Mental Wellness and Addictions Recovery Survey

REPORT ON KEY FINDINGS

Sondage sur le mieux-être psychologique et le traitement des dépendances

RAPPORT SUR LES PRINCIPALES CONSTATATIONS

Le présent document contient la traduction française du sommaire.

May · Mai | 2025

Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

K’áhshó got’ı̨ne xədə k’é hederı ɔedı̨htl’é yerınıwę nı dé dúle.
Dene Kədə

ʔerıhtl’ís Dëne Sųłıné yatı t’a huts’elkër xa beyáyatı theɔą ɔat’e, nuwe ts’ën yółtı.
Dëne Sųłıné

Edı gondı dehgáh got’ı̨e zhatıé k’ę́é edatł’éh enahddhę nıde naxets’é edahłí.
Dene Zhatıé

Jii gwandak izhii ginjìk vat’atr’ijąhch’uu zhit yinohthan jì’, diits’àt ginohkhìi.
Dinjii Zhu’ Ginjik

Uvanittuaq ilitchurisukupku Inuvialuktun, ququaqluta.
Inuvialuktun

ᑲᑦᑯᐊ ᑎᑎᖅᑲᐃᑦ ᐱᕆᒪᔨᕕᒋᑦ ᐃᓄᖅᑎᑐᓕᖅᓯᒪᓂᑎᖅ, ᐅᕐᓂᑎᖅᓄᓄᑦ ᐅᖃᓕᕆᔨᓇᖅᑐᑎᑦ.
Inuktitut

Hapkua titiqqat pijumagupkit Inuinnaqtun, uvaptinnut hivajarlutit.
Inuinnaqtun

kīspin ki nitawihtīn ē nīhīyawihk ōma ācimōwin, tipwāsinān.
nēhiyawēwin

Tłı̨chǫ yatı k’ę̀è. Dı wegodı newǫ dè, gots’o gonede.
Tłı̨chǫ

Indigenous Languages
request_Indigenous_languages@gov.nt.ca

Executive Summary

The Mental Wellness and Addictions Recovery (MWAR) Survey was conducted by the Department of Health and Social Services (DHSS) between January and April 2024. The purpose of the survey was to gather direct feedback from people living in the NWT about their experiences with mental wellness and addictions recovery / substance use health supports. The goal of the survey was to better understand what is and is not working well, and where improvements are needed to inform future program planning and service delivery.

Mental wellness and substance use health / addictions recovery support in the NWT includes different formal and informal resources that people use in various ways depending on their unique needs and life circumstances. The 2024 survey focused primarily on four DHSS-funded program areas: the Community Counselling Program (CCP), Facility-Based Addictions Treatment (FBAT), Mental Wellness Helplines, and E-Mental Health supports. It also gathered feedback on access to addictions treatment aftercare, healthcare, peer support, community-based supports, and withdrawal management.

Respondent demographic characteristics and perceived mental health

A total of 664 people responded to the survey, most completing it online (94%) and in English (99%). The survey reached a wide cross-section of NWT residents, though the sample was not representative of the general population. Women (75%), people with post-secondary education (76%), and those who rarely or never faced financial hardship (57%) were overrepresented, while men (22%), young people under 20 (3%), and residents outside of Yellowknife and the Beaufort Delta (28%) were underrepresented. These differences, along with selection bias (i.e., when certain people are less likely to respond, such as those struggling with mental health or addictions) mean the survey may reflect more positive experiences than would be seen across all service users.

Self-perceived mental health was generally lower among respondents than in the general NWT population. Only 24% of MWAR survey respondents rated their mental health as ‘Excellent’ or ‘Very Good’, compared to an estimated 59% of the general NWT population in the 2019/20 Canadian Community Health Survey – highlighting how different the survey group is from the broader population. The lowest self-perceived mental health ratings in the MWAR survey were reported by younger people, 2SLGBTQIA+ respondents, those without post-secondary education, and individuals who reported struggling to afford basic needs at least once a week. Respondents identified strong support networks, healthy habits, and cultural or spiritual connection as the top positive influences on their mental well-being, while work stress, financial concerns, and life crises were the most common negative factors.

Key findings

This section summarizes key patterns in awareness, access, satisfaction, and outcomes across MWAR services, assessed by program and demographic group. Analyses considered factors such as

age, gender, Indigeneity, racial identity, education, and financial hardship. Financial hardship was measured by how often respondents struggled to afford basic needs like housing, food, clothing, or medicine—those who reported *'always'* struggling (i.e., daily or almost every day) or *'often'* struggling (i.e., at least once a week) were categorized as facing greater financial hardship. While many respondents reported positive experiences—especially with the CCP and FBAT—awareness and access varied widely, with equity-deserving groups more often reporting barriers and lower satisfaction.

Awareness of MWAR services varied significantly by program and demographic group. The CCP was the most well-known service (61%), likely due to survey promotion at CCP offices. However, awareness of FBAT, Helplines, and E-Mental Health supports was lower, particularly among men, older adults, people who reported lower income or education, and Indigenous and racial minority respondents.

Accessibility of MWAR services also varied. The CCP had the highest reported access barriers, especially among those facing financial hardship. FBAT and E-Mental Health supports were harder to access for Indigenous Peoples, 2SLGBTQIA+ individuals, and small community residents, while Helplines were generally reported as being more accessible but still posed challenges for some groups. Common barriers identified included long wait times, poor program fit, distrust in services, and lack of information. Challenges booking an appointment with the CCP was also raised as a barrier in written feedback.

Satisfaction with MWAR services was generally high, especially with the CCP (84%) and FBAT (82%), where many respondents reported feeling respected, cared for, and involved in their care. However, satisfaction was lower among some equity-deserving groups, including First Nations and 2SLGBTQIA+ respondents, younger people, and those who reported facing financial challenges. Booking processes and wait times were common areas of dissatisfaction. Written feedback suggests that staff shortages and turnover in the CCP are impacting the availability of services and continuity of care with some people going without services or opting to pay out of pocket for care in the private sector.

Self-reported outcomes were also positive overall. Most respondents said the services helped them build skills and improve their well-being: 70% for the CCP, 92% for FBAT, and around two-thirds for Helplines and E-Mental Health. However, these positive outcomes were reported less frequently by the same populations who also reported more difficulty accessing services.

Implications

The survey findings highlight both strengths and gaps in the mental health and substance use health / addictions recovery system in the NWT. While many respondents reported positive experiences and outcomes, the overall picture reflects a sample population with lower self-rated mental health than the general NWT population among equity deserving groups, particularly younger people,

2SLGBTQIA+ individuals, and those facing financial or educational barriers. This underscores a need for services that are not only effective but also responsive to the deeper social and economic factors that shape people's mental wellness.

To advance equity in the mental wellness and substance use health / addictions recovery system, future efforts should focus on improving how service users are linked to care, outreach, engagement, and service delivery for equity-deserving groups, including Indigenous Peoples, men, 2SLGBTQIA+ individuals, youth, people living in small communities, and those with lower income or education levels. This includes ensuring services are culturally safe, accessible in multiple formats, and designed with input from those most affected. Even with its limitations, the survey provides valuable insight into how experiences differ across groups and can support more inclusive and responsive program planning.

Sommaire

Le sondage sur le mieux-être psychologique et le traitement des dépendances (MPTD) a été réalisé par le ministère de la Santé et des Services sociaux (MSSS) du gouvernement des Territoires du Nord-Ouest (GTNO) de janvier à avril 2024. Le but premier de ce sondage était de récolter les commentaires de résidents ténois au sujet de leur expérience avec les ressources offertes en la matière. Notre objectif était ainsi de mieux comprendre ce qui fonctionne, ce qui doit être amélioré, et les mesures à prendre afin d'éclairer la planification des programmes et la prestation des services à l'avenir.

Le soutien en MPTD aux TNO comprend différentes ressources formelles et informelles que chacun peut utiliser de différentes manières, en fonction des besoins et de sa situation personnelle. Les données du sondage de 2024 portent principalement sur quatre programmes ou domaines d'action financés par le MSSS : le Programme de counseling communautaire, le traitement des dépendances en centre, les lignes d'aide en santé mentale et les aides virtuelles en santé mentale. De plus, nous avons aussi recueilli des données portant sur l'accès aux soins post-traitement, aux soins de santé, au soutien par les pairs, aux services de soutien communautaire et à la gestion du sevrage.

Caractéristiques démographiques des répondants et santé mentale perçue

Un total de 664 personnes ont répondu au sondage, dont la majorité a répondu en ligne (94 %) et en anglais (99 %). Un large éventail de résidents des TNO a répondu au sondage, bien que cet échantillon ne soit pas représentatif de la population générale. Les femmes (75 %), les personnes détenant un diplôme d'études postsecondaires (76 %) et les personnes qui ne font que rarement, voire jamais, face à des difficultés financières (57 %) étaient surreprésentées, alors que les hommes (22 %), les personnes de moins de 20 ans (3 %) et les résidents provenant de l'extérieur de Yellowknife et de la région de Beaufort-Delta (28 %) étaient sous-représentés. Ces disparités ainsi que les biais de sélection (c.-à-d. le fait que certaines personnes soient moins susceptibles de répondre, dont celles aux prises avec des problèmes de santé mentale ou de toxicomanie) pourraient faire en sorte que le sondage reflète une expérience plus positive des services que celle vécue par l'ensemble des usagers.

Le niveau de santé mentale perçu était généralement plus bas chez les répondants que celui de la population générale des TNO. Seuls 24 % des répondants au sondage ont donné la note « Excellente » ou « Très bonne » à la qualité de leur santé mentale, contre 59 % de la population générale des TNO, tel que relevé dans le cadre de l'enquête sur la santé dans les collectivités canadiennes de 2019-2020. Ainsi, on peut constater la différence marquée entre les groupes recensés dans le sondage et la population globale. Dans le sondage, les réponses les plus basses relatives à la santé mentale ont été données par les jeunes, les membres de la communauté 2ELGBTQIA+, les personnes n'ayant obtenu aucun diplôme d'études postsecondaires, et les personnes qui ont mentionné avoir de la difficulté à subvenir à leurs besoins de base au moins une fois par semaine. Plusieurs personnes ont désigné les réseaux de soutien tissés serrés, les habitudes

saines ainsi que les liens culturels ou spirituels comme étant les sources principales d'influence positive sur leur santé mentale, et ont nommé le stress au travail, les soucis financiers et les crises existentielles comme étant les facteurs négatifs principaux.

Principales constatations

Cette section a pour but de résumer les tendances principales en ce qui a trait à la sensibilisation et à l'accès aux services en MPTD ainsi qu'à la satisfaction et à leurs effets, en fonction du programme et du groupe démographique. Les analyses ont tenu compte de facteurs tels que l'âge, le sexe, l'identité autochtone, l'identité raciale, l'éducation et les difficultés financières. Les difficultés financières ont été mesurées en fonction de la fréquence des obstacles rencontrés par les personnes interrogées pour subvenir à des besoins fondamentaux tels que le logement, la nourriture, les vêtements ou les médicaments. Les personnes qui ont déclaré « toujours » avoir des difficultés (c'est-à-dire tous les jours ou presque) ou « souvent » en avoir (c'est-à-dire au moins une fois par semaine) ont été classées comme étant confrontées à des difficultés financières plus importantes. Bien que plusieurs répondants aient signalé avoir eu des expériences positives (surtout avec le Programme de counseling communautaire et le traitement des dépendances en centre), la sensibilisation et l'accès à ces ressources variaient largement, et les personnes appartenant à des groupes méritant l'équité ont plus fréquemment indiqué avoir fait face à des obstacles pour en bénéficier et en être généralement moins satisfaites.

La **sensibilisation** aux services en MPTD variait grandement d'un programme et d'un groupe démographique à l'autre. Le Programme de counseling communautaire était le mieux connu (61 % des répondants le mentionnant), sans doute en raison de la promotion du sondage dans les bureaux de prestation de ce programme. Quant au traitement des dépendances en centre, aux lignes d'aide en santé mentale et aux aides virtuelles en santé mentale, les réponses n'étaient pas aussi positives, surtout auprès des hommes, des adultes plus âgés, des personnes ayant déclaré un revenu ou un niveau d'éducation plus faible, des personnes autochtones et des personnes appartenant à d'autres minorités raciales.

L'accessibilité aux services en MPTD était aussi variée. Les répondants ont noté avoir eu le plus de difficulté à accéder au Programme de counseling communautaire, surtout ceux qui rencontrent des difficultés financières. Le traitement des dépendances en centre et les aides virtuelles en santé mentale étaient plus difficiles à obtenir pour les personnes autochtones, les membres de la communauté 2ELGBTQIA+ et les résidents de collectivités éloignées, tandis que les lignes d'aide étaient plus accessibles, mais pouvaient tout de même être difficiles d'accès pour certaines personnes. Parmi les obstacles mentionnés, citons le temps d'attente, le manque de compatibilité du programme, le manque de confiance envers les services et le peu d'information offerte. Les répondants ont aussi mentionné avoir de la difficulté à prendre rendez-vous dans le cadre du Programme de counseling communautaire.

La satisfaction à l'égard des services en MPTD était généralement bonne, surtout dans le cas du Programme de counseling communautaire (84 %) et du traitement des dépendances en centre (82 %), et plusieurs répondants ont mentionné s'être sentis respectés, pris en charge, et impliqués dans le cadre de leur traitement. Cependant, la satisfaction était moins grande chez les répondants faisant partie de groupes méritant l'équité, y compris les communautés autochtones et 2ELGBTQIA+, les jeunes et les personnes ayant des difficultés financières. Plusieurs répondants étaient insatisfaits des processus de prise de rendez-vous et des temps d'attente. Les commentaires suggéraient que le manque de personnel et le taux de roulement de celui-ci affectent la disponibilité des services et la continuité des soins; certains répondants ont mentionné devoir se passer de ces services ou payer de leur poche dans le secteur privé pour en bénéficier.

Les résultats déclarés par les répondants étaient généralement positifs. Plusieurs d'entre eux ont mentionné que les services offerts les ont aidés à accroître leurs compétences et améliorer leur bien-être : 70 % des répondants l'ont mentionné dans le cas du Programme de counseling communautaire, 92 % l'ont fait pour le traitement des dépendances en centre, et environ 65 % l'ont fait pour les lignes d'aide et les aides virtuelles. Cependant, ces résultats positifs étaient moins fréquents chez les personnes qui avaient aussi eu plus de difficulté à accéder à ces services.

Répercussions

Les résultats du sondage révèlent à la fois les forces et les faiblesses du système de santé mentale et de traitement des dépendances aux TNO. Bien que de nombreux répondants aient témoigné d'expériences et de résultats positifs, on constate que cet échantillon de population présente, selon les autoévaluations faites, un niveau de santé mentale plus faible que l'ensemble de la population des TNO pour les groupes méritant l'équité, en particulier les jeunes, les membres de la communauté 2ELGBTQIA+ et les personnes confrontées à des difficultés financières ou à des obstacles liés à l'éducation. Il est donc nécessaire de mettre en place des services qui soient non seulement efficaces, mais aussi adaptés aux facteurs sociaux et économiques sous-jacents qui affectent le bien-être psychologique des personnes qui en bénéficieront.

Pour promouvoir l'équité dans le système de mieux-être psychologique, de santé liée à l'utilisation de substances psychoactives et de traitement des dépendances, il convient de concentrer nos efforts sur les moyens d'améliorer les liens entre les utilisateurs de services et les soins, la sensibilisation, les échanges et la prestation de services pour les groupes méritant l'équité, y compris les personnes autochtones, les hommes, les personnes 2ELGBTQIA+, les jeunes, les personnes vivant dans des collectivités éloignées et celles dont les revenus ou le niveau d'éducation sont moins élevés. Pour cela, il nous faut notamment nous assurer que les services sont fournis dans le respect de la culture de chacun, qu'ils sont accessibles dans différents formats et que leur conception intègre les remarques livrées par les groupes les plus concernés. En dépit de ses limites, ce sondage offre un aperçu précieux des différentes expériences vécues par les groupes, et il peut contribuer à mettre au point des programmes plus inclusifs et plus adaptés.

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Abbreviations

CCP	Community Counselling Program
DHSS	Department of Health and Social Services
FBAT	Facility-Based Addictions Treatment
MWAR	Mental Wellness and Addictions Recovery
N	Number of responses to the survey question
n	Number of responses from a sub-group of the total e.g., a demographic group
NWT	Northwest Territories
SFI	Strongest Families Institute

Introduction

Survey goal: The aim of the Mental Wellness and Addictions Recovery (MWAR) survey was to get direct feedback from people on their experience with supports and services in the Northwest Territories (NWT). Findings will be used to inform future program planning and design.

Supports and services in the NWT include a broad range of formal and informal resources that promote mental wellbeing, build resilience, and help people manage problematic substance use. How people navigate different options is personal and based on evolving needs, goals, preferences, and circumstances. People may engage with one or multiple options at the same time, transition between different types over time, and/or revisit options as needed.

Supports and services assessed in the survey

- **Primary focus:** Four Department of Health and Social Services (DHSS)-funded program areas – the Community Counselling Program (CCP), Facility-Based Addictions Treatment (FBAT), Helplines, and E-Mental Health supports (see Table 1 for details on each option).
- The survey also assessed accessibility of Healthcare Services, Peer Support Groups, Community-Based supports, Aftercare supports, and Medical Withdrawal Management.

Topics covered in the survey: The objective of the survey was to understand awareness, accessibility, and service-user satisfaction with MWAR supports and services.

- **Awareness:** Do people know about supports available in the NWT?
- **Accessibility:** Are people able to access the supports they want? What are the barriers to accessing support?
- **Satisfaction:** Are people satisfied with the quality of services and how they are delivered?
- **Outcomes:** Do people gain useful skills and experience life improvements because of using the services?

How the survey was conducted

- **Timeline:** The survey was administered by the Department of Health and Social Services (DHSS) from January 25, 2024 to April 25, 2024.
- **Target audience:** All people living in the Northwest Territories (NWT) were encouraged to participate, whether they had used mental health and substance use / addictions recovery supports or not. People were encouraged to respond about their experiences or the experiences of someone in their care.
- **Administration:** The survey was available online or on paper. Paper copies and pre-paid return envelopes were made available at local health centers and CCP offices across the NWT. The survey included a combination of multiple choice and open-ended questions.
- **Promotion:** The survey was advertised on posters, postcards mailed out to households across the NWT (12,000), on the radio, and through paid adverts on social media. Letters on

the purpose of the survey and how residents could provide feedback were also sent to Indigenous Governments and Members of the Legislative Assembly.

Report structure

The report is organized into eight sections:

- **Section 1** presents respondents' demographic characteristics and discusses key limitations related to the composition of the sample.
- **Section 2** explores perceived mental health status and the main barriers and facilitators to good mental well-being and substance use health.
- **Section 3** provides a comparative overview of awareness, accessibility, satisfaction, and key outcomes across the four main support types: the Community Counselling Program, Facility-Based Addictions Treatment, Mental Health helplines, and E-Mental Health supports.
- **Sections 4 through 7** then examine each of these four support types individually, reporting on awareness, accessibility, satisfaction, and outcomes by different demographic groups where the sample size was large enough.
- Finally, **Section 8** looks at access to other types of support, including addictions treatment aftercare, healthcare services, peer support groups, community-based supports, and medical withdrawal management.
- A brief **Conclusion** summarizes key findings and implications for planning and service delivery.

Table 1. Summary of DHSS-funded Mental Wellness and Addictions Supports and Services assessed in the survey

	Community Counselling Program	Facility-Based Addictions Treatment	Mental Health Helplines	E-Mental Health supports
Summary	Free counselling services and crisis intervention for all NWT residents.	GNWT-approved recovery treatment programs outside of the NWT that residents can attend at no charge.	Phone or text services that provide immediate support to assist with concerns.	Free online supports (apps and platforms) provided by third-party service providers.
About supports and service	• Community counselling positions are in 18 communities across all seven NWT regions. • Virtual and fly-in services are available to communities without local staff. • Services are provided in-person or virtually / over the phone. • Engagement is flexible. Service users can come back as many times as they want.	In the two years prior to the survey, the following facilities were GNWT approved - • Fresh Start • Aventa • Renascent • Edgewood • Sunrise • Thorpe • Poundmaker's Treatment programs ranged from 5 weeks to 3 months in length depending on the facility and program.	In the two years prior to the survey, the DHSS funded the following helplines to be available for free to NWT residents – • 811 • Kid's Help Phone The GNWT also administered the NWT Helpline and NWT Quitline which have since been merged into 811.	In the two years prior to the survey, the DHSS funded the following apps to be available for free to NWT residents – • Strongest Families Institute • Breathing Room • EHN Wagon There are countless other online supports people may choose to use to meet their needs.
Ways to connect	List of contact numbers by community to contact the program	More information about accessing treatment as an NWT resident	List of Mental Wellness and Addictions Recovery Helplines	List of different Online Supports and information on how to access them

All the services above are provided for free to all residents of the NWT.

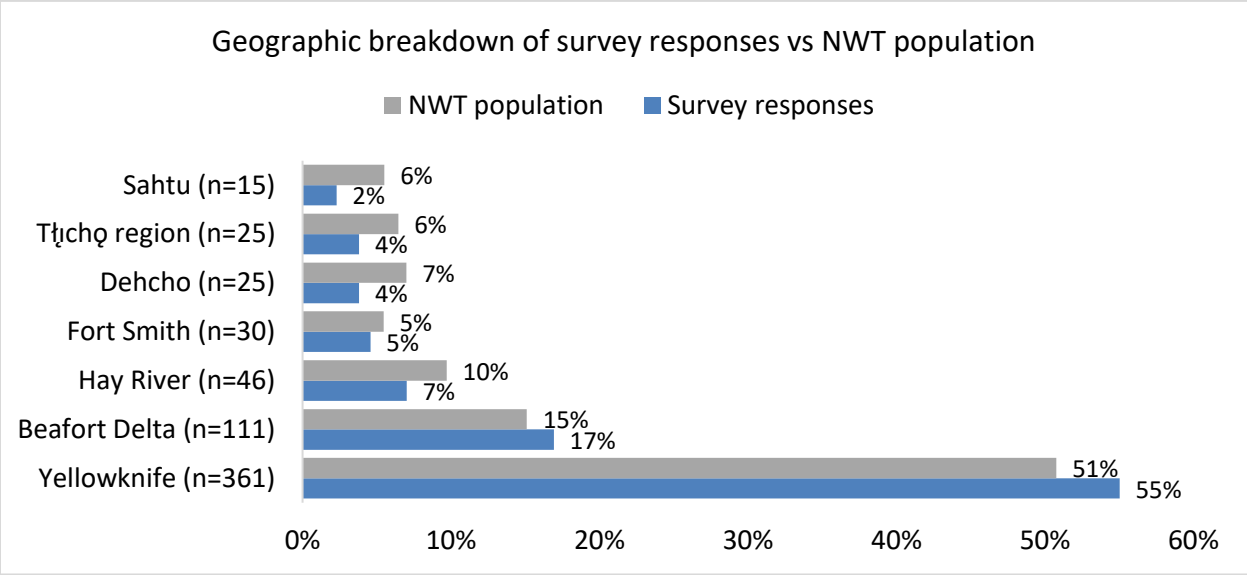
Visit www.gov.nt.ca/wellness for more information about these and other mental wellness and recovery supports and services in the NWT.

Section 1: Characteristics of Survey Respondents

Highlights

- 664 people responded to the survey. Most completed online (94.2%) and in English (99.1%).
- Respondents could skip questions; total number of responses (N/n) are shown for each.
- Yellowknife and the Beaufort Delta were slightly overrepresented in the survey compared to their share of the general population, while other regions were underrepresented.
- Inuit/Inuvialuit respondents were mostly from the Beaufort Delta (73%), while racial minorities and white respondents were primarily from Yellowknife (85% and 73% respectively).
- The survey had more responses from women (75%), people with post secondary education (76%), and people who reported rarely or never struggling to meet basic financial needs (57%).
- Demographic questions asked at the end of the survey had lower response rates e.g., sexual orientation (60%) and financial stability (66%) compared to those asked earlier in the survey e.g., age (98%), and gender (96%).

Figure 1. Location of respondents' services vs 2021 NWT population census (N=659).



Notes: Not included in the graph: 4% of respondents received most of their services outside of the NWT and 3% did not report their geographic location.

