knew"* [female consumer, Port Colborne]
>
> …
>
> **Interviewer:** *At the hospital, were you treated well?*
>
> **Participant (female consumer, Port Colborne):** *No, because you know what, some do but in the case like when you are on methadone you get shunned even when you are trying to make yourself better in life and cure yourself, make yourself well. That's a really bad feeling.*

Stigma against mothers who have mental health and/or substance use problems was highlighted by a few women as a barrier to treatment:

> *"I slipped maybe a couple of times in the last 5 years, that doesn't make me a bad person…but they won't look at it that way…especially mental health too. Automatically, if I go in for say a chemical imbalance or depression, all of a sudden I'm a bad mother"* [female consumer, Welland]
>
> …
>
> *"I try to hide [my mental health problems] as much as possible because of the fact that my son is so young…I can't have anything that makes me look nuts linked to him"* [female consumer, Welland]

Suggestions for Improvement

Based on their personal experiences in the system, participants offered suggestions for improving care for people with mental health and substance use problems. Their suggestions clearly draw from the barriers and facilitators that they or their family member faced in their journey through the system. Participants' suggestions for improvement are listed in Figure 2.3.

Figure 2.3: Participants' Suggestions for Improvement

More services or improved services

- More local health care professionals/treatment services for mental health, addictions, and concurrent disorders
- Addictions recovery homes
- Addictions treatment specifically for women and for women with children
- Affordable/free talk therapy
- Family-oriented treatment/counselling
- Residential/short-term mental health care other than psychiatric floor in hospital
- More/better mental health assessment services

- More community-based programs providing recreational activities for people with mental health problems
- Extended treatment hours
- Programs for individuals who are abused by people other than spouses

Improved supports and information

- Ongoing support/case management
- Transportation assistance
- More supports for families of people with mental health problems
- More follow-up care by psychiatrists
- Develop mechanisms/programs to have students in health care professions provide support/be somebody to talk to
- More substance use education/prevention directed toward youth
- More public information about mental health/addictions problems and services

In general, participants emphasized the need for more services and for services that are more specialized to deal with mental health problems, addictions problems, and concurrent disorders. Participants also felt that the system needed to be designed to provide care and guidance along the entire journey, starting before entry into the system and continuing along the length of the journey. Services suggested to facilitate entry into the system included more public information about mental health and substance use problems to help people know when they have a problem, as well as more information about services available in the community. Services suggested to improve the journey once the person has entered the system included better initial assessment services, more support in accessing services that meet their unique needs (including services for violence; short-term residential programs for mental health; counselling; services for concurrent disorders, etc.), and more aftercare and follow-up services. Case management was identified as an important way in which care could be improved. Additionally, participants indicated that more transportation assistance would improve access to services given the regional structure of the system. A few participants also felt that more recreational programs for people who have mental health problems would be helpful. Some participants felt that more addictions prevention programming in schools was needed *("They really need to address more in schools. I think they should have panels of people who are drug addicts to go in and talk to the kids because kids is where it's going to begin" [female consumer, Welland])*.

Of all of the suggestions for improvement made by participants, one of the most commonly reported was the need for free or affordable counselling:

> *"The only thing I would like, but it's kind of selfish of me is, is there to be, like psychological counselling out there that doesn't cost an arm and a leg…I like the idea of going to see a counsellor but…I don't want just to have somebody to talk to, I want to get deeper and get into my thoughts and where is this coming from, is this depression, is it bipolar, that's what I would have liked for me"* [male consumer, Welland]

In some cases, family member participants reported that they had received counselling but would have benefited from more family-based services:

> *"I just wish that they had more like family depression programs out there because like if it's only, you know like it doesn't help if it's only personal depression, not like families that are going through it like ours. We are not really getting the help that we need… when I reached out for counselling, I got you know well it's more marriage based, where they weren't actually looking at the situation, they made it more personal like it has to be about you, not what you're going through"* [family member participant, Welland, who suffers from depression and whose husband suffers from depression and anxiety]

One participant suggested that it would be good to have students in health care professions more involved in helping consumers. This person noted that developing programs in connection with educational institutions would be a way of providing consumers with more support, such as giving them someone to talk to and assistance navigating the system.

Summary and Discussion

Overall, participants in the Consumer Journey study had complex and emotionally difficult stories to tell. Most participants suffered from co-occurring mental health and substance use problems, which appeared to complicate their journeys through the system. Some participants had experienced a degree of success and reported having some key facilitators such as caring family members or supportive health professionals. Nevertheless, most consumers and family members in Port Colborne and Welland felt that the local system had not provided them with sufficient care, and that individuals with mental health or substance use problems were often left to rely on themselves or family members in their efforts to receive care or achieve stability. Lack of local services and the tendency of primary care physicians and psychiatrists to simply provide medications for mental health and dismiss substance abuse were major concerns. Participants commonly felt that health care professionals only 'treat the symptoms' and do not help consumers identify and address the underlying causes of their problems, thereby failing to help them develop better coping mechanisms that could improve their long-term outcome. Given that many treatment options cost money or require consumers to travel outside of the community, transportation and financial barriers were viewed as key impediments to receiving needed care.

Participants frequently commented that individual staff members at local agencies, such as Port Cares, the Hope Centre, and New Port, were kind and helpful. Many also expressed optimism that the opening of the new Bridges Community Health Centre would help improve the local situation in Port Colborne and fill in the gaps by increasing access to family physicians. For methodone users, staff members at methadone clinics in both Port Colborne and Welland were viewed as professional and kind. However, the overall message from participants was that these communities are underserved in terms of primary care physicians as well as addictions and mental health care programs, and that greater availability of healthcare professionals and improvements in health care professionals' attitudes toward individuals with mental health and substance use problems are needed. Again, the need for health care professionals to acknowledge and help consumers deal with co-occurring problems was highlighted by most participants.

As the results revealed, the individuals participating in this research suffered extensive difficulties receiving care. It is important to note that these findings do not necessarily mean that all consumers of mental health and substance abuse services in Port Colborne and Welland experience this same degree of difficulty in accessing and receiving services. Many people who volunteered for the study had severe and/or co-occurring problems and were commonly frustrated by their experiences seeking and receiving care. The scientific literature suggests that people who have concurrent disorders tend to use the most services yet have the highest level of unmet need compared to individuals with single disorders (Bland et al., 1997; Kessler et al., 1994; Lin et al., 1996; Regier et al., 1993; Ross et al., 1999; Rush, 2008; Wang et al., 2005; Wu et al., 1999) – this seems to be the case among the present sample. In contrast, it is likely that those who have had a more positive experience in the system or more easily reached a stable outcome may have been less likely to participate in the research. It is possible that the study attracted people who had experienced difficulties and wanted to tell their stories in the hopes that it could lead to system improvement. Nevertheless, the consistency with which the themes presented in this chapter emerged across participants and communities suggests that at least a portion of the local population with extreme and complex problems may not be receiving the care they feel they need. At the very least, the issues presented in this chapter represent an important starting point for further discussion of ways to improve care for people with mental health and substance use problems.

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FORUM DISCUSSION

Forum attendees expressed agreement with the study findings based on their own experience within the system, noting that systems issues (such as having insufficient time for individual clients, not enough hours available to provide care) come up over and over again in agency settings. Attendees empathized at how difficult it would be for a person dealing with mental health and addictions to navigate through the complex system of care associated with mental health and addictions. To this end, the need for case management or assistance with system navigation was raised as a key component of adequately serving people with mental health and addictions problems.

Service providers in attendance pointed to research suggesting that a high volume of services (the Emergency Room in particular) is being used by a small proportion of consumers. Indeed, the participants in this study were by and large heavy users of the system. Therefore, it is very possible that their experiences in the system may differ from the experiences of individuals who require less assistance or who have achieved a stable outcome without requiring ongoing or repeated care.

Forum attendees, particularly front-line service providers, corroborated the study finding that there seems to be a high degree of early trauma in people with mental health and addiction problems, including physical/emotional/sexual abuse, neglect, and exposure to addiction as children/youth. According to these service providers, without addressing the traumatic roots of clients' problems there is a high likelihood that the mental health and addiction problems will continue. However, attendees commented that extensive time with consumers and a high degree of support is required to adequately address these issues. This requires frequent treatment, and agencies often do not have the resources to provide the intensity of care needed to help these clients. Other agencies may not be equipped with the expertise needed to deal with clients' traumatic experiences. It was pointed out that individuals suffering from Post-traumatic Stress Disorder, for example, often have very complex histories; their struggles are often associated with many different underlying issues, making their treatment needs equally complex.

Another important issue raised by attendees is the lack of affordable and safe housing. It was pointed out that many people are trying to cope with mental health and addictions while living in areas where they are surrounded by substance abuse, violence and crime. As a result, available resources do not always help them move forward in their journeys because their living conditions are not conducive to recovery.

Forum attendees also commented on an important gap in the system that was not raised by participants in the Consumer Journey study – namely, the disconnect in the system when an individual transitions from being under pediatric to adult care. It was noted that transitioning into the adult world poses many challenges that can create further difficulties for individuals suffering from mental health or addictions problems, and the potential for individuals to "fall through the cracks" at this time is heightened due to the disconnect in the system. As such, it was noted by attendees that service providers need to ensure that people needing help stay connected to resources during this transitional period.

Chapter 3: Intimate Partner Conflict and Communication (IPCC) Study

Intimate partner violence is a widespread health and social problem that cuts across socio-economic, cultural and ethnic boundaries and causes substantial social and health harms. Intimate partners can engage in a wide range of aggressive acts and not all aggression would necessarily be considered intimate partner violence, as it is commonly understood. In 1995, Michael Johnson, an internationally renowned expert on domestic violence, proposed that there were at least two very different types of intimate partner aggression. The first he labelled intimate terrorism which is primarily characterized by control and dominance by one partner (usually the male partner) over the other, with this control involving some form of abuse. The abuse is not necessarily physical; it could include verbal, emotional and economic abuse. He labelled the second type of partner aggression "common couple" violence, characterized by verbal or physical aggression by either partner that is not rooted in the aggressive partner trying to control the other partner. Common couple violence has more recently been labelled "situational" violence so as not to minimize the potential dangers of this type of aggression.

Johnson's 2008 book extended his typology of intimate violence to include four types:

(1) *Intimate terrorism:* One partner is violent *and* controlling; the other partner is not.
(2) *Violent resistance:* One partner is violent *and* controlling; the other partner is violent, but not controlling.
(3) *Mutual violent resistance:* Both partners are violent *and* controlling.
(4) *Situational couple violence:* One or both partners are violent, but neither is violent *and* controlling.

Despite this more differentiated typology, the first three types still involve intimate terrorism (i.e., violence and controlling behaviour by at least one partner). The first two types are differentiated only by whether the victim of intimate terrorism is also violent. The third, which Johnson notes is rare, involves "each behaving in a manner that would identify him or her as an intimate terrorist if it weren't for the fact that their partner also seems to be engaged in the same sort of violent attempt to control the relationship." (p. 12).

The remaining category, situational couple violence, is the most common form of aggressive conflict between intimate partners. However, although there is a great deal of knowledge regarding the nature of intimate terrorism based on interviews with female victims of abuse, much less is known about the nature of situational couple violence. Research on situational couple violence has consisted mostly of prevalence studies of physical aggression between intimate partners in the general population and studies of risk factors for partner aggression. **Therefore, it is important to obtain a better understanding of the nature of aggression between intimate partners in a general population sample, including assessing the extent that incidents tend to fit into the four types of intimate violence described by Johnson and exploring further differentiation of types of situational couple aggression.**

Another important gap in the literature on intimate partner violence is the relative lack of research on young adults. Young adults are a key population to target in the study of intimate partner violence because physical aggression and risk of injury is most prevalent in this age group. In addition, understanding the dynamics of intimate partner aggression among young adults may lead to early interventions that can be used to prevent entrenchment and escalation of violent, abusive and unhealthy patterns of couple interactions. A major impediment to conducting research on this population, however, has been difficulties in recruitment of research participants, especially young men. **Therefore, it is important to develop innovative methods for recruiting unbiased samples of young adults from the general population.**

A number of theories have been proposed to explain intimate partner violence and considerable research has been directed toward identifying individual risk factors for violence. However, little research has addressed the ***perceptions*** of those involved in partner violence, and almost no research has examined perceptions by the partners involved of the factors that contributed to specific incidents of partner

aggression. Yet, perceptions of why a particular aggressive incident happened are important because they influence how people will behave in similar situations in the future. Knowledge of perceived contributing factors for partner aggression may also identify circumstances that differentiate minor intimate partner aggression from aggression leading to emotional or physical harms and intimate terrorism from situational conflict. **Thus, it is important to develop a measure of perceived contributing factors to incidents of aggression and violence.**

To address these important gaps in the literature, the current pilot study had three main research objectives:

1. to test a new method for recruiting a representative sample of young adult participants called Respondent Driven Sampling;
2. to develop a measure of perceived contributing factors to incidents of aggression and violence;
3. to develop a better understanding of intimate partner aggression and violence among young adults.

Addressing these objectives will help us develop a better understanding of intimate partner conflict, aggression and violence among young adults. Such an understanding can provide critical insight for developing effective preventive and remedial interventions.

1. TESTING RESPONDENT DRIVEN SAMPLING (RDS)

Respondent Driven Sampling (RDS) is a form of chain referral or "snowball sampling" involving recruitment of a small number of initial participants known as "seeds" who then recruit additional eligible participants. RDS is used in research to access hidden populations, that is, groups that are hard to tap into but are highly networked, meaning that they are likely best recruited through their own peers. In order to encourage referral of potential participants, RDS uses a dual incentive scheme, whereby participants are compensated both for their own participation and for the participation of people they recruit. Research has shown that with sufficient number of iterations (5 or 6), the strategy results in an unbiased sample that is independent of the characteristics of initial participants.

Port Colborne RDS

Different RDS strategies were used in Port Colborne and Welland. In Port Colborne, we used the standard RDS approach of recruiting a small number of initial seeds who were to form the start of recruitment of others. Seeds were recruited through posters placed in general community locations, including local restaurants, video stores, grocery stores, and laundromats. The initial goal was to obtain three female and three male seeds. After participating in the research, each seed was given three "coupons" to recruit other participants. Participants were given $50 in gift cards for participating ($25 for the current study, $25 for the RHOC core measures described in Chapter 1). For every new participant they referred, individuals received another $25 gift card. Participants recruited by seeds were also given three coupons at the time of their participation to hand out to eligible individuals of the same sex until the desired sample size was reached (a target of 15 men and 15 women in each community).

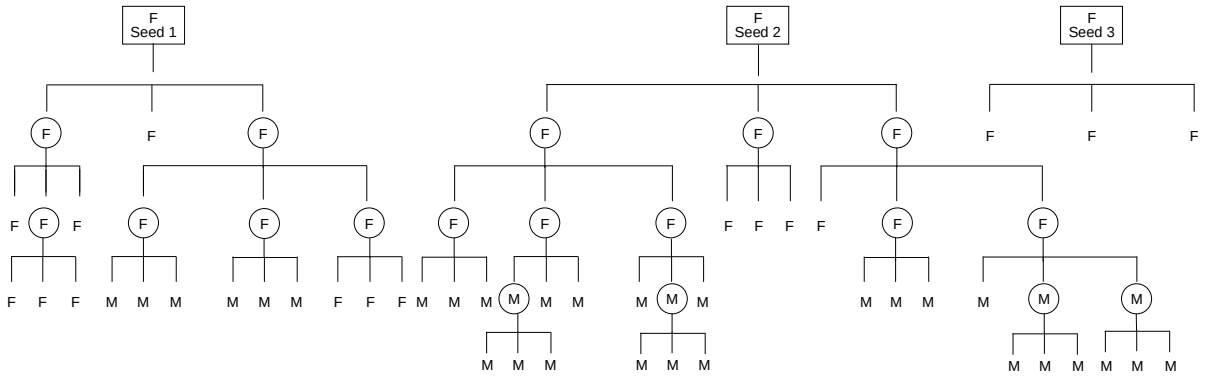
Women were asked to recruit other women and men to recruit men. We used same-sex recruitment to avoid having participants recruiting current or former intimate partners[2]. However, we found that men were more difficult to recruit than women (as described in more detail in the results section). Therefore, to recruit more men from Port Colborne, we later relaxed the rule for same sex recruitment and allowed participating females to recruit males, as long as the male was not a current or previous intimate partner. Flyers were also distributed more widely (including being handed out by project staff in public spaces) in

[2] We did not have any participants who reported having same sex intimate partners. If we had any, they would have been asked not to recruit former or current partners.

an attempt to recruit more male seeds. Three additional seeds were recruited in this manner but none came to their scheduled appointments.

A total of 17 women and 7 men were recruited for participation in the Port Colborne study; however, one of the men was somewhat uncooperative and did not provide information about any specific incidents of aggression, thus reducing the effective sample to 6 men. Thus, RDS was found to be a successful method of recruitment for females but not for males. The circles in Figure 3.1 below show the recruitment from the original seeds. For example, as shown in Figure 3.1, Seed 1 recruited two women, Seed 2 recruited three women and Seed 3 did not recruit any additional participants. Of the two women recruited by Seed 1, one recruited one woman and one recruited three women, and so on. Also as shown, of the seven female participants who were asked to recruit men instead of women, one of the women recruited two men and two recruited one man each. No men recruited other men.

Figure 3.1: RDS with female seeds (Port Colborne)



Overall, RDS proved ineffective for recruiting male participants for research on intimate partner conflict. None of the three initial male seeds in Port Colborne recruited other participants. Also, our attempt to recruit additional male seeds through other strategies (e.g., handing out flyers at a nearby beach) failed. Although the staff were able to set up appointments with additional men, none showed up for their scheduled appointment, and of the seven men recruited in total, one had to be excluded from the analyses because he did not provide specific incidents of aggression.

In sum, although RDS allowed us to quickly recruit enough women for the pilot study, it was unsuccessful for men. In addition, it appeared that the method may have oversampled women who had financial difficulties, as many women reported that they participated because they needed the gift certificates for groceries.

Welland RDS

In Welland, we adopted a different strategy because of the lack of success with recruiting men in Port Colborne. We changed both the initial strategy for recruiting seeds as well as the incentive for seeds to recruit others. In particular, it was concluded from the experience in Port Colborne that setting appointments was not a reliable way to ensure participation among young men. Therefore, it was expected that young men might be willing to participate if they could complete the study immediately at the time of recruitment. Given that the mobile lab was parked at the local mall (Seaway Mall), it was determined that a convenient option would be to recruit seeds from the mall and offer eligible individuals the opportunity to participate immediately. If they were not available at that time, they could book an

appointment to complete the study at a later date. Study staff canvassed the mall in pairs and approached individuals or groups who appeared to be in the study's target age range (19 to 29). Individuals were informed of the study and screened for eligibility.

The RDS compensation scheme in Welland was also modified to determine if a larger incentive offered as part of a lottery would be more effective in recruiting participants. Each time a seed successfully recruited a participant, both the seed and the participant were entered into a draw to be completed at the end of the study. The first prize in the draw was $250 cash and the second prize was $100 cash. Separate draws were conducted for men and women. Participants were given a $50 gift certificate as was done in Port Colborne but were not given compensation for recruiting other participants other than being entered into the draw.