Figure 2. Type of community where respondents live (N=637)

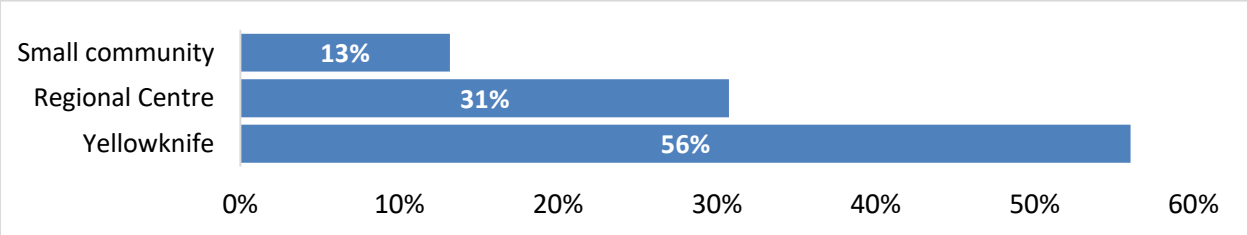


Figure 3. Respondents' Indigenous identity and race (N=616)

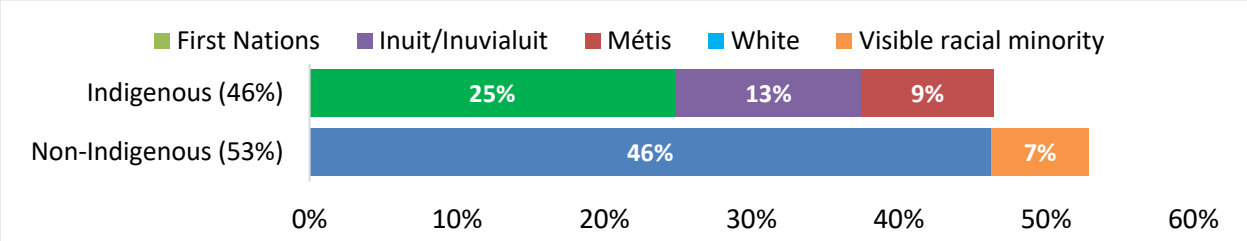


Figure 4. Respondents' Indigenous identity and race, by region (N=570)

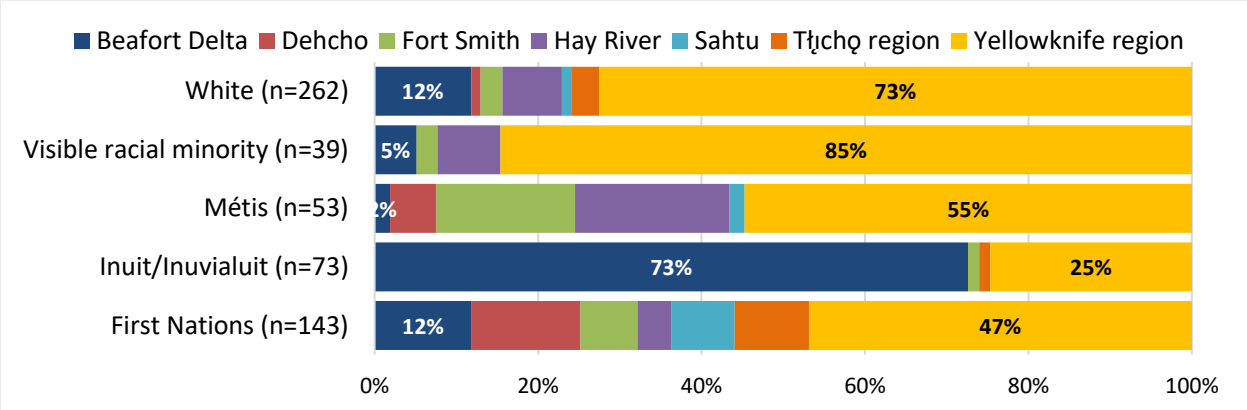
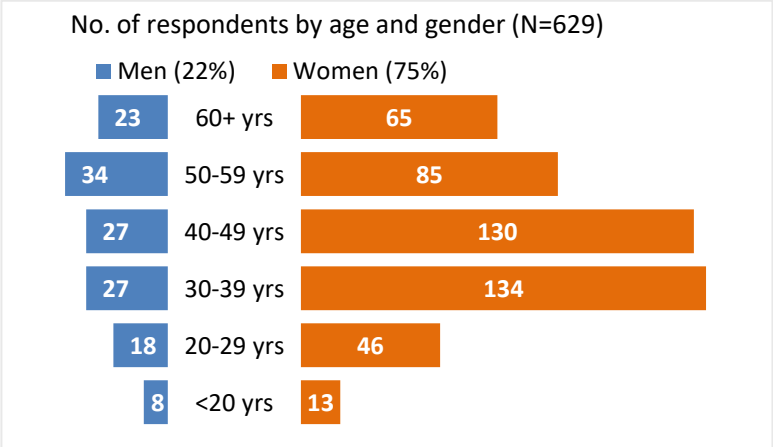


Figure 5. Respondents' age and gender



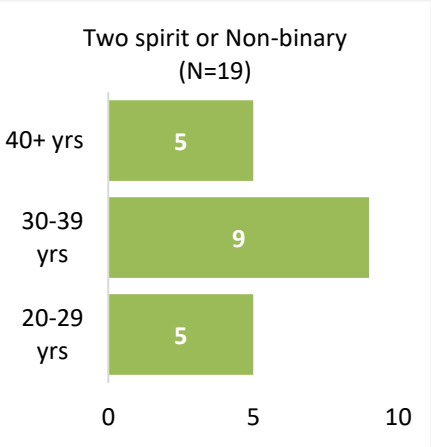


Figure 6. Respondents' relationship status (N=438)

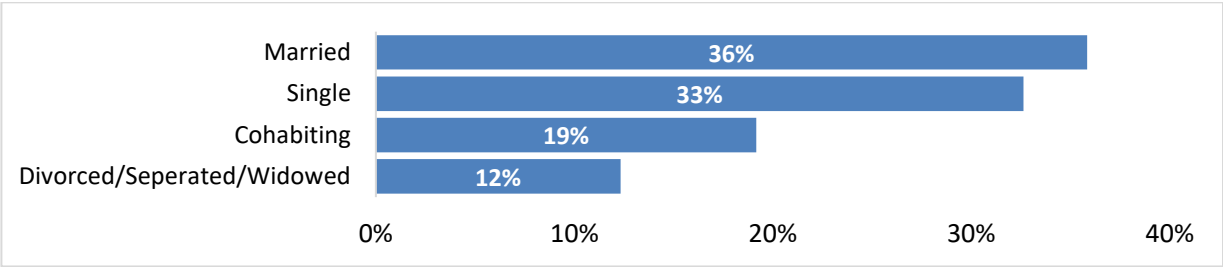


Figure 7. Respondents' sexual orientation/2SLGBTQIA+ self-identification

(Respondents who indicated their gender to be Two-Spirit or Non-Binary or respondents who selected any sexual orientation category other than 'heterosexual or straight' were combined as 2SLGBTQIA+)

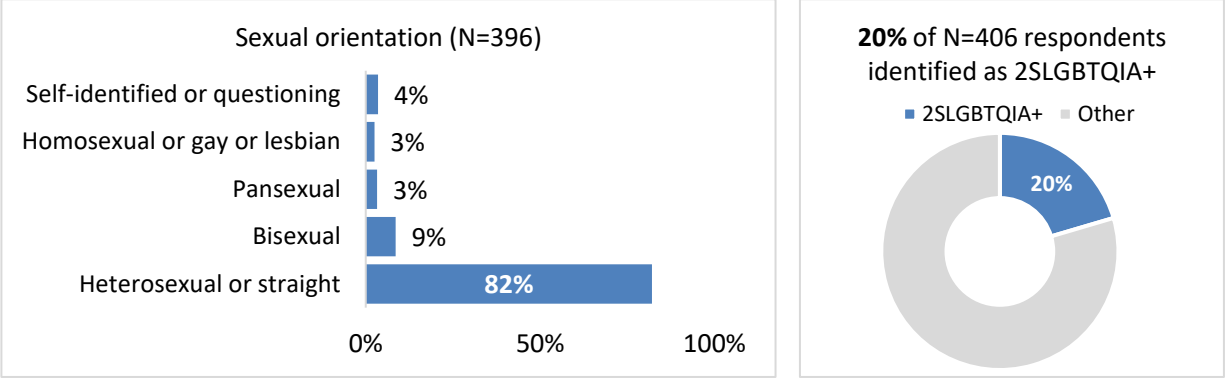


Figure 8. Respondent's highest education level (N=442)

(Respondents indicating 'high school or equivalent', 'some high school, but did not graduate', and elementary' were combined into 'No post-secondary education' for future analyses)

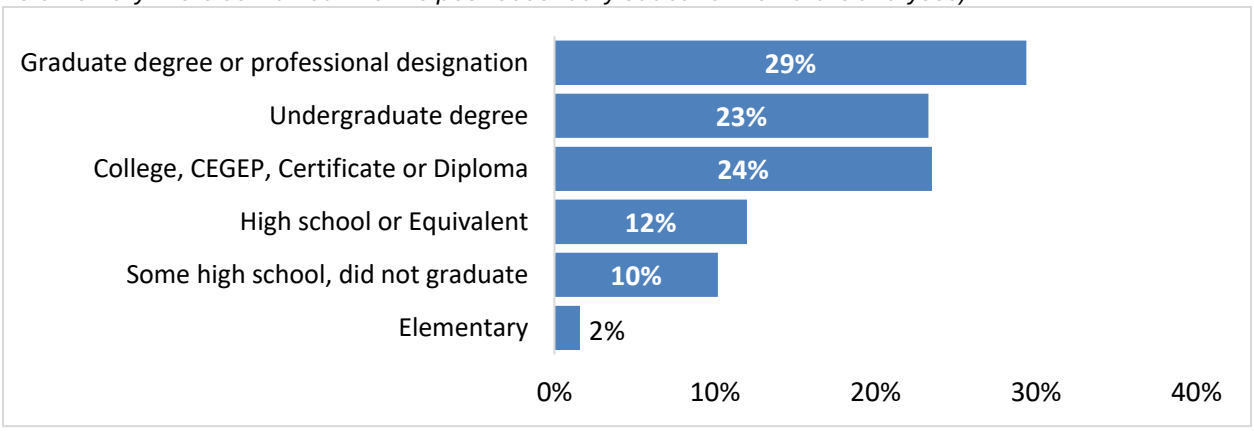
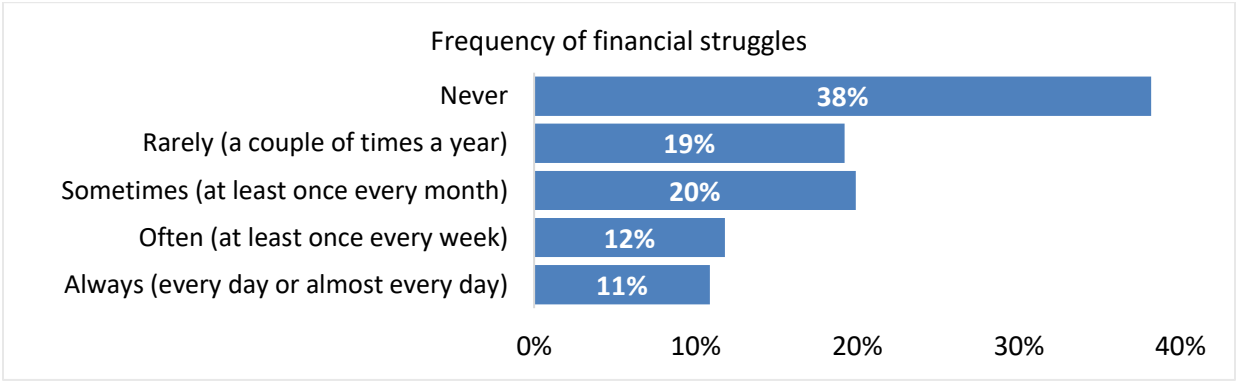


Figure 8. Respondents' frequency struggling to meet basic financial needs (N= 432)

i.e., How often the respondent struggles to get enough money for basic needs like housing, food, clothing, or medicine. Throughout the survey, respondents were considered to be experiencing 'financial hardship' compared to the rest of the population if they reported 'always', or 'often' struggling.



Related survey limitations

Who we heard from and who we may have missed (selection bias)

People actively struggling with mental health or addiction may not have been able to respond to the survey. Other groups who may have had difficulty accessing the survey include those experiencing financial hardship, people experiencing homelessness or housing instability, people without access to the internet, people who do not speak English/French, people with low literacy or with cognitive disabilities, and young children/youth not reached through the adult-oriented promotion channels. These groups may experience greater systemic barriers to accessing services and may be at greater risk of negative mental health outcomes. As a result, the findings may reflect more positive experiences than what might be seen across all service users.

Survey findings are not representative of the entire NWT population

The survey was open to anyone who chose to respond, and some groups may be overrepresented or underrepresented compared to the NWT general population limiting the generalizability of findings.

- **Economic privilege:** A lot of survey respondents reported having post-secondary education (76%) and never or rarely had challenges meeting their basic financial needs like housing, food and clothing (57%). These factors (or social determinants of health) could make it easier for them to maintain good mental health and access supports. As a result, the survey results may reflect more positive experiences than those of people facing greater daily socio-economic challenges.
- **Men with more positive outcomes:** Only 22% of respondents were men compared to 51% of the general population (2021 NWT Census). If men are less likely to respond to a survey like this, it may be the case that the men who did participate have had more positive experiences or found it easier to access support. Their responses may not fully reflect the experiences of all NWT men.
- **Insufficient children and adolescent participation:** With just 21 respondents under the age of 20, this survey does not offer a reliable picture of youth mental health, and findings should not be used to generalize about young people's experiences.

Since the survey does not reflect the full population, it is more useful to explore how experiences differ between demographic groups.

Small sample sizes and broad groupings limit interpretation for some demographics

Some demographic groups had fewer than 50 respondents - a practical threshold we used to flag where results may be less stable and more prone to random variation. When group sizes are small, percentages can swing widely, and differences may reflect chance rather than consistent patterns. For example, while results are shown separately for First Nations, Inuit/Inuvialuit, and Métis respondents, the number of Métis participants was especially small (N=44). Similarly, only 41 respondents identified as a visible racial minority - a category that includes people from many different backgrounds with diverse experiences and needs. Because of this internal diversity and small size, findings for this group are difficult to interpret meaningfully. More broadly, **small differences of just a few percentage points should be interpreted cautiously** - it's more useful to focus on larger, more meaningful gaps supported by a clear rationale or potential explanation.

Respondents are more likely to have interacted with the Community Counselling Program
Because the survey was promoted in CCP offices, respondents were more likely to have used the program. As a result, they may have greater awareness of services and different mental health needs than the general NWT population, further limiting the survey's generalizability to the broader population.

Section 2: Mental Health Rating and Concerns

Highlights

- About 1 in 4 respondents (24%) reported having 'Excellent' or 'Very Good' mental health.
  - In comparison, an estimated 58.9% of the NWT population reported 'Excellent' or 'Very Good' mental health according to the 2019/20 Canadian Community Health Survey[1].
- Respondents who were younger, 2SLGBTQIA+, had no post-secondary education, and who frequently struggled with meeting their basic financial needs had some of the poorest self-perceived mental health.
- The top 3 factors that had a positive impact on people's self-perceived mental wellbeing were their support network, exercising and eating well, and connection to their culture or spirituality.
- The top 3 negative factors were work stress, financial concerns, and experiencing a life crisis.

Figure 9. Self-perceived mental health rating (N=647)

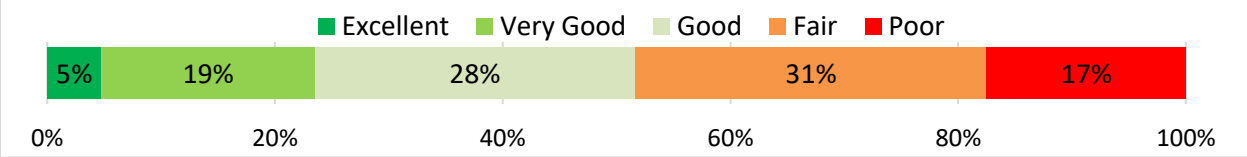
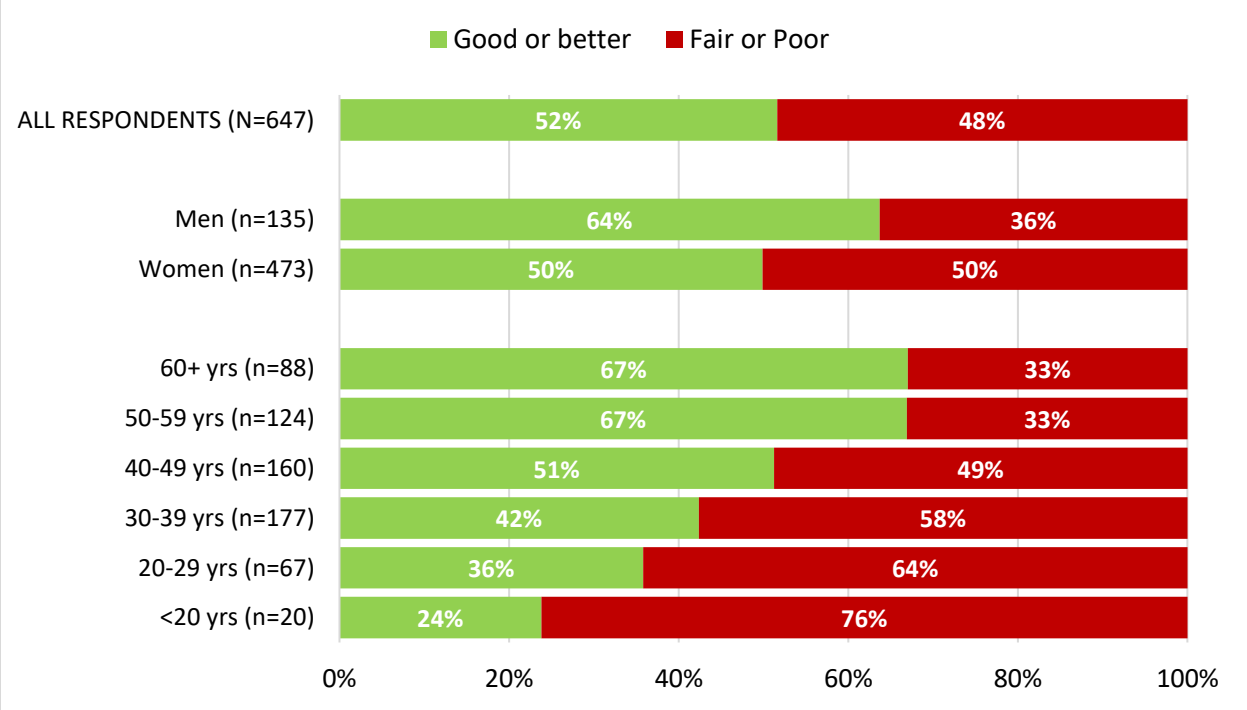


Figure 10. Self-perceived mental health rating by gender and age



[1] The Canadian Community Health Survey is designed to be representative of the NWT population – NWT Mental Health Rating is reported in the NWT Health Status Chartbook PowerPoint Presentation

Figure 11. Self-perceived mental health rating by race, relationship status, and 2SLGBTQIA+ identity

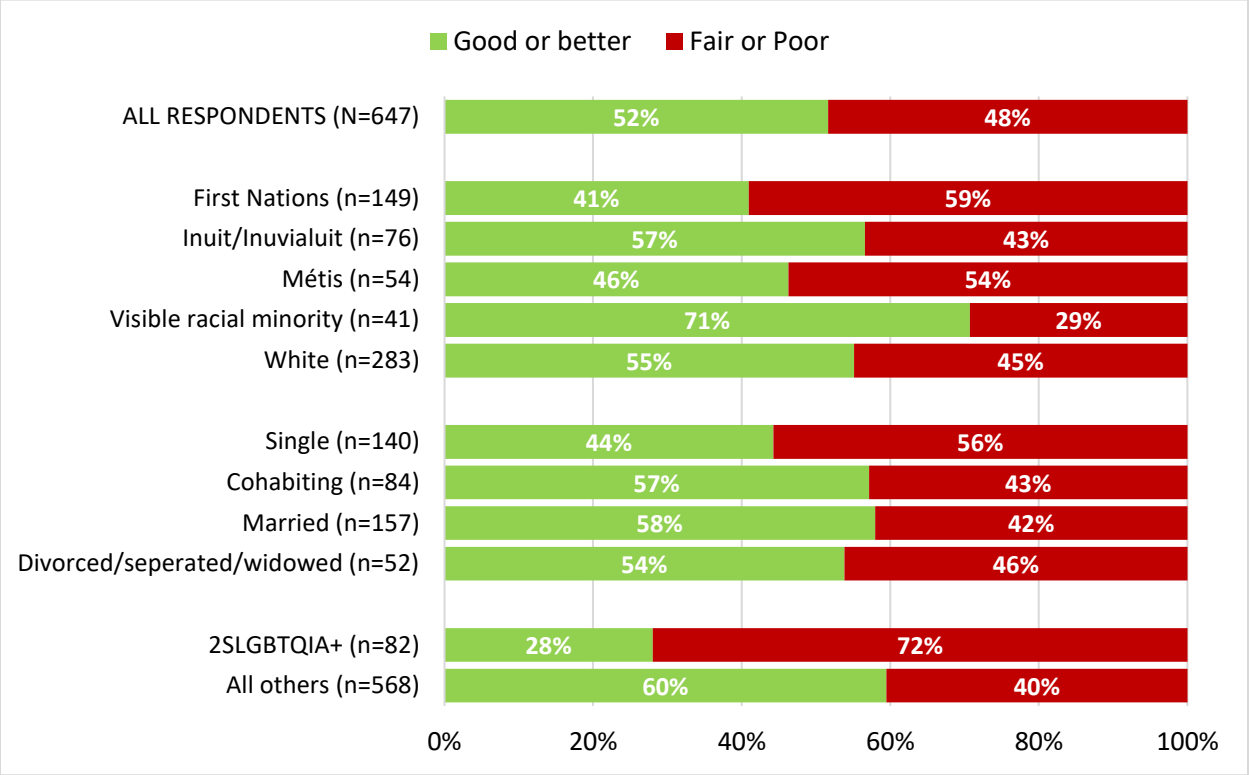


Figure 12. Self-perceived mental health rating by community type, education, and financial stability

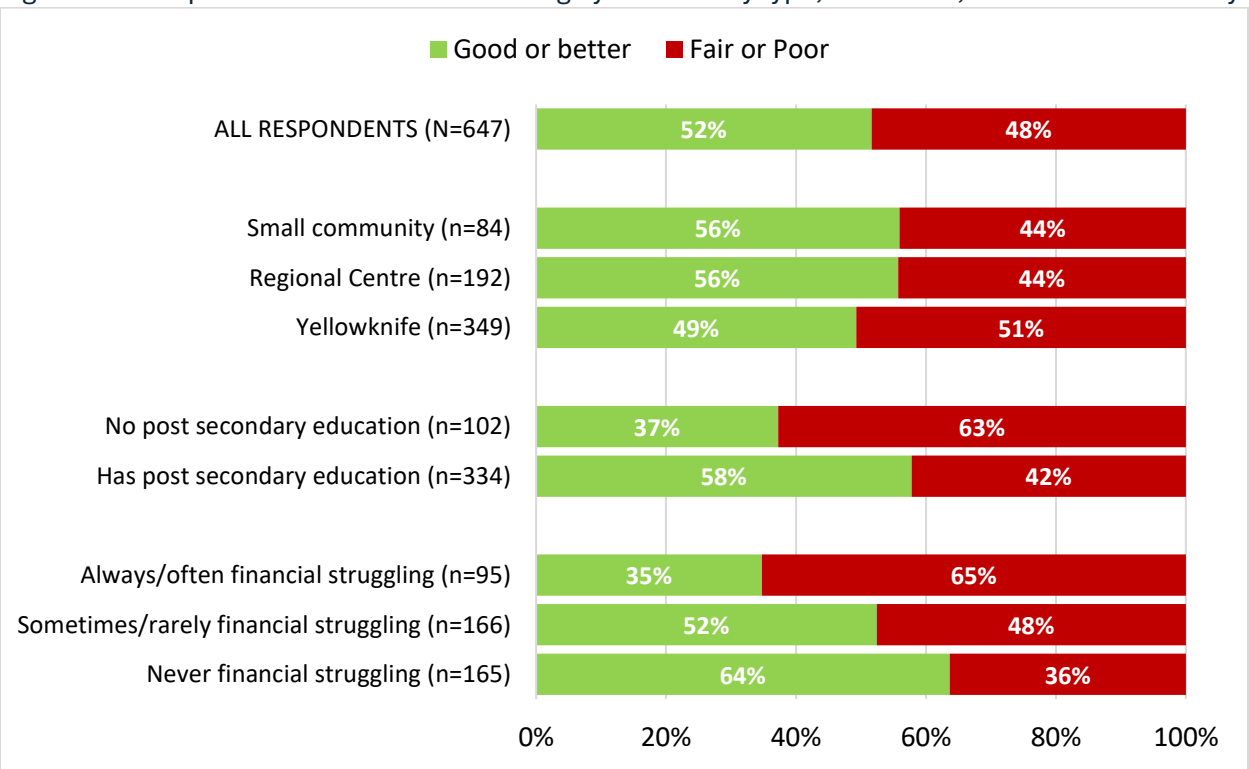


Figure 13. Concerns that led respondents to use or consider using mental health and addictions recovery supports (N=664). *(could choose more than one answer from a set list)*

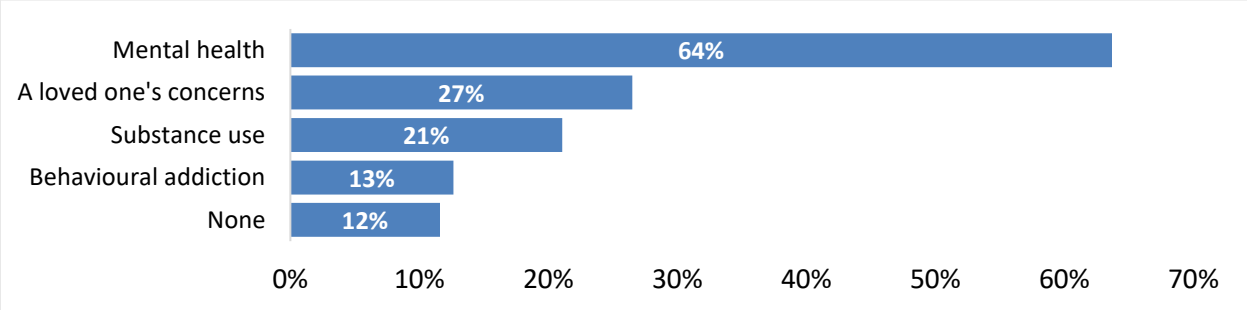


Figure 14. Factors that have a POSITIVE impact on mental wellness, use of substances, or concerning behaviours (N=664). *(could choose more than one answer from a set list)*

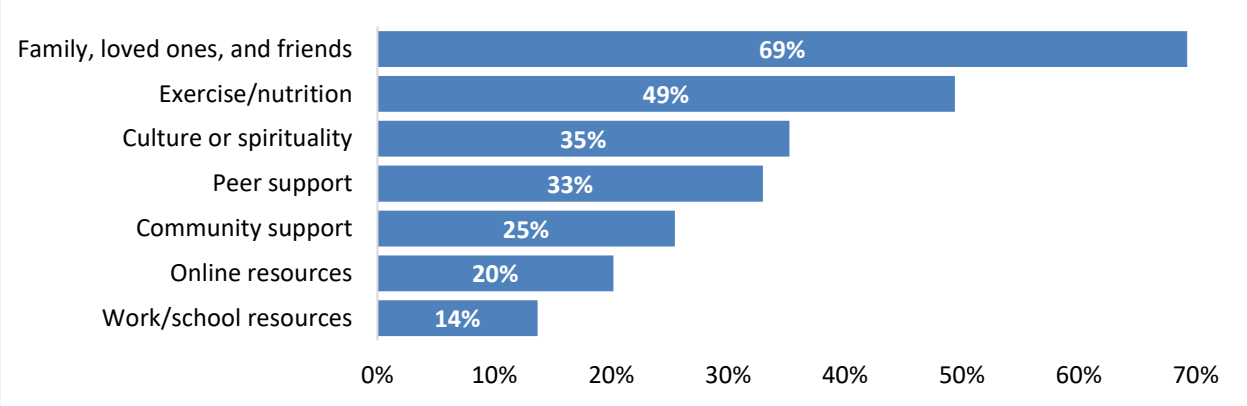
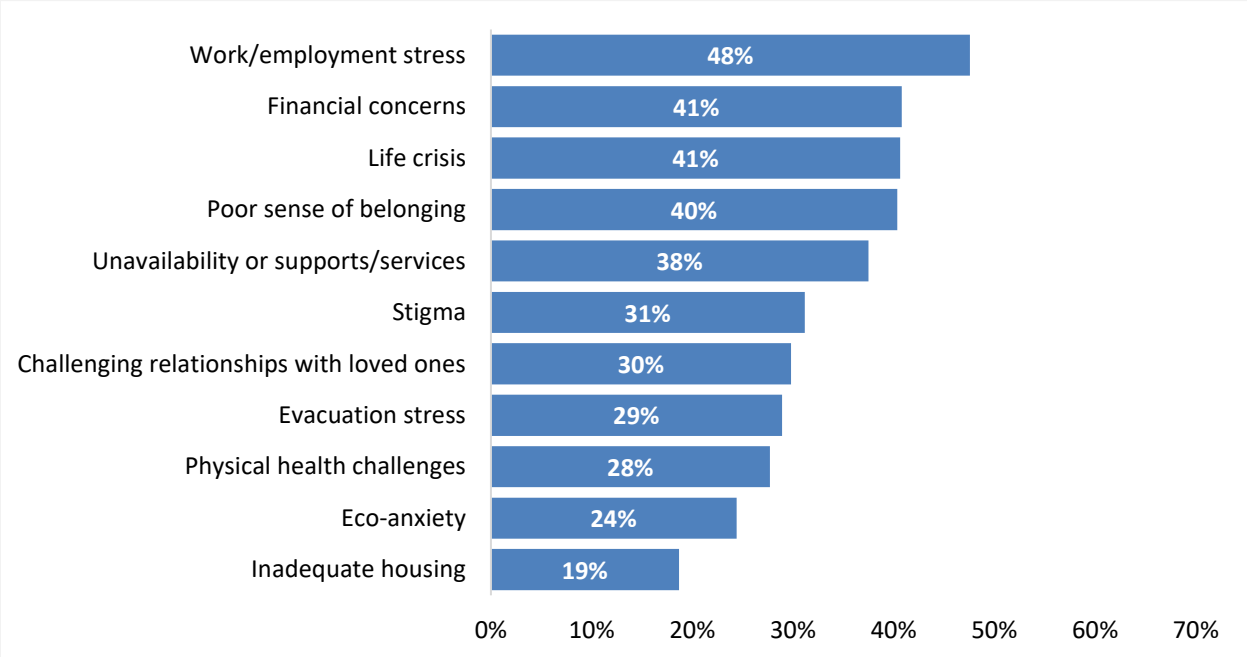


Figure 15. Factors that have a NEGATIVE impact on mental wellness, use of substances, or concerning behaviours (N=664). *(could choose more than one answer from a set list)*



Section 3: Summary: Awareness, Accessibility, and Satisfaction

Highlights

- The CCP was the support respondents were most aware of (note that the survey was promoted at CCP offices). Respondents also reported greatest difficulty accessing the CCP.
- People who had reported using mental health and/or addictions recovery services also reported on their overall satisfaction, skill development, and improved wellbeing. Some respondents may have used more than one service.
  - FBAT had the highest satisfaction rate (84%) followed by Helplines (71%), the CCP (69%), and E-Mental health supports (67%).
  - More FBAT service users (90%) felt they developed useful skills and strategies, compared to E-Mental health support users (66%), and CCP service users (65%).
  - More FBAT service users (92%) felt the service had improved their health and wellbeing, followed by E-Mental health support users (72%), and CCP service users (69%).