All study participants were given study information cards that included information about the research, contact information and a "secret word" (e.g., "purple," "zebra") that was unique to each participant. These cards were given to participants so that they could be handed out to friends or distribute through social media. The "secret word" was needed to link the participant to the person who recruited them so that the recruiter could be entered in the draw. This linking also allowed us to monitor patterns of recruitment in order to evaluate the success of the recruitment method. Participants were told that they could inform as many eligible people as possible about the study, but that only the first two eligible individuals to contact the study team using the participant's "secret word" would be able to participate. This was done to encourage timely participation in the study. As in the original Port Colborne design, men were asked to recruit men and women to recruit women. We also decided to recruit a larger number of seeds (a target of 15 men and 15 women).

A total of 16 females and 18 males were recruited for participation in the study in Welland. The method of recruiting seeds in the mall proved to be successful, with a total of 14 female and 16 male seeds recruited fairly easily with some participating immediately and others making appointments to come back later. One reason for the success of the mall recruitment may have been that the study staff were very skilled at recruitment. The young female and male staff who approached people in the mall had worked previously on our "Random Walk" study in Port Colborne (see Chapter 4) and were highly skilled at describing the research and encouraging participation; therefore, it is likely that much of the success of this strategy was due to them.

Although mall recruitment worked well, the RDS component of the study was unsuccessful, with only one female and two male participants recruiting additional participants. The female recruited two other females and the males recruited one male each. It is unclear whether the procedure with the "secret word" was too complicated or the incentive of a lottery did not work. In addition, two female participants had to be excluded from the analyses because they did not have any incidents of aggression to report.

As with the Port Colborne sample, the Welland sample was not necessarily fully representative of the young adult population in that community. The staff approached everyone they saw who looked about the right age but there was no attempt at random selection. In addition, there were clearly some who participated because they had experienced violence and saw this as an opportunity either to tell their story or to make a contribution to the prevention of violence for others. For example, when one Welland participant was asked why she had volunteered for the study, she indicated that she hoped that by telling about her experience she could help others:

> *Just because I think you guys need more insight on what happens and how people get involved in situations like this. Kind of wanted, hoping it doesn't happen so much in the future…I had no one, no one, even my mom when I told her, I didn't tell her until about a year ago actually that my first relationship was abusive…and she couldn't stop crying for days. Like "I didn't know you were at that point of the situation. I didn't" – like she had no clue and I didn't tell anyone. It was just my own little life and I thought I was this little adult and I wasn't. I should have went to her. I just wish more was offered to the kids to make them realize that this is not how things are supposed to be.*

Another female participant said:

> *Well, because I definitely have good relationships but I also had bad relationships and I know that when a relationship is good, it's usually really good, and if you can sort of help people understand the bad things in the relationship and make them stay away maybe from the bad relationships and have good relationships. It's definitely worth it because I am in a good relationship right now and I am really happy you know. You know, we don't fight a lot and when we do, we understand each other's boundaries so you just stay away until the other cools down. And you know we are really really happy so I think that by going through rough relationships, you learn the things in a relationship that keep you happy then you should definitely share that.*

Thus, the present data should not be used to estimate the prevalence of violence among young adults.

Demographic characteristics of Port Colborne and Welland participants

As shown in the following figures, the Port Colborne and Welland samples differed considerably in their demographic profile, probably partly because of differences in recruitment methods as well as possible differences between the two communities. As reported above, there were more men recruited in Welland than in Port Colborne. Also, Welland participants tended to be younger, less likely to be living with a current partner, more educated, more likely to be students and more likely to report household income over $20,000. Port Colborne participants included 34% who were caring for family or on disability while no Welland participants were included in these employment categories.

Although the samples are not suitable for estimating prevalence, the two samples combined provide descriptions of incidents of partner conflict and aggression that are rich and heterogeneous. Thus, these data are ideal for the present purposes of developing an understanding of intimate partner aggression among young adults.

Figure 3.2: Percent of participants by gender, age group and community

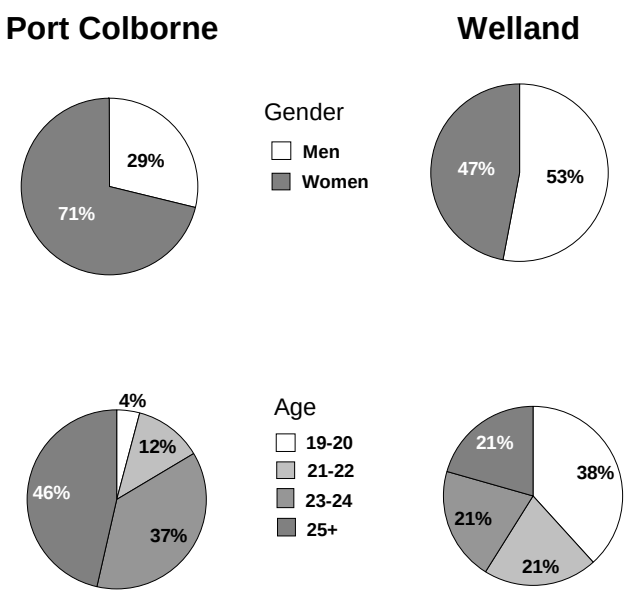


Figure 3.3: Percent of participants by living with partner, education and community

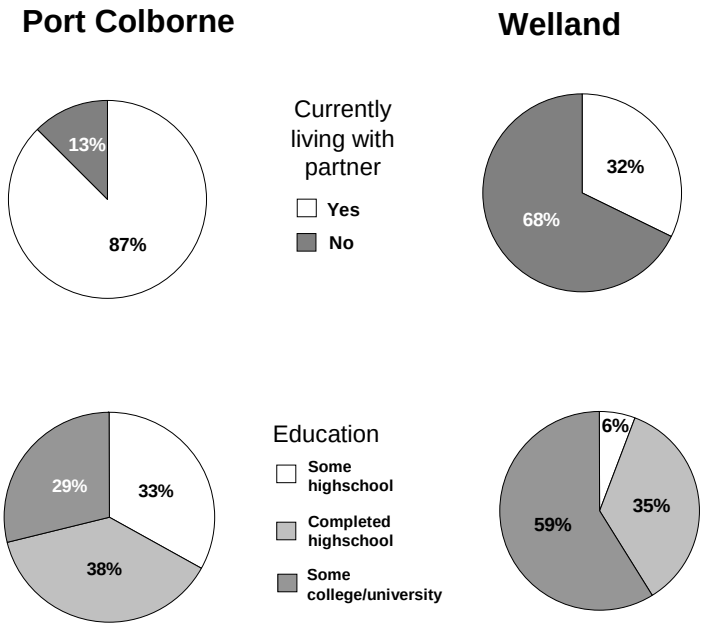
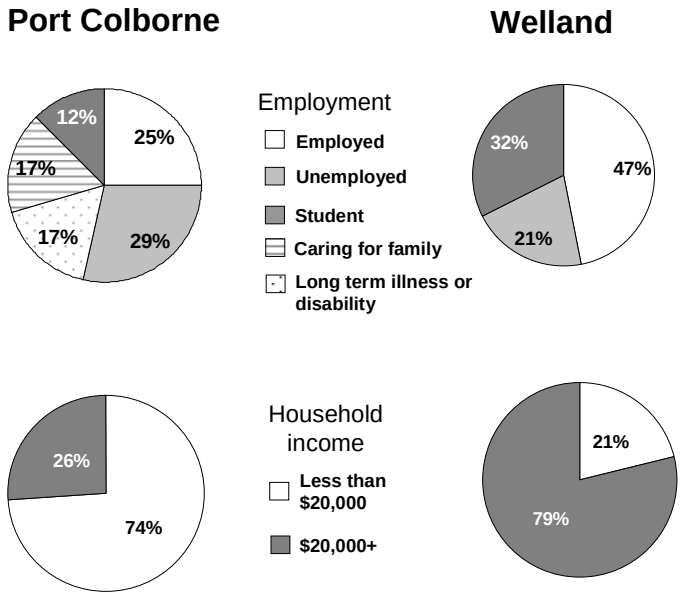


Figure 3.4: Percent of participants by employment, income and community



2. MEASURING PERCEIVED CONTRIBUTING FACTORS TO INCIDENTS OF AGGRESSION AND VIOLENCE

The second objective of the research was to develop a questionnaire that captures people's perceptions about contributing factors to intimate partner aggression.

To address this objective, participants were asked to describe incidents of aggression they experienced with an intimate partner in the past five years. They were then asked to rate the contributing role of various factors (see below) to these incidents of aggression. In Port Colborne, participants were asked to describe the most recent conflict with an intimate partner that involved physical aggression. If there had been no physical aggression, participants were asked to describe the most recent conflict. Then participants were asked to describe the most physically aggressive thing done to them by an intimate partner or by them toward an intimate partner if they had never experienced physical aggression by a partner. If they had experienced no physical aggression in the past five years, they were asked about the most serious incident of aggression, which could include verbal aggression or other forms of non-physical aggression.

While it was originally expected that participants would be able to describe as many as 3 incidents, information regarding a third incident was rarely collected because of the significant amount of time it took for people to describe the first two incidents. In fact, a number of respondents reported only one incident. Therefore, the method was altered for Welland participants. Instead of asking about the most recent incident of aggression, participants were asked about the most physically aggressive act by a partner for the first incident and the most aggressive act by the participant toward a partner followed by probes related to the participant's behaviour.

Particpants rated the role of potential contributing factors to their partner's aggression in the incident and to their own aggression if they were also aggressive in the incident. The factors were grouped under the headings listed below. The wording below was used for a male participant to rate factors influencing his aggression (similar wording was used for rating the factors affecting the partner's aggression):

- communication issues
- something your partner did or something you thought that she did
- you thought she didn't care about you, didn't respect you, etc.
- you felt angry, upset, etc.
- you wanted to get the upper hand with her
- you wanted to get back at her or teach her a lesson
- you wanted to hurt her in some way
- because of how you were feeling before the incident, e.g., depressed, effects of alcohol
- worries, pressures or stress
- problems in your life at the time
- ongoing relationship issues
- something about the way you are generally
- kind of person you are/your partner is
- past experiences or attitudes
- other, e.g., wanted to push her buttons

Because the questionnaire was revised several times to improve the way the questions were being asked, we describe findings from only the final questionnaire used in Welland (i.e., the most recent version of the questionnaire). These provide a flavour for the most important issues that participants saw as contributing to their aggression and that of their partners. Most of the items were asked of both Port Colborne and Welland participants but some that were added later were included only in Welland.

As noted above, the number of incidents and whether the participant rated him/herself and/or the partner varied. Therefore, in the results shown in Supplementary Table S3.1 shown at the end of this section, we report the percent of participants who endorsed a particular contributing factor relating to their own

aggression for any incident they discussed in the interview, and the percent who reported that the factor applied to their partner's aggression in any incident.

Most frequently cited contributing factors

As shown in Supplementary Table S3.1 (end of section), the most frequently cited factors seen as contributing to both the participant's and the partner's aggression related to communication issues, such as trying to get one's point across (71% for partner's aggression and 66% for participant's), and to feelings, such as frustration (64% for partner and 73% for participant) and being upset (75% for partner and 66% for participant). Factors related to something that the participant or partner had done were also rated as playing a role, such as not showing respect (24% for partner and 42% for participant), being stubborn (41% for partner and 25% for participant), and doing something wrong (33% for partner and 43% for participant).

Differences in perceptions of contributing factors to partner's aggression versus participant's own aggression

Some factors were perceived as contributing to partner's aggression by a substantial proportion of participants but less as contributors to their own aggression. To explore partner-participant differences, we analyzed each possible contributing factor to test for statistical significance between the percent of participants who felt the factor contributed to their own behaviour versus whether the factor contributed to their partners' behaviour.

As shown in Table 3.1 below, participants were more likely to report a number of personality characteristics of the partner as contributing to their partner's aggression (e.g., losing temper easily, reacting to things without thinking, tending to be aggressive, controlling, etc.) than they were to attribute their own aggression to their personality. This is consistent with attribution research that has found that people tend to attribute dispositional influences (e.g., character) for the behaviour of others and discount possible situational factors. For their own behaviour, on the other hand, people tend to focus on situational factors to account for their own behaviour and discount their own disposition.

A number of other factors more frequently attributed to partner's aggression related to power and control by the partner – including getting their own way, making the participant feel scared, making the participant feel guilty or bad about something, showing who is boss, and showing they were in control.

Only two factors were considered significantly more likely to have contributed to the participant's aggression than to the partner's aggression: being aggressive because the partner had disrespected them and being aggressive because the participant wanted to end the fight.

Table 3.1. Significant differences between the percent of participants who reported the factor contributed to their partner's aggression and the percent who reported that the factor contributed to their own aggression

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
thought participant was paying too little attention to them	**24**	8	thought partner was paying too little attention to you
get their own way	**42**	16	get your own way
make you feel scared or afraid	**16**	2	make them feel scared or afraid
show you who is boss	**18**	2	show them who is boss
make you feel guilty	**39**	11	make them feel guilty
make you feel bad about something you did	**52**	25	make them feel bad about something they did
in a bad mood	**42**	20	in a bad mood

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
lose their temper easily	**45**	17	lose your temper easily
snap over little things	**42**	7	snap over little things
react to things without thinking	**58**	15	react to things without thinking
aggressive	**29**	8	aggressive
controlling	**33**	5	controlling
emotional	**50**	24	emotional
jealous	**37**	12	jealous
immature	**33**	3	immature
stubborn	**45**	17	stubborn
show that they were in control	**22**	3	show that you were in control
thought participant had disrespected them	16	**38**	**thought partner had disrespected them**
wanted to end the fight	7	**42**	**wanted to end the fight**

Self-other differences provide important insight into how people view incidents and how these views may be affecting their behaviour. For example, if both partners see the other person as at fault for the incident (e.g., because partner was in a bad mood, partner is aggressive and controlling, partner disrespected them), then they will be less likely to look at how their own personality and behaviours contribute to the incident. The present results can only be considered preliminary, because of the very small samples. With the development of this comprehensive measure, however, it is now possible to conduct research with larger samples in order to explore how perceptions of contributing factors contribute to the dynamic process of intimate partner aggression and violence.

Gender differences in perceptions of contributing factors

Our previous review of the literature found that certain explanations may be more likely to be attributed to men while others are more often attributed to women. We analyzed gender differences separately relating to partner's aggression and to the participant's own aggression. As shown in Table 3.2 below, female participants were more likely than male participants to perceive factors such as their partner not being committed to the relationship, not showing them respect, not respecting them, not caring enough about them and having done something wrong as contributing to their own aggression. Female participants were also more likely to report that they acted the way they did because they felt humiliated, felt insecure and were feeling the effects of alcohol. Only one factor was endorsed more often by male than by female participants – acting the way they acted to change the partner's mind about something.

Table 3.2. Significant differences between the percent of male participants and the percent of female participants who reported the factor contributed to their own aggression

CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION		
Participant…	% yes for female participants	% yes for male participants
thought partner was not committed to the relationship	**50**	5
thought partner was not showing them respect	**67**	20
thought partner had done something wrong	**57**	24
thought partner didn't care enough about them	**43**	9
thought partner didn't respect them	**46**	12
felt humiliated	**33**	5
felt insecure	**44**	5
was feeling the effects of alcohol	**39**	5
wanted to change the partner's mind about something	8	**50**

We also tested whether there were significant gender differences in endorsement of contributing factors to their *partner's* aggression. As shown in Table 3.3 below, male participants were more likely than females to report that their partner was aggressive because she wanted to make them feel guilty and because she was emotional. Female participants were more likely than male participants to report that their partner was aggressive because he wanted to change her mind about something, because he tends to be stubborn and because they were not getting along.

Table 3.3. Significant differences between the percent of male participants and the percent of female participants who reported the factor contributed to their partner's aggression

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		
Partner…	% yes for female participants	% yes for male participants
wanted to make participant feel guilty	14	**59**
tends to be emotional	29	**69**
felt frustrated	**80**	45
tends to be stubborn	**63**	29
and participant were not getting along	**47**	10

Again, these data provide the foundation for full scale research on gender differences in perceptions of contributing factors. Such gender differences are also likely to play a role in the dynamic process of partner aggression.

Supplementary Table S3.1. Percent of participants who endorsed each factor as contributing to their partner's aggression and to their own aggression

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION ***Did communication issues play a role in how angry or aggressive your partner got in this incident? For example, did they act the way they did because they wanted to…***	**% yes**	**% yes**	CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION ***Did communication issues play a role in how angry or aggressive you got in this incident? For example, did you act the way you did because you wanted to…***
get you to listen	50	50	get your partner to listen
get your attention	69	55	get your partner's attention
get their point across	71	66	get your point across
change your mind about something	52	31	change your partner's mind about something
show you how important something was to them	49	42	show your partner how important something was to you
get you to understand their point of view	43	56	get your partner to understand your point of view
get you to talk to them	35	38	get your partner to talk to you
get you to stop keeping things bottled up	19	17	get your partner to stop keeping things bottled up
get you to understand them better	23	45	get your partner to understand you better

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
Did your partner act the way they did because of something you did or something they thought that you did? For example, because they thought you were…		***Did you act the way you did because of something your partner did or something you thought that your partner did? For example, because you thought they were…***	
interested in someone else	27	16	interested in someone else
not committed to the relationship	17	26	not committed to the relationship
spending too much time with other people	12	11	spending too much time with other people
paying too little attention to them	24	8	paying too little attention to you
ignoring them	19	21	ignoring you
nagging them	3	20	nagging you
not being supportive	15	11	not being supportive
not being fair to them	29	31	not being fair to you
not being honest with them	10	28	not being honest with you
being selfish	23	23	being selfish
being stubborn	41	25	being stubborn
not giving them enough space	9	15	not giving you enough space
not showing them respect	24	42	not showing you respect
using them	3	7	using you
taking advantage of them	5	8	taking advantage of you
spending too much money	4	4	spending too much money
not doing enough around the house	3	0	not doing enough around the house
giving them advice they didn't want	6	0	giving you advice you didn't want
criticizing them	16	14	criticizing you
being unreliable	6	3	being unreliable
trying to control them	10	22	trying to control you
treating them in a way they didn't like	23	38	treating you in a way you didn't like
Did your partner act the way they did because you had done something or they thought you had done something? For example, they thought you had…		***Did you act the way you did because your partner had done something or you thought they had done something? For example, you thought they had…***	
been aggressive toward them first	15	30	been aggressive toward you first
hurt them physically	6	14	hurt you physically
done something wrong	33	43	done something wrong
misunderstood what they had done or said	26	26	misunderstood what you had done or said
violated their trust	18	28	violated your trust
lied to them about something	23	31	lied to you about something
been unfaithful	18	16	been unfaithful
disrespected them	16	38	disrespected you
invaded their privacy	7	8	invaded your privacy
touched their belongings without their permission	3	11	touched your belongings without your permission
done something else they didn't like	34	24	done something else you didn't like
Did your partner act the way they did because they thought you…		***Did you act the way you did because you thought your partner…***	
didn't care enough about them	36	27	didn't care enough about you
didn't love them	16	20	didn't love you
didn't trust them	13	23	didn't trust you
didn't respect them	13	27	didn't respect you
were going to leave them	23	12	was going to leave you