Figure 16. Summary - Awareness of different supports and services (N=664)
i.e., Proportion of respondents who knew about the support/service before the survey.

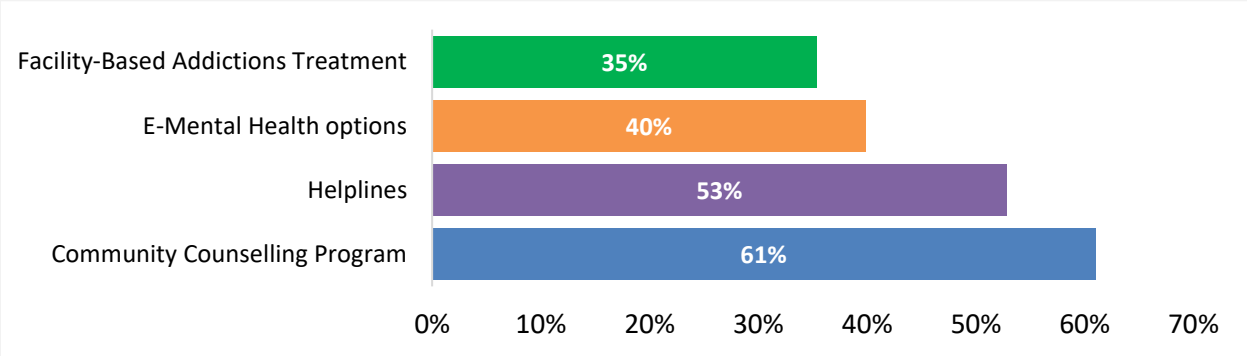


Figure 17. Summary – Difficulty accessing different supports and services
i.e., Proportion of respondents who reported they would have liked to access the support/service but had a hard time accessing or were not able to access at all.

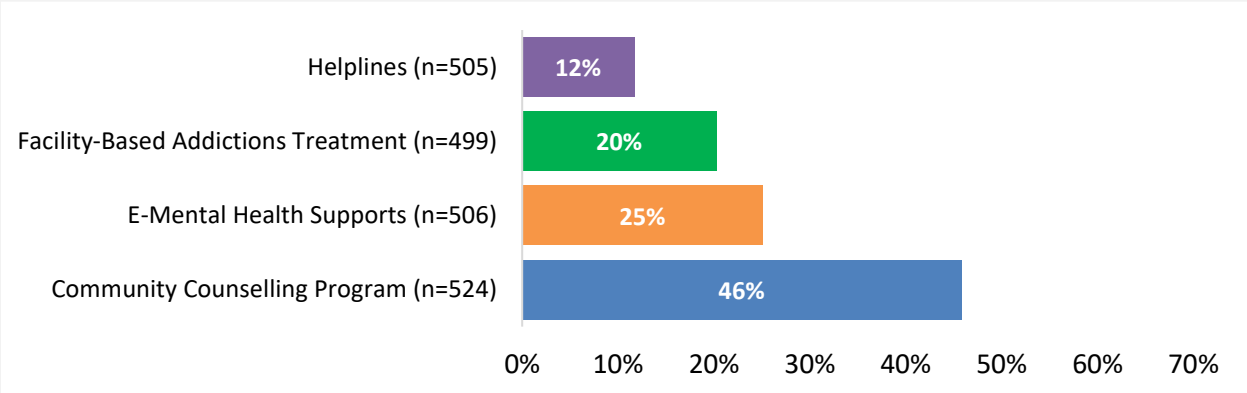


Figure 18. Summary – Satisfaction with the overall experience using different supports and services

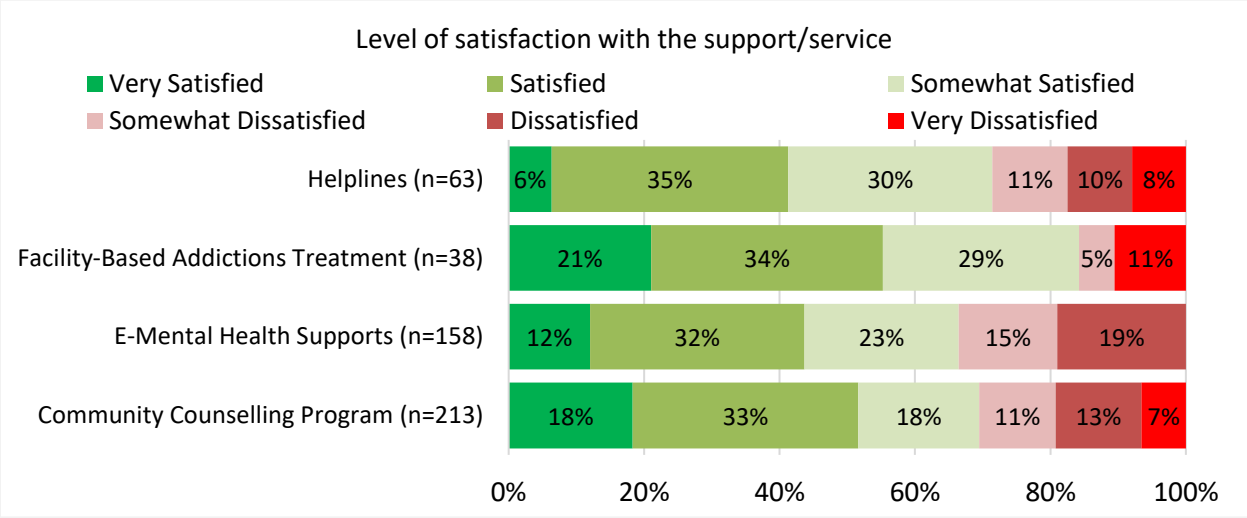


Figure 19. Summary – Skill development from using different supports and services

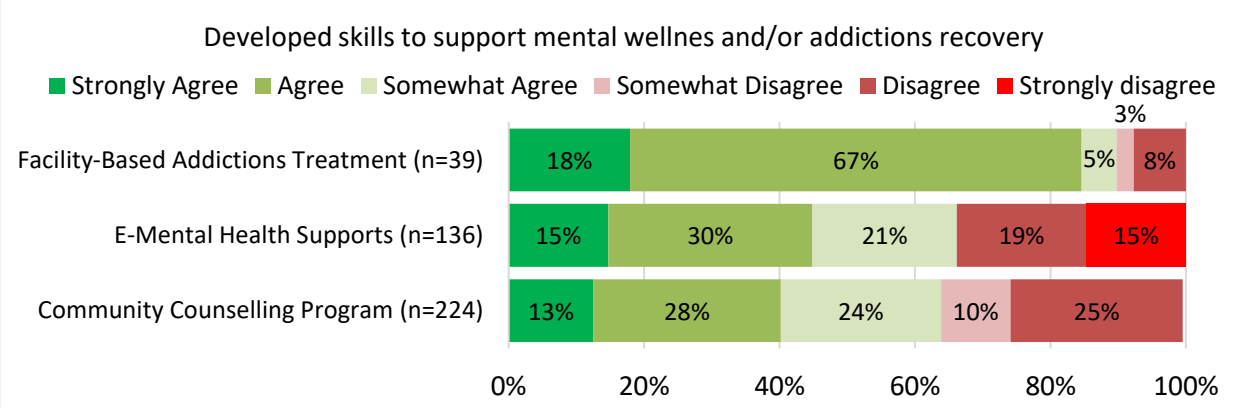
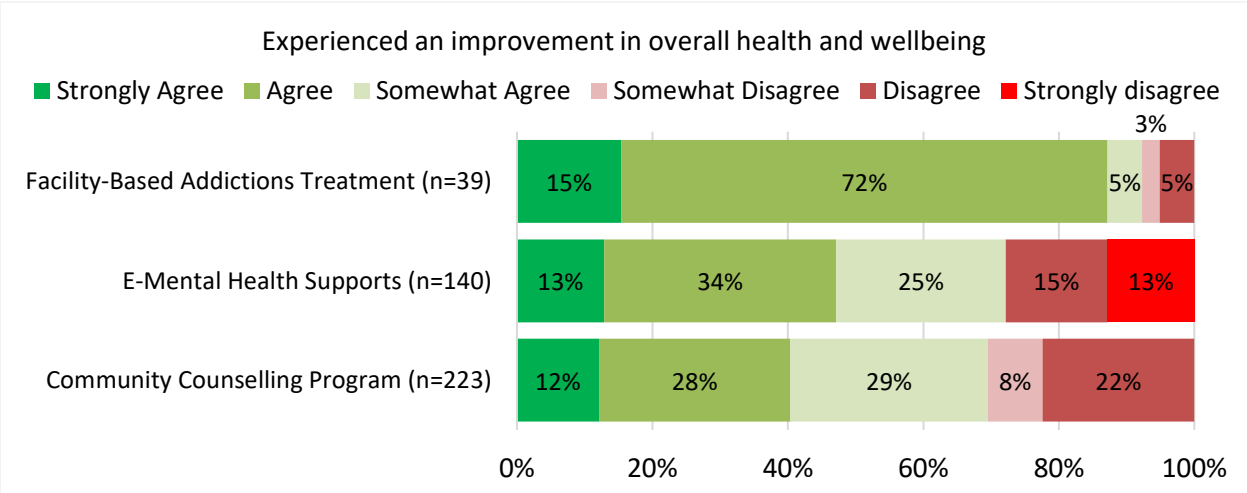


Figure 20. Summary – Improved wellbeing from different supports and services



Section 4: Community Counselling Program (CCP)

Awareness

Highlight - 61% of respondents were aware of the CCP i.e., they knew about the CCP before the survey. Men and older people reported less awareness of the CCP than other survey respondents.

Figure 21. Awareness of the Community Counselling Program by gender and age

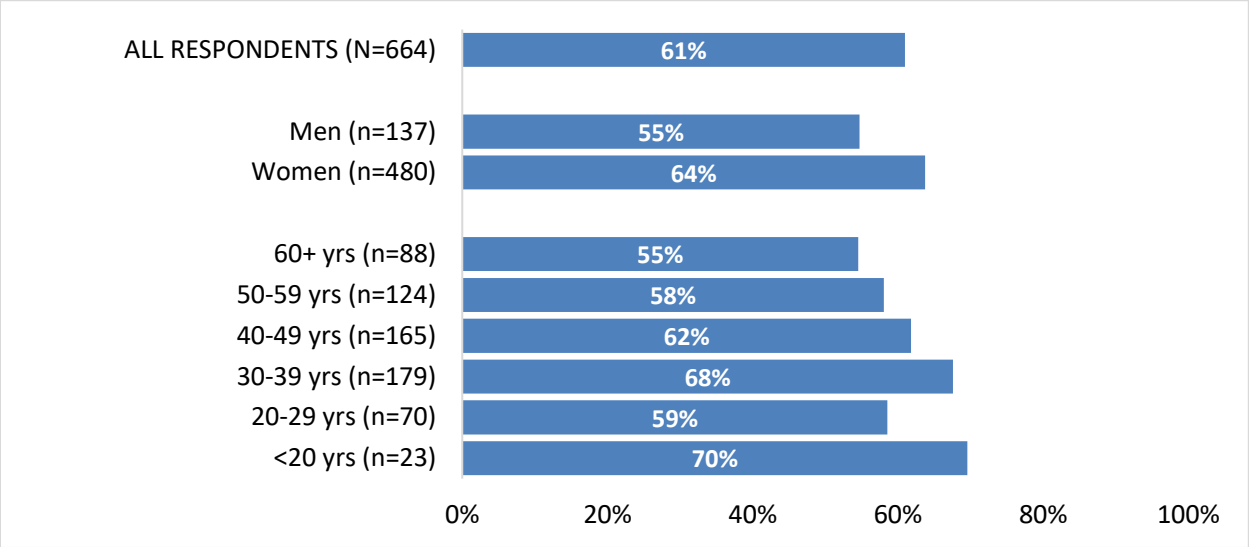


Figure 22. Awareness of the Community Counselling Program by race, relationship status, 2SLGBTQIA+ identity

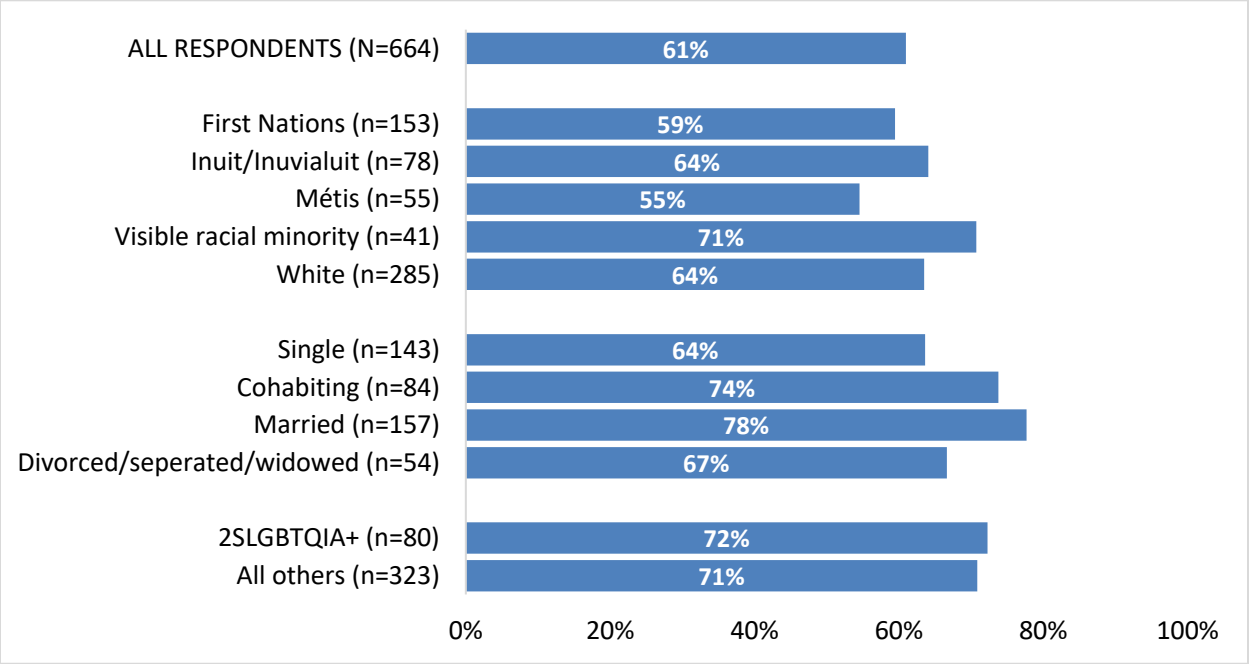
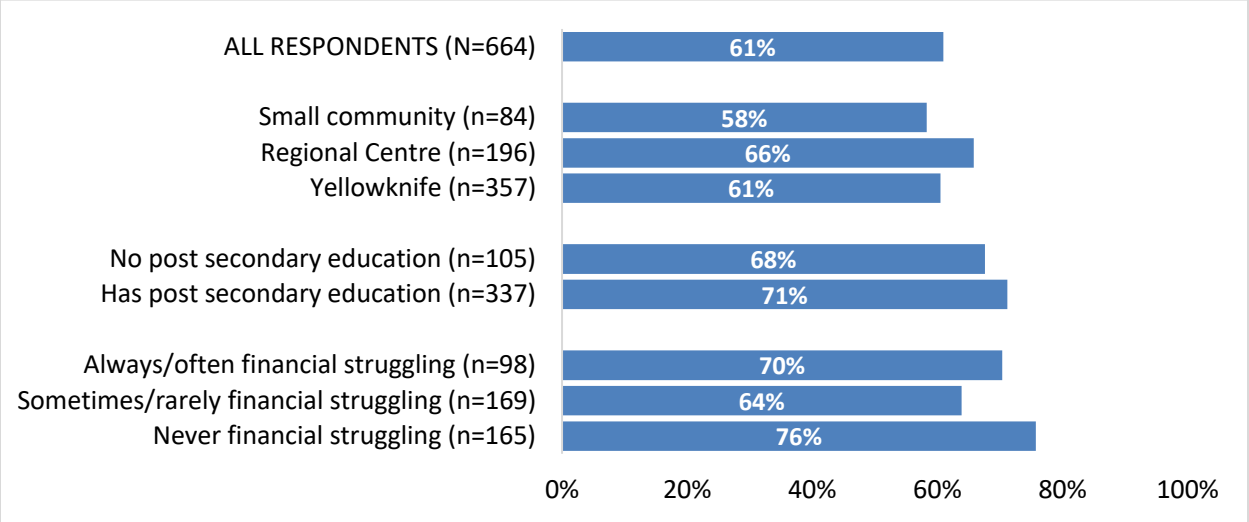


Figure 23. Awareness of the Community Counselling Program (by community type, education, and financial stability)



Accessibility

Highlights

- Almost half (46%) of respondents reported having a hard time accessing the CCP. About 3 in 5 respondents (59%) who reported struggling most frequently to meet basic financial needs had a hard time accessing the CCP.
- Top reported CCP access barriers were long waitlists (46%), the program not feeling like a good fit (37%), and distrust of the program or provider (34%). In open text feedback respondents noted challenges when trying to book appointments long wait times, staffing issues (few staff and high turn over), and limited services outside regular hours.

Figure 24. Had difficulty accessing the Community Counselling Program by gender and age

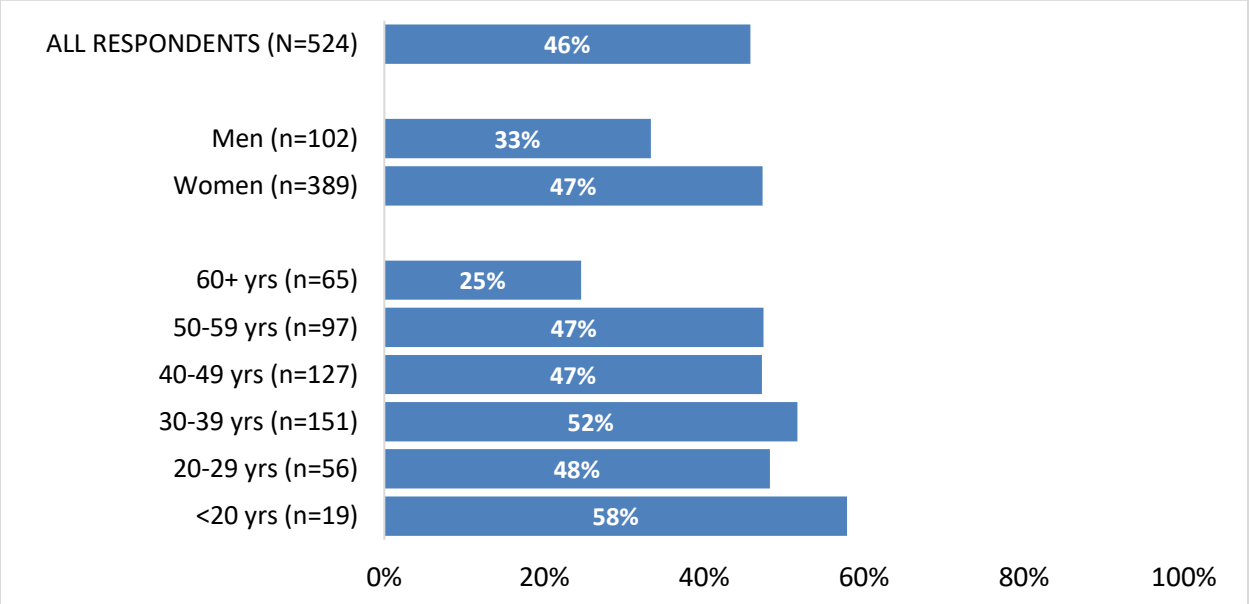


Figure 25. Had difficulty accessing the Community Counselling Program by race, relationship status, and 2SLGBTQIA+

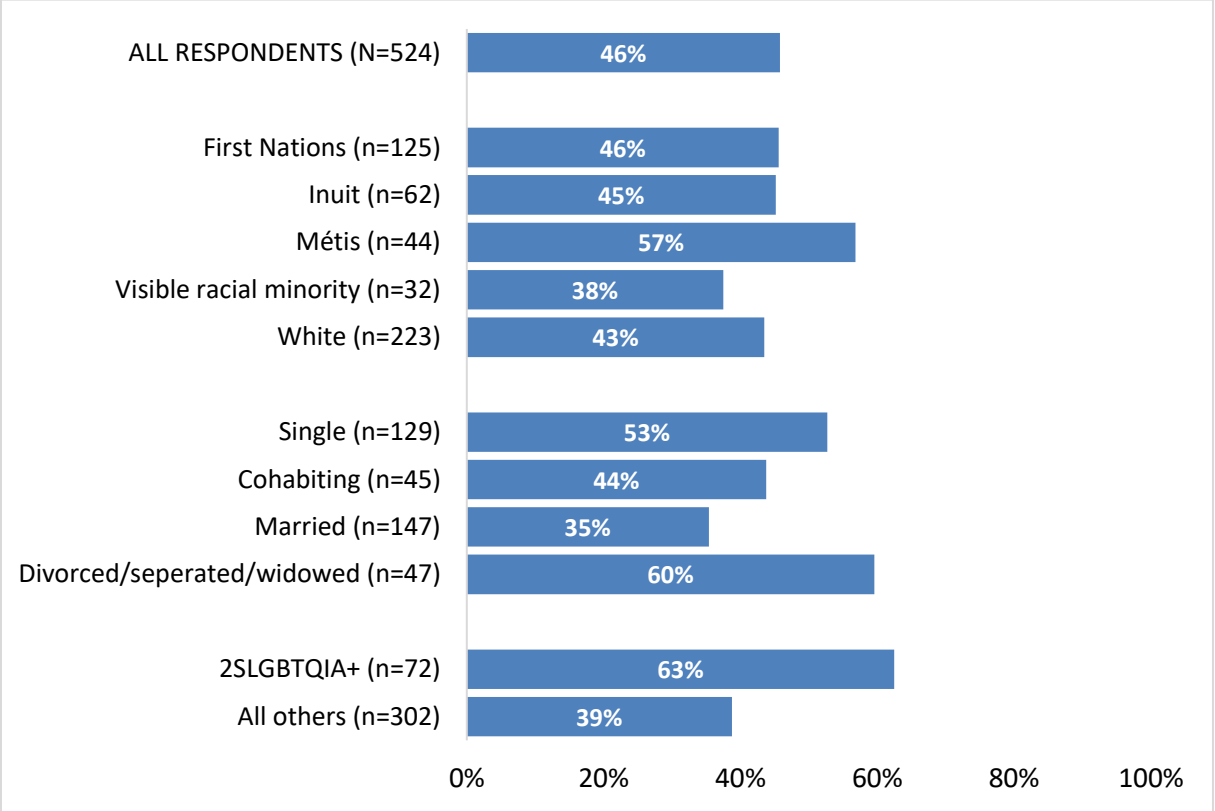


Figure 26. Had difficulty accessing the Community Counselling Program by community type, education, and financial stability

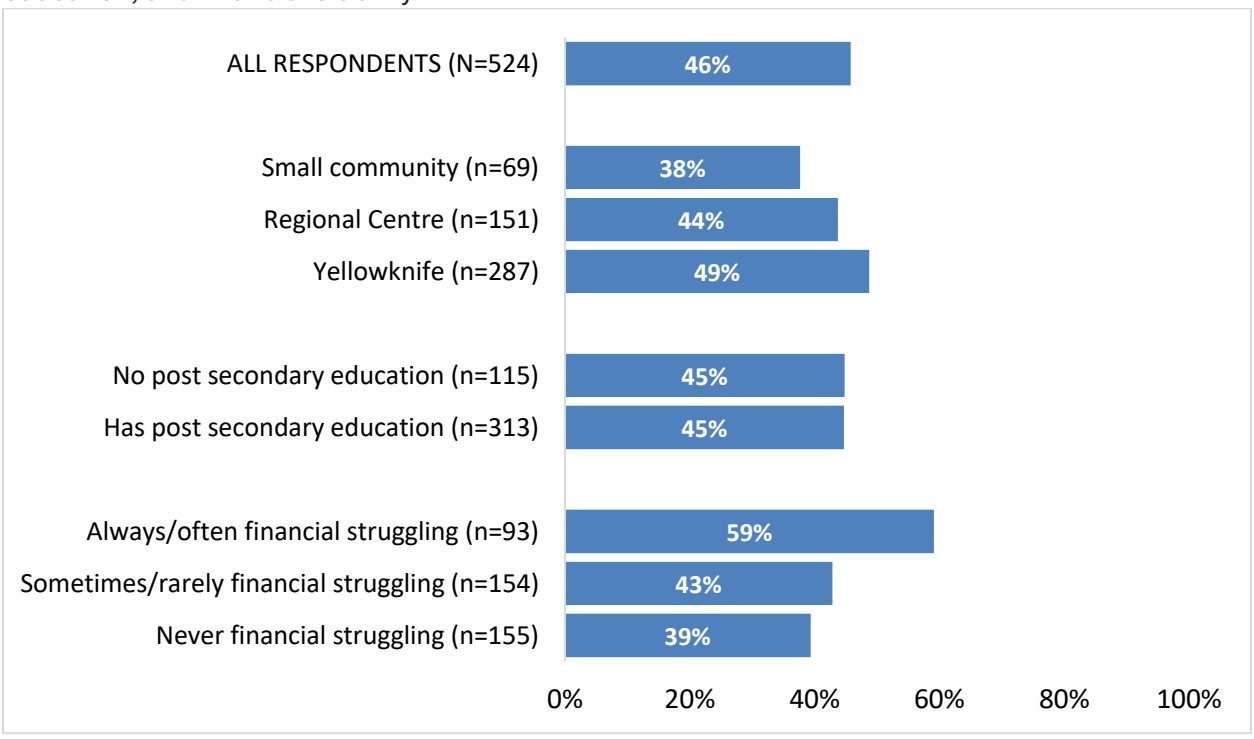
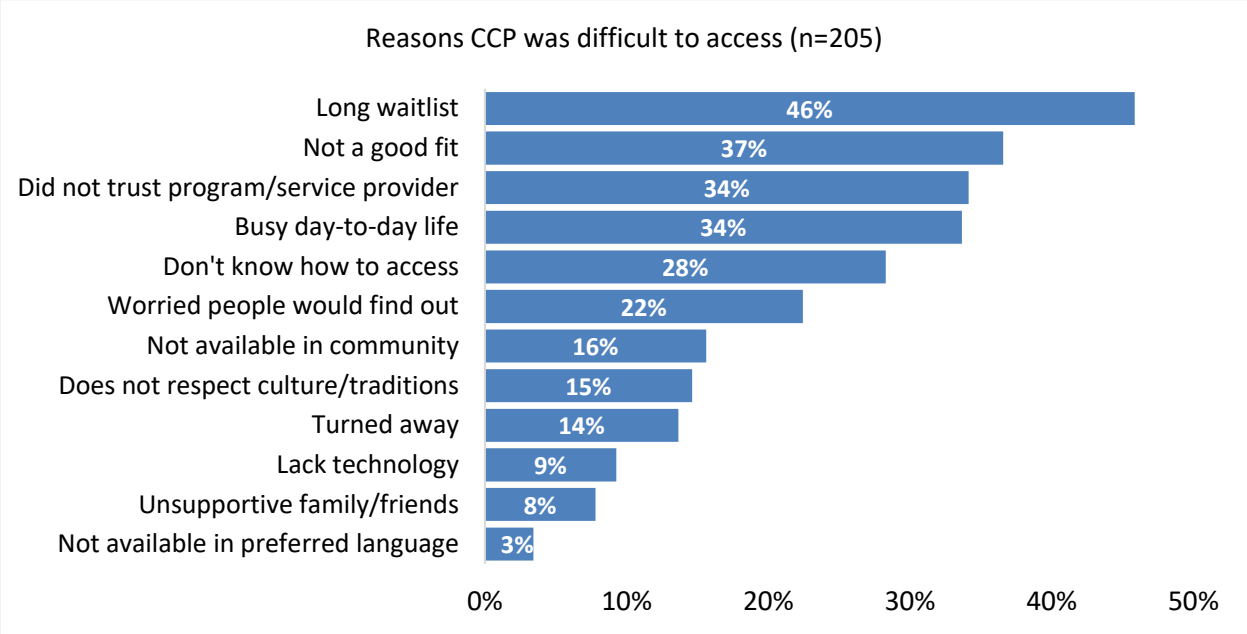


Figure 27. Barriers to accessing the Community Counselling Program (N=205).
(could choose more than one answer from a set list).



52 respondents who had a difficult time accessing the CCP gave written feedback about barriers they had faced

- **Appointment booking:** The most common barrier (n=14) was the appointment booking process with some finding it to be difficult (required a phone they did not have or a stringent time frame like early morning calls only), not responsive (unanswered calls/referrals or no call back), or it took too long. In some cases, they were offered a time that did not work from them (e.g., only offered an appointment on the same day when they wanted to schedule later or vice versa).
- **Tailored services:** Another recurring theme was a perception that CCP services would not be able to meet their unique needs (n=10) because they wanted different therapy methods than those offered (e.g., physical activity or group sessions), they needed specialized service for a diagnosed mental health condition, or they were not confident that staff could tailor services to their unique needs (e.g., 2SLGBTQIA+ friendly services).
- **CCP staffing:** Some respondents (n=7) gave feedback related to CCP staffing. They expressed a desire for better relationships with staff built on shared lived experience (e.g., from the same community/ethnicity or personal experience navigating mental health or addictions). Respondents also expressed a desire for longer retention of staff to allow for relationship building and better staff integration in small communities.
- **Hours/Location:** The operational setup of the CCP (i.e., location, hours of service) was also raised as a challenge by some respondents (n=8). For example, they had challenges with working full-time but being expected to schedule an appointment during regular working hours.
- **Bad experiences:** Specific bad experiences with the CCP hindered 5 respondents from seeking care again. The experiences included uncaring or factually incorrect statements shared by staff, unprofessional behaviour, or not feeling heard.

Satisfaction

Highlights

- Respondents who had used the CCP were more likely to have had an individual session (88%), to have scheduled a session on a future date (83%) rather than being seen on the same day (17%) and to have had their session(s) in person (68%).
- Most respondents who were CCP service users felt mutual trust with their counsellor (80%), cared for by staff (77%), and involved in decision-making related to their care (73%).
- While 73% felt the CCP was free from discrimination, this was lower among First Nations (63%) and 2SLGBTQIA+ (65%) respondents.
- Only 49% of Indigenous respondents in Yellowknife felt the CCP respects Indigenous Peoples compared to 75% in the Beaufort Delta and 64% in all other regions.
- The program had an 83% overall satisfaction rate from survey respondents.
- Respondents were most satisfied with the type of session (virtual vs. in-person) they were offered (84%), program location (79%), and service hours (80%).
- Respondents were least satisfied with the ease of appointment (64%) and wait times (66%).
- Written feedback suggests that staff shortages and turnover are impacting availability of services and continuity of care with some service users opting for private sector care.

Figure 28. Summary of how the respondents used the Community Counselling Program

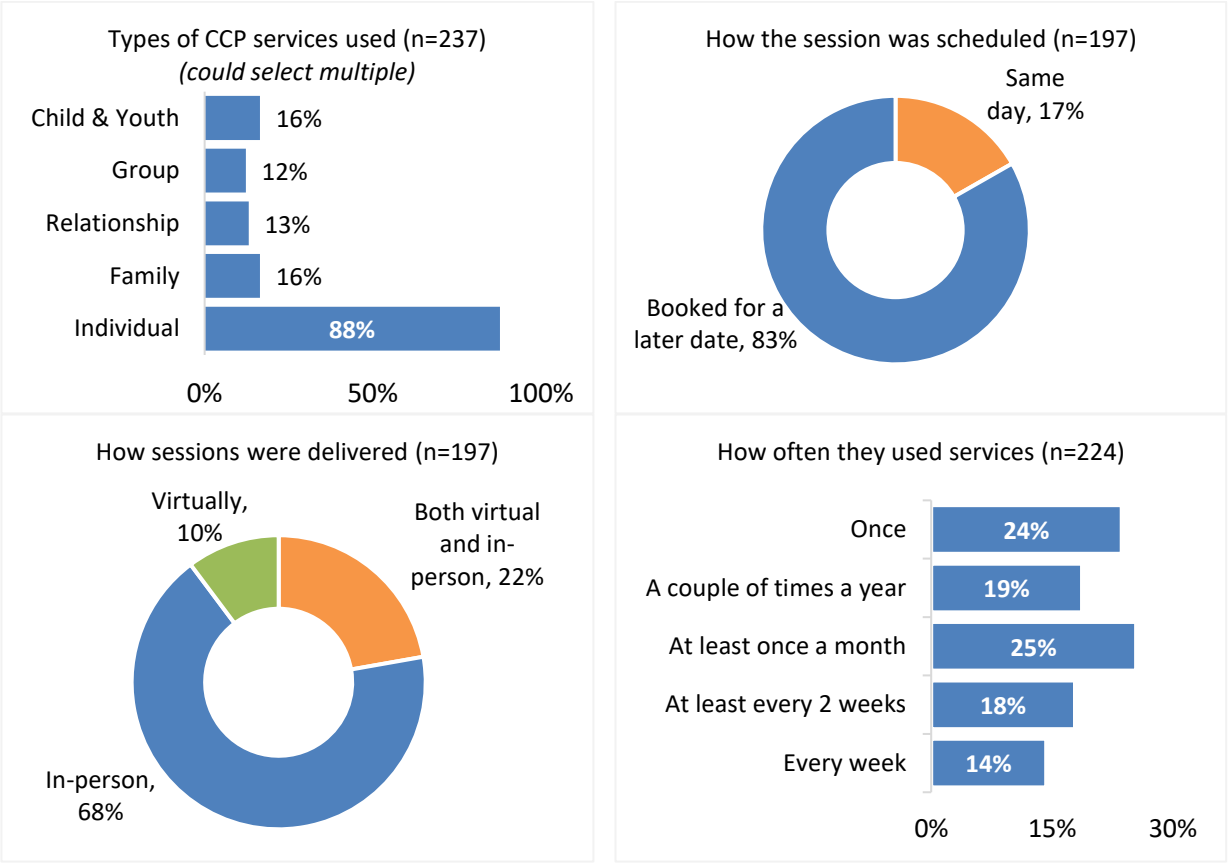


Figure 29: Satisfaction with different aspects of the Community Counselling Program

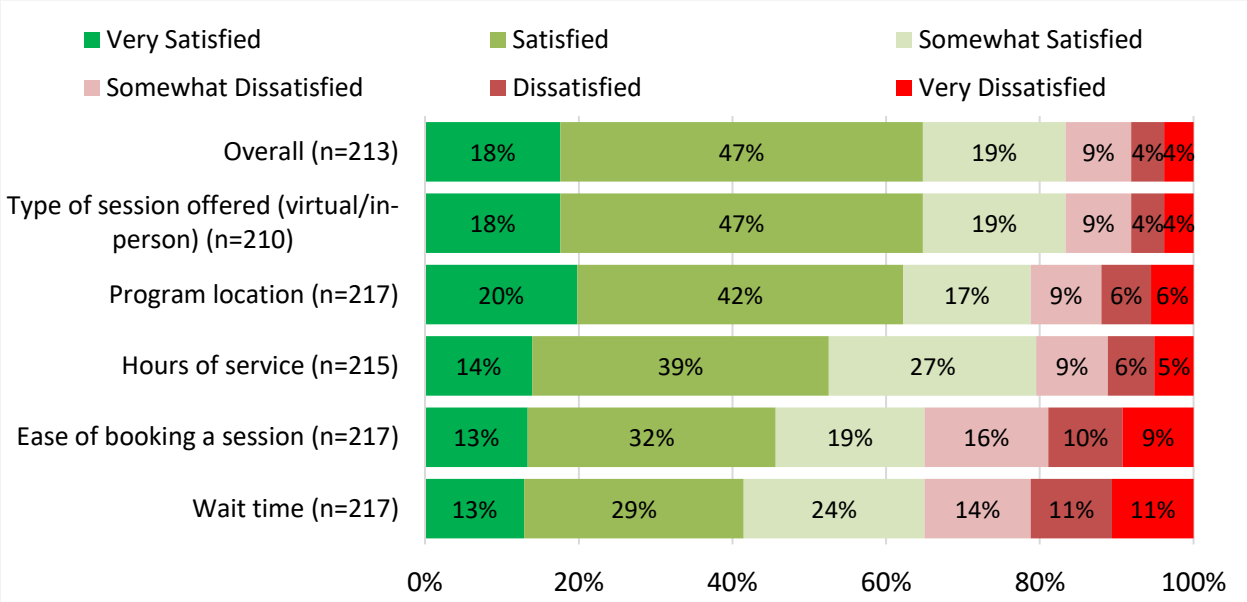


Figure 30: Experience booking an appointment with the Community Counselling Program

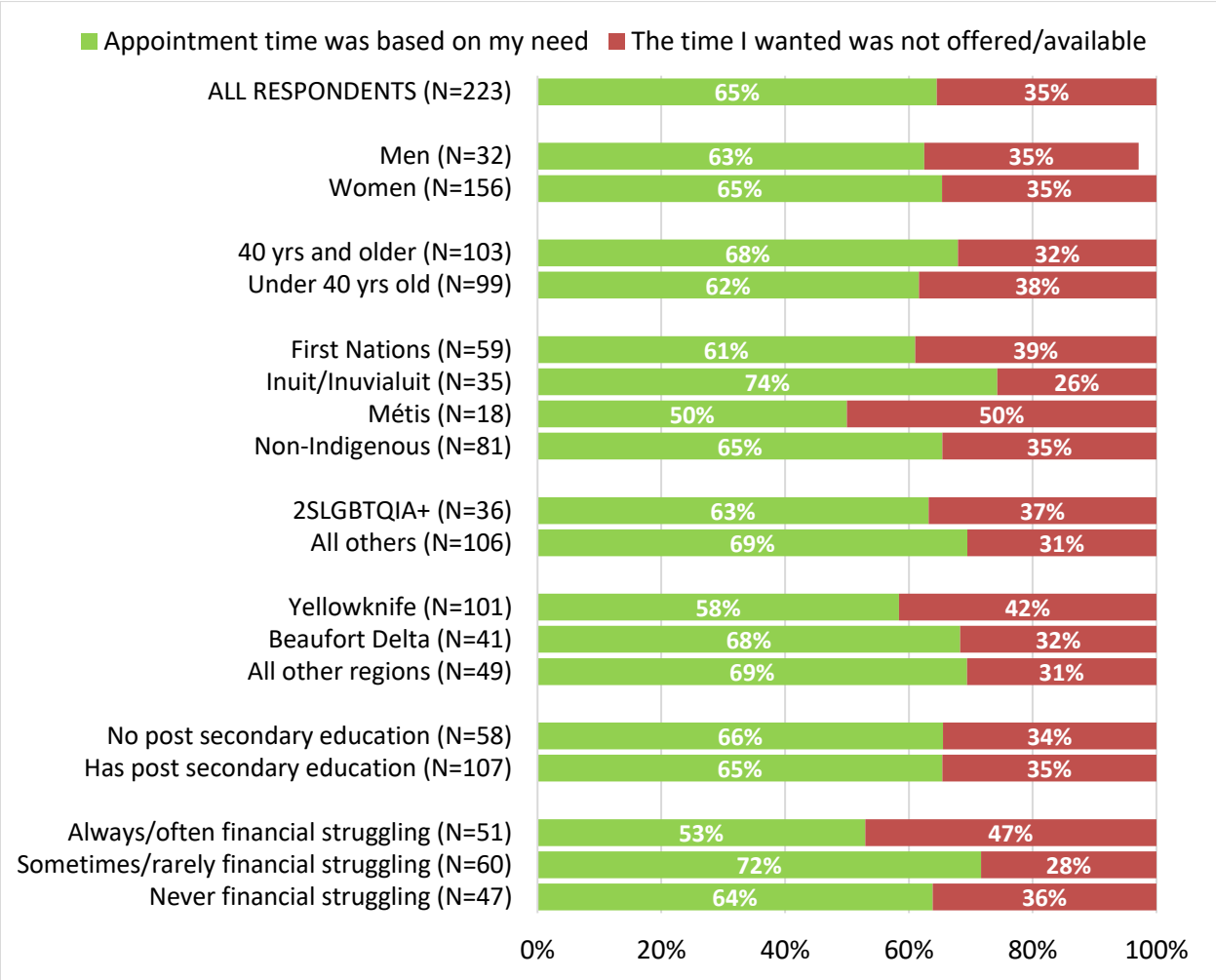
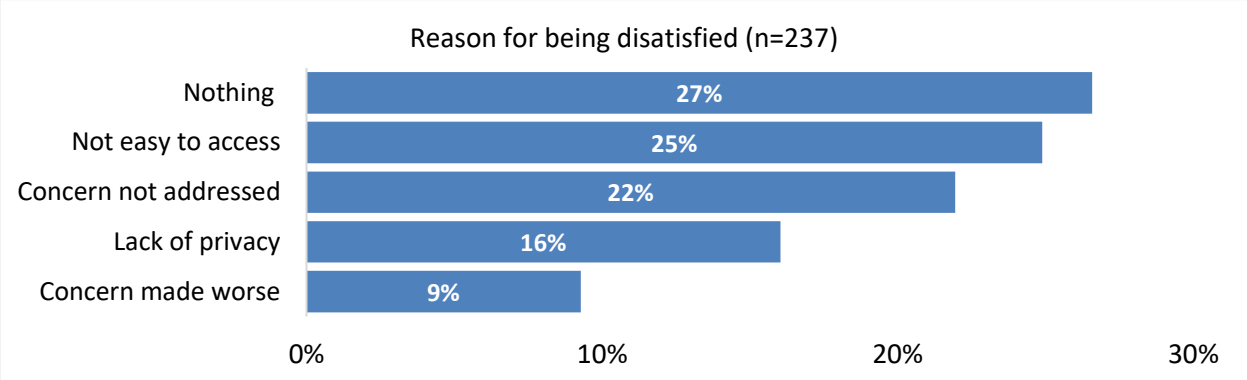


Figure 31: Factors that made service-users feel dissatisfied with the Community Counselling Program (n=237)
(could choose more than one answer from a set list).



98 respondents who had used the CCP gave written feedback on their satisfaction

(N=207 comments in total because one service user could provide multiple comments in different sections of the survey)

- **Positive feedback:** There were 23 positive comments including expressions of gratitude and experiences with counselors described as kind, calming, supportive, and dedicated.
- **Long-term consistent services**: The most common negative theme (n=25) was respondents desiring more long-term consistency in the services provided to them but finding it challenging to setup. This could be due to difficulty booking regular sessions or not seeing the same counselor consistently because of staff turnover or an inability to select a specific counselor when booking a session.
- **Service availability**: The second most common negative theme (n=21) related to limited-service availability because there were too few staff. Some comments related to high staff turnover (n=11) which impacted both availability of services and service users' ability to form strong relationships with staff over time. Some comments (n=4) expressed dismay at the reduced staffing and removal of Child and Youth Counselors from schools following the CYC program redesign.
- **Appointment booking**: Respondents commented on challenges with the process to book an appointment (n=7), long wait times (n=9), and dissatisfaction with not being able to book an appointment based on their preference i.e., they wanted to schedule an appointment on a future date but this was not an option (n=7) or they wanted to see someone on the same day but no one was available (n=3). Some respondents (n=10) also expressed a desire for services being available outside of regular work hours to accommodate school and work schedules.
- **Indigenous Cultural Safety**: Some respondents (n=13) shared feedback related to the cultural safety of the CCP for Indigenous Peoples including a desire for more Indigenous staff, for current staff to receive more training on Indigenous mental health, and for staff to have a deeper understanding of Indigenous Peoples. They also expressed a desire for deeper

integration of Indigenous cultural practices in the CCP e.g., On the Land programming, knowledge holders' circles, guidance from Elders.

- **Community integration:** Another recurring theme was about how the CCP interacts with the community. Some respondents expressed a desire for CCP staff to be more deeply integrated in the life of the community (n=9) including to "meet people where they are at" by going out into the community.

- **Physical space:** Some comments (n=9) expressed that offices they visited did not feel welcoming if it was messy or in an overly clinical space. Four respondents in Hay River expressed dissatisfaction with the change in location because the rooms are not soundproof and made them concerned about their privacy. Some stopped going to the CCP as a result.

- **Connection to other service providers:** A few respondents (n=4) raised strong concerns about the relationship between the CCP and other Social Services which suggests they do not see a distinction between different entities e.g., Child and Family Services. For this reason, they did not want to engage with CCP because of the perceived impact this could have on their children, or they had previous negative experiences with other Social Services. The offices being co-located or CCP staff relaying information on behalf of other Social Services staff exacerbated this concern in some of their experiences.

- **Cost of mental health care.** All CCP services are provided for free. However, respondent feedback (n=10) suggest that limited CCP service availability pushes some NWT residents to seek out private sector care at a great personal cost. For some respondents this was after receiving satisfactory services through the CCP but having challenges establishing continued consistent care.

Summary of insights from written feedback
Staffing shortages emerged as a core challenge connecting many of the barriers identified in the feedback, particularly affecting appointment booking, service continuity, and service-user choice. Insufficient staffing made it difficult for people to book appointments when needed, limited their ability to select or consistently see the same counselor over time, and led some to ultimately forgo care or seek costly private services.

These issues were compounded by operational factors such as difficulties with the booking process, limited-service hours, and a lack of flexibility to accommodate people's work or school schedules. Beyond staffing, respondents highlighted important areas for program improvement, including strengthening Indigenous Cultural Safety, offering more welcoming and private physical spaces, deeper community integration, and ensuring a clearer distinction between CCP services and other social services to rebuild trust.

Together, these findings suggest that while dedicated and supportive counselors were appreciated, systemic changes are needed to ensure more accessible, culturally safe, community-integrated, and responsive mental health services.

Figure 32: How people felt about their experience with the Community Counselling Program

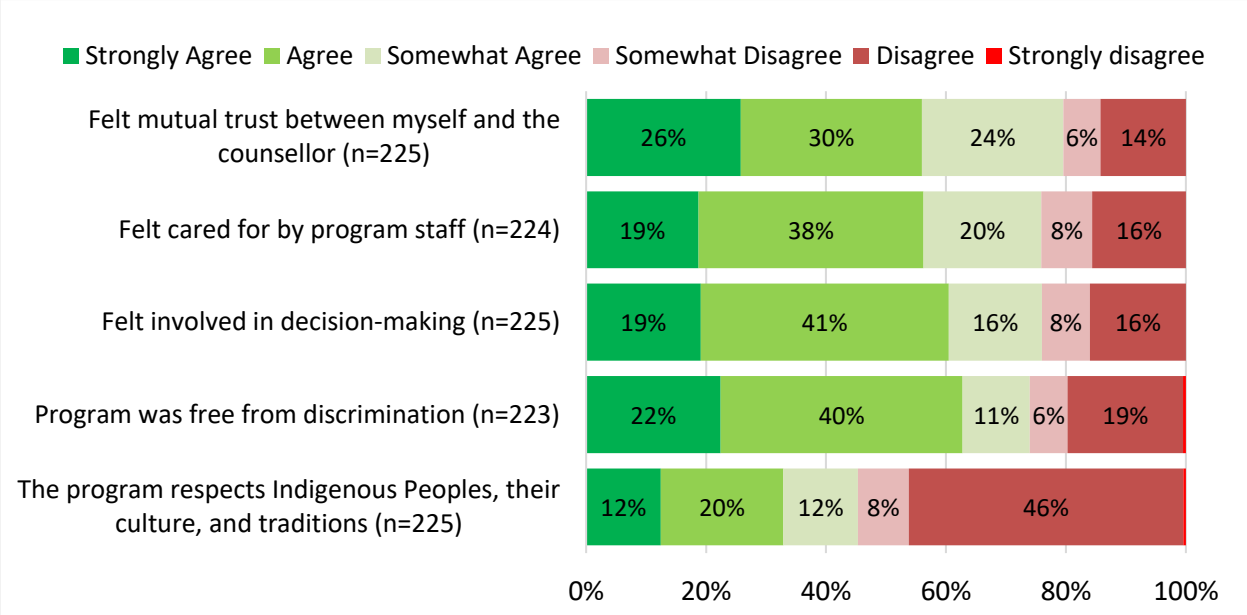


Figure 33: Perceived discrimination in the Community Counselling Program by gender, age, Indigenous identity, 2SLGBTQIA+ identity, region, and financial stability

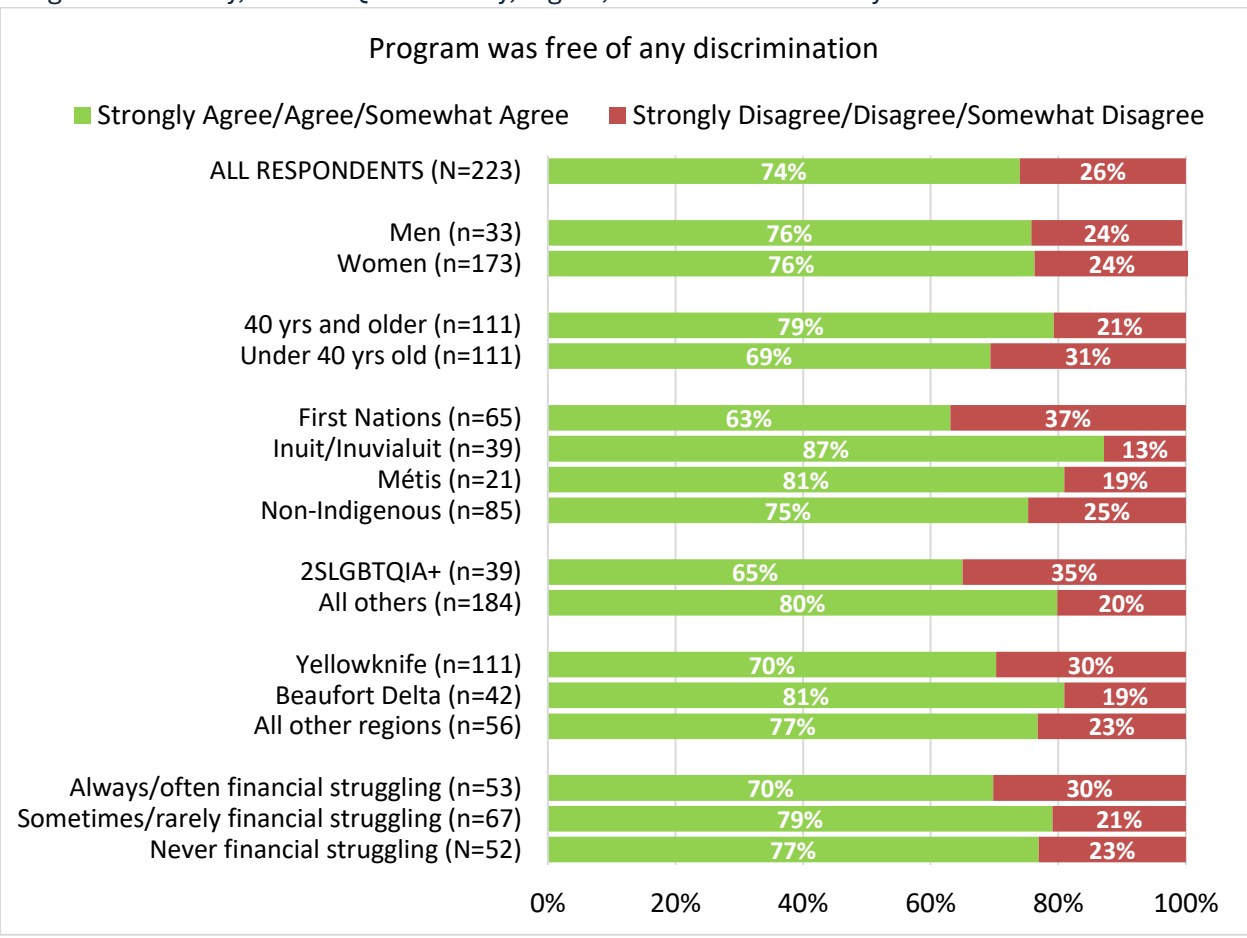
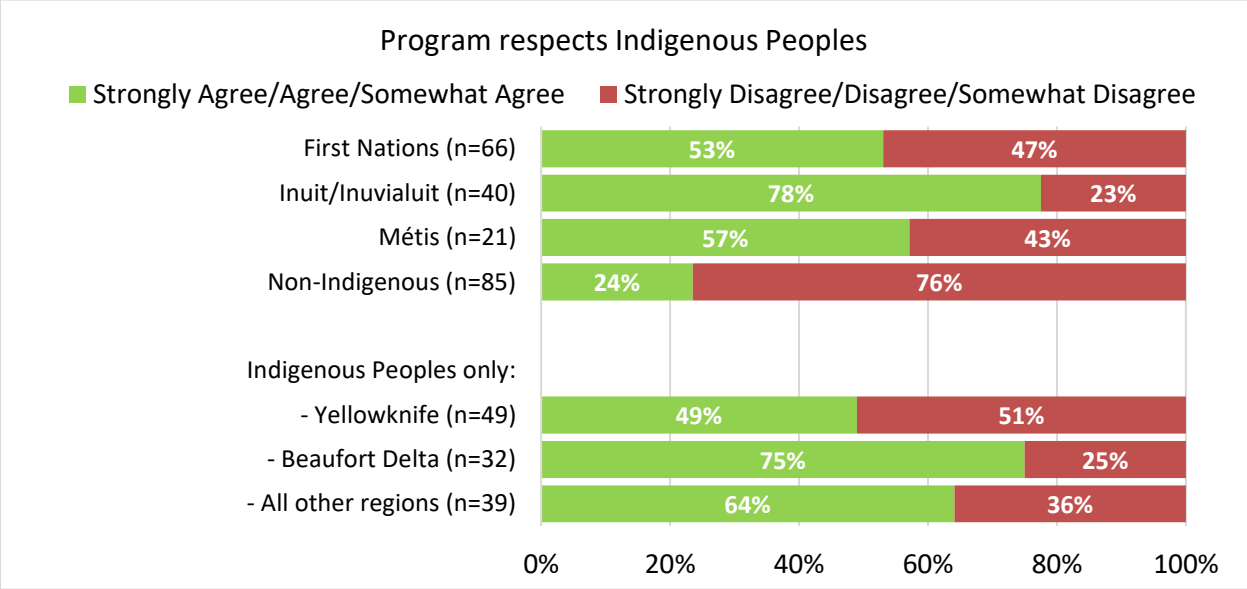


Figure 34. Indigenous Cultural Safety in the Community Counselling Program by Indigenous identity and region



Outcomes

Highlights

- 64% of respondents felt counselling helped them build skills to address their concern, and 70% said it improved their overall health and wellbeing.
- Skill development and health improvements were reported less often by 2SLGBTQIA+ respondents, those facing the most financial challenges, First Nations respondents, Yellowknife residents, and those under 40 years old.