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
Did your partner act the way they did because they felt…		***Did you act the way you did because you felt…***	
angry	64	51	angry
upset	75	66	upset
scared	27	28	scared
frustrated	64	73	frustrated
powerless	15	20	powerless
embarrassed	9	20	embarrassed
humiliated	5	18	humiliated
insecure	27	24	insecure
hurt	29	45	hurt
Did your partner act the way they did because they wanted to get the upper hand with you? For example, they wanted to…		***Did you act the way you did because you wanted to get the upper hand with your partner? For example, you wanted to…***	
control what you do	24	11	control what they did
get you to stop seeing certain people	20	11	get them to stop seeing certain people
get their own way	42	16	get your own way
make you feel scared or afraid	16	2	make them feel scared or afraid
make you feel small	9	0	make them feel small
show you who is boss	18	2	show them who is boss
show their own importance	24	11	show your own importance
show they are tougher than you	12	3	show you are tougher than they are
make you feel intimidated	16	0	make them feel intimidated
get you to do what they wanted	34	17	get them to do what you wanted
have sex with you even though you didn't want to	2	0	have sex with them even though they didn't want to
Did your partner act the way they did to get back at you or teach you a lesson? For example, they wanted to…		***Did you act the way you did to get back at your partner or teach them a lesson? For example, you wanted to…***	
punish you	12	11	punish them
make you feel guilty	39	11	make them feel guilty
get even with you	10	8	get even with them
make sure you didn't do something again	19	17	make sure they didn't do something again
make you apologize	26	25	make them apologize
make you feel bad about something you did	52	25	make them feel bad about something they did
teach you a lesson	16	14	teach them a lesson
Did your partner act the way they did because they wanted to hurt you in some way? For example, they wanted to…		***Did you act the way you did because you wanted to hurt your partner in some way? For example, you wanted to…***	
humiliate you	5	3	humiliate them
embarrass you	10	3	embarrass them
hurt you	22	8	hurt them
make you feel bad about yourself	13	14	make them feel bad about themself
Did how your partner was feeling <u>before</u> the incident affect how they acted in the incident? For example, were they…		***Did how you were feeling <u>before</u> the incident affect how you acted in the incident? For example, were you…***	
depressed	10	10	depressed
in a bad mood	42	20	in a bad mood
in physical pain	3	3	in physical pain
feeling the effects of alcohol	22	21	feeling the effects of alcohol
hungover (suffering from the after-effects of drinking)	0	0	hungover (suffering from the after-effects of drinking)
feeling the effects of drugs	12	3	feeling the effects of drugs
suffering from the after-effects of drug use	5	0	suffering from the after-effects of drug use

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
Was your partner experiencing any of the following worries, pressures or stress?		***Were you experiencing any of the following worries, pressures or stress?***	
money or debt	20	22	money or debt
work	24	10	work
school	6	10	school
children	6	4	children
a new baby	0	0	a new baby
problems with family	20	17	problems with family
unemployment	20	16	unemployment
having too many responsibilities	11	18	having too many responsibilities
having too much to do	6	4	having too much to do
having nothing to do	0	10	having nothing to do
legal issues	0	0	legal issues
the loss of someone close to them	0	0	the loss of someone close to you
a major change in their life (please specify)	3	3	a major change in your life (please specify)
some other kind of pressure or worry (please specify)	20	16	some other kind of pressure or worry (please specify)
Was your partner having problems in their life at the time? For example, did they…		***Were you having problems in your life at the time? For example, did you…***	
have a psychological or mental health problem, such as depression	17	12	have a psychological or mental health problem, such as depression
feel they were not good enough	27	16	feel you were not good enough
have low self esteem	23	11	have low self esteem
feel like a failure	17	8	feel like a failure
feel bad about him/herself	10	10	feel bad about yourself
have a problem with alcohol	7	4	have a problem with alcohol
have a problem with drugs	9	2	have a problem with drugs
have a gambling problem	2	0	have a gambling problem
have a physical health problem	11	6	have a physical health problem
feel that nobody was supportive of them	5	8	feel that nobody was supportive of you
feel they had no friends	0	5	feel you had no friends
have something else about their life at the time that affected how they acted (please specify)	18	10	have something else about your life at the time that affected how you acted (please specify)
Were there any ongoing relationship issues that may have affected how they acted in this incident? For example, the two of you…		***Were there any ongoing relationship issues that may have affected how you acted in this incident? For example, the two of you…***	
weren't getting along	28	16	weren't getting along
argued or fought a lot	29	14	argued or fought a lot
didn't trust each other	26	17	didn't trust each other
had different values	7	7	had different values
had different priorities	17	12	had different priorities
had a lot of resentment toward each other	7	3	had a lot of resentment toward each other
had something else about your relationship that affected how they acted (please specify)	7	11	had something else about your relationship that affected how you acted (please specify)

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION		CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION	
Was the way your partner acted in the incident related to something about the way they are generally? For example, do they tend to…		***Was the way you acted in the incident related to something about the way you are generally? For example, do you tend to***	
lose their temper easily	45	17	lose your temper easily
snap over little things	42	7	snap over little things
react to things without thinking	58	15	react to things without thinking
have strong beliefs about what is right in a relationship	13	29	have strong beliefs about what is right in a relationship
keep things bottled up and let it out all at once	32	14	keep things bottled up and let it out all at once
bully people	6	0	bully people
worry or stress about everything	16	11	worry or stress about everything
be negative about most things	15	0	be negative about most things
get aggressive when they drink	10	10	get aggressive when you drink
get aggressive when they use drugs	0	0	get aggressive when you use drugs
think only what they want matters	28	0	think only what you want matters
Would you say any of the following are true of your partner? For example, they tend to be…		***Would you say any of the following are true of you? For example, you tend to be…***	
aggressive	29	8	aggressive
abusive	10	0	abusive
controlling	33	5	controlling
emotional	50	24	emotional
moody	35	22	moody
mean	15	0	mean
jealous	37	12	jealous
impulsive	25	21	impulsive
irresponsible	18	3	irresponsible
immature	33	3	immature
insecure in intimate relationships	25	10	insecure in intimate relationships
stubborn	45	17	stubborn
competitive	10	8	competitive
selfish	20	0	selfish
Were any of the following true about your partner's past experiences or their attitudes?		***Were any of the following true about your past experiences or your attitudes?***	
your partner witnessed aggression in their family	20	3	you have witnessed aggression in your family
they experienced aggression as a child	21	15	you experienced aggression as a child
they had a bad childhood	13	6	you had a bad childhood
they had bad experiences in past relationships	28	11	you had bad experiences in past relationships
they think it's healthy to express aggression	6	0	you think it's healthy to express aggression

CONTRIBUTING FACTORS TO PARTNER'S AGGRESSION *Did any of the following factors affect how your partner acted in this incident? For example, they wanted to …*			CONTRIBUTING FACTORS TO PARTICIPANT'S AGGRESSION *Did any of the following factors affect how you acted in this incident? For example, you wanted to …*
get in an argument or fight for fun or excitement	10	0	get in an argument or fight for fun or excitement
get in an argument or fight because it "turns them on"	2	0	get in an argument or fight because it "turns you on"
push your buttons	13	3	push your partner's buttons
play mind games	13	0	play mind games
be difficult	26	10	be difficult
make you angry	10	7	make your partner angry
annoy you for their own enjoyment	10	0	annoy your partner for your own enjoyment
make you upset	20	7	make your partner upset
show that they were in control	22	3	show that you were in control
end the argument or fight	7	42	end the argument or fight
defend him/herself	27	24	defend yourself
show they were right	35	16	show you were right

3. Developing a Better Understanding of Intimate Partner Aggression and Violence Among Young Adults

As noted above, the interviews, which included extended discussion with participants about the perceived contributing factors to aggression and violence, provide a rich source of knowledge about the nature of intimate conflict and communication among young adults. In this section, we use these data to extend this understanding starting with the typology proposed by Johnson.

In the following description of findings, we explore the extent that incidents can be classified into the four categories defined by Johnson. In addition, we explore whether further subclassifications can be identified for incidents that appear to be situational couple aggression. Classifications are important because they provide a way of summarizing the findings. In addition, classifications can provide insight into the core distinctions between different forms of intimate partner aggression. For example, the distinction between intimate terrorism and situational couple aggression draws attention to the key role of control, dominance and power that is part of abuse as compared to factors that characterize other forms of aggression between intimate partners.

For these analyses, we chose to focus our classification on only one incident per person, specifically, the most violent incident. For example, if the participant described one incident that involved a fairly minor argument and another where there was physical violence by one or both partners, we used the incident with physical violence for classification. Incidents involving apparent intimate terrorism took priority over other violent incidents where control did not appear to be a factor. This allowed us to classify participants into mutually exclusive categories according to the most serious aggression that they experienced and examine the characteristics of individuals such as gender for those experiencing each type of incident.

We first classified the participants according to whether they had experienced intimate terrorism or not. We then examined the incidents reported by those who had experienced intimate terrorism to assess the extent that their experience fit one of the three categories defined by Johnson: one-sided intimate terrorism, intimate terrorism with violent resistance, and mutual violence.

We next examined the remainder of the incidents which would fall under Johnson's broad category of situational couple violence. We found that situational incidents could be further classified into distinct types: participants who reported incidents that appeared to be truly situational; and participants whose incidents did not appear to involve control or intimate terrorism but where the aggression appeared to be part of a troubled or unhealthy relationship rather than just a situational response.

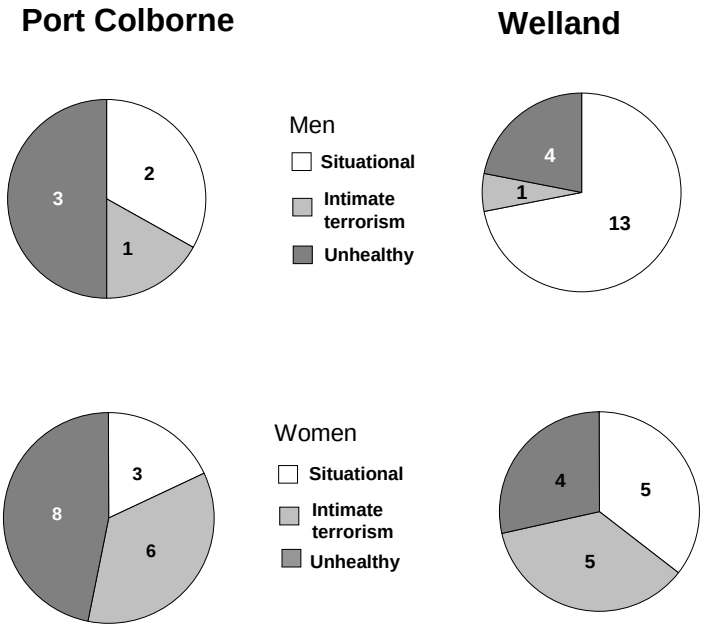
The number of participants classified as situational aggression only, unhealthy relationship, and intimate terrorism or mutual violence is shown in Figure 3.5 by gender and community. As shown in this figure, men were more likely than women to be classified as reporting situational incidents only in both communities, but especially in Welland. Intimate terrorism and mutual violence was reported mostly by women. Women were also more likely to report incidents indicative of a troubled or unhealthy relationship.

In the following sections we give examples of incidents that were classified as intimate terrorism or mutual violence, unhealthy relationship and situational conflict.

Intimate terrorism/mutual violence

A total of 13 participants (11 females) reported incidents classified as involving intimate terrorism or mutual violence; of these, six were with a current partner (five from Port Colborne and one from Welland). Seven described what was apparently one-sided aggression by a partner, three described violent resistance and three mutual violence.

Figure 3:5: Number of participants classified as situational aggression only, unhealthy relationship, and intimate terrorism or mutual violence



One-sided intimate terrorism

Four Welland participants reported an incident involving intimate terrorism by a previous partner. These included one relationship when the participant was in high school where her partner was so controlling and violent that her parents finally intervened. Another reported a very vicious attack by a boyfriend who was drunk and on steroids.

Three Port Colborne participants reported incidents included as probable intimate terrorism – one involved nonphysical aggression and two involved physical violence. For the two participants who reported physical violence, the presence of ongoing control and dominance by the male partner was not explicitly stated in the interview. However, we have classified these incidents as intimate terrorism because of the fear they invoked in the participant. For one participant, the man became so violent that she had to escape out a window. The other reported a single occasion of violence for which the partner went to jail for a week. The argument started over his gaming on the internet plus other issues. She had shut off the internet. They were in the basement arguing and he said he was leaving…

> *I said "You realize if you take a harsh step like this there might be no turning back". He then went to push me back. I went down the stairs. I said "Don't touch me." He then came back and said, "This is touching you," and that's when he punched me in the face and I hit my head off the ground, and I had to call 911 off my phone because I had that on me at the time, and that's when he stopped and left.*

Although there was no indication of a pattern of control from this single incident and the participant said in the interview that she would not tolerate future violence from him, we included the incident in this category because of the level of violence and his comment "*This* is touching you," which is suggestive of intimidation and power.

The following incident of nonphysical aggression was judged as reflective of intimate terrorism because of the apparent ongoing verbal criticism by the male partner and the participant's expressed feelings of powerlessness:

I: What did he say, do you remember?
P: "Why is there a mess out here?"
I: And how did you respond?
P: Same way I normally do [saying] – "I was going to come out there and clean it."
I: So what did he say?
P: "Well. You should know better by now. I've asked you over and over again. I feel like you don't respect me when you do this."
I: Okay and what happened next?
P: And then … I don't remember. I usually start crying and then I start doing the dishes. And basically started tuning him out.
…
I: And is this kind of incident typical of your relationship or unusual?
P: Typical.

Intimate terrorism with violent resistance

Three Port Colborne participants described incidents of intimate terrorism in which they were also aggressive and where their aggression appeared to be in response to intimate terrorism. One participant described how her previous partner had beaten her up when she was pregnant with his child. She said that the police didn't charge him because she fought back.

Another participant reported a current relationship that involved physical violence by both the partner and the participant. The relationship was defined as intimate terrorism by the male partner and resistance by the female partner because of the clear control the male partner had over the participant: he lived in her house along with another girlfriend of his and he had additional girlfriends on the side. Moreover, the participant's physical aggression was minimal and she left the house for the night after the fight because she was afraid of him.

The third participant reported an extensive history of verbal and physical aggression, including her partner having spent time in jail for assaulting her. In the particular incident that she described, however, the participant was physically aggressive (slapped him) in response to his initial verbal and physical aggression toward her (he kicked her to the ground, after being clearly verbally aggressive and controlling, telling her what to do and calling her names). Notwithstanding his violence, she told the interviewer that she blamed herself for the incident. She called the police but didn't tell them that her partner had kicked her and was willing to spend time in jail so that he didn't have to:

He went to jail on an assault charge on me [in the past]. I don't want to put him in jail for this whatever so I just took all the rap for it so cause basically I shouldn't have hit him in the first place, I shouldn't have let it get to that point but I did. So we're even so if I go to jail it will teach me a lesson and it has.

Although she was willing to blame herself and even go to jail for the incident she described, when asked later whether there was anything going on in her life that may have contributed to the way her partner acted, she described how she no longer puts up with his violence passively:

P: Well me and him got in a huge fight where I got a black eye from him so basically now I don't take his crap and he knows it…Like we had a few fights in the past where literally either he got hurt or I got hurt. But I got home one day and like sitting beside him saying why the hell am I taking his crap…So now I fight back and he hates it….
I: Was there anything about your relationship with him that may have affected the way he acted?

P: I think the reason why is because I don't think I'm really happy with him…But I just stay because I think it's a comfort zone with me.

Mutual violence

Three participants reported what appeared to be mutual terrorism. One female participant reported two incidents both suggestive of mutual violence that possibly involved power and control issues by both partners. In one very violent incident her current partner shoved her against the wall, then she punched him in the face (apparently breaking his nose), and then he grabbed her hair and dragged her down the hall out the front door and shut the door, leaving her outside. Another person was there at the time who did not intervene. The participant noted that both she and her partner were drug users/addicts. The second incident she described was equally violent by both partners. When asked about reasons for her own aggression in that incident, she indicated that aggression is normative for her and described a background involving mutually violent relationships:

Well, I did have a couple of beers that night so I think maybe like before when I got like, when I went out to bars and got drunk like I've gotten into fights with other people and I've gotten into trouble with the police when I was drunk before – so I am guessing, yes, that I do get aggressive when I drink.
… when I was younger, I've seen my parents fight and stuff. So I think maybe that's why I'm aggressive…when I was younger I was, like, that I used to get the belt and when you see aggression as a child maybe you carry it along with you as an adult.

A male participant described a violent incident with a previous partner where she bit him, grabbed him by the neck and dug her nails into him. In return, he shoved her, then picked her up by her collar and belt so that she was at face level with him and threw her a couple of feet where she landed on the lawn and "she kind of bounced up and rolled and was on her feet again so she's fine." He identified relationship problems as the main reason for the aggression:

I: Okay so what was the issue that led to the incident then?
P: I think it was just our relationship just degraded to that point…just needed to end.

A male participant reported two incidents of aggression that took place with his current partner. The second incident was very violent. She tipped his chair, he hit his head on the coffee table and she "kicked him in the balls." He said he could not remember his own violence because he blacked out but apparently he punched her in the face after he blacked out because she had a black eye. The issue leading to the conflict was that she swept dust under the coffee table rather than sweeping it into a dustpan. Police were called and the couple were not allowed to be together for 6 months but were back together at the time of the interview.

Situational couple aggression – troubled or unhealthy relationships

As described above, for participants who did not report intimate terrorism, we defined two categories of situational couple aggression: (1) incidents indicative of a pattern of troubled or unhealthy relationship interactions; and (2) incidents that appeared to be truly situational. For this categorization, incidents indicative of an unhealthy relationship took priority. Thus, if a participant reported one incident suggestive of a troubled or unhealthy relationship and one that appeared to be situational, the person was included in the category of troubled/unhealthy relationship. This further categorization resulted in 19 participants classified as troubled/unhealthy relationship and 23 categorized as situational only.

Of the 19 participants (11 females) in the troubled/unhealthy relationship category, 8 described relationship problems with their current partner (four from Port Colborne and four from Welland). As described below, troubled or unhealthy relationships involving aggression and violence were related to: (1) mental health problems of one or both partners; (2) substance use or addiction by one or both; (3)

trust/jealousy issues. Sometimes all three factors appeared to be involved. Other contributors may have been personality or attitudes of one or both partners. In a few cases, underlying issues for the relationship problems were not identified.

Mental health problems

Four female and two male participants described an aggressive incident that seemed to be related to mental health problems of one or both partners. Of these, one male participant described how his mental health problems caused him to have unreasonable jealousy:

> *…so once I have something in my head, I believe it. It's really hard for me not to believe that something is going on and I think that's the situation we are talking about right now. I thought that she was out fooling around with someone else or something like that. It turns out that I was wrong…*

In another instance related to mental health problems, a female participant described an incident that happened the morning before she came to the interview and later in the interview linked it to her male partner's mental health problem:

> *He doesn't like people, can't be around people. Like I don't know. It's all screwed – like he feels like they're out to get him. I think it's a problem. He talks to somebody about that because I got him to do something about that.*

In terms of other mental health problems, one female participant described her partner as bipolar and attributed the incident to his not being diagnosed at the time, and two participants (1 male, 1 female) attributed the incident to anxiety problems of the partner, although the incident reported by the female participant also appeared to be related to the male partner's infidelity as well as use of alcohol and cocaine by both partners.