Figure 35. Skill development and improved wellbeing with the Community Counselling Program

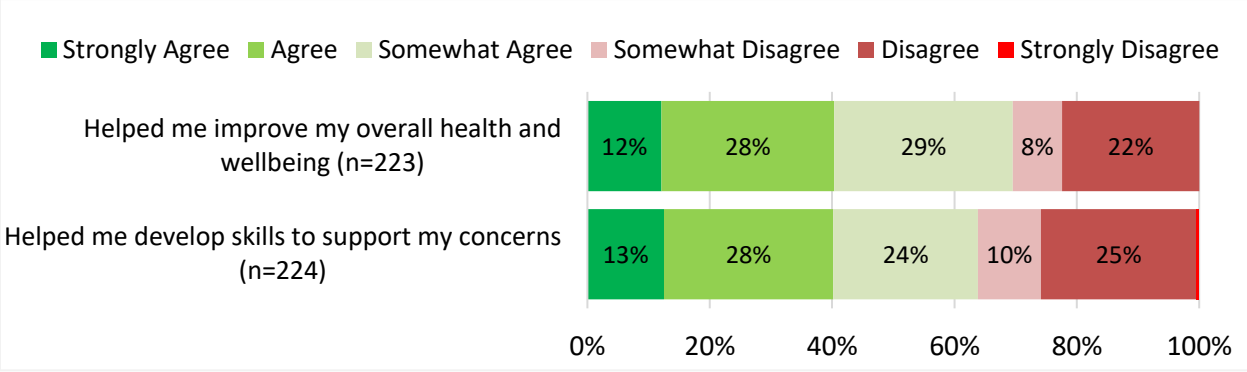


Figure 36. Skill development with the Community Counselling Program by gender, age, Indigenous identity, 2SLGBTQIA+ identity, region, and financial struggles

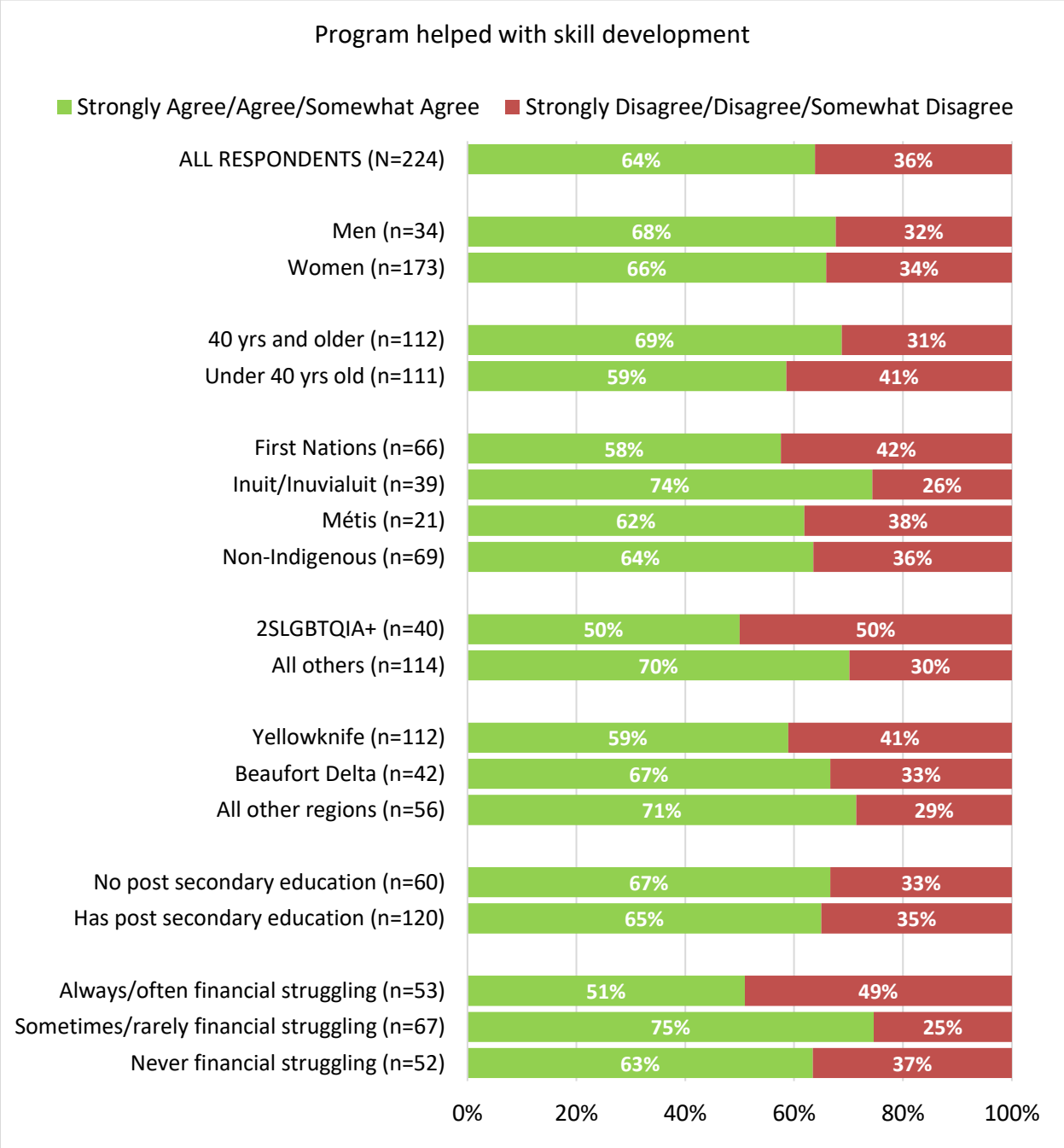
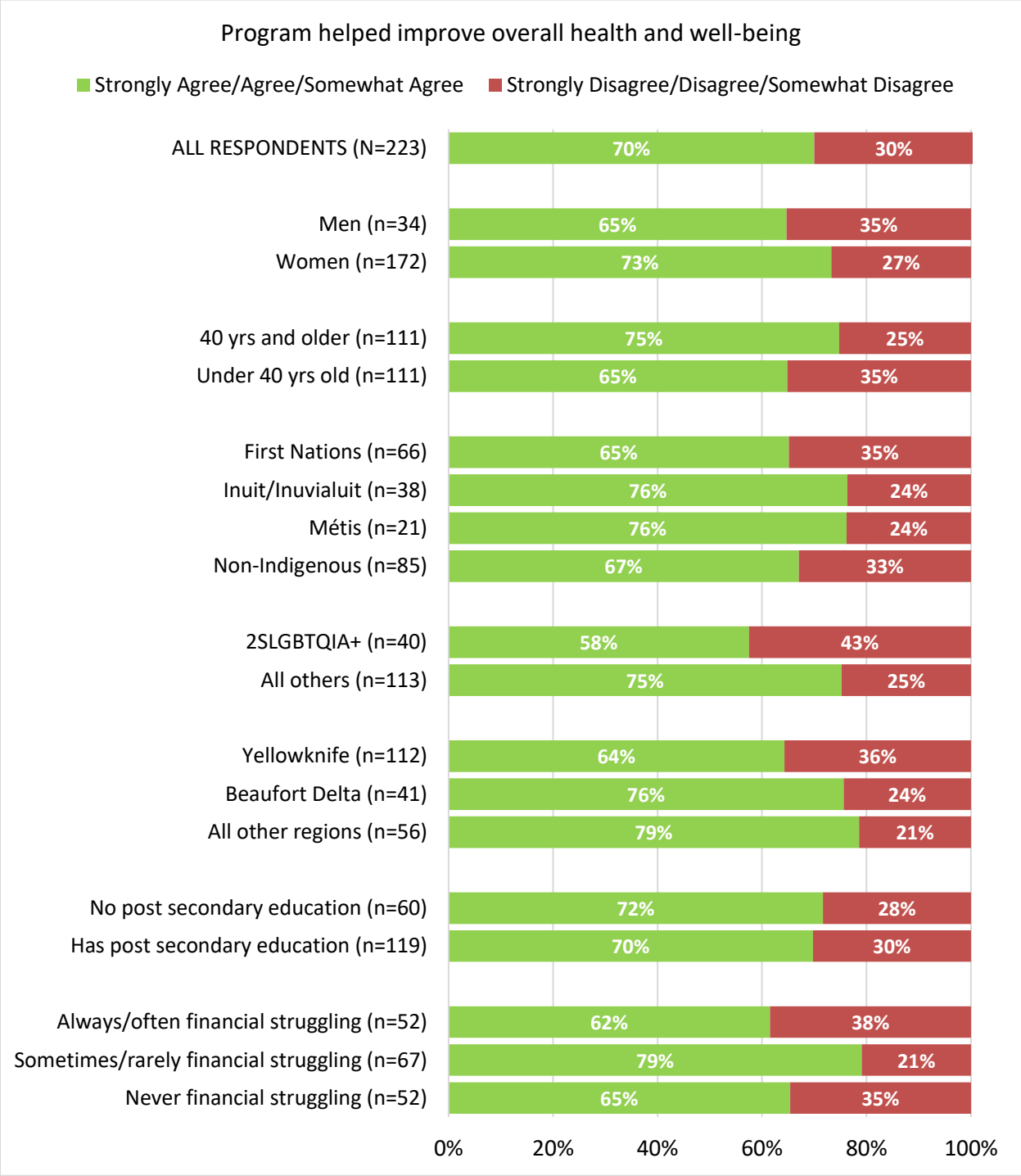


Figure 37. Improved wellbeing with the Community Counselling Program by gender, age, Indigenous identity, 2SLGBTQIA+ identity, region, and financial struggles



Section 5: Facility-Based Addictions Treatment (FBAT)

Awareness

Highlight – 35% of respondents were aware of the FBAT program. Awareness was lower among small community residents, men, and people without post secondary education.

Figure 38. Awareness of Facility-Based Addictions Treatment by gender and age

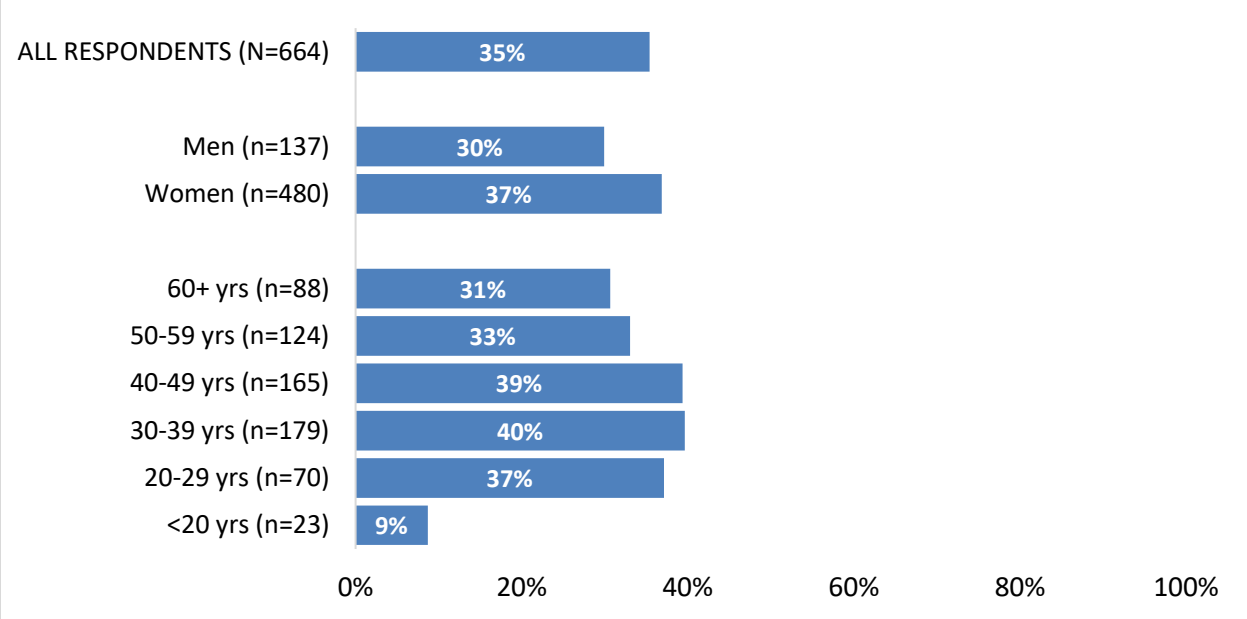


Figure 39. Awareness of Facility-Based Addictions Treatment by race, relationship status, 2SLGBTQIA+ identity

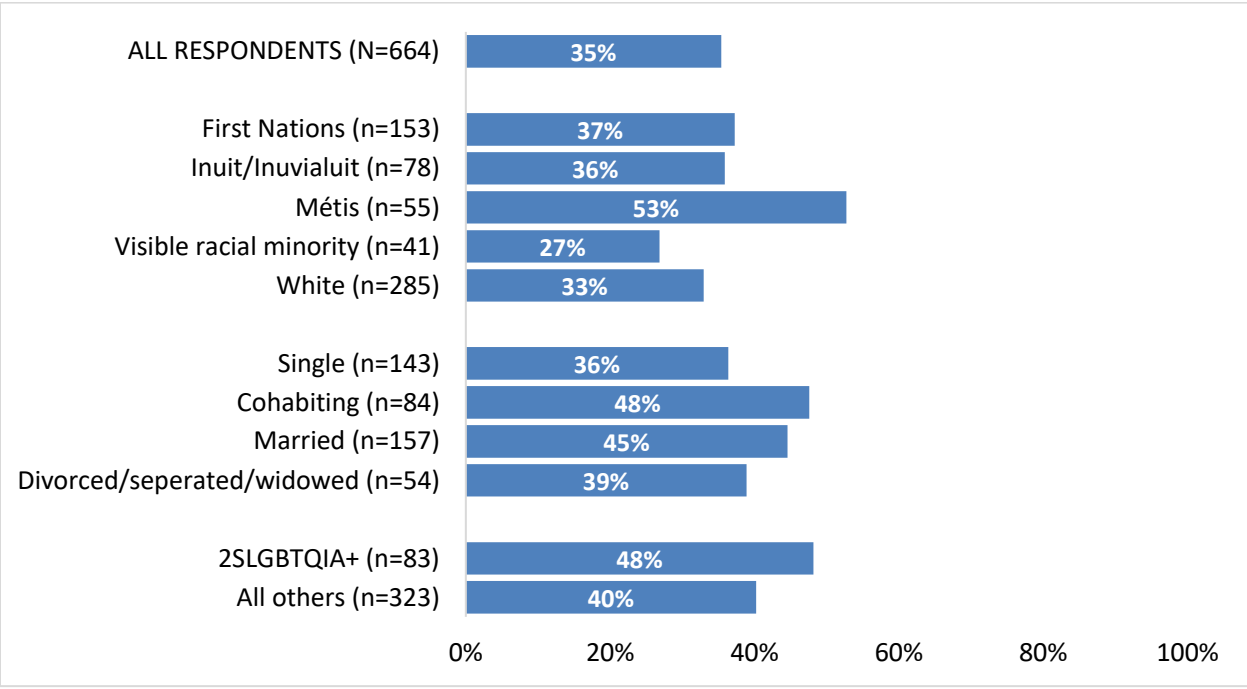
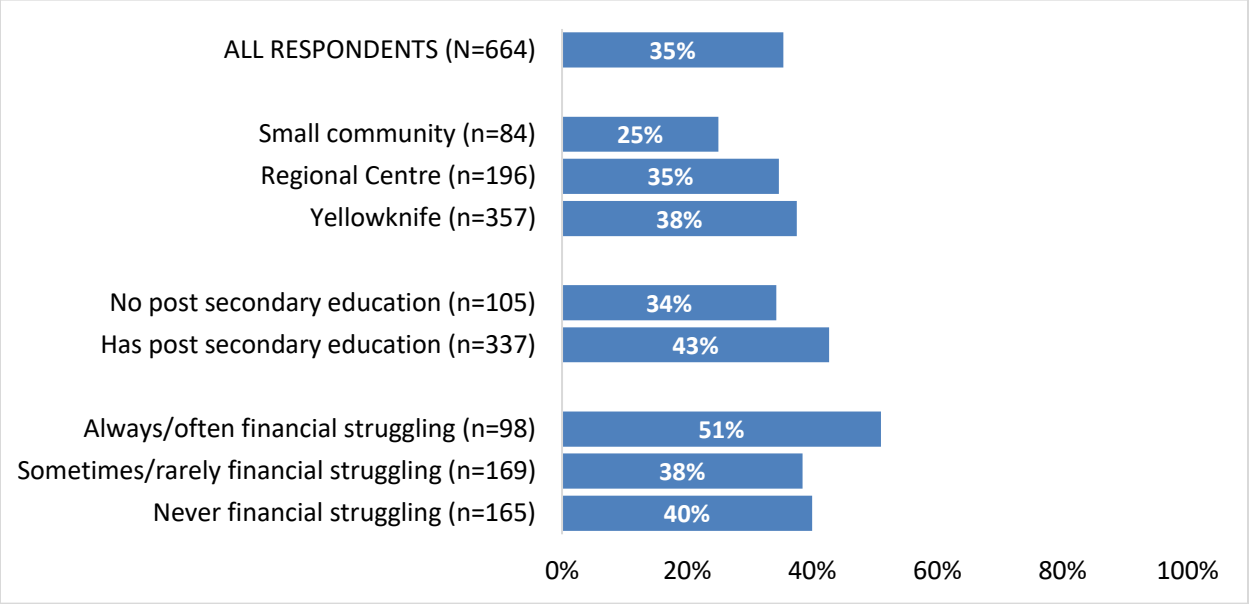


Figure 40. Awareness of Facility-Based Addictions Treatment by community type, education and financial stability



Accessibility

Highlights

- About 1 in 5 respondents (20%) reported having difficulty accessing treatment. This was more common among those facing financial hardship (42%), without post-secondary education (40%), First Nations (37%) and Métis (38%) respondents, and 2SLGBTQIA+ individuals (28%).
- Top barriers to accessing treatment reported were the application process (38%), not knowing how to access it (38%), and reluctance to leave the NWT (35%).
- Written feedback was provided by 31 respondents on the barriers they faced which included the application process and paperwork being complicated (n=4), hurdles getting linked to care (n=4) e.g., being denied treatment or incomplete referrals, and competing demands which made it difficult to leave the territory (n=4) e.g., work, childcare, animal care.

Figure 41. Had difficulty accessing Facility-Based Addictions Treatment by gender and age

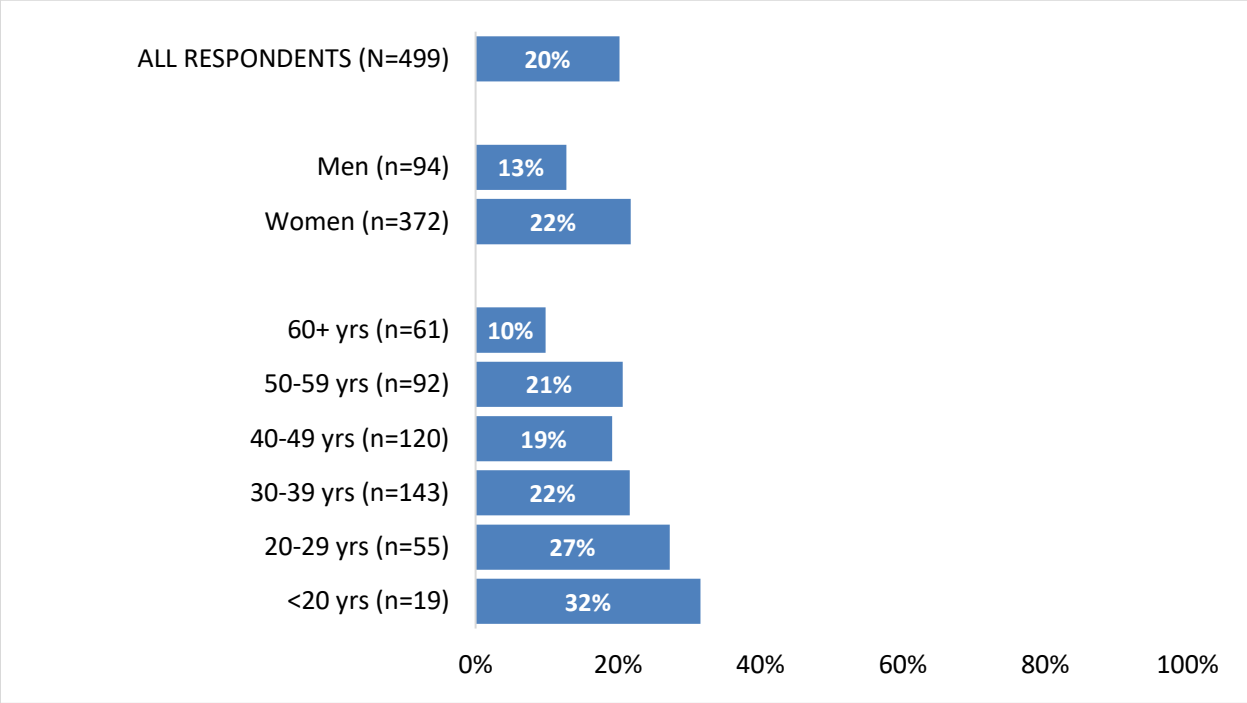


Figure 42. Had difficulty accessing Facility-Based Addictions Treatment by race, relationship status, 2SLGBTQIA+ identity

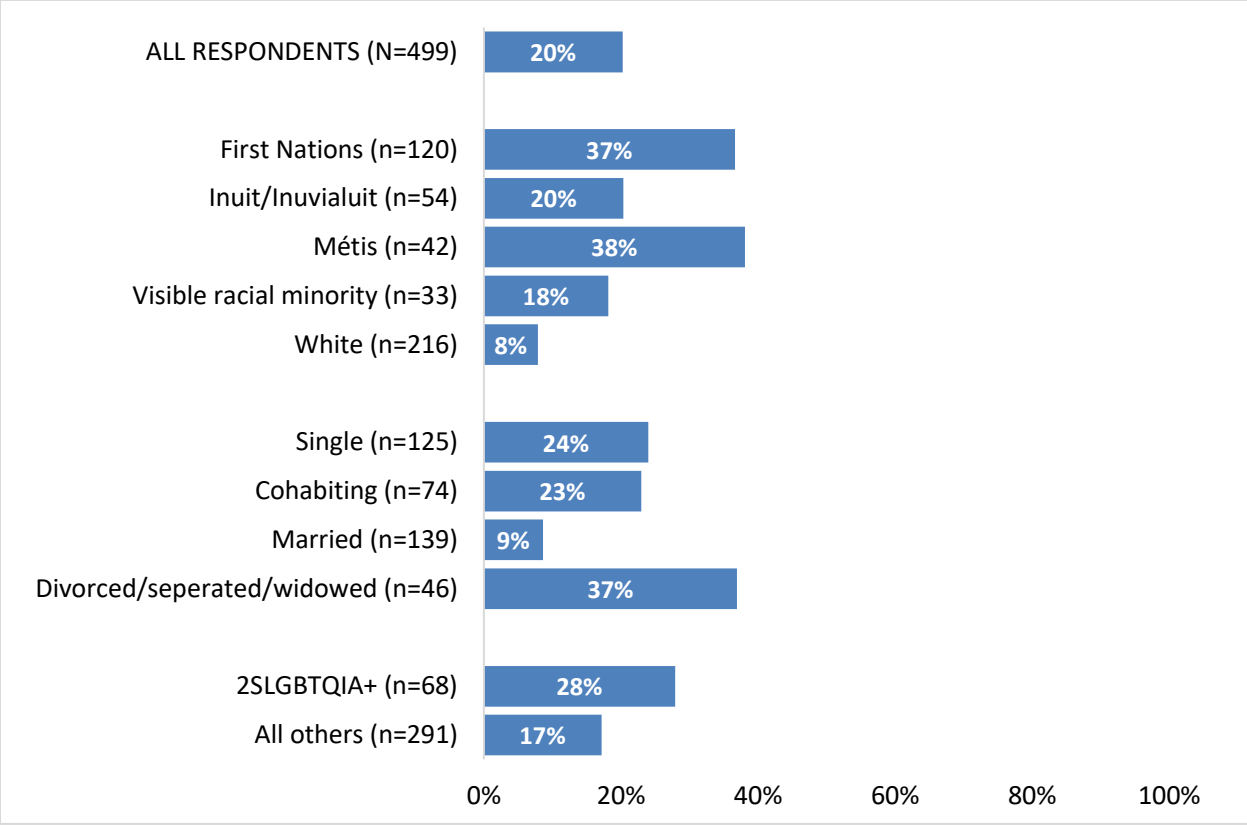


Figure 43. Had difficulty accessing Facility-Based Addictions Treatment by community type, education and financial stability