Alcohol or drug use/abuse

Two female participants reported incidents that appeared to be related to problems with alcohol or drug use by one or both partners. In one current relationship, the female participant reported ongoing conflicts about her partner's drug addiction as well as her own depression. The other participant reported physical violence related to her own and her partner's alcohol problems.

Jealousy or trust issues

Five male and three female participants reported conflicts that occurred in the context of relationships that had ongoing jealousy/trust issues. Four of the male participants and two of the female participants reported incidents related to the female partner not trusting the male partner.

For incidents reported by three of the male participants and one incident reported by a female participant, the incident seemed to be related to the male partner's relationship with another woman or to his being flirtatious.

The three men describing these incidents seemed to discount the role that their own behaviour and their attitudes toward the relationship may have had in fuelling the jealousy or lack of trust. For example, one described his partner as "clingy" but also acknowledged that some of her lack of trust may have stemmed from the fact that he had left another girl for her. Plus, as he noted, he "*likes to flirt*." He commented on his dissatisfaction with their relationship:

> *Yeah, she thinks because me and her are dating that I can't talk to other girls, I can't flirt with them, for example.*
> *She's a girl. She naturally has a bachelor of arts in mind games. I call it screwology, you know, the art of messing with people.*

For another of the three male participants, an aggravating factor, or possibly the main issue, was that he was still hanging out with this ex-girlfriend even though he has been dating his current girlfriend for four years. His time with his ex-girlfriend included going out to bars at night when his current girlfriend was at work. He described his ex as his best friend to whom he talks about his current relationship and from whom he receives a lot of "good advice." He viewed his current partner's jealousy as being her problem, not his:

> *I think part of it is she doesn't trust me and I think part of it is she is not experienced in relationships. I am the first relationship she has ever had so she is not used to guys actually hanging out with female friends and going out to bars.*

Of the three female participants who described jealousy/trust issues in a previous relationship, one described an incident that led to her leaving a previous partner with the main reason being the partner's infidelity. Another described an incident that was minor in nature stemming from her partner's jealousy about her going out with her female friend, which was part of ongoing problems in their relationship.

The third female participant reported an incident with a previous partner relating to her jealousy, although she also described him as jealous and untrusting. In the incident, she had grabbed his cell phone away from him, saw that he was in contact with a girl and accused him of cheating. There was a particular girl she thought he had been cheating with, who also happened to be his best friend. The argument led to him pushing her against the wall and putting his fist through the drywall. She left him because the incident made her worry about the potential for his violence to get worse:

> *…like obviously we have grown up with like a lot of stuff about physical violence in like there has been presentations and like speakers who have always said that "you think he just like spit on you this one time and whatever but like it gets worse, like it always progresses to the next level. You know, you think it's just minor and then before you know it, he is hitting you right?" So that was just kind of in my mind*

Other problems in the relationship

Two female participants reported incidents related to previous relationships where the underlying problem in the relationship may have been intimate terrorism by the male partner but there was insufficient information to draw this conclusion. What was clear was that both described troubled or unhealthy relationships. One participant reported an incident where her partner punched her in the face and spit on her. She attributed the incident to their bad relationship. The second described an incident in which she was aggressive and her partner had restrained her. The incident was indicative of possible intimate terrorism because her partner and his friends had moved in with the participant and then had robbed her when they moved out. Thus, despite her physical aggression, the main problem in the relationship may have been his dominance and control.

Finally, one female participant did not identify specific problems in the relationship and reported only minor incidents but her description of the relationship indicated an ongoing pattern of conflict, miscommunication and hurt feelings. She reported: "We fight so much."

The common factor of relationship problems

Whether the underlying issue was mental health, substance use, jealousy/trust or something else, a number of participants referred to the relationship as troubled or unhealthy, as in the following examples:

> *Oh we just weren't communicating and we weren't able to get along…because we actually fought a lot so I mean when you have fights and where you can't come to a resolution, it finally boils over.*

Because we broke up a couple of years ago for 6 months so like it was kind of good because it gave us a break but at the same time, I wonder if he will leave me again, so it affected me a lot.

It was always, always, always a recurring problem, right. The problem never went away and if he, and if I ever tried to deal with it or like confront him about it, it was just the same thing – we get angry and then I would just forget about it for the time being….So it was extremely unhealthy, looking back.

Everything, like little thing, is just a fight all the time and I can't stand it…We fight all the time, like every day…I'm at the point where I just want to stop breathing because I don't want to fight. I don't want to be upset because it's not the way it's supposed to be.

It was off and on, like our whole relationship. At first it was fine, and then by the halfway point, we kind of always fought, broke up, got back together.

One female participant's ambivalence about leaving the relationship with a partner who was experiencing mental health problems was apparent in her description of how they still had some good times but that problems had gotten worse over time:

Like that's what I mean, we'll find something funny on TV and that always makes us laugh forever over nothing. But I don't know, sometimes it's really bad and it never used to be like that, it was always good and now it's all screwed up.

Finally, although we have distinguished partner aggression related to unhealthy relationships from truly situational partner aggression, even within unhealthy relationships, there may be more than one kind. The relationships involving jealousy by the female partner and lack of commitment of the male partner may simply be a function of the age and maturity of the individuals. Other problematic relationships associated with violence may, however, be more intransigent and difficult to resolve, especially when problems are related to mental health, substance abuse and economic disadvantage.

Situational couple aggression – situational conflict only

Twenty-three participants (8 females) reported incidents that appeared to be situational couple aggression – that is, ordinary conflicts in relationships that did not appear to have any major ongoing problems and did not reflect intimate terrorism. These incidents consisted mostly of verbal aggression such as arguments, yelling, ignoring or name calling about various issues. In a few incidents, minor physical aggression was used but these did not appear to reflect assertion of power or control. For example, in one incident, during an argument, the male participant pushed his female partner out of the way because he wanted to leave the argument and she was blocking him. He told the interviewer that he ended up staying to work through the problem because he felt bad about the argument and about pushing her.

Issues that led to the conflict included: the female partner wanting the male partner to do something or do more around the house; physical horseplay that turned serious; getting on each other's nerves; one or both partner being in a bad mood or feeling stressed; the male partner making a comment about the female partner's weight; the female partner bugging the male partner about his smoking; and, in at least 12 incidents, jealousy or trust. Seven participants from Welland (5 male, 2 female) reported an incident that involved a single occasion of a female slapping the male's face or being physically aggressive in some other way. These incidents were classified as situational couple aggression, despite the physical aggression being one-sided, because the aggression happened on a single occasion and did not appear to reflect a pattern of control. Five of the seven incidents involved either jealousy over an ex-girlfriend or a response to a conflict about the male partner being unfaithful.

Comparing those experiencing intimate terrorism/mutual violence, aggression related to unhealthy relationships and situational conflict on mental health and substance use problems

Core questionnaire data were used to determine the association between type of partner aggression (i.e., intimate terrorism, unhealthy relationship or situational conflict) and mental health and substance use problems (see Chapter 4 for description of measures). As shown in Figure 3.6, those who had experienced or were experiencing intimate terrorism or mutual violence tended to have more substance use and mental health problems than did those who had only situational conflicts. Those who reported incidents that seemed to be reflective of relationship problems did not differ from those reporting only situational conflicts on substance use measures but were more likely to meet clinical criteria for major depression and more likely to report anxiety.

Figure 3.6: Percentage of participants who reported symptoms of alcohol dependence, used illicit drugs, met criteria for major depression and reported anxiety by type of partner aggression (situational, unhealthy and intimate terrorism)

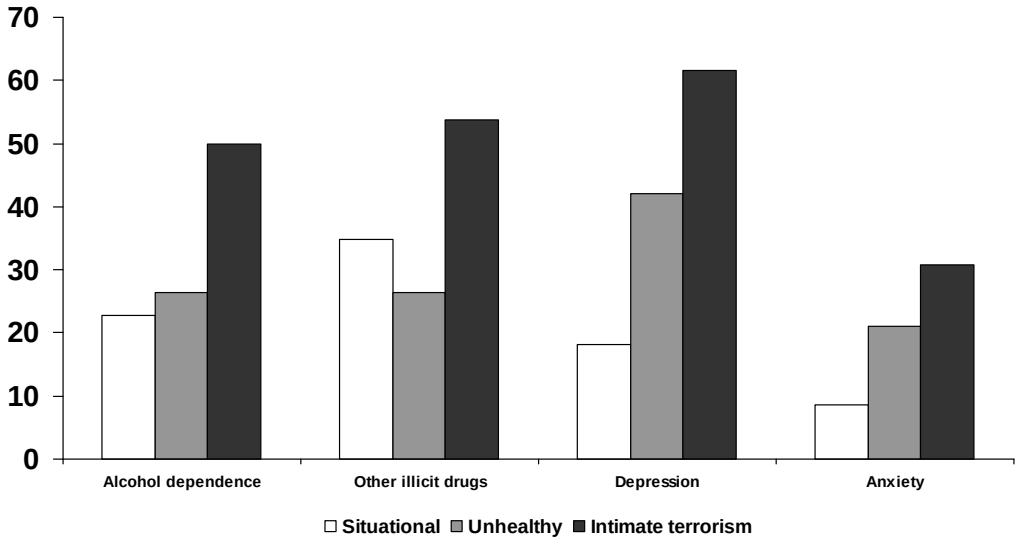
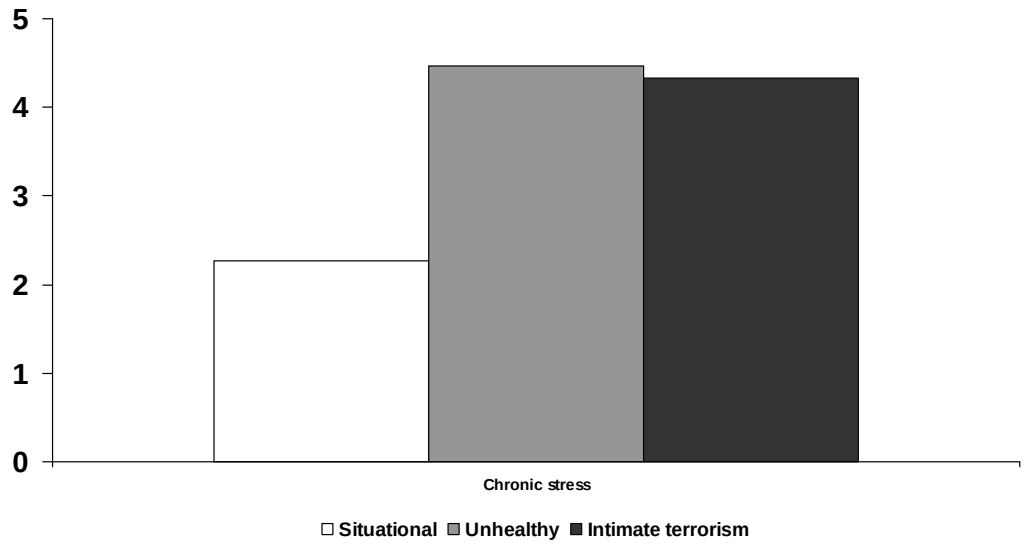


Figure 3.7 shows scores on chronic stress by type of intimate partner aggression (see Chapter 4 for items measuring chronic stress). As shown below, those experiencing only situational aggression reported lower chronic stress compared with the other two groups.

Figure 3.7: Scores on the chronic stress scale by type of partner aggression (situational, unhealthy and intimate terrorism)



Some implications relating to the different types of partner aggression

Perhaps the most important finding of these analyses is the identification of the importance of troubled/unhealthy relationships in intimate partner aggression and violence. Johnson expanded thinking on intimate partner violence by recognizing that not all violence was about control. His distinction was necessary because findings of violence by female partners provoked a major controversy in the research literature and in the media around whether women were as violent as men and just as likely to physically abuse men as the reverse. By distinguishing between intimate terrorism and situational conflict, it was possible to identify abusive control by one partner as being perpetrated more often by the male partner, often grounded in traditional patriarchal views.

A potential drawback of Johnson's dichotomy between intimate terrorism and situational conflict, however, is the thinking that situational conflict is *only* situational, and therefore of little concern. It is clear that even situational conflict can also be important when it involves physical violence that could lead to risk of injury and psychological trauma. In addition, the present findings suggest that some types of situational conflict, specifically conflicts that are part of an unhealthy relationship, may reflect more systematic problems. That is, aggression occurring in the context of an unhealthy relationship is of particular concern because of the psychological and physical effects of ongoing conflict.

Although the relationship between partner aggression and marital dissatisfaction is well-known, the integral role of ongoing relationship problems and the way that these problems contribute to aggression by partners have not been given a great deal of attention. The present findings suggest that it is important to recognize aggression and violence that occurs in these contexts and not focus solely on intimate terrorism. Of course, prevention of and services for intimate terrorism is of highest priority. However, incidents of aggression that occur in unhealthy relationships appear to have psychological and physical risk and, as such, services are needed addressing these relationship problems as well. Moreover, incidents falling in this category are unlikely to come to the attention of the criminal justice system and typically do not result in seeking help from shelters.

A first step towards developing assistance for these types of relationship problems may simply involve helping the individuals see that their relationships may be unhealthy. This seems to have been an unintended by-product of the research conducted in Welland and Port Colborne. For example, one

participant said that she had wanted help to address problems in her past relationships for a long time but didn't know where to go. The interviewer told her that she would be given a package containing contact information for places from which she could receive help at the end of the interview. The respondent said that just talking about her experiences in the interview had helped her even though the interviewer wasn't able to respond or give advice. Another participant said he agreed to take part in the research to "help and hopefully get something from it." When asked what he hoped to gain from the interview, he replied, "just ways to look at things differently and maybe ways to handle things." These comments suggest that young people experiencing relationship difficulties may need access to information about relationship problems and possibly some counselling. People are often embarrassed about relationship difficulties and, as indicated by some participants, they often keep both unhealthy relationships and intimate terrorism a secret from families.

Assistance for unhealthy relationships as well as for intimate terrorism might also include economic assistance to help the partners leave the relationship when the relationship is untenable. In addition, as noted above, a substantial proportion of relationship problems were related to the mental health problems of one or both partners; therefore, addressing these mental health problems could have broader effects on the quality of young people's relationships. In fact, several participants noted that problems had been reduced when the partner's mental health problems had been treated.

A surprisingly large proportion of participants reported incidents that seemed to meet criteria for intimate terrorism or mutual violence. As described above, this high rate was partly attributable to people in these relationships either wanting to tell their story about past relationships or possibly looking for answers related to current relationships. The high number reporting these incidents does, however, suggest that such experiences may be more typical than is commonly assumed and supports efforts such as the Ontario Woman Abuse Screening Project (http://womanabusescreening.ca/index.php) to reach out to women who are possibly being victimized. However, it was not always clear in the interviews that women saw themselves as being abused. Moreover, even those who did were often not able to see a way out. That six participants described incidents of intimate terrorism involving a current partner is of particular concern, especially with some of them blaming themselves for the violence.

Perhaps the most common theme that emerged in situational incidents and among those reporting unhealthy relationships was that of jealousy and trust. Not only did jealousy or trust form the basis of eight of the incidents indicative of unhealthy relationships, many incidents categorized as situational only were also related to jealousy or trust. The common theme of jealousy and trust is perhaps not surprising given the age of participants. Especially for the younger participants, this is an age when they are developing new relationships and exploring being with different partners. Related to this was a theme described by both male and female participants of women wanting commitment and men not being ready for commitment (or for the kind of commitment wanted by the woman), but at the same time wanting to stay in the relationship. Thus, prevention programs and counselling targeting young adults may need to focus on trust and jealousy issues in relationships.

Where participants have sought help for partner aggression problems

As part of the interview, participants were asked whether they had sought help for problems they were having with an intimate partner. Of 49 participants who were asked this question, 37 said they had sought or received help. Twenty-one (43%) sought help from a friend and 11 (22%) from a family member. Seven participants (14%) sought help from a counsellor or therapist, 3 (6%) from a doctor, and 2 (4%) from a psychiatrist. Three participants (6%) mentioned that they sought help from an agency. One participant said that he had been court-ordered to attend a program for partner assault but he did not in fact attend the program.

While participants tended to seek help from family members, one participant said she often takes her family's advice "with a grain of salt" because "they really don't understand. With family it's hard to tell them everything." Another female participant described the relationship she had been in as "horrible" and

noted that she had a girlfriend she talked to a lot and who gave her emotional support. She did not talk to her family about it because she didn't want them to know that she was in an unhealthy relationship.

Participants were also asked where they would go to obtain help if they needed it. Again most participants indicated they would go to friends (32%) or family (39%). Four participants (8%) said they would use self-help resources such as the internet or books. Two participants who indicated they would go to friends said they would not seek professional help: one said he would not "pay some counsellor or anything" and another said she "wouldn't go further than that. I wouldn't want to involve other people."

Among the types of professional help that participants indicated they would seek, the most common was counselling (25%), with 4 participants (9%) mentioning a doctor, 2 (4%) saying they would seek help from a priest or pastor, and 1 (2%) said a psychiatrist. Agencies were mentioned by 14 participants (27%), including 3 who said they would seek help from a women's shelter. One agency (Port Cares) was mentioned by 3 participants. Police, hospital and rape hotline were also mentioned (each by one participant). Three participants indicated they wanted help but did not know where to get the help they wanted (one had previously received limited help from family and friends and one had tried to get information from a local agency (Port Cares) but did not get the information needed).

FORUM DISCUSSION

Forum attendees raised several important questions and comments regarding the findings from this study on partner aggression. Attendees queried the role of alcohol in the incidents of aggression reported by participants. Given the link between alcohol and aggression that has been demonstrated in previous research and reported anecdotally by service providers in the field of partner violence, it was somewhat surprising to both the researchers and forum attendees that alcohol was not more prominent in the reported incidents. Drugs, however, were a much more common factor, which the lead researcher speculated may be due to alcohol being relatively expensive compared to some drugs.

Forum attendees involved in primary care pointed out that unhealthy relationships are sometimes revealed or become apparent to health care providers during annual physical health exams and sexual health exams. Hence, this is an important point of contact for screening. Forum attendees also noted that young adults often do not have an adequate understanding of healthy relationships and of sexual health. Thus, programming is needed so that young people can learn about what characterizes a healthy relationship versus a unhealthy relationship.

Another comment raised by forum attendees was that, in their professional experience, individuals involved in violent relationships often seem to have had traumatic childhoods or are experiencing many overlapping issues (e.g., mental health and addictions). Accordingly, the importance of service providers treating people holistically and recognizing the fact that violence, mental health, addictions, and trauma are often intertwined was emphasized by attendees. Forum attendees also

noted the importance of recognizing the financial dimension of abuse, wherein violence manifests as control over finances, often precluding victims of abuse from being able to access care.

The changing role of the clergy in assisting individuals in challenging life circumstances was also raised by attendees. Attendees commented that clergy used to provide support to victims of violence. However, now there are liability issues involved, and thus the clergy must be careful not to term what they are doing as “counselling.” It seemed to attendees that the clergy was a resource that is not being tapped into sufficiently solely due to liability concerns, particularly given the high co-occurrence of mental health, addiction, and violence issues. It was queried that since there are not enough counsellors, is there a way of proving liability protection for clergy to provide support for people who seek help from them?

Another concern raised by attendees was the need for individuals who engage in informal support (e.g., clergy) to have better knowledge of mental health, addictions, and violence. It was suggested that an online education program that can teach people about mental health, addictions, and violence would be valuable as it would allow individuals to better know how to talk about these issues if they are approached by someone experiencing these types of problems.

The researchers pointed out that they had anticipated that people would participate in the study with hopes of receiving more formal help. The study interviewers were advised that they could not provide any form of help, given that this was a research study and staff were not qualified to provide assistance. However, it became apparent that just talking and listening to participants seemed to provide participants with some degree of help and in some cases brought participants to the self-realization that they were in unhealthy relationships. By coincidence, it was even brought to the researchers’ attention that one research participant left her boyfriend after participating in the study.

Finally, attendees commented on the difficulty this study had in recruiting young men and contemplated how, moving forward, recruitment of this population group could be improved in studies on partner violence. Suggestions for helping to recruit more male participants included vouchers for sporting events and food.

Chapter 4: Stress and Mental Health Study ("Random-Walk" Study)

Population surveys provide essential information about population health and well-being that is used in the development of public health programming and policy. However, declining response rates in epidemiological surveys have become a major source of concern to researchers and health planners, as lower response rates can introduce bias into the survey findings. For example, while the telephone survey is the most common method for collecting data in the general population, growth in use of answering machines, caller ID and cell phones, a growing aversion to aggressive telemarketing and the introduction of "do not call" lists have contributed to a notable decline in telephone survey response rates. Some evidence suggests that better participation in surveys can be achieved using door-to-door recruitment strategies. A face-to-face recruitment approach allows researchers to better explain the purpose of the study and demonstrate the integrity and importance of the research.

In the Stress and Mental Health Study we tested a "random walk" technique for participant recruitment in Port Colborne. This approach involves a door-to-door recruitment strategy at randomly selected households. This method has been used extensively in developing countries to assess immunization rates and may be a promising approach to collecting information about population health and well-being in Canadian communities.

This chapter describes the "random walk" approach for obtaining a random community sample in Port Colborne and provides descriptive data for this sample on different types of stress, depression, substance use, the impact of other people's drinking, sources of social support and ways of coping with stress. Participants in this study were recruited door-to-door and invited to visit the mobile lab for completion of the RHOC core measures (see Chapter 1), including a questionnaire about mental health, substance use, and various sources of stress (such as stressful life events, chronic stressors and childhood adversities), as well as the impact of having a person in one's life who has an alcohol problem. These issues are of great relevance when assessing the well-being of a population in light of their impact on individuals, families, and communities. As people try to cope with the many demands and pressures in their lives, stress has become a growing concern in the study of population health. Additionally, enormous health and social costs are associated with mental illness and substance abuse/addiction. This chapter also describes people's coping strategies and sources of social support, as these have been shown to buffer the effect of stress on people's mental health. Where possible, comparisons with national or provincial survey data are provided.

Methods

A sample of 200 households was selected as the target for this study. The sample was selected in three stages. First, a random sample of 20 census blocks was selected using the 2006 Canadian Census data for the city of Port Colborne. Second, 10 households were randomly selected from each randomly selected block. Third, an adult was randomly selected from each household.

Prior to data collection, aerial maps for the census tracts and for each randomly selected block were prepared. These maps indicated the starting point and route that study staff followed to randomly select the 200 households. The field workers were provided with specific instructions about the number of households to skip in each block in order to ensure objectivity in household selection. "Households" were defined as places of residence identified by either an address number, a mailbox, and/or an apartment number. The field workers always travelled in male-female pairs to ensure staff safety. They also wore photo identification badges issued by CAMH and carried study investigators' business cards and additional literature about the project to confirm the legitimacy of the study.

Each randomly selected household was contacted up to 6 times either by letter drop-off, in person, or by phone to request their voluntary participation in the study. On the first household visit, an advance letter and study literature (an informational flyer) were dropped off. At the second household visit, the field

workers knocked on residents' doors in order to request participation. If contact was not made at this time, a second letter was left outlining the study again and informing the resident that the staff would return within the next few days. Not including the first letter drop-off, field staff visited each household in person up to three times. Times and days of the week for these visits were systematically varied to maximize the chance that residents would be reached.

If contact was not made during the three in-person visits, the field researchers tried to locate telephone numbers for the given address using available listings (specifically, reverse telephone number look-up on Canada 411.ca). Subsequent recruitment attempts were made by telephone with a total of up to three callbacks, again varying the times of day and days of the week. Households for which telephone numbers could not be found were revisited in person, such that 6 attempted contacts were made for each selected household.

When contact was made with a household member, the field staff asked whether the resident had received the advance letter(s) and if necessary provided the resident with additional information about the study. The staff then requested permission to randomly select an adult in the household for participation in the study. If the resident was the only person living in the household and was 18 years of age or older, that person was automatically selected for participation. Otherwise, the researchers used "Kish tables" (Kish, 1949) to randomly select an adult from the household. Kish tables are commonly used in survey research to ensure random selection of a household member, guaranteeing that each adult in the household has an equal chance of being selected for participation. With this approach, an eligible person from the household was selected for participation. When the eligible person was reached, the study was explained to them in detail, including a description of what their participation would involve and the knowledge that the research team hoped to gain from the study. Potential participants were informed that the study was taking place at the mobile lab and were provided with the lab's location. They were also told that all parts of the study were voluntary and that all data were kept confidential. If the selected individual agreed to participate, a time was scheduled for them to go to the mobile lab.

All study participants were asked to complete an expanded version of the RHOC core questionnaire. The questionnaire included the same questions that were asked of all participants in other RHOC studies (i.e., questions about service utilization, mental health, substance use and violence) as well as additional questions about stress, the impact of having a family member with an alcohol problem (the "second hand effects" of alcohol), social support and coping. As with all RHOC participants, individuals in the Stress and Mental Health study were also asked to provide a hair and a saliva sample.

Consent and compensation

Informed consent was carried out in the lab before data collection took place. Participants were asked to read an information sheet and sign a consent form. After data collection, participants were compensated $25 in the form of gift cards for completing the questionnaire and $25 in gift cards for providing a hair and/or a saliva sample.

A cautionary note about these data

As stated above, the primary purpose of this pilot study was to test the random walk data collection procedure. It is important to emphasize that the sample size for this study is quite small, making breakdowns by age, employment status, or income unreliable. The small sample requires that the reader be cautious when interpreting results. Although the recruitment approach was designed to produce a generalizable sample, it is possible that the data do not fully represent the population of Port Colborne. Most recruitment took place in July, August and September of 2011. Although research staff visited households on different days of the week and at different times, people who were vacationing during the summer months had an increased likelihood of being missed. The sample may over-represent people who spend more time at home, such as unemployed or retired people.

Additionally, in this report we provide comparisons with national or provincial survey data. However, the statistical significance of these comparisons is not computed. Thus, apparent differences between the present sample and national/provincial population data may be due to sampling error or the small sample size used in this study.

Results

Participation in the random walk survey

A total of 186 residents were contacted. The final sample consisted of 92 participants, resulting in a response rate (defined as the number of participants (n = 92) divided by the number of households that were contacted (n = 186)) of 49.5%.

Of the 92 study participants, 88 (95.6%) provided a saliva sample. Of the seventy-five participants who were eligible to provide hair samples, seventy-four (98.7%) provided samples.

Demographic characteristics of the sample

The sample consisted of 52 males and 40 females, with a mean age of about 50. About half the sample were married (50%), while about one fifth were never married (20%) and about 12% were living with a partner. More than one-third had completed high school (36%), completed college/technical school (20%) or had some college/technical school education (15%). A large proportion of the sample was employed (48% working for pay, 13% self-employed). About 38% had personal incomes of less than $20,000 and about one-fifth of the sample (21%) had household incomes of less than $20,000 (see Appendix B for complete demographic results).

Stress and mental health

To assess stress in the community, we examined three different types of stress: chronic strains, recent negative events and childhood trauma. Chronic strains are assessed by asking respondents about ongoing sources of personal stress, including, for example, taking on too many things at once, feeling

pressured by others or wanting to move but not being able to. A negative life event is a significant event that is a major source of stress in a person life, such as having a major financial crisis or a change in job. In the present study we examined life events experienced in the 12 months prior to the interview. Childhood traumas are events that occur in the person's childhood that may have a long term impact on their life, such as parental divorce or childhood abuse.

Chronic stress

Table 4.1 shows the wide range of chronic strains experienced in the Port Colborne sample. As shown in Figure 4.1, the most common forms of chronic strains included trying to do too many things at once (reported by 42% of respondents), financial problems (37%), having too many things expected of them (25%) and having a family member who has a drinking or drug problem (24%). Interestingly, three of these strains were also among the most common sources of stress found in the 1994/95 National Population Health Survey (Statistics Canada, 2004), with the exception of having a family member with a substance use problem (reported by only 15% of the general Canadian population, compared with 24% of the present sample).

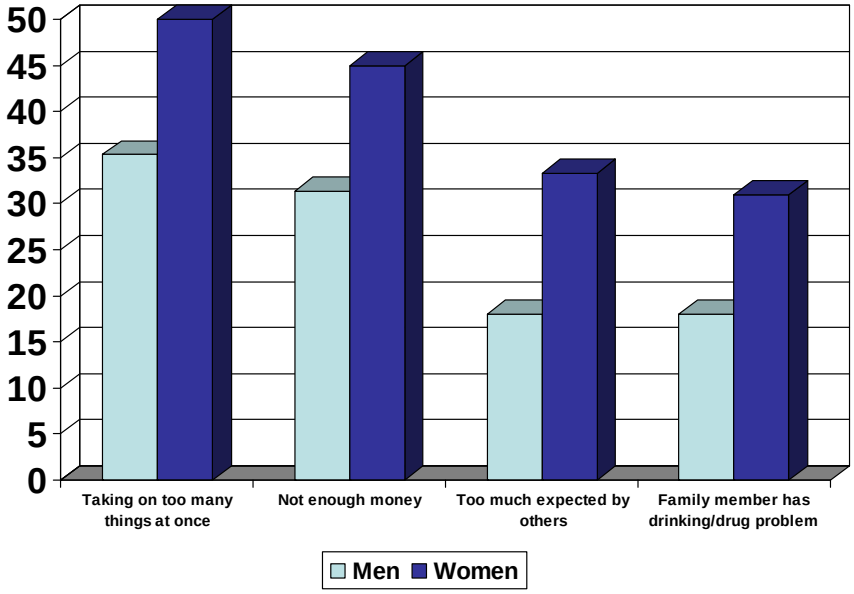
Table 4.1. Percentage of respondents reporting chronic strain for men, women and total sample

	Port Colborne Sample			1994/1995 NPHS		
	Men	**Women**	**Total**	**Men**	**Women**	**Total**
Personal stress						
Trying to take on too much at once	35	50	42	41	46*	44
Too much expected by others	18	33	25	29	33*	31
Your work around the home is not appreciated	18	30	23	9	16*	13
People are too critical of you	16	23	19	12	12	12
Too much pressure to be like others	4	23*	12	15	17*	16
Friends are a bad influence	16*	0	9	5*	2	4
Financial problems						
Not enough money to buy things needed	31	45	37	40*	37	38
Relationship problems[a]						
Partner doesn't understand you	14	19	16	12	16*	14
Partner doesn't show enough affection	17	14	16	10	15*	12
Partner isn't committed enough to relationship	7	7	7	5	7*	6
Child problems[b]						
Child's behaviour is a serious concern	38	29	33	30	30	30
Child seems very unhappy	15	28	21	14	18*	16
Neighbourhood problems						
Want to move but cannot	20	26	23	21	21	21
Neighbourhood is noisy or polluted	6	5	6	10	10	10
Family health						
Family member has drinking/drug problem	18	31	24	12	15*	14
Family member in very bad health	14	13	14	10	12*	11

* Significantly higher than other sex ($p<.05$); [a] Only respondents with a partner answered this question; [b] Only respondents with children answered these questions.

Other common sources of stress included a child's behaviour being a source of serious concern (33%) or a child seeming very unhappy (21%) (both asked only of those who have children), work around the home not being appreciated (23%), and wanting to move but not being able to (23%).

Figure 4.1: Common sources of stress for men and women (% of participants)



Recent negative life events

The most common negative life event experienced by respondents was the respondent or a family member having a major financial crisis, which was reported by 33% of sample. This compares with 13% of the Canadian population from the 1994/95 National Population Health Survey (Statistics Canada, 2004). Other common negative life events included increased arguments with partner (18%) and work-related stressors, such as the respondent or their partner being demoted at work (17%) or having to change jobs to a worse one (11%). About 51% of respondents reported experiencing at least one negative life event in the past year, with women (68%) significantly more likely than men (37%) to experience such an event (see Figure 4.2).

Childhood trauma

In terms of childhood trauma, a large proportion of respondents reported a traumatic event that scared them for years (31%), parental divorce (28%), and parental drinking/drug use causing family problems (25%). Additionally, a large proportion reported that they had been physically abused by someone close to them in their childhood (12%). Consistent with previous evidence (Statistics Canada, 2004), some traumatic events were significantly more likely to be experienced by women than by men, including being scared as a child and being physically abused as a child. About 65% of respondents reported experiencing a childhood trauma, with 64% of men and 67% of women reporting such an event (see Figure 4.2).

Table 4.2. Percentage of respondents reporting recent negative life events for men, women and total sample

	Port Colborne Sample			1994/1995 NPHS		
	Men	Women	Total	Men	Women	Total
You/family member had major financial crisis	27	42	33	12	15*	13
Increased arguments with partner	15	22	18	7	10*	9
You/partner demoted at work or took a pay cut	15	19	17	12*	11	12
You/partner changed job for worse one	13	8	11	6*	5	5
Child moved back in house	10	13	11	5	6	5
Went on welfare	8	13	10	6	7	6
You/family member had abortion/miscarriage	4	18	9	2	4*	3
You/family member failed school/training program	6	11	8	5	5	5
You/someone close physically attacked	6	3	4	5	5	5
You/family member had unwanted pregnancy	0	3	1	2	2*	2

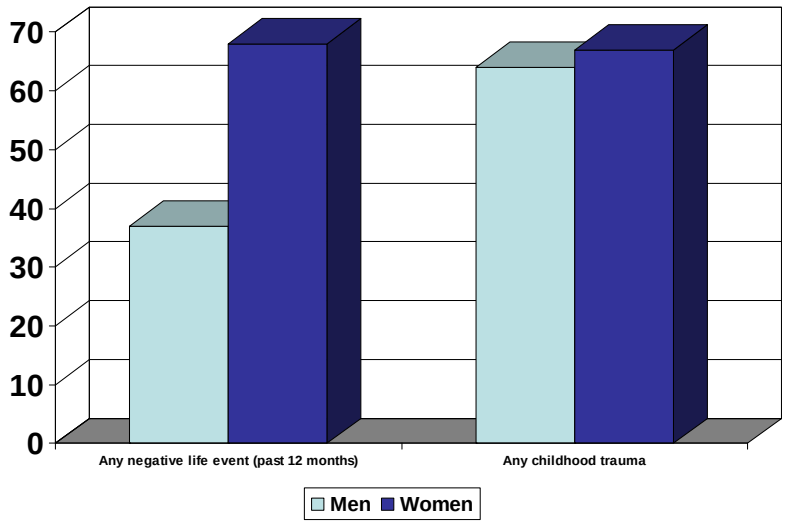
* Significantly higher than other sex (p<.05).

Table 4.3. Percentage of respondents reporting childhood traumas for men, women and total sample

	Port Colborne Sample			1994/1995 NPHS		
	Men	Women	Total	Men	Women	Total
Something scared you so much that you thought about it for years	22	42*	31	19	25*	22
Parents divorced	30	26	28	10	12*	11
Parental drinking/drug use caused family problems	24	27	25	13	15*	15
Spent two or more weeks in hospital	26	11	20	16	15	16
Parent did not have job for long time	17	22	19	13	14	13
Physically abused by someone close	6	21*	12	5	10*	8
Sent away from home because you did something wrong	2	5	3	3	2	3

* Significantly higher than other sex (p<.05).

Figure 4.2: Percentage of respondents reporting any negative event in the previous 12 months and any childhood trauma for men and women



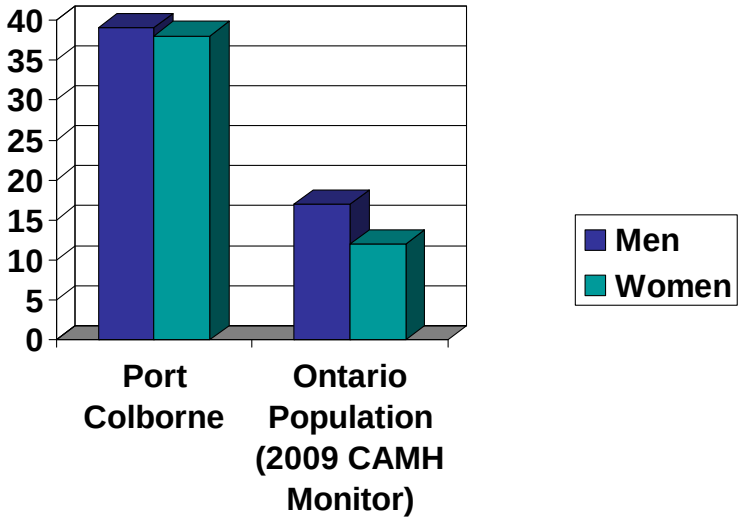
Depression

To assess depression, a subset of questions from the Composite International Diagnostic Interview, Short Form (CIDI-SF) was used that reflect symptoms for depressive disorder. From these questions, we computed the percentage of people considered to have experienced a major depressive disorder in the previous 12 months. About 13% of respondents were found to have a major depressive disorder, with 15% of men and 11% of women reporting such symptoms. In contrast, the 1998/99 National Population Health Survey found that 4% of Canadians (3% of men and 6% of women) reported symptoms of a major depressive episode (Statistics Canada, 2001). Notably, most research indicates that depression is significantly more common among women than among men, thus depression among men appears to be elevated in the present sample. About 16% of respondents (10% of men and 23% of women) reported using antidepressants in the previous 12 months. This compares with 6% of people in the general population of Ontario (6% of men and 7% of women) who reported using prescription medication to treat depression in the previous 12 months based on the CAMH Monitor (Ialomiteanu et al., 2011).

Substance use

In terms of tobacco use, approximately 40% (41% of men and 38% of women) of respondents reported that they smoked cigarettes in the previous 12 months. As shown in Figure 4.3, daily smoking was reported by 35% of respondents (33% of men and 38% of women). These data can be compared with data on daily smoking in the Ontario population as found in the 2009 CAMH Monitor, where 15% reported daily smoking (17% of men and 12% of women) (Ialomiteanu et al., 2011).