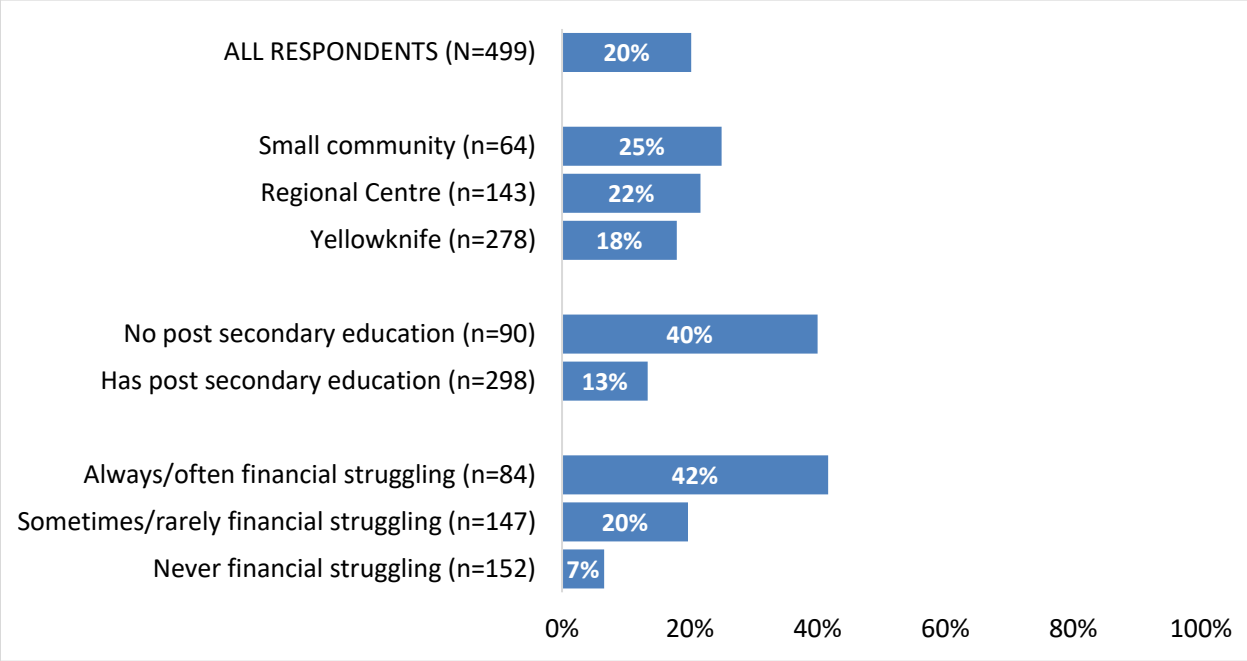
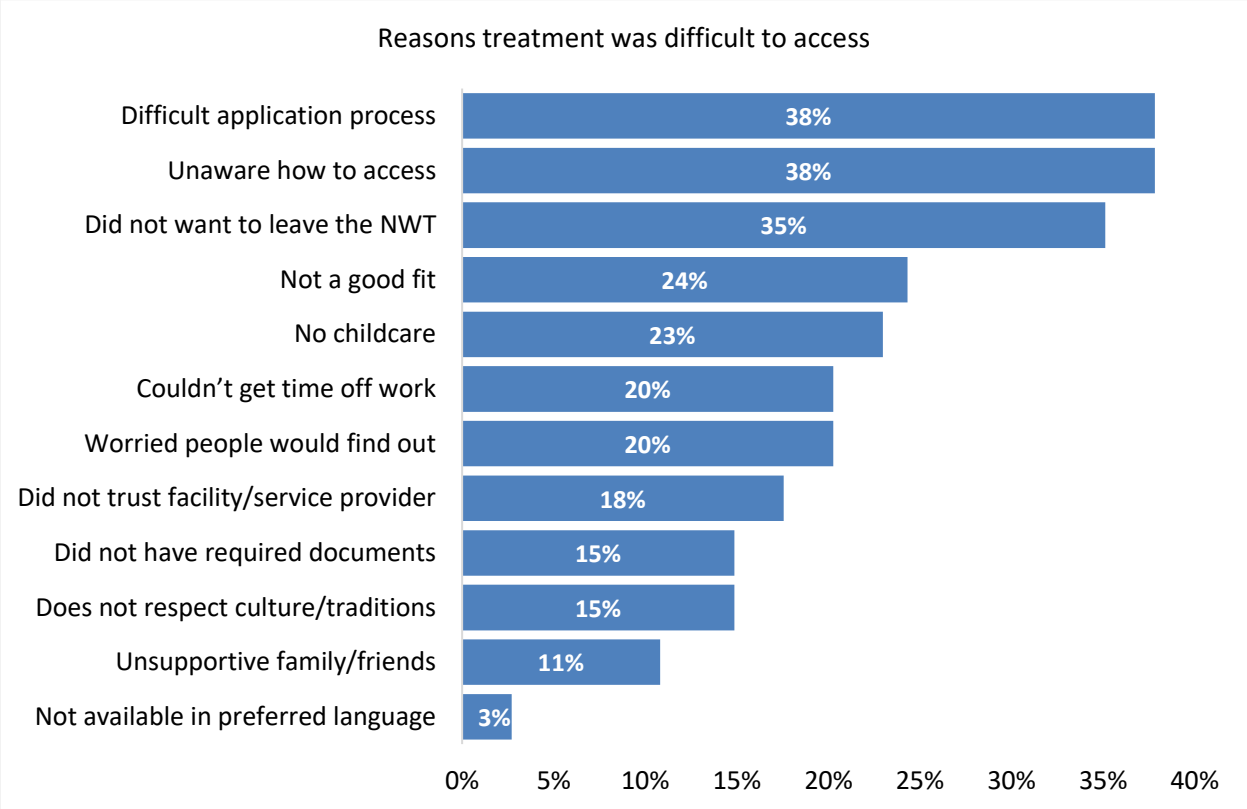


Figure 44. Barriers to accessing Facility-Based Addictions Treatment (n=74)
(could choose more than one answer from a set list).

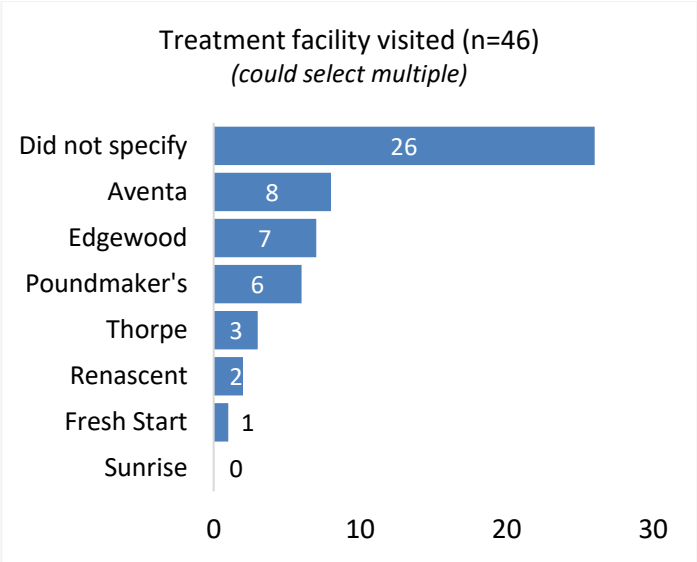


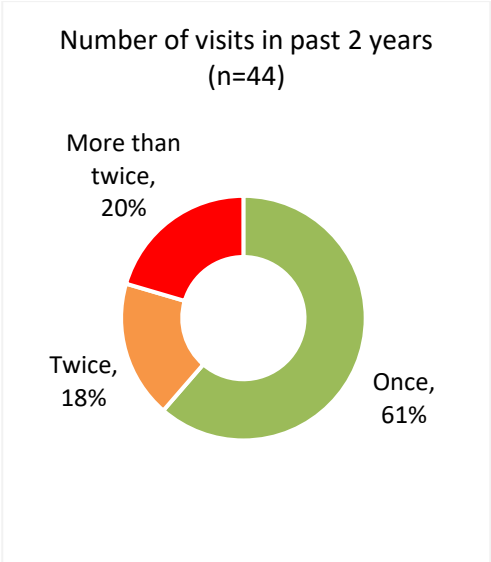
Satisfaction and Outcomes

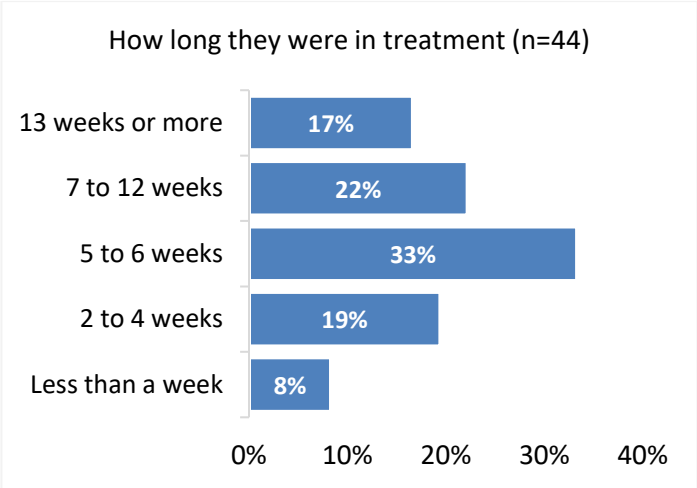
Highlights

- With only 46 respondents who had attended treatment, results should be interpreted with caution and could not be broken down by facility or demographic group.
- The sample also skewed towards women (70%), even though women make up only about 40% of those who have attended treatment since 2018.
- Most respondents were satisfied with facility living conditions (82%) and their overall experience (82%), but only half (51%) were satisfied with information provided about aftercare.
- The most common reported dissatisfaction was leaving their home community to get treatment (39%). In written feedback, the most common issue raised was a lack of aftercare and housing support when people returned from treatment.
- 90% of respondents felt treatment helped them build skills to address their addictions concern, and 92% said it improved their overall health and wellbeing.

Figure 45. Summary of how respondents engaged with Facility-Based Addictions Treatment and their basic demographics







Basic demographics of respondents (n=46)

70% Women

57% Over 40 years old

85% Indigenous

11% 2SLGBTQIA+

39% Always/often stuggle financially

Figure 46. How people felt about their experience in a Facility-Based Addictions Treatment program

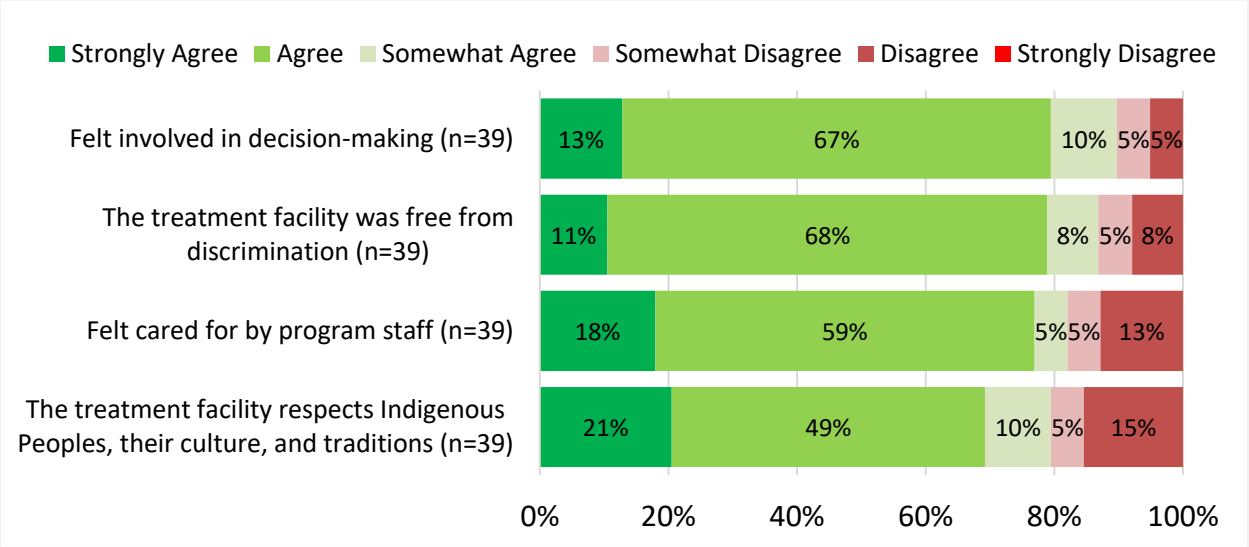


Figure 47. Quality rating of Facility-Based Addictions Treatment facility (n=37)

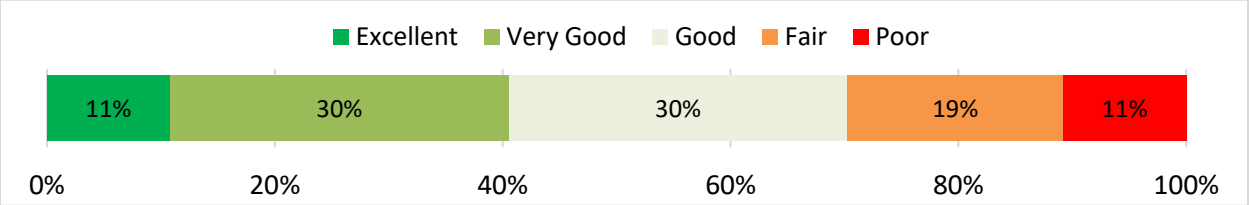


Figure 48. Level of satisfaction with the Facility-Based Addictions Treatment program

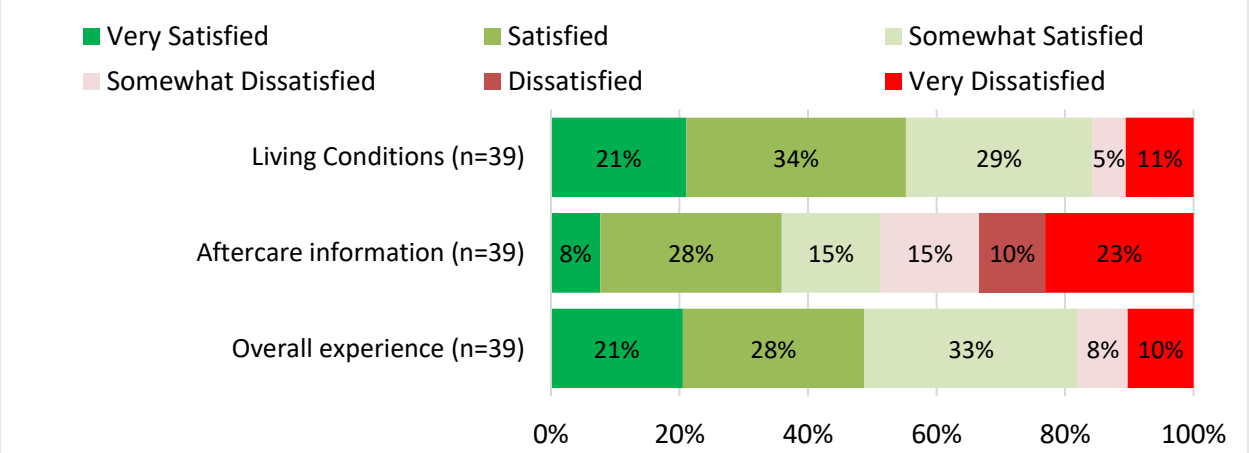


Figure 49. Factors that made service-users feel dissatisfied with the Facility-Based Addictions Treatment program (n=46)
(could choose more than one answer from a set list)

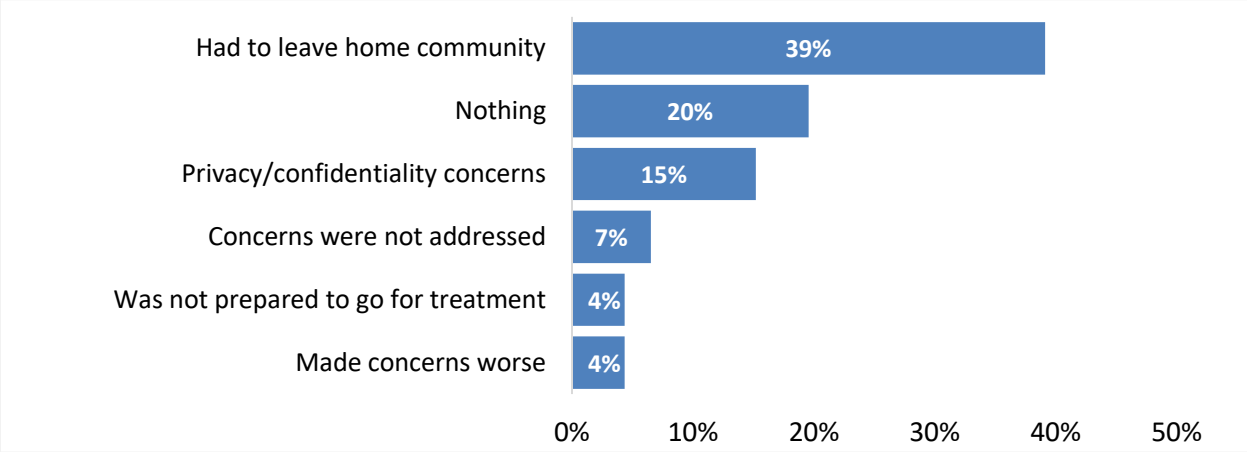
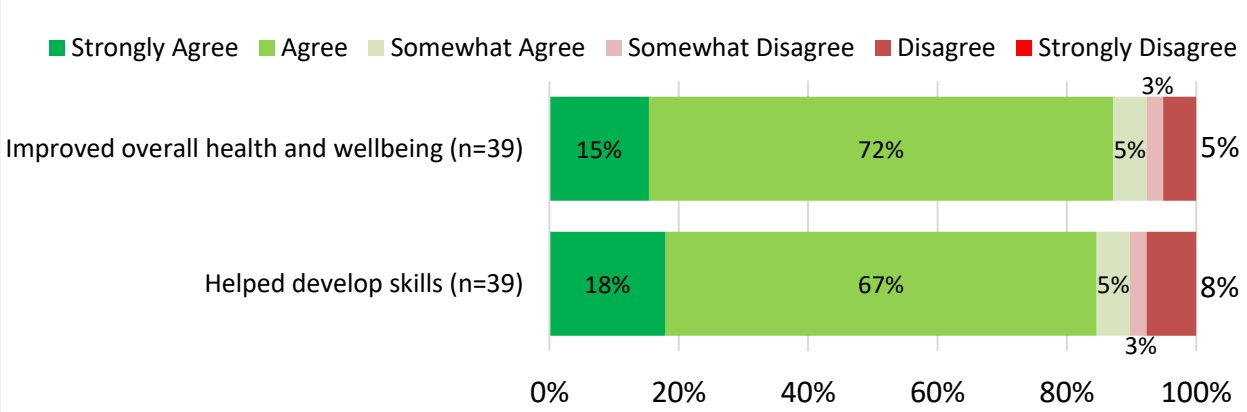


Figure 50. How much people felt Facility-Based Addictions Treatment helped them develop skills and helped them improve overall health and wellbeing



Section 6: Mental Health Helplines

Awareness

Highlight – 53% of respondents were aware of the Mental Health Helplines. Men, people without post-secondary education, and those experiencing financial difficulty were less aware.

Figure 51. Awareness of Mental Health Helplines by gender and age

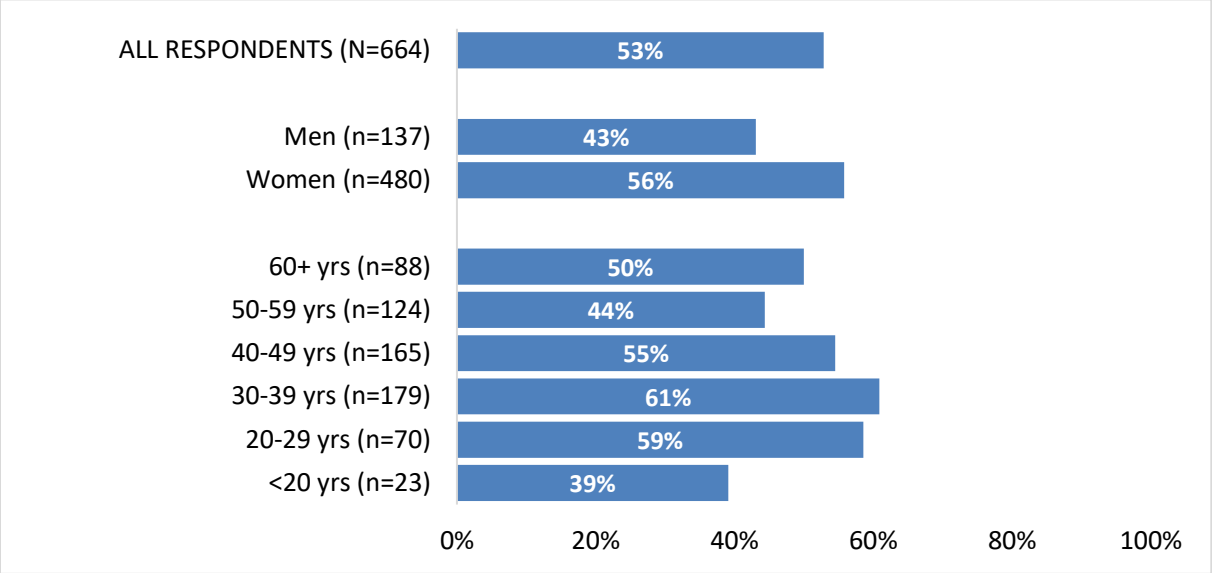


Figure 52. Awareness of Mental Health Helplines by race, relationship status, 2SLGBTQIA+ identity

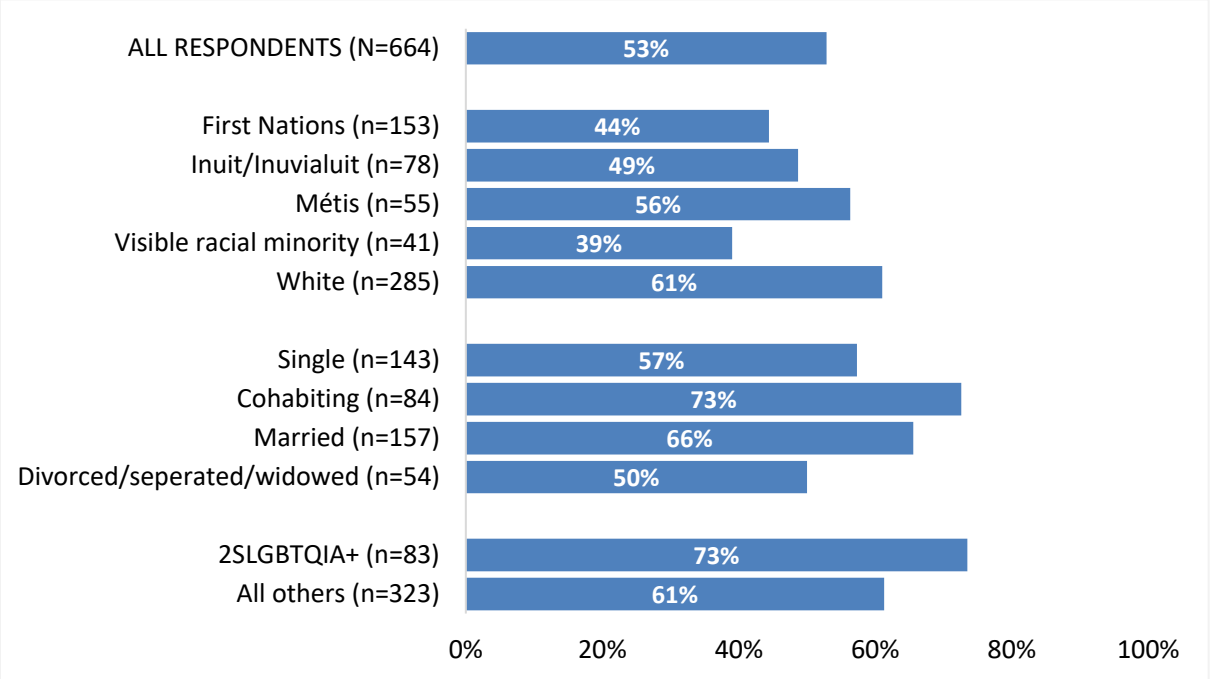
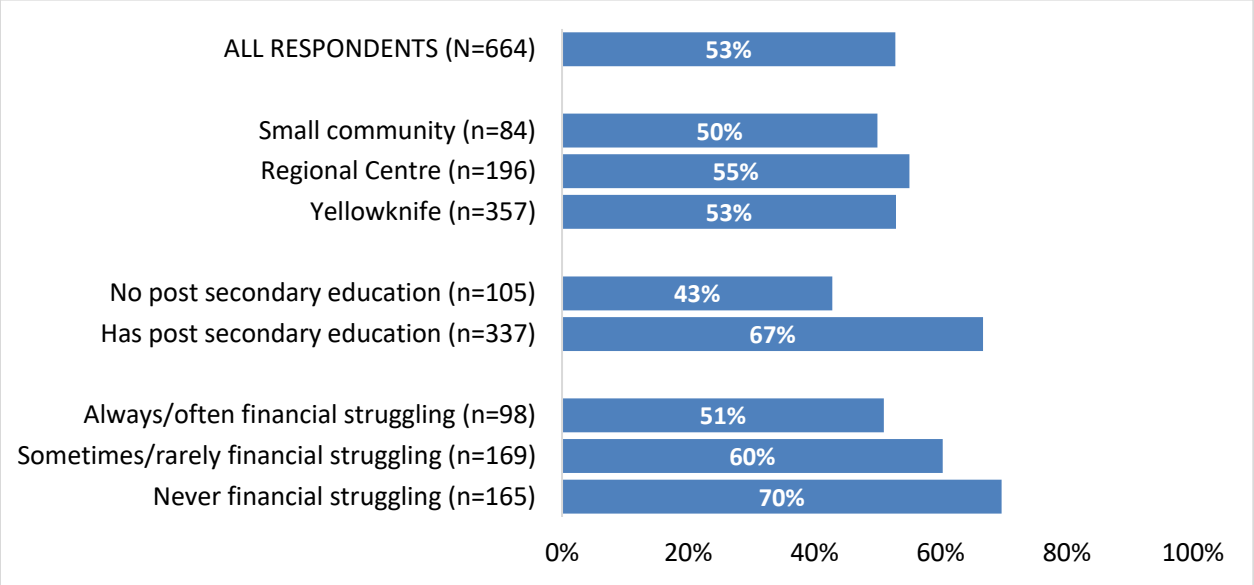


Figure 53. Awareness of Mental Health Helplines by community type, education and financial stability



Accessibility

Highlights

- About 1 in 10 respondents (12%) reported difficulty accessing Helplines. This was more common among First Nations respondents (23%), those most frequently struggling financially (21%), 2SLGBTQIA+ individuals (18%), and those living in small communities (16%).
- Top barriers reported to accessing Helplines were people not feeling like the helpline was a good fit (27%), distrust in the service provider (27%), and not knowing how to access them (23%).