Figure 4.3: Percentage reporting smoking in the past daily past 12 months

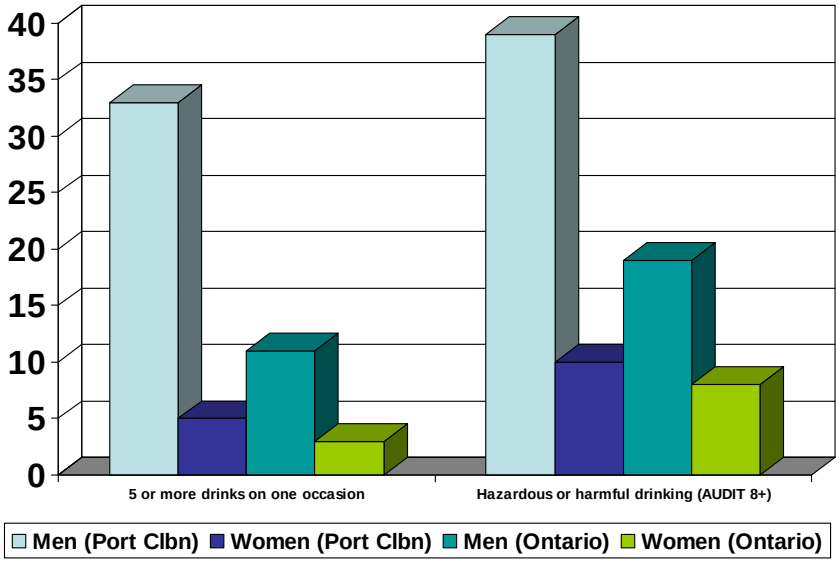


In terms of alcohol use, about 86% (90% of men and 80% of women) of respondents had consumed alcohol in the previous 12 months. As shown in Figure 4.4, the proportion of people reporting heavy episodic drinking (i.e., 5 or more drinks on a single occasion at least once a week) was high, particularly among men, with about 33% of men and about 5% of women reporting this level of consumption. These numbers compare with 11% and 3% for men and women respectively in the general population of Ontario based on the 2009 CAMH Monitor (Ialomiteanu et al., 2011).

Hazardous or harmful drinking was measured with the *Alcohol Use Disorders Identification Test* (AUDIT) which consists of a series of questions relating to alcohol intake and problems related to drinking (including lack of control over one's own drinking, failure to meet expectations, drinking in the morning, feelings of guilt, black-outs, injuries resulting from drinking, and having someone express concern about

your drinking). A composite of these questions is computed and people who have a total score of 8 or more (out of 40) are considered to drink at hazardous or harmful levels or to be at potential risk of becoming alcohol dependent. As shown in Figure 4.4, about 39% of men and 10% of women in the present sample would be considered hazardous or harmful drinkers based on the AUDIT. This compares with 19% of men and 8% of women in the general population of Ontario (Ialomiteanu et al., 2011).

Figure 4.4: Percentage reporting heavy episodic drinking and hazardous or harmful drinking for men and women compared with Ontario population



In terms of drug use, about 27% of respondents reported using Cannabis in the past 12 months, with significantly more men (35%) than women (16%) using this substance. By comparison, past year cannabis use in the general Ontario population was recently found to be 13% (17% men, 10% women) (Ialomiteanu et al., 2011).

Other illicit drug use (excluding cannabis, but including heroin, methamphetamine, ecstasy, hallucinogens, cocaine/crack and inhalants) in the past year was reported by 7% of respondents (8% of men, 5% of women). Very few people reported use of specific illicit substances, (e.g., only one person reported using methamphetamine), thus these numbers are not reported here. By comparison, in the Canadian general population, past year use of at least one of five illicit drugs excluding cannabis (i.e., cocaine or crack, speed, ecstasy, hallucinogens (excluding salvia) or heroin) was reported by 1.7% of Canadians, with 2.4% of males and 1.0% of females reporting use of these substances (based on data from the 2011 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS); see Health Canada, 2011).

Table 4.4. Percentage reporting use of tobacco, alcohol and illicit substances

	Men	Women	Total
Tobacco use			
Any tobacco use in previous 12 months	41	38	40
Daily tobacco use	33	38	35
Alcohol use			
Alcohol use past 12 months	90	80	86
5 or more drinks on a single occasion at least once a week	33	5	30
Harmful/hazardous drinking	39	10	26

	Men	Women	Total
Illicit drug use			
Cannabis use past 12 months	35*	16	27
Illicit drug use *excluding cannabis* past 12 months	8	5	7

* Significantly higher than other sex (p<.05).

Impact of other people's drinking

Traditionally, research on alcohol problems has primarily focused on the health harms experienced by the drinker. However, there are many harms of alcohol incurred due to other individuals' drinking that may negatively impact community members, including property damage and emotional well-being, among other effects. Therefore, we included a series of questions pertaining to the second hand effects of alcohol.

We asked respondents whether they had a person in their life, such as a family member, a friend or co-worker, who is a heavy drinker or sometimes drinks too much. As shown in Table 4.5, more than half the sample (55%) indicated that they had someone in their life who was a heavy drinker or sometimes drinks too much. Participants were then asked whether they were affected in various ways by this person's drinking behaviour, with the most common responses being that they were emotionally hurt or neglected by this person (21%), a social occasion was negatively affected because of this person's drinking (21%) and they had a serious argument with this person (that did not involve physical violence) when that person had been drinking (20%). We also asked respondents a series of questions relating to impact of the drinking behaviour of strangers. As shown in Table 4.5, the most common responses were being verbally abused by a person who had been drinking (23%) or being annoyed by people vomiting, urinating or littering because of drinking (21%).

Table 4.5. Percentage reporting impacts of other people's drinking

	Men	Women	Total
Affected by person in life (e.g., family, friend, coworker)			
Person in life who is a heavy drinker	60	49	55
Emotionally hurt or neglected because of their drinking	22	18	21
Social occasion negatively affected because of their drinking	20	24	21
Serious argument because of their drinking	22	18	20
Person failed to do something because of their drinking	16	24	19
Felt threatened because of their drinking	4	8	6
Put at risk in a car because of their drinking	4	5	5
Physically hurt because of their drinking	0	5	2
Forced or pressured into sex because of their drinking	2	5	3
Affected by stranger's drinking			
Verbally abused by someone who had been drinking	26	18	23
Annoyed by people vomiting, urinating or littering when drinking	24	18	21
Serious argument with someone who had been drinking	16	13	15
Felt unsafe in public because of someone's drinking	16	13	15
Felt threatened by someone who had been drinking	12	18	15
Called the police because of someone's drinking	6	13	9
Physically abused by someone who had been drinking	2	8	4
Property damaged because of someone's drinking	6	3	4

Social support and ways of coping

Social support refers to the emotional and physical support received by individuals during stressful or difficult times. Participants in the present study were asked to indicate the extent to which they agreed or disagreed (strongly disagree, disagree, agree, or strongly agree) with five questions about support that is available to them. As shown in Table 4.6, most participants had people in their lives whose opinions they trusted, who helped keep their spirits up, who they wanted to be with when they feel down or discouraged and with whom they could confide their deepest secrets. Importantly, however, almost one fifth of participants (21% of men and 13% of women) felt that they did not have someone who understands them.

Table 4.6. Percentage reporting that they agreed or strongly agreed to the following statements about social support

	Men	Women	Total
You have a friend or relative whose opinions you trust	90	93	91
You have people around you who help you to keep your spirits up	89	88	88
You have at least one friend or relative you want to be with when you feel down or discouraged	81	90	85
You have at least one friend or relative to whom you could confide your deepest secrets	79	85	82
There is no one who really understands you	21	13	18

In terms of coping, participants were asked how often (often, sometimes, rarely, never) they dealt with stress in different ways. As shown in Table 4.7, the most common ways people dealt with stress at least sometimes (i.e., sometimes or often) included trying to solve the problem, trying to look on the bright side of things, relaxing by doing something enjoyable, and wishing the situation would go away. Exercising as a way of dealing with stress was reported by more than 40% of respondents. Compared with the other coping strategies, substance use as a means to feel better, such as smoking, drinking and taking medications, were reported less frequently. However, almost one third of women reported smoking more cigarettes than usual to try to feel better and almost one quarter of men reported drinking alcohol to feel better. In terms of significant gender differences in coping strategies, women were more likely than men to report dealing with stress by wishing the situation would go away, talking to others, praying or seeking spiritual help, or trying to feel better by eating more or less than usual.

Table 4.7. Percentage reporting that they dealt with stress in the following ways at least sometimes

	Men	Women	Total
Try to solve the problem	94	97	96
Try to look on the bright side of things	90	90	90
Try to relax by doing something enjoyable	88	79	84
Wish the situation would go away or somehow be finished	59	90*	72
Talk to others	58	82*	69
Avoid being with people	53	64	58
Blame yourself	54	51	53
Jog or do other exercise to deal with stress	43	44	43
Pray or seek spiritual help to deal with stress	25	56*	39
Try to feel better by eating more, or less, than usual	18	56*	34
Try to feel better by smoking more cigarettes than usual	22	33	27
Sleep more than usual to deal with stress	16	32	23
Try to feel better by drinking alcohol	24	10	18
Try to feel better by using drugs or medication	14	18	16

* Significantly higher than other sex ($p < .05$)

Summary and discussion

This chapter summarizes the findings from a pilot study conducted in Port Colborne which tested a "random walk" technique for recruiting a community sample for participation in a study on mental health, stress, substance use, and the impact of other people's drinking. The "random walk" approach, involving a door-to-door recruitment strategy at randomly selected households, resulted in a final sample of 92 participants (response rate of 49.5%). This response rate is comparable to recent response rates obtained in telephone surveys.

The present findings suggest that respondents in the present sample have experienced a great deal of stress. In terms of chronic stressors, the most common were trying to do too much at once, not having enough money, having too many things expected of them and having a family member who has a drinking or drug problem. About half of respondents reported experiencing at least one negative life event in the past year, with the most common life events including the respondent or a family member having a major financial crisis or having work-related stress (e.g. being demoted at work or having to change to a worse job) and increased arguments with their partner. Overall, the findings suggest that financial and employment problems are common sources of stress in this population, many of which are also the main types of stress seen in the general Canadian population.

Almost two third of participants reported experiencing a childhood trauma. The most common childhood traumas were being scared as a child, parents getting divorced and parental drinking/drug use causing family problems.

Women were more likely than men to experience stress. Specifically, women were more likely than men to report experiencing at least one negative life event in the past year and to have experienced being scared and physically abused as a child.

A large proportion of respondents reported symptoms of a major depressive episode in the previous 12 months. While most research evidence suggests a larger proportion of women than men report symptoms of depression (Piccinelli & Wilkinson, 2000), the current study found no such difference between men and women. Thus, depression among men appears to be elevated in the present sample. Compared with the general population of Ontario, use of antidepressants also appeared to be elevated in this sample.

In terms of substance use, daily use of tobacco was high compared with the general population of Ontario. Heavy episodic drinking (i.e., 5 or more drinks on a single occasion at least once a week) and hazardous or harmful drinking were high in this sample, particularly among men. Many respondents also reported being negatively affected in various ways by another person's drinking, including people in their personal lives as well as strangers. Overall, the findings suggest that alcohol use is having a detrimental effect on this community both in terms of individual levels of use/abuse and the effect that alcohol use is having on others.

Despite these high levels of alcohol use, participants in this study indicated that they had a great deal of social support from friends and family, from whom they are able to seek help and whom they trust with their secrets. They also employ a range of coping strategies to deal with stress, including trying to look on the bright side of things and trying to relax by doing something enjoyable. However, a notable proportion of respondents reported using substances in order to feel better.

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Chapter 5: Service Utilization and Unmet Need

In this chapter we present information regarding service utilization for mental health, substance use and violence problems. We also describe the extent of unmet need for these problems. This chapter uses data from all the pilot studies conducted in both Port Colborne and Welland (i.e., all data combined).

Methods

The core questionnaire, which was completed by participants in each of the four pilot studies conducted in Port Colborne and/or Welland, included a series of questions regarding use of services. In particular, participants were provided with a list of health professionals (e.g., family doctor, psychiatrist, psychologist, social worker, nurse), community agencies/services (e.g., community centre, Alcoholics Anonymous, community shelter), informal supports (e.g., family member, friend, co-worker, minister) and resources (e.g., internet, self help book, help-line) and asked whether they had sought help from any of them for problems with any one or more of the following types of issues in the past 12 months: (1) emotions, (2) mental health, (3) use of alcohol or drugs, or (4) experiences of violence ("yes" or "no" response). If they answered "yes" they were asked to specify whether they sought help for their emotional or mental health, their use of alcohol, their use of drugs, and/or their experiences of violence.

As a measure of unmet need, participants were also asked whether there was a time when they felt that they needed help for any one or more of their emotions, mental health, use of alcohol or drugs, or experiences with violence, but did not receive it ("yes" or "no" response). If participants answered "yes," they were then asked to identify the problem(s) for which they did NOT receive help (i.e., their emotions, mental health, use of alcohol or drugs, or experiences of violence).

Results

Figures 5.1 and 5.2 (see also Table 5.1 at the end of the chapter) display the percentage of study participants (all data combined for both Port Colborne and Welland) who indicated that they had sought help for their emotions, mental health, use of alcohol or drugs, or experiences of violence in the previous 12 months. These data are shown by study (i.e., Consumer Journey (excluding family members[3]), Communication and Conflict, Random Walk, and Evaluation of Health States). Not surprisingly, given that the study's eligibility criteria required that they had to have sought help for mental health or substance use problems to participate in the research, the group most likely to seek help were the Consumer Journey study participants; this was true for most types of services, informal supports and resources. Also not surprising was that the Random Walk participants, a general population sample, were least likely to have used services for mental health, substance use, or violence.

In all four studies, participants were most likely to seek help from their friends and family members. Consumers were most likely to seek help from: a friend (81% of consumers who sought any form of help); a family doctor (75%); a family member (75%); the internet (61%); a social worker, counsellor or psychotherapist (50%); or a psychiatrist (44%). Intimate Partner Communication and Conflict study participants sought help from: a friend (52%); a family member (48%); the internet (35%); a family doctor (30%); a psychiatrist (11%); and a psychologist (9%). Random Walk participants (Port Colborne only) were most likely to seek help from: a family member (36%); a friend (32%); a family doctor (26%); the internet (14%); self-help books (13%); and a co-worker, supervisor or boss (10%). Evaluation of Health States participants were most likely to seek help from: a family member (59%); a friend (55%); a family

[3] Because of differing eligibility criteria and the fact that consumers by definition would have sought/used services, it was deemed inappropriate to group together all Consumer Journey participants (i.e., consumers and family members). However, the number of family members was too small (25 in total for Port Colborne and Welland) to analyze as a separate group as the results would not be reliable. As such, family member participants were excluded from the present chapter's results.

doctor (46%); a social worker, counsellor or psychotherapist (31%); the internet (30%); and self-help books (25%). (See Figure 5.1. and Table 5.1).

Figure 5.1: Service utilization by study

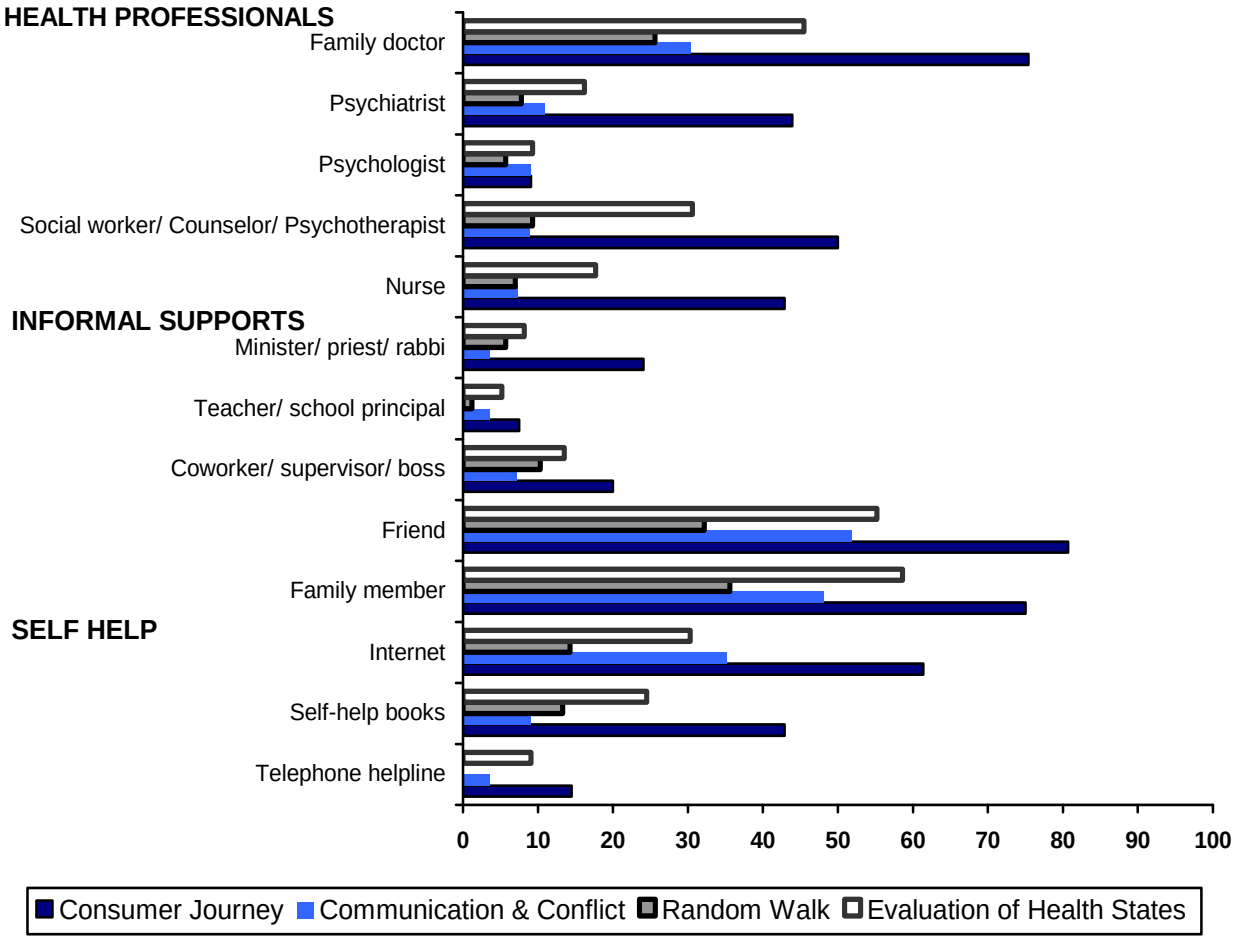
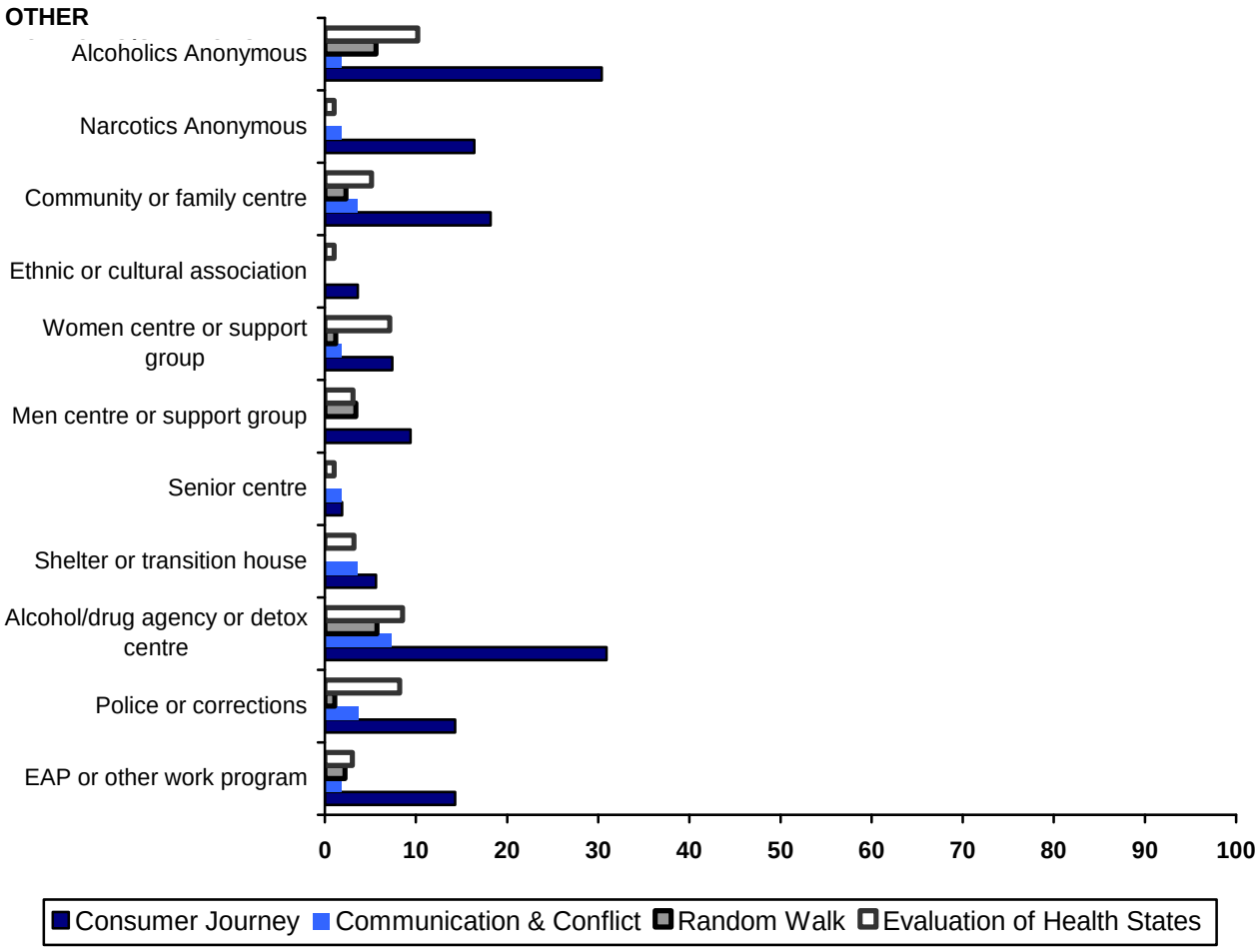