Figure 54. Had difficulty accessing Mental Health Helplines by gender and age

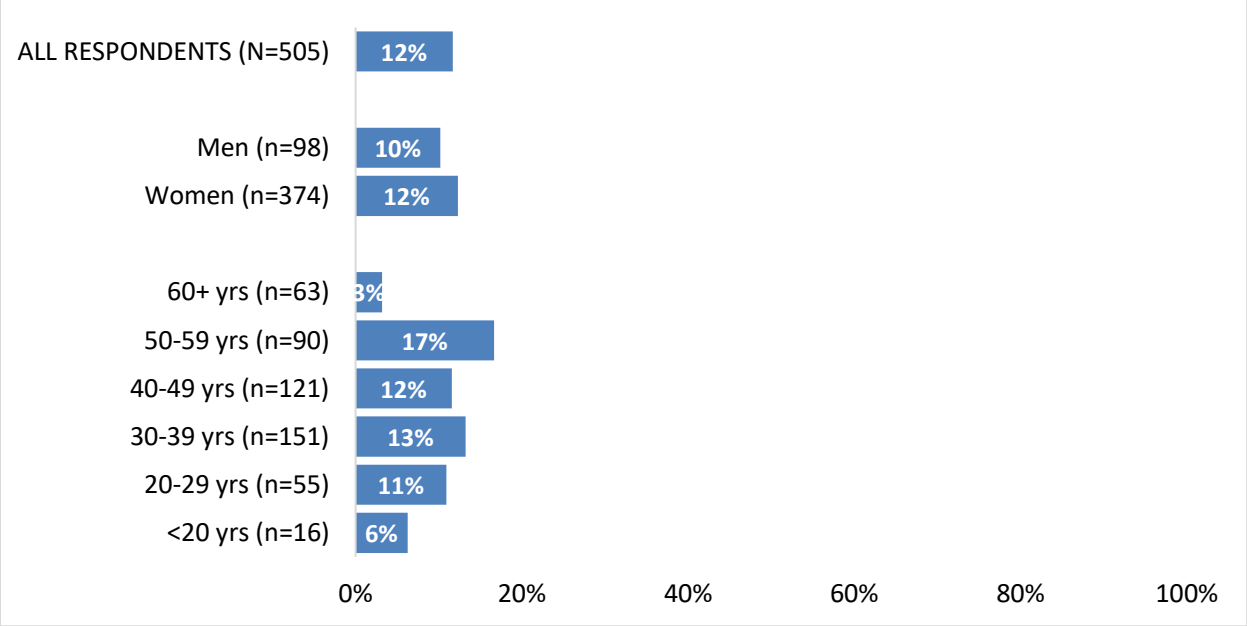


Figure 55. Had difficulty accessing Mental Health Helplines by race, relationship status, 2SLGBTQIA+ identity

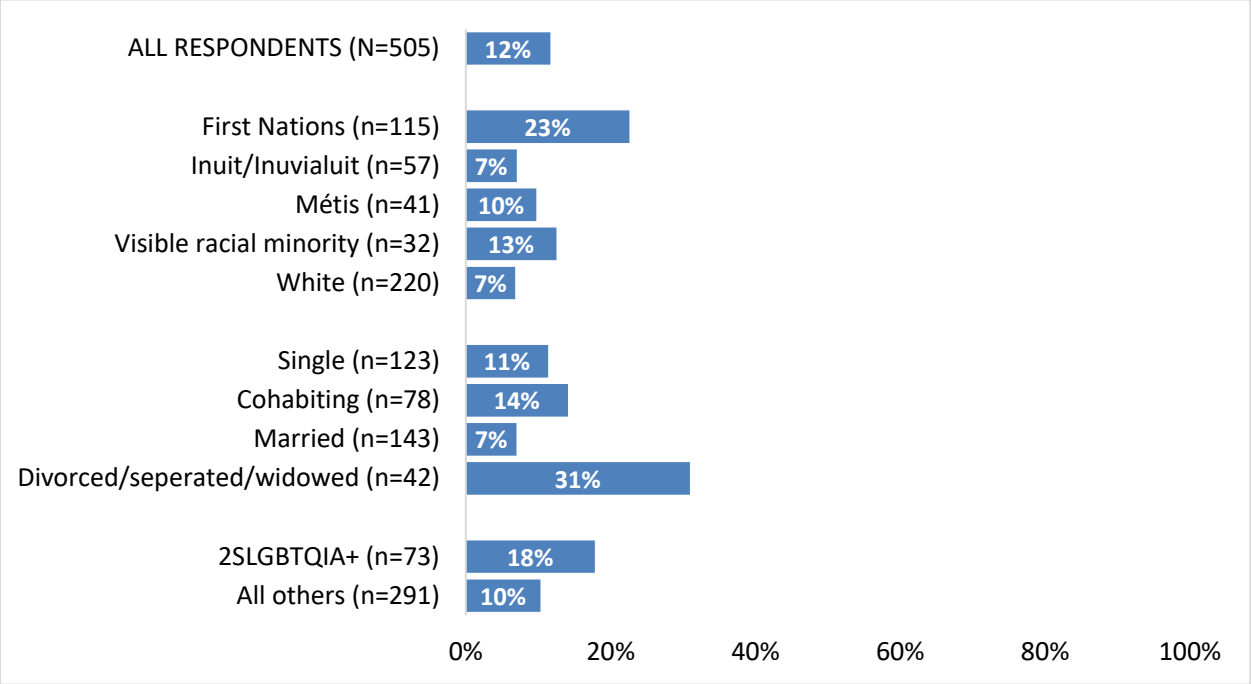


Figure 56. Had difficulty accessing Mental Health Helplines by community type, education and financial stability

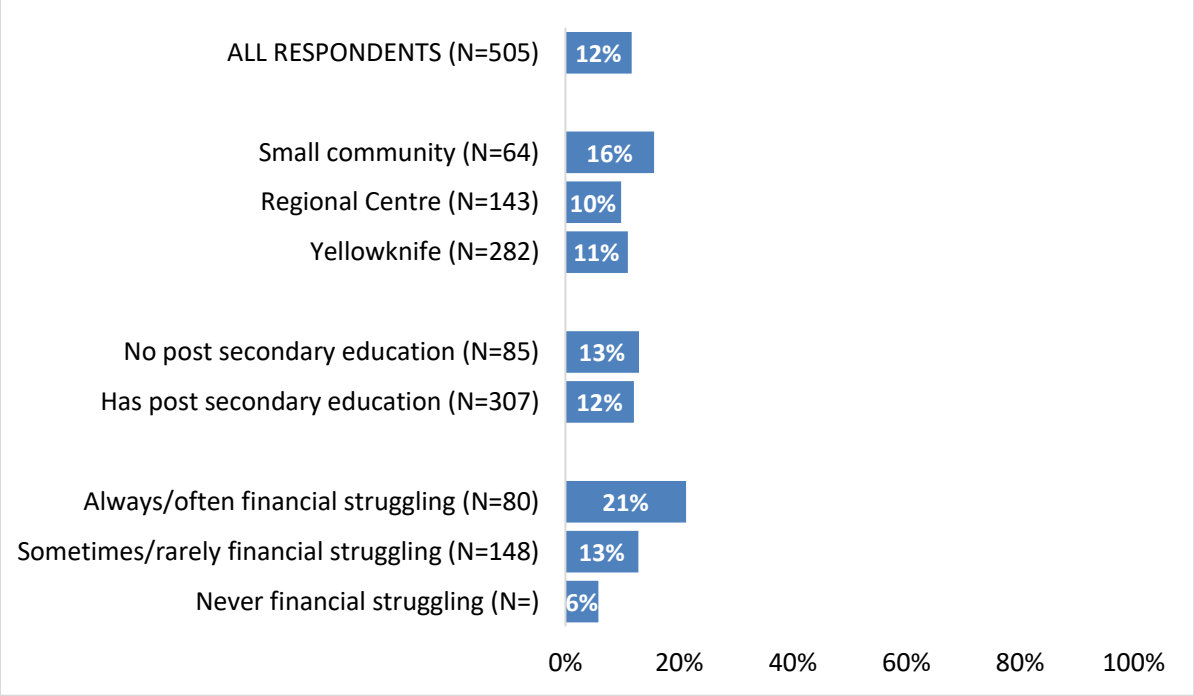
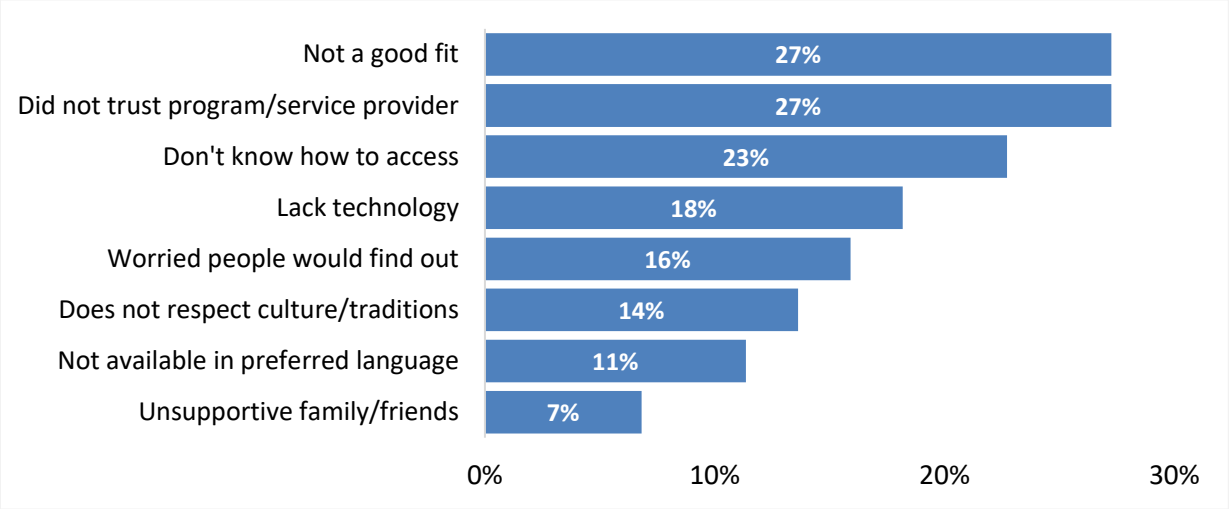


Figure 57. Barriers to accessing Mental Health Helplines (n=44).
(could choose more than one answer from a set list).

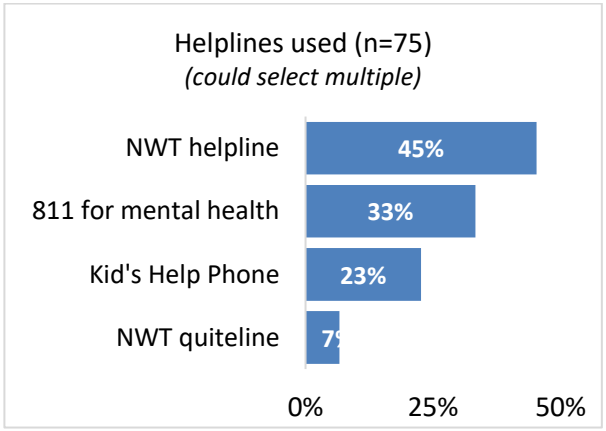


Satisfaction and Outcomes

Highlight

- With only 75 respondents who had used helplines, results could not reliably be broken down by type of helpline used or demographic group.
- 71% of respondents were satisfied with their experience using helplines and 69% were satisfied with how it helped address their concern.

Figure 58. Mental Health Helplines that respondents used and basic demographics



Basic demographics of respondents (n=75)

69% Women

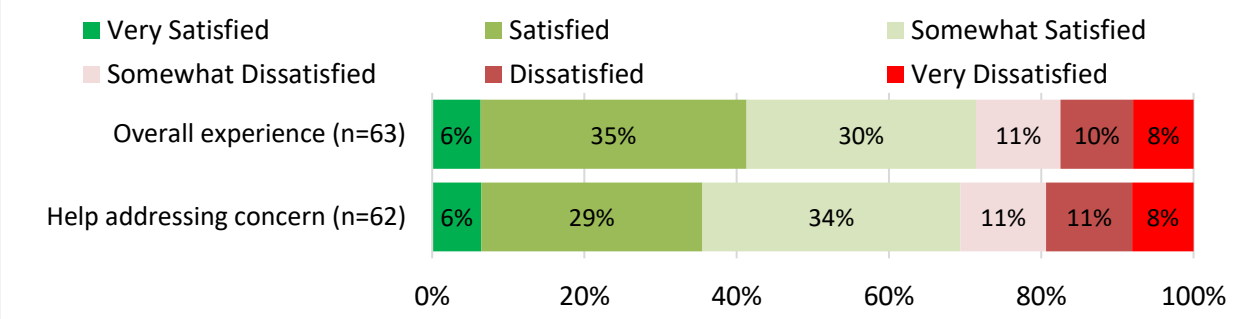
43% Over 40 years old

45% Indigenous

31% 2SLGBTQIA+

25% Always/often stuggle financially

Figure 59. Satisfaction with Helplines



Section 7: E-Mental Health Supports

Awareness

Highlight – 40% of respondents were aware of E-Mental Health supports. Awareness was lower among men, those over 60, First Nations and Inuit/Inuvialuit respondents, people without post-secondary education, and those facing financial challenges.

Figure 60. Awareness of E-Mental Health supports by gender and age

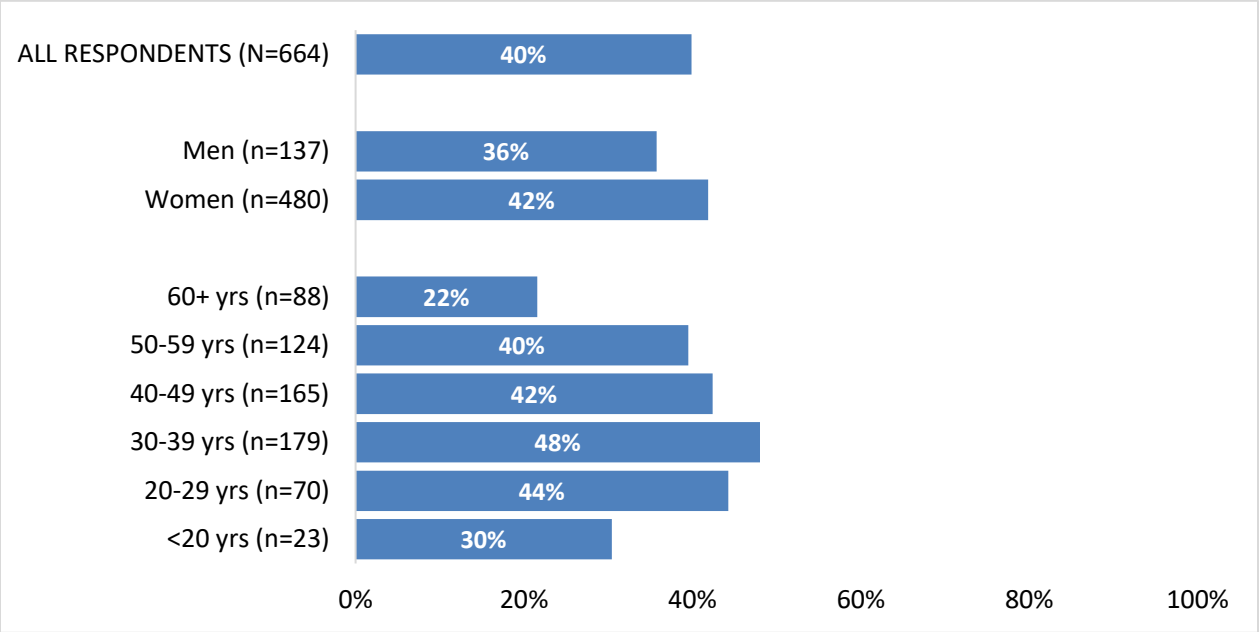


Figure 61. Awareness of E-Mental Health supports by race, relationship status, 2SLGBTQIA+ identity

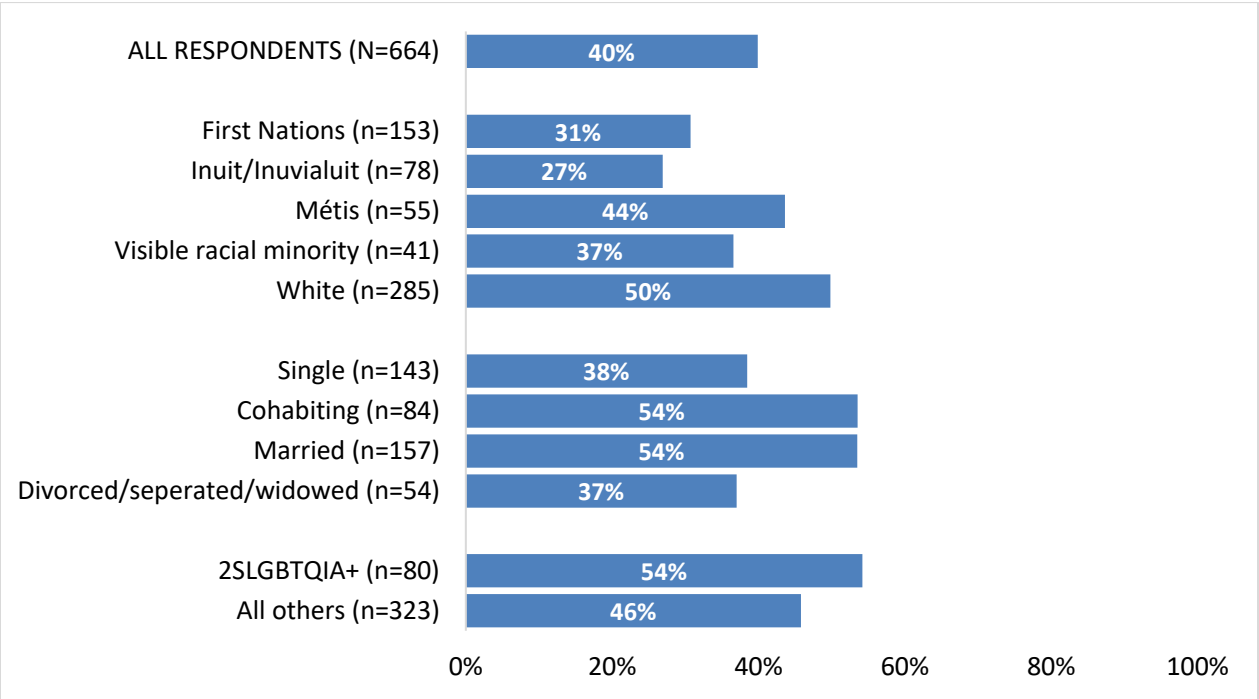
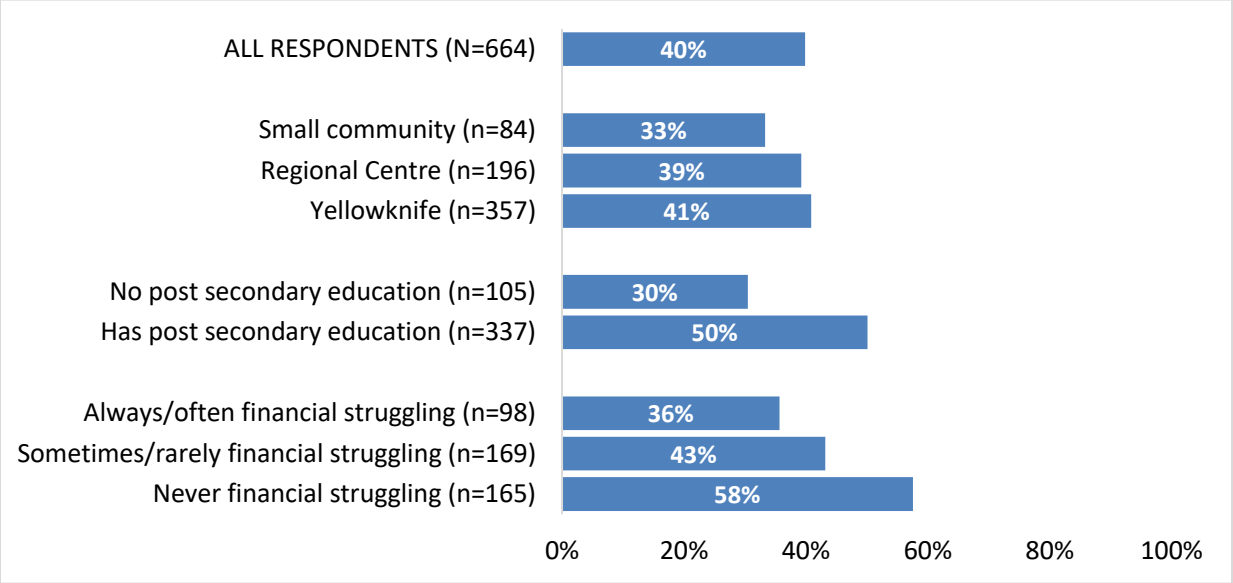


Figure 62. Awareness of the E-Mental Health supports by community type, education, and financial stability



Accessibility

Highlights

- About a quarter of respondents (25%) had difficulty accessing E-Mental Health supports. This was more common among those facing the most financial challenges (44%), First Nations respondents (34%), 2SLGBTQIA+ respondents (34%), and people in small communities (32%).
- The top barriers reported for E-Mental Health supports were poor fit (41%), not knowing how to access supports (30%), and being too busy with daily life (26%).

Figure 63. Had difficulty accessing E-Mental Health supports by gender and age

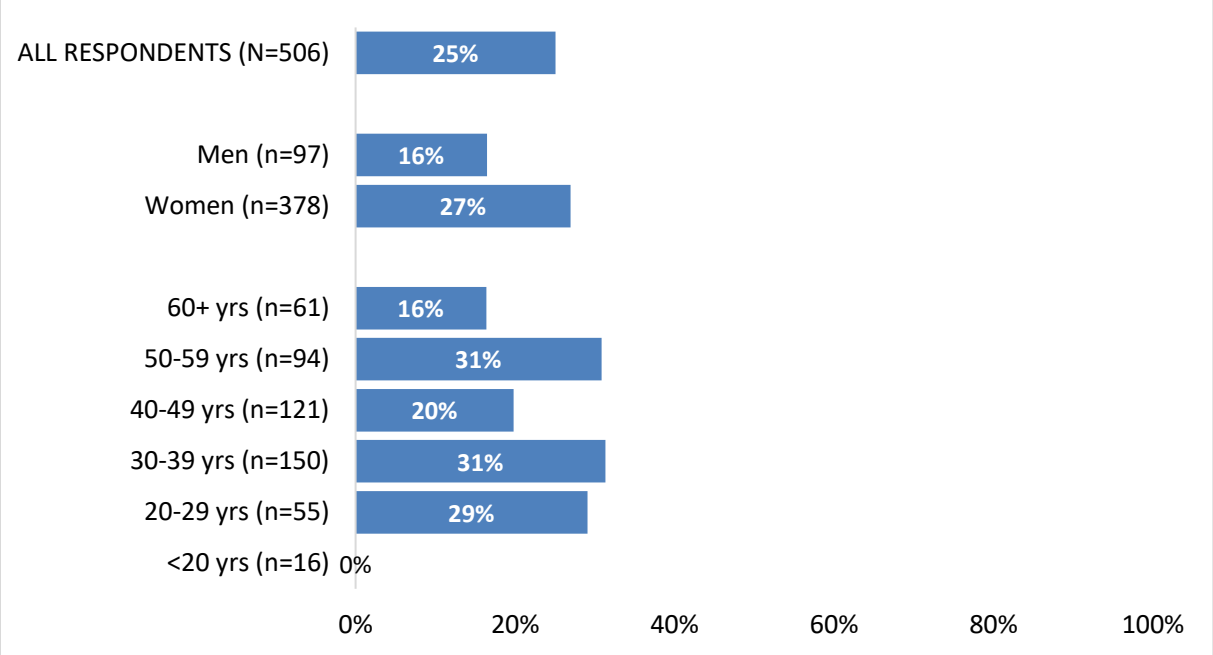


Figure 64. Had difficulty accessing E-Mental Health supports by race, relationship status, and 2SLGBTQIA+

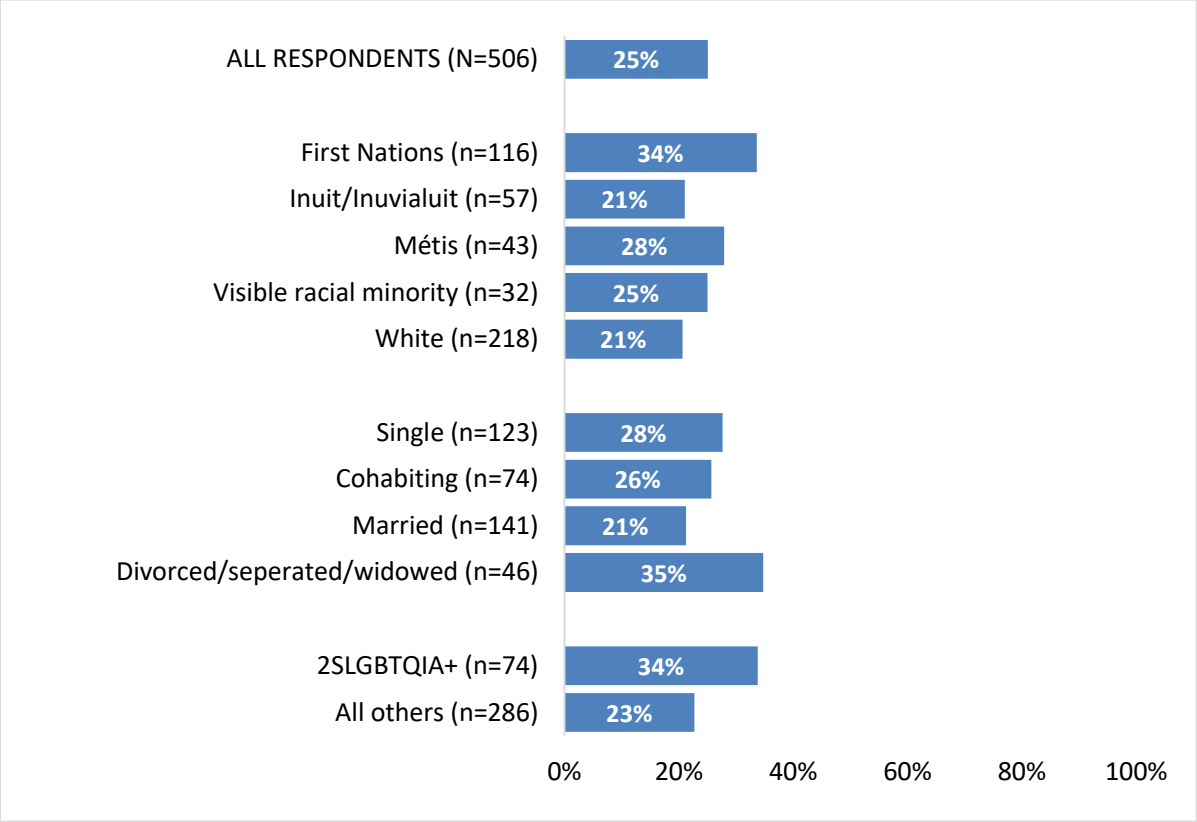


Figure 65. Had difficulty accessing E-Mental Health supports by community type, education, and financial stability