Figure 5.2: Service utilization by study (Other agencies/services)



Figures 5.3 and 5.4 (see also Table 5.2 at the end of the chapter) display the services from whom individuals sought help by type of problem (i.e., emotional/mental health, alcohol or drugs, and violence) for all data combined. Overall, participants were most likely to seek help for emotional/mental health problems and least likely to seek help for violence problems. Those who sought help for emotional/mental health problems were most likely to seek help from: a friend (48% of participants); a family member (45%); a family doctor (34%); the internet (30%); a social worker, counsellor or psychotherapist (22%); and self-help books (17%). For substance use problems, people were most likely to report seeking help from: a friend (26%); a family member (24%); a family doctor (17%); a social worker, counsellor or psychotherapist (15%); Alcoholics Anonymous (14%); and an alcohol/drug treatment agency or detox centre (14%). For violence problems, participants were most likely to seek help from: a family member (8% of all participants); a friend (8%); a social worker, counsellor or psychotherapist (6%); a family doctor (3.3%); a nurse (3.1%); the police or corrections (2.4%); and a women's centre or support group (2.4%).

Figure 5.3: Service utilization by type of problem

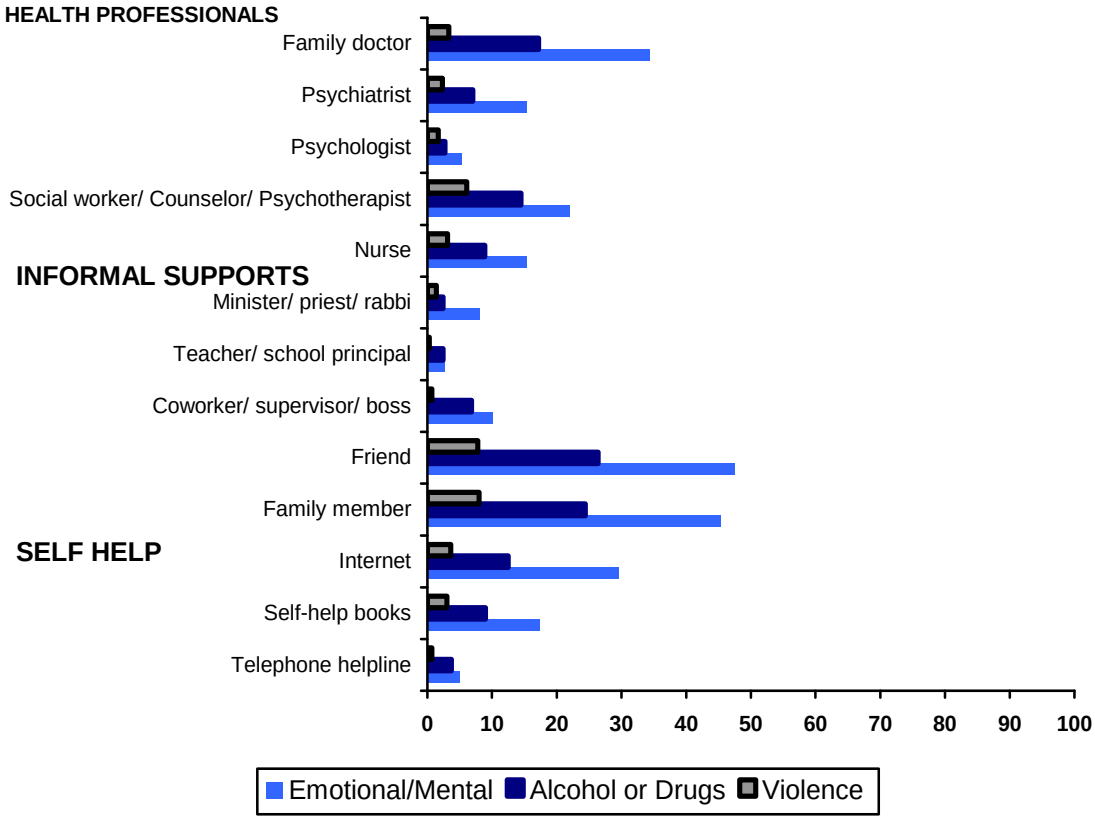
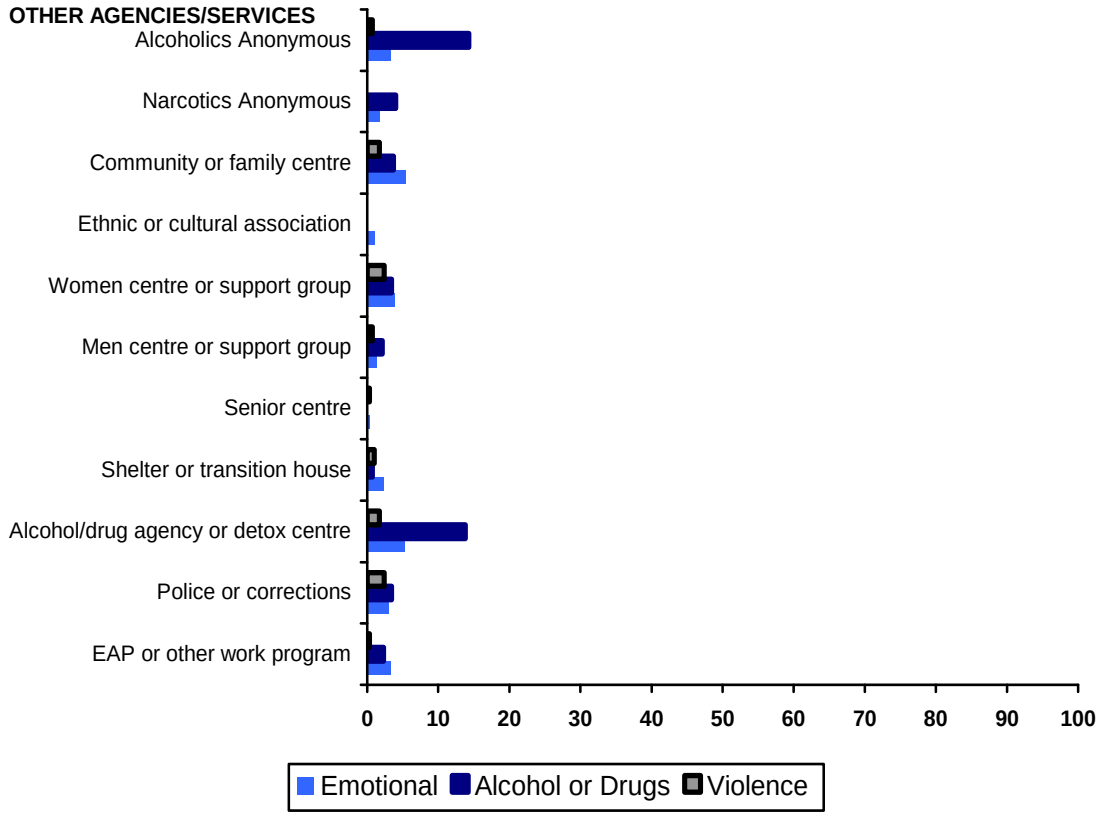


Figure 5.4: Service utilization by type of problem (Other agencies/services)

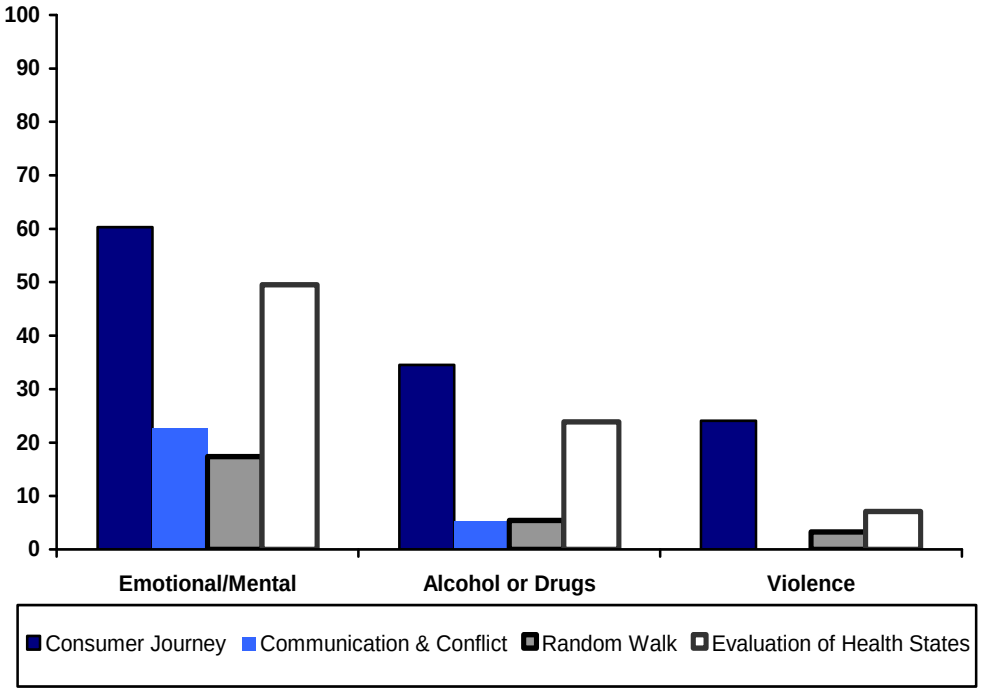


Unmet need

The percentages of all participants who reported that they needed help for their emotions, mental health, use of alcohol or drugs, and/or experiences with violence but did not receive it were 67.2% in the Consumer Journey study followed by 52.5% among Evaluation of Health States participants, 28.1% among Communication and Conflict participants, and, lastly, 20.7% among the Random Walk participants.

Figure 5.5 displays the percentage of participants who reported unmet need by type of problem (i.e., emotional/mental health, use of alcohol or drugs, or experiences of violence) and by study (see also Table 5.3 at the end of the chapter). Participants were most likely to report unmet need for an emotional/mental health problem (37%), followed by a substance use problem (16%) and lastly a violence problem (8%). This pattern was true for all study participants, with unmet need for services highest among those who participated in the Consumer Journey study followed by participants in the Evaluation of Health States study.

Figure 5.5: Problems for which respondents felt they needed help but did not receive it by study



Discussion

This chapter examined service utilization and unmet need for emotional/mental health problems, substance use and violence problems among all RHOC study participants in Port Colborne and Welland. The results indicated that friends and family members are a primary resource for individuals who are experiencing emotional/mental health problems, substance use and violence problems. Family doctors are also an extremely important point of contact for people seeking help for these types of problems. It is also very notable that the internet ranked third or fourth for a source of help across all study participants. This suggests that the internet may represent a critical locale for information about emotional/mental health, substance use and violence problems and available services/supports for these problems in local communities. Such reliance on the internet suggests that is it critical that online information about local services be up-to-date and comprehensive, with sufficient information to guide individuals toward receiving the help they need within their community.

Of all study participants, consumers were most likely to seek help and use a wide range of services for their problems, but they were also most likely to report that their needs were not met, particularly for mental health problems. This finding is consistent with themes that emerged in Chapter 2 and with national data indicating that people who have concurrent mental health and substance use problems (as was true of most Consumer Journey participants) are heavy users of the system but also most likely to report unmet need (Bland et al., 1997; Kessler et al., 1994; Lin et al., 1996; Regier et al., 1993; Ross et al., 1999; Rush, 2008; Wang et al., 2005; Wu et al., 1999).

Table 5.1. Service utilization by study

Variables	Study			
	Consumer Journey n = 59	**Communic. and Conflict n = 58**	**Random Walk n = 92**	**Eval of Health States n = 101**
Health Professionals				
Family doctor (general practitioner)	75.4	30.4	25.6	45.5
Psychiatrist	43.9	10.9	7.8	16.2
Psychologist	9.1	9.1	5.7	9.3
Social worker/Counselor/Psychotherapist	50.0	8.9	9.3	30.6
Nurse	42.9	7.3	7.0	17.7
Informal Supports				
Minister, priest, rabbi	24.1	3.6	5.7	8.2
Teacher or school principal	7.5	3.5	1.2	5.2
Co-worker, supervisor, boss	20.0	7.1	10.3	13.5
Friend	80.7	51.8	32.2	55.2
Family member	75.0	48.1	35.6	58.6
Self Help				
Internet	61.4	35.1	14.3	30.3
Self-help books	42.9	9.1	13.3	24.5
Telephone helpline	14.5	3.5	0	9.1
Agencies/Services				
Alcoholics Anonymous	30.4	1.8	5.6	10.2
Narcotics Anonymous	16.4	1.8	0	1.0
Community or family centre	18.2	3.6	2.3	5.1
Ethnic or cultural assoc/org	3.6	0	0	1.0
Women centre or support group	7.4	1.8	1.2	7.1
Men centre or support group	9.4	0	3.4	3.1
Senior’s centre	1.9	1.8	0	1.0
Shelter or transition house	5.6	3.6	0	3.2
Alcohol/drug agency or detox centre	30.9	7.3	5.7	8.5
Police or corrections	14.3	3.7	1.1	8.2
EAP and other work program	14.3	1.8	2.2	3.0

Table 5.2. Service utilization by type of problem

Services	Problems: Emotional/ Mental Health	Problems: Alcohol or Drugs	Problems: Violence
Health Professionals			
Family doctor (general practitioner)	34.4	17.2	3.3
Psychiatrist	15.3	7.0	2.3
Psychologist	5.4	2.7	1.7
Social worker/Counselor/Psychotherapist	22.0	14.5	6.1
Nurse	15.4	8.9	3.1
Informal Supports			
Minister, priest, rabbi	8.1	2.4	1.4
Teacher or school principal	2.7	2.4	0.3
Co-worker, supervisor, boss	10.2	6.8	0.7
Friend	47.6	26.4	7.8
Family member	45.3	24.4	8.0
Self Help			
Internet	29.6	12.5	3.6
Self-help books	17.4	9.0	3.0
Telephone helpline	5.0	3.7	0.7
Other Agencies/Services			
Alcoholics Anonymous	3.3	14.3	0.7
Narcotics Anonymous	1.7	4.0	0
Community or family centre	5.4	3.7	1.7
Ethnic or cultural assoc/org	1.0	0	0
Women centre or support group	3.8	3.4	2.4
Men centre or support group	1.4	2.1	0.7
Senior's centre	0.3	0	0.3
Shelter or transition house	2.4	0.7	1.0
Alcohol/drug agency or detox centre	5.2	13.8	1.7
Police or corrections	3.0	3.4	2.4
EAP and other work program	3.3	2.3	0.3

Table 5.3. Problems for which respondents felt they needed help but did not receive it

Problems for which you felt that you needed help but did not receive it	Consumer Journey n = 59	Communic. and Conflict n = 58	Study Random Walk n = 92	Eval of Health States n = 101	Total n = 310
Emotional /Mental Health	60.3	22.8	17.4	49.5	36.9
Alcohol or Drugs	34.5	5.3	5.4	23.9	16.3
Violence	24.1	0	3.3	7.1	7.8

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FORUM DISCUSSION

Forum attendees were very vocal about the participants' reported use of the internet as a primary means of help-seeking for mental health, substance use, and violence problems. Service providers in attendance recalled instances (e.g., H1N1 flu pandemic in 2009) where information gleaned from the internet contributed to a degree of "panic" among community members. In this context, internet literacy was highlighted as critical given the high reliance of community members on the internet for information gathering. Public education on proper use of internet resources, including the provision of information about trustworthy websites was identified as a worthwhile public health objective/activity.

Another concern raised by forum attendees in light of the high reliance on the internet for help-seeking was unequal access to the internet. Port Cares was identified as a key locale for individuals without home internet access, and was viewed by attendees as a critical resource in the community for reducing the disparity in internet access associated with income differences. Yet, it was noted that individuals relying on public access locations for the internet may be at a further disadvantage in critically evaluating information on the internet. As such, the need for better internet access and better support relating to critical use of the internet for disadvantaged population groups was emphasized.

Some service providers attending the forum pointed out that South Niagara, particularly smaller towns in this region, is experiencing a high degree of unmet need for services in general, with individuals experiencing a lack of resources and numerous challenges associated with accessing available resources. In this context, access to up-to-date, reliable information on services was also highlighted as a priority. Connex Ontario Health Services Information and 211 were identified as resources that are available to community members and that provide key information on local services. However, attendees pointed out that online information is not always sufficiently updated; moreover, it was noted that many community members are not aware of Connex Ontario and 211. The importance of improved updates on available services and public education regarding resources such as Connex Ontario and 211 was emphasized.

Appendix A: Evaluation of Health States Study

Existing measures of population health often involve asking participants to make preference judgments, or evaluations of the disabling effects of specific health conditions; these assessments commonly use simple comparisons between two options and rank ordering of more than two health conditions. Since health is a dynamic concept, these evaluations may be influenced by a number of factors, such one's own health status, relation to the disease in question, and demographics. The role of these factors in affecting health evaluations, however, is not yet well understood.

Led by Jürgen Rehm, this pilot study examined the association between individuals' own health status, including depression and drinking problems, and their evaluations of health conditions. More specifically, this research: (1) tested the feasibility of assessing health evaluation data among people who have mental health and substance use problems; (2) assessed how health evaluations differ in the presence or absence of one or more problem; and (3) examined factors that influence perceptions of disability associated with different problems. Overall, this research is being used to improve measurement of population health and provide a better understanding of the burden of disease associated with depression and drinking problems. More specifically, the results from this research will be used to refine statistical weighting techniques relating to measurement and analysis of disability and will inform further research on measurement of disability in larger populations.

This study consisted of two components. First, participants were given a "homework assignment" to complete on their own time and return to the mobile lab upon completion. This consisted of a series of questions regarding various health conditions. Participants were asked to rank order the health conditions in terms of the extent to which they felt the conditions would be disabling. Second, upon returning to the mobile lab, participants completed an expanded version of the core questionnaire, which included more extensive questions regarding mental health and substance use problems, to be used to better understand the connections between health status and evaluations of disability associated with different health conditions.

Recruitment

An advertisement was posted in the local newspaper and posters were placed at various locations in the community, including agencies for people with mental health and substance use problems and other general community locations (e.g., Laundromats, restaurants). The poster stated "Do you sometimes feel sad or blue or think you drink too much? Are you a resident of Port Colborne [Welland]?"

Consent and Compensation

Before all study components, participants were asked to read an information sheet and sign a consent form. Participants were compensated $25 in the form of gift cards for completing the homework assignment and $25 in gift cards for completing the core measures (expanded questionnaire and provision of hair and/or saliva samples).

Appendix B: Core Questionnaire Data - Port Colborne

DEMOGRAPHICS

Variables	Study: Consumer Journey n = 28	Study: Communication and Conflict n = 24	Study: Random Walk n = 92	Study: Eval of Health States n = 51	Total N = 195	Other Surveys
Gender (%)						Census 2011 (P. Colborne)
Men	53.6	29.2	56.5	33.3	46.7	48.6
Women	46.4	70.8	43.5	66.7	53.3	51.4
Age (Mean, SD)	38.00 (10.86)	24.09 (2.19)	49.25 (15.20)	49.63 (16.03)	44.71 (16.33)	
Age categories (%)						
18-24	7.4	60.9	9.0	5.9	14.2	
25-39	48.1	39.1	14.6	19.6	23.7	
40-59	37.0	0	51.7	54.9	44.2	
60-74	7.4	0	21.3	11.8	14.2	
75+	0	0	3.4	7.8	3.7	
Marital Status (%)						
Married	10.7	25.0	49.5	28.0	35.2	
Living with partner	10.7	62.5	12.1	32.0	23.3	
Widowed	7.1	0	5.5	6.0	5.2	
Divorced	14.3	0	8.8	10.0	8.8	
Separated	21.4	4.2	4.4	2.0	6.2	
Never married	35.7	8.3	19.8	22.0	21.2	
Education (%)						
None to completed elementary	7.1	0	6.5	2.0	4.6	
Some high school	32.1	33.3	13.0	11.8	17.9	
Completed high school	25.0	37.5	35.9	25.5	31.8	
Some college/technical	7.1	20.8	15.2	13.7	14.4	
Completed college/technical	28.6	4.2	19.6	21.6	19.5	
Some university	0	0	4.3	11.8	5.1	
Completed university	0	4.2	5.4	13.7	6.7	
Employment (%)						
Working for pay	3.7	20.8	47.8	27.5	33.0	
Self-employed	3.7	4.2	13.0	11.8	10.3	
Going to school	11.1	16.7	6.5	2.0	7.2	
Caring for family	3.7	16.7	0	0	2.6	
Long-term illness / on disability	48.1	12.5	12.0	17.6	18.6	
Retired	3.7	0	16.3	25.5	14.9	
Unemployed	25.9	29.2	4.3	15.7	13.4	
Personal Income (%)						
Less than $20,000	83.3	78.3	38.2	52.1	52.7	
Between $20,000 and $29,000	0	21.7	18.0	8.3	13.6	
Between $30,000 and $39,000	12.5	0	7.9	20.8	10.9	
Between $40,000 and $49,000	0	0	7.9	8.3	6.0	

Variables	Study: Consumer Journey n = 28	Study: Communication and Conflict n = 24	Study: Random Walk n = 92	Study: Eval of Health States n = 51	Total N = 195	Other Surveys
Between $50,000 and $59,000	0	0	10.1	2.1	5.4)	
$60,000 or more	4.2	0	18.0	8.3	11.4	
Household income (%)						
Less than $20,000	73.1	73.9	20.5	27.1	36.2	
Between $20,000 and $29,000	3.8	13.0	9.1	10.4	9.2	
Between $30,000 and $39,000	7.7	0	14.8	12.5	11.4	
Between $40,000 and $49,000	3.8	0	11.4	14.6	9.7	
Between $50,000 and $59,000	3.8	8.7	5.7	4.2	5.4	
$60,000 or more	7.7	4.3	38.6	31.3	28.1	

ALCOHOL CONSUMPTION

Variables	Study: Consumer Journey n = 28	Study: Communication and Conflict n = 24	Study: Random Walk n = 92	Study: Eval of Health States n = 51	Total N = 195	CAMH monitor 2009
Percentage consuming 5 or more drinks on a single occasion weekly						
Total	**14.8**	**4.3**	**29.9**	**24.0**	**18.8**	**7.1**
Men	21.4	14.3	33.3	52.9	33.7	11.4
Women	7.7	0	5.0	9.1	5.9	3.1
Percentage reporting hazardous or harmful drinking (AUDIT 8+)						
Total	**42.9**	**30.4**	**26.4**	**37.3**	**32.1**	**13.0**
Men	40.0	28.6	39.2	58.8	42.2	19.0
Women	46.2	31.3	10.0	26.5	23.3	7.5

SMOKING

Variables	Study: Consumer Journey n = 28	Study: Communic. and Conflict n = 24	Study: Random Walk n = 92	Study: Eval of Health States n = 51	Total N = 195	CAMH monitor 2009	Stats Can 2011
Percentage currently smoking daily or occasional							
Total	**85.7**	**66.7**	**38.0**	**41.2**	**49.2**	**18.6**	**19.9**
Men	86.7	71.4	38.5	47.1	50.5	21.2	22.3
Women	84.6	64.7	37.5	38.2	48.1	16.2	17.5
Percentage currently smoking daily							
Total	**85.7**	**54.2**	**34.8**	**39.2**	**45.6**	**14.5**	**-**
Men	86.7	42.9	32.7	47.1	45.1	17.0	-
Women	84.6	58.8	37.5	35.3	46.2	12.2	-

ILLICIT DRUG USE

Variables	Study: Consumer Journey n = 28	Study: Communic. and Conflict n = 24	Study: Random Walk n = 92	Study: Eval of Health States n = 51	Total N = 195	CAMH monitor 2009*
Percentage using following drugs in the past 12 months						
Cannabis						
Total	**60.0**	**66.7**	**27.0**	**26.5**	**35.9**	**13.3**
Men	76.9	71.4	35.3	43.8	46.0	17.4
Women	41.7	64.3	15.8	18.2	26.8	9.5
Heroin						
Total	**0**	**4.2**	**0**	**0**	**0.5**	
Men	0	0	0	0	0	
Women	0	5.9	0	0	1.0	
Methamphetamine (including Crystal M.)						
Total	**3.7**	**8.3**	**1.1**	**0**	**2.1**	
Men	0	0	1.9	0	1.1	
Women	7.7	11.8	0	0	2.9	
Ecstasy (MDMA)						
Total	**7.4**	**8.7**	**2.2**	**2.0**	**3.6**	
Men	7.1	0	3.8	5.9	4.4	
Women	7.7	12.5	0	0	2.9	
Hallucinogens						
Total	**3.8**	**4.2**	**1.1**	**0**	**1.6**	
Men	0	0	1.9	0	1.1	
Women	7.7	5.9	0	0	1.9	

Variables	Study: Consumer Journey n = 28	Communic. and Conflict n = 24	Random Walk n = 92	Eval of Health States n = 51	Total N = 195	CAMH monitor 2009*
Crack						
Total	**26.9**	**8.3**	**3.3**	**5.9**	**7.8**	
Men	23.1	14.3	3.8	11.8	9.0	
Women	30.8	5.9	2.5	2.9	6.7	
Cocaine						*2008
Total	**40.7**	**8.3**	**4.3**	**9.8**	**11.3**	**< 1.0**
Men	28.6	14.3	3.8	17.6	11.1	< 1.0
Women	53.8	5.9	5.0	5.9	11.5	< 1.0
Over counter cough/cold (non med use)						
Total	**16.0**	**4.2**	**10.9**	**4.0**	**8.9**	
Men	0	0	11.5	6.3	8.0	
Women	33.3	5.9	10.0	2.9	9.7	
Any illicit (including cannabis)						
Total	**74.1**	**62.5**	**34.8**	**33.3**	**43.3**	
Men	71.4	71.4	44.2	52.9	52.5	
Women	76.9	58.8	22.5	23.5	35.6	

MENTAL HEALTH

Variables	Study: Consumer Journey n = 28	Communic. and Conflict n = 24	Random Walk n = 92	Eval of Health States n = 51	Total N = 195	
CIDI-SF depression (%)						
Total	**74.1**	**37.5**	**12.9**	**34.0**	**30.6**	
Men	64.3	14.3	14.6	43.8	28.2	
Women	84.6	47.1	10.8	29.4	32.7	
Chronic stress Means (SD)						
Total	**6.48 (4.49)**	**4.39 (3.42)**	**3.67 (3.62)**	**3.92 (3.30)**	**4.23 (3.75)**	
Men	4.14 (3.80)	4.33 (4.08)	3.27 (3.48)	4.21 (2.75)	3.66 (3.44)	*
Women	9.00 (3.85)	4.41 (3.30)	4.15 (3.77)	3.79 (3.53)	4.69 (3.94)	
Perceived Stress Scale Means (SD)						**
Total	**23.93 (6.13)**	**21.13 (8.23)**	**13.84 (8.51)**	**16.55 (8.56)**	**16.91 (8.94)**	
Men	21.93 (5.95)	16.14 (6.47)	14.20 (8.12)	19.13 (7.67)	16.54 (8.08)	
Women	26.23 (5.70)	23.18 (8.14)	13.38 (9.06)	15.30 (8.79)	17.23 (9.65)	
Percent using antidepressants - past 12 months						CAMH Monitor 2009
Total	**66.7**	**12.5**	**15.7**	**19.6**	**23.0**	**6.2**
Men	61.5	0	10.0	13.3	17.6	5.5
Women	72.7	17.6	23.1	22.6	27.6	6.9

Variables	Study: Consumer Journey n = 28	Communic. and Conflict n = 24	Random Walk n = 92	Eval of Health States n = 51	Total N = 195	
Percent using sedatives - past 12 months						
Total	**61.5**	**12.5**	**15.9**	**27.7**	**24.9**	**6.8**
Men	38.5	0	9.8	33.3	17.4	5.0
Women	84.6	17.6	24.3	25.0	31.3	8.5

* Chronic Stress Index. Score was computed as in Cairney et al. (2003). In their article, single mothers had a mean chronic score of 5.24 (SD = 3.15); married mothers had a chronic score of 3.31 (SD = 2.51). ** Perceived Stress Scale norms based on U.S. sample of 2,387 respondents. Means (SD) for males and females were 12.1 (5.9) and 13.7 (6.6) respectively.

Appendix C: Core Questionnaire Data - Welland

DEMOGRAPHICS

Variables	Study: Consumer Journey n = 31	Study: Communication and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	Other Surveys
Gender (%)					Census 2011 (Welland)
Men	48.4	52.9	36.0	44.3	48.2
Women	51.6	47.1	64.0	55.7	51.8
Age (Mean, SD)	39.32 (11.35)	21.91 (2.73)	39.12 (13.66)	34.09 (13.38)	
Age categories (%)					
18-24	3.2	79.4	18.0	32.2	
25-39	48.4	20.6	32.0	33.0	
40-59	41.9	0	42.0	29.6	
60-74	6.5	0	8.0	5.2	
75+	0	0	0	0	
Marital Status (%)					
Married	26.7	2.9	8.0	11.4	
Living with partner	23.3	29.4	24.0	25.4	
Widowed	0	0	6.0	2.6	
Divorced	13.3	0	18.0	11.4	
Separated	13.3	2.9	6.0	7.0	
Never married	23.3	64.7	38.0	42.1	
Education (%)					
None to completed elementary	3.2	0	2.0	1.7	
Some high school	9.7	5.9	20.0	13.0	
Completed high school	35.5	35.3	24.0	30.4	
Some college/technical	19.4	23.5	14.0	18.3	
Completed college/technical	19.4	8.8	24.0	18.3	
Some university	9.7	17.6	12.0	13.0	
Completed university	3.2	8.8	4.0	5.2	
Employment (%)					
Working for pay	19.4	44.1	22.0	27.8	
Self-employed	6.5	2.9	0	2.6	
Going to school	9.7	32.4	12.0	17.4	
Caring for family	0	0	4.0	1.7	
Long-term illness / on disability	41.9	0	30.0	24.3	
Retired	6.5	0	6.0	4.3	
Unemployed	16.1	20.6	26.0	21.7	
Personal Income (%)					
Less than $20,000	69.0	69.7	68.8	69.1	
Between $20,000 and $29,000	20.7	15.2	12.5	15.5	
Between $30,000 and $39,000	6.9	12.1	8.3	9.1	
Between $40,000 and $49,000	0	0	8.3	3.6	

Variables	Study: Consumer Journey n = 31	Study: Communication and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	Other Surveys
Between $50,000 and $59,000	3.4	3.0	0	1.8	
$60,000 or more	0	0	2.1	0.9	
Household income (%)					
Less than $20,000	60.0	21.2	57.4	47.3	
Between $20,000 and $29,000	16.7	24.2	14.9	18.2	
Between $30,000 and $39,000	6.7	12.1	6.4	8.2	
Between $40,000 and $49,000	0	9.1	8.5	6.4	
Between $50,000 and $59,000	6.7	0	4.3	3.6	
$60,000 or more	10.0	33.3	8.5	16.4	

ALCOHOL CONSUMPTION

Variables	Study: Consumer Journey n = 31	Study: Communication and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	CAMH monitor 2009
Percentage consuming 5 or more drinks on a single occasion weekly					
Total	**17.2**	**29.4**	**34.0**	**28.3**	**7.1**
Men	26.7	27.8	16.7	23.5	11.4
Women	7.1	31.3	43.8	32.3	3.1
Percentage reporting hazardous or harmful drinking (AUDIT 8+)					
Total	**50.0**	**55.9**	**50.0**	**51.8**	**13.0**
Men	53.3	55.6	38.9	49.0	19.0
Women	46.7	56.3	56.3	54.0	7.5

SMOKING

Variables	Study: Consumer Journey n = 31	Study: Communic. and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	CAMH monitor 2009	Stats Can 2011
Percentage currently smoking daily or occasional						
Total	**53.3**	**44.1**	**64.0**	**55.3**	**18.6**	**19.9**
Men	53.3	61.1	66.7	60.8	21.2	22.3
Women	53.3	25.0	62.5	50.8	16.2	17.5
Percentage currently smoking daily						
Total	**50.0**	**26.5**	**50.0**	**43.0**	**14.5**	**-**
Men	46.7	33.3	61.1	47.1	17.0	-
Women	53.3	18.8	43.8	39.7	12.2	-

ILLICIT DRUG USE

Variables	Study: Consumer Journey n = 31	Study: Communic. and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	CAMH monitor 2009*
Percentage using following drugs in the past 12 months Cannabis					
Total	**44.8**	**71.9**	**56.3**	**57.8**	**13.3**
Men	42.9	75.0	50.0	56.3	17.4
Women	46.7	68.8	60.0	59.0	9.5
Heroin					
Total	**3.4**	**3.1**	**2.1**	**2.8**	
Men	6.7	6.3	6.3	6.4	
Women	0	0	0	0	
Methamphetamine (including Crystal M.)					
Total	**3.6**	**3.0**	**10.4**	**6.4**	
Men	0	5.9	18.8	8.5	
Women	7.1	0	6.3	4.8	
Ecstasy (MDMA)					
Total	**10.7**	**24.2**	**12.8**	**15.7**	
Men	14.3	23.5	12.5	17.0	
Women	7.1	25.0	12.9	14.8	
Hallucinogens					
Total	**7.1**	**16.1**	**10.4**	**11.2**	
Men	14.3	25.0	12.5	17.4	
Women	0	6.7	9.4	6.6	
Crack					
Total	**10.7**	**0**	**10.4**	**7.4**	
Men	14.3	0	18.8	10.9	
Women	7.1	0	6.3	4.8	

Variables	Study: Consumer Journey n = 31	Study: Communic. and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	CAMH monitor 2009*
Cocaine					*2008
Total	**20.7**	**20.6**	**27.1**	**23.4**	< 1.0
Men	33.3	22.2	31.3	28.6	< 1.0
Women	7.1	18.8	25.0	19.4	< 1.0
Over counter cough/cold (non med use)					
Total	**17.9**	**6.1**	**12.5**	**11.9**	
Men	14.3	5.9	25.0	14.9	
Women	21.4	6.3	6.3	9.7	
Any illicit (including cannabis)					
Total	**63.3**	**73.5**	**62.0**	**65.8**	
Men	73.3	77.8	66.7	72.5	
Women	53.3	68.8	59.4	60.3	

MENTAL HEALTH

Variables	Study: Consumer Journey n = 31	Study: Communic. and Conflict n = 34	Study: Eval of Health States n = 50	Total N = 115	
CIDI-SF depression (%)					
Total	**76.9**	**39.4**	**62.5**	**58.9**	
Men	84.6	38.9	66.7	61.2	
Women	69.2	40.0	60.0	56.9	
Chronic stress Means (SD)					
Total	**7.23 (3.24)**	**3.15 (2.91)**	**6.96 (3.87)**	**5.85 (3.87)**	
Men	6.23 (3.00)	2.94 (1.98)	6.94 (3.15)	5.30 (3.24)	
Women	8.23 (3.27)	3.38 (3.70)	6.97 (4.26)	6.28 (4.27)	
Perceived Stress Scale Means (SD)					
Total	**25.32 (7.48)**	**18.06 (7.96)**	**23.22 (8.00)**	**22.26 (8.29)**	
Men	23.87 (6.66)	18.00 (7.53)	22.50 (6.09)	21.31 (7.12)	
Women	26.69 (8.15)	18.13 (8.67)	23.63 (8.96)	23.02 (9.11)	
Percent using antidepressants - past 12 months					CAMH Monitor 2009
Total	**62.1**	**5.9**	**51.1**	**40.0**	**6.2**
Men	57.1	11.1	53.3	38.3	5.5
Women	66.7	0	50.0	41.3	6.9
Percent using sedatives - past 12 months					
Total	**67.9**	**11.8**	**41.3**	**38.9**	**6.8**
Men	57.1	11.1	43.8	35.4	5.0
Women	78.6	12.5	40.0	41.7	8.5