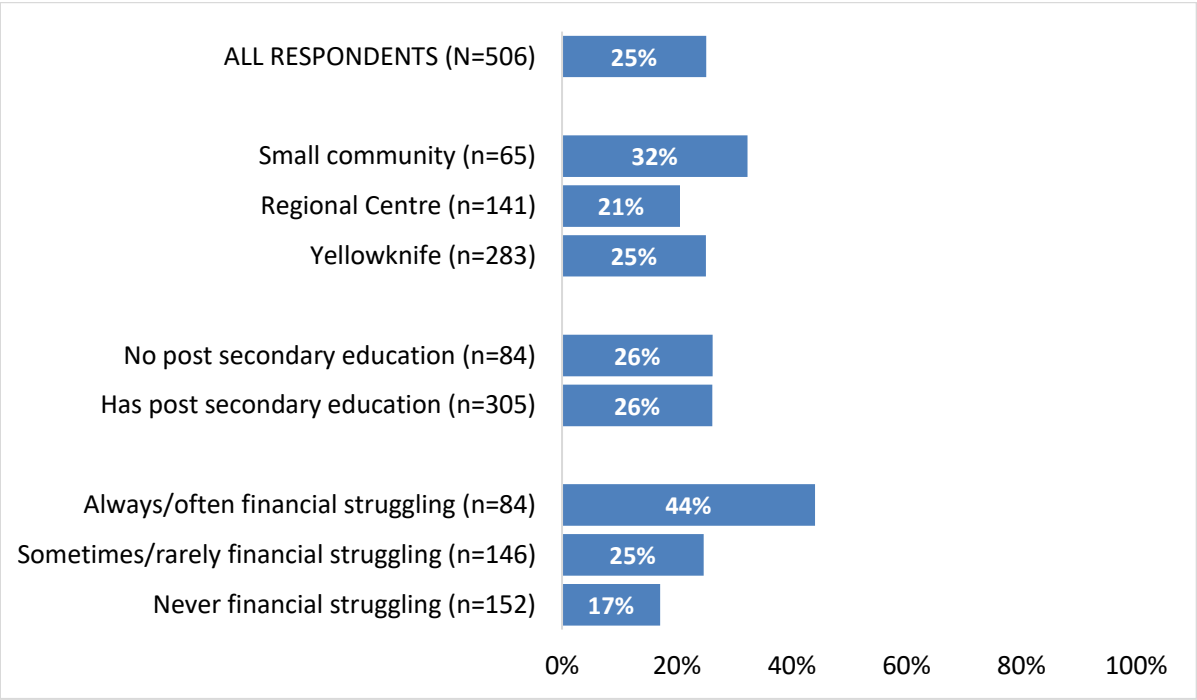
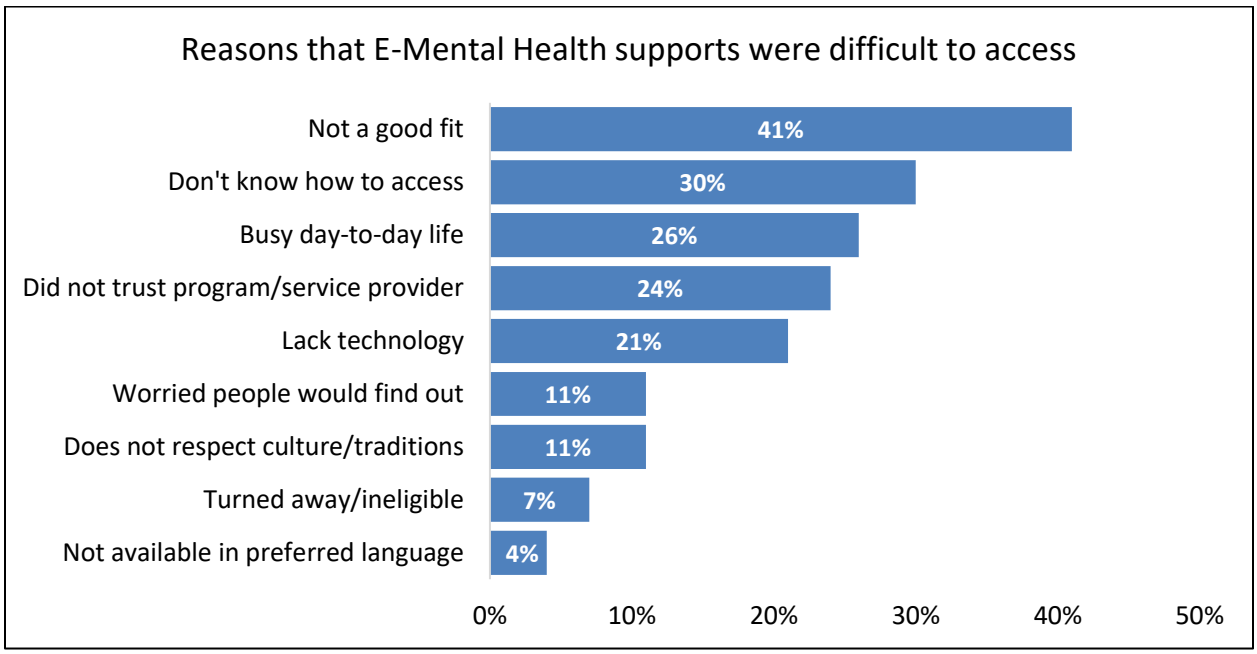


Figure 66. Barriers to E-Mental Health supports (N=100).
(could choose more than one answer from a set list).

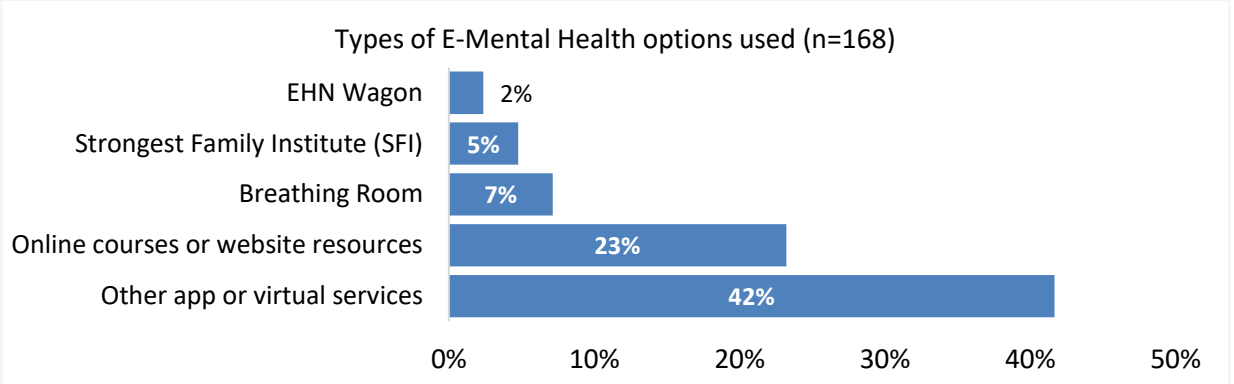


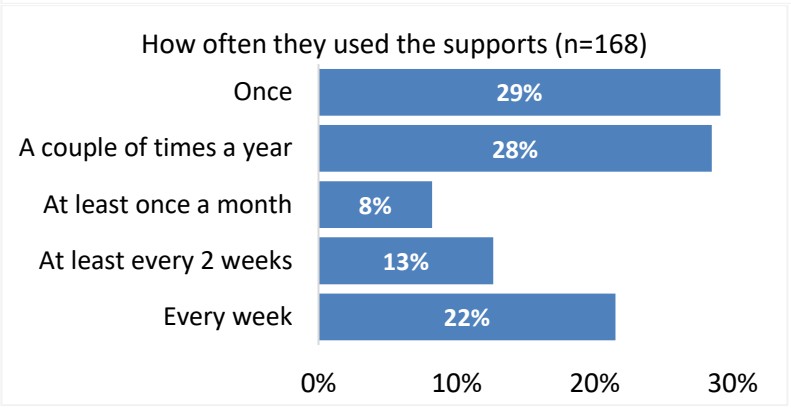
Satisfaction and Outcomes

Highlights

- Only 24 respondents (14%) had used DHSS-funded E-Mental Health options, so findings reflect overall experiences with E-Mental Health rather than specific programs. The wide range of available options also limits how broadly these results can be applied.
- A lot of respondents reported using supports infrequently; once (29%) or a couple of times a year (28%).
- 84% of respondents felt the support was free from discrimination, 75% felt they were able to make decisions about their care, and 75% felt cared for by the support provider.
- 71% of Indigenous respondents felt the support they used respected Indigenous Peoples, their culture and traditions.
- 75% of respondents were satisfied with how easy the support was to use and 66% were satisfied with the overall experience.
- The top reasons for being dissatisfied were difficulty navigating the support (20%) and the support not addressing their concern (15%).
- 71% of respondents were satisfied with their experience using E-Mental Health supports and 69% were satisfied with how it helped address their concern.
- 66% of respondents felt the E-Mental Health support they used helped them build skills to address their concern, and 72% said it improved their overall health and wellbeing.

Figure 67. Types and frequency of E-Mental health supports used and basic demographics





Basic demographics of respondents (n=168)

79% Women

57% Over 40 years old

36% Indigenous

21% 2SLGBTQIA+

18% Always/often stuggle financially

Figure 68. How people felt about their experience with E-Mental Health supports

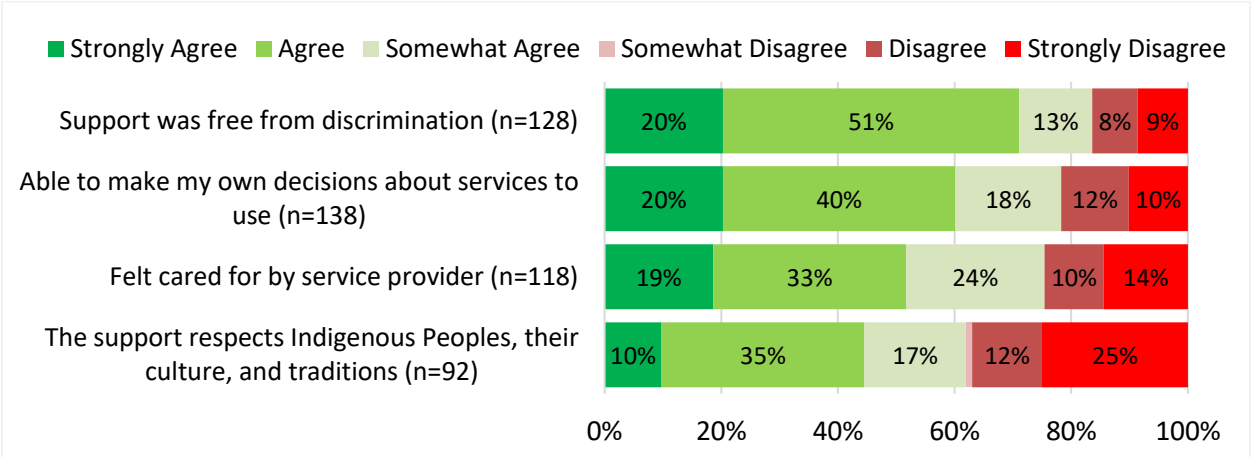


Figure 69. Indigenous Cultural Safety of E-Mental Health supports

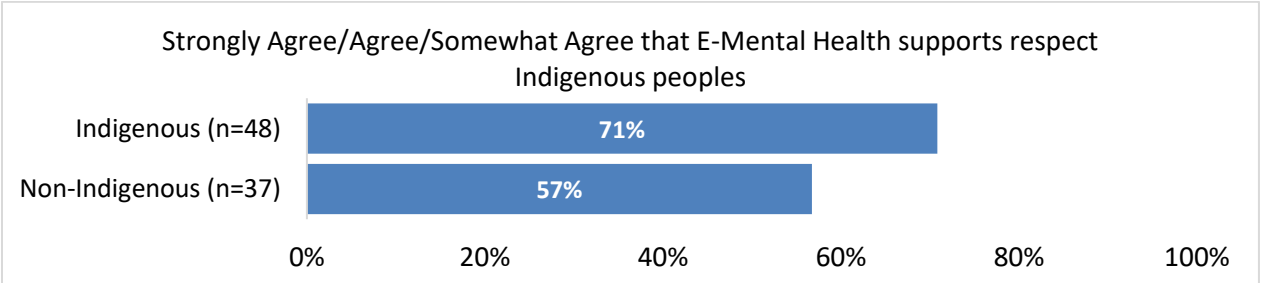


Figure 70. Satisfaction with E-Mental Health supports (n=158)

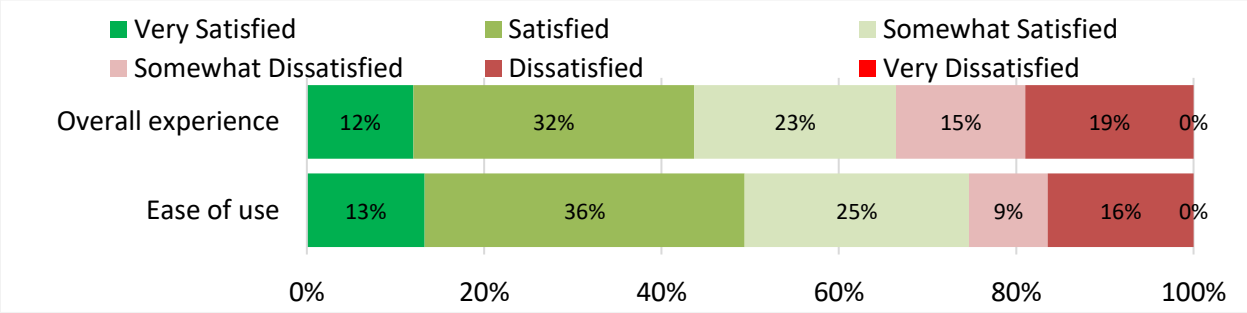


Figure 71. Reasons for dissatisfaction with E-Mental Health supports (n=168)
(could choose more than one answer from a set list).

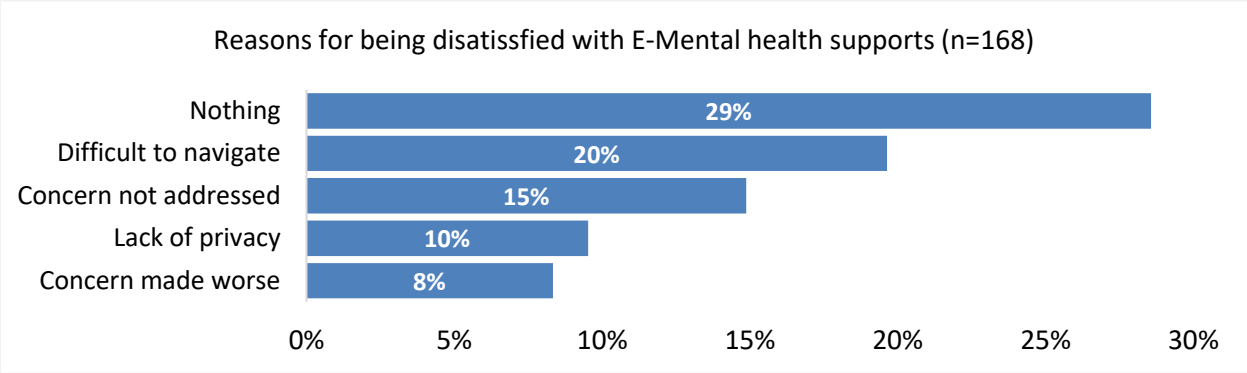
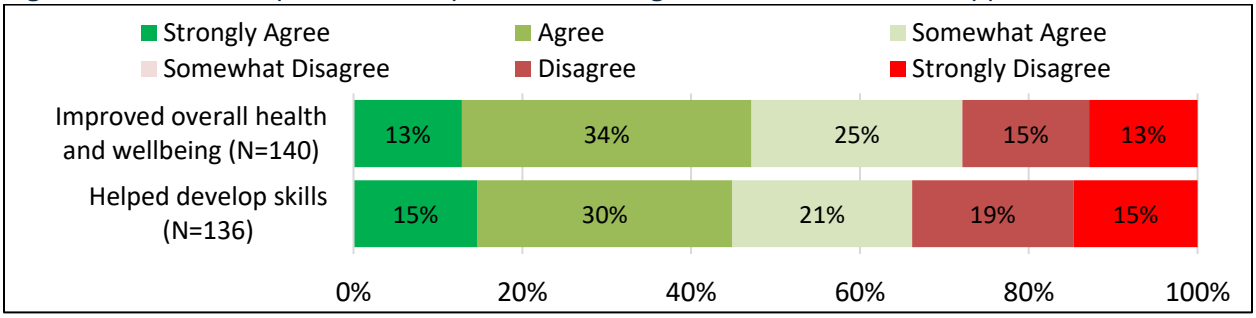


Figure 72. Skill development and improved wellbeing with E-Mental Health supports



Satisfaction with DHSS-funded E-Mental Health supports

The third-party service providers who run the E-Mental Health supports funded by DHSS have independent processes to monitor service user satisfaction. These are their findings for NWT service users from the 2023/24 fiscal year:

- **Strongest Families Institute** (SFI) is provided to individuals and families experiencing mild to moderate mental wellness and behavioural concerns. In SFI satisfaction surveys, respondents reported **100% satisfaction** (out of 13 respondents) with **85%** (out of 34 respondents) **experiencing a reduction in their symptoms** and **82%** (out of 33 respondents) **reported overall improvements** after using SFI.

- **Breathing Room** is provided to people who want to learn how to manage stress, symptoms of depression and anxiety, and/or strengthen their existing coping strategies. In a Breathing Room satisfaction survey with 116 respondents since 2021, **74% found it helpful**.
- **EHN Wagon** is provided to people who have experienced addiction and substance use disorders who are working towards recovery. Due to low response rates, we cannot report satisfaction with EHN for the 2023/24 fiscal year.

Section 8: Accessibility of other supports

Highlights

- Questions about all other supports were asked at the end of the survey and so had a lower response rate (42%-58%) as respondents dropped out. Due to the smaller sample size, Indigenous respondents were combined into a single group.
- **Aftercare:** About a quarter of respondents (26%) had difficulty accessing Aftercare supports which are provided for people working towards recovery after attending addictions treatment.
    - Difficulty accessing aftercare was more common among those who reported frequently struggling financially (60%), people living in small communities (43%), Indigenous Peoples (39%), 2SLGBTQIA+ individuals (37%), and people under 40 (33%).
- **Healthcare services**: Almost half of respondents (46%) reported difficulty accessing healthcare services like emergency rooms, health centres, and hospitals for mental wellness and substance use related issues.
    - Difficulty accessing health care services more commonly reported among people struggling financially (70%), 2SLGBTQIA+ individuals (63%), and people under 40 (55%).
- **Peer support groups**: A little under a third (29%) of respondents reported difficulty accessing Peer support groups for people going through similar mental health or substance use concerns as them.
    - Difficulty accessing peer support was more commonly reported among people struggling financially (52%), 2SLGBTQIA+ individuals (46%), people living in small communities (42%), Indigenous Peoples (37%), and people under 40 (36%).
- **Community-based supports**: Over a third of respondents (36%) reported difficulty accessing community-based supports to support their mental health or substance use concerns.
    - Difficulty accessing community-based supports was more commonly reported among those struggling financially (64%), Indigenous Peoples (48%), and 2SLGBTQIA+ individuals (48%).
- **Withdrawal management:** 8% of respondents reported difficulty accessing medical withdrawal services, like drug-replacement therapy, that are provided to ensure that people can withdraw from substance use safely.
    - Difficulty accessing withdrawal management was more commonly reported among those struggling financially (23%), people living in small communities (18%), and Indigenous Peoples (15%).

Figure 73. Summary – Had difficulty accessing other mental health and addictions supports

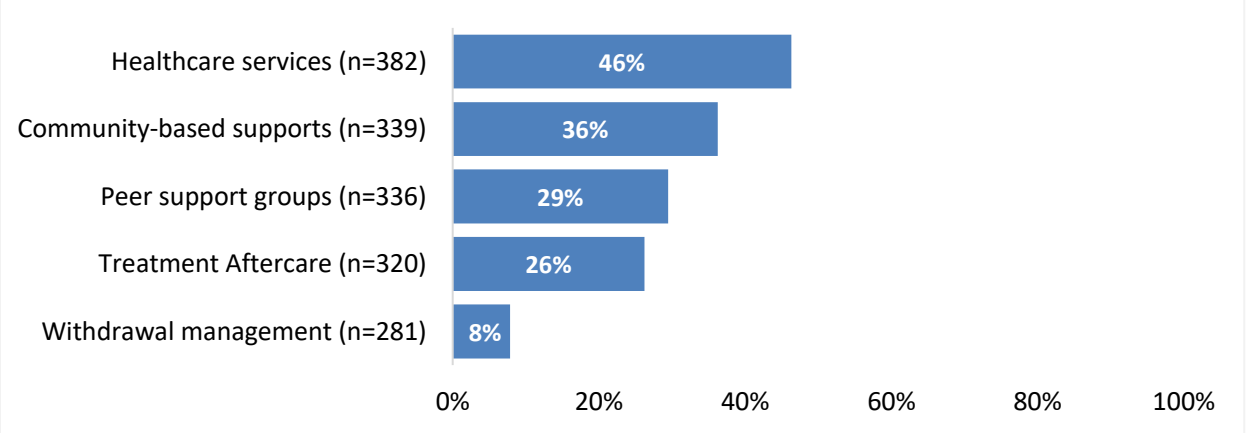


Figure 74. Had difficulty accessing addictions treatment aftercare by gender, age, Indigenous Identity, 2SLGBTQIA identity, community type, and financial stability

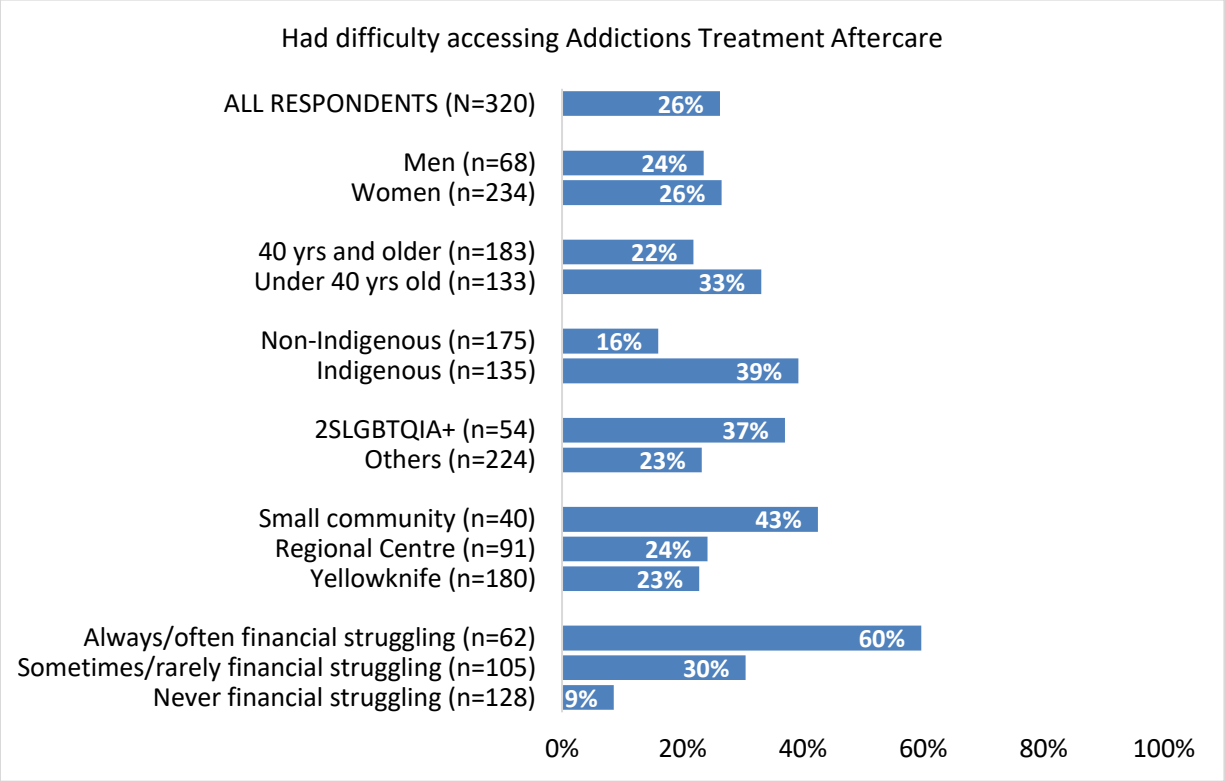


Figure 75. Had difficulty accessing healthcare services for mental wellness or substance use related issues by gender, age, Indigenous Identity, 2SLGBTQIA identity, community type, and financial stability

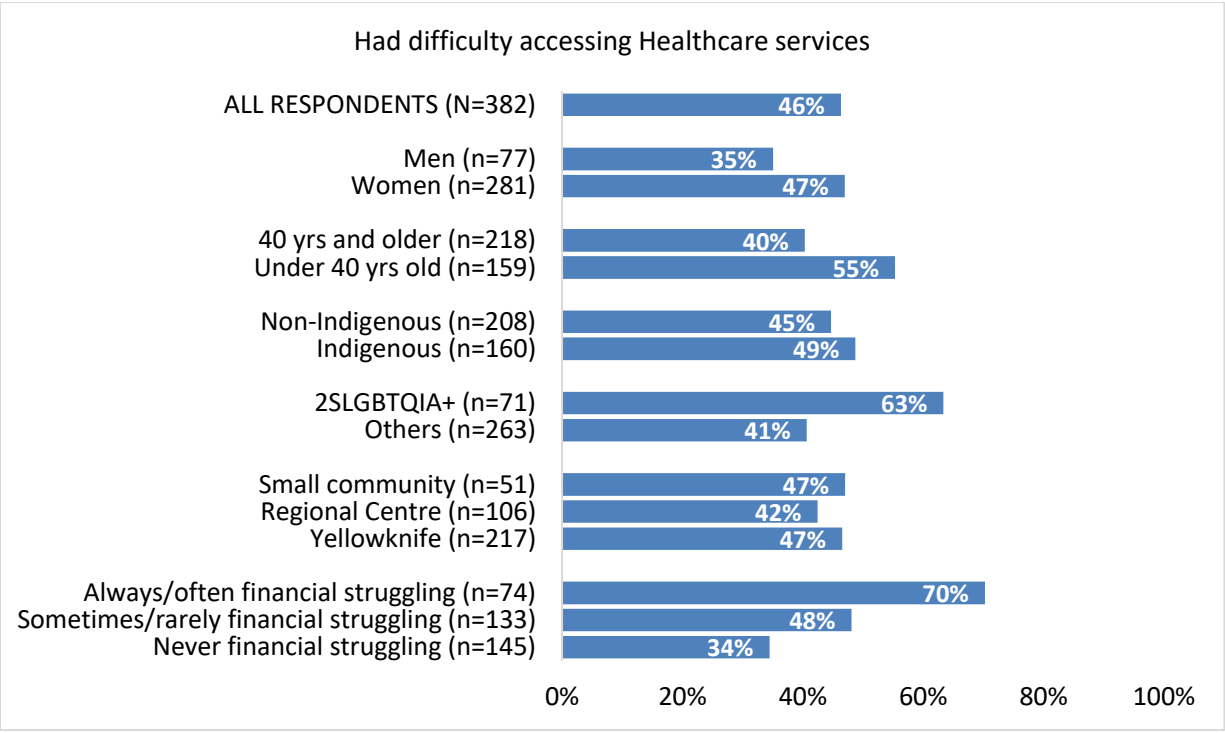


Figure 76. Difficulty accessing Peer support groups for people going through similar experiences by demographic characteristics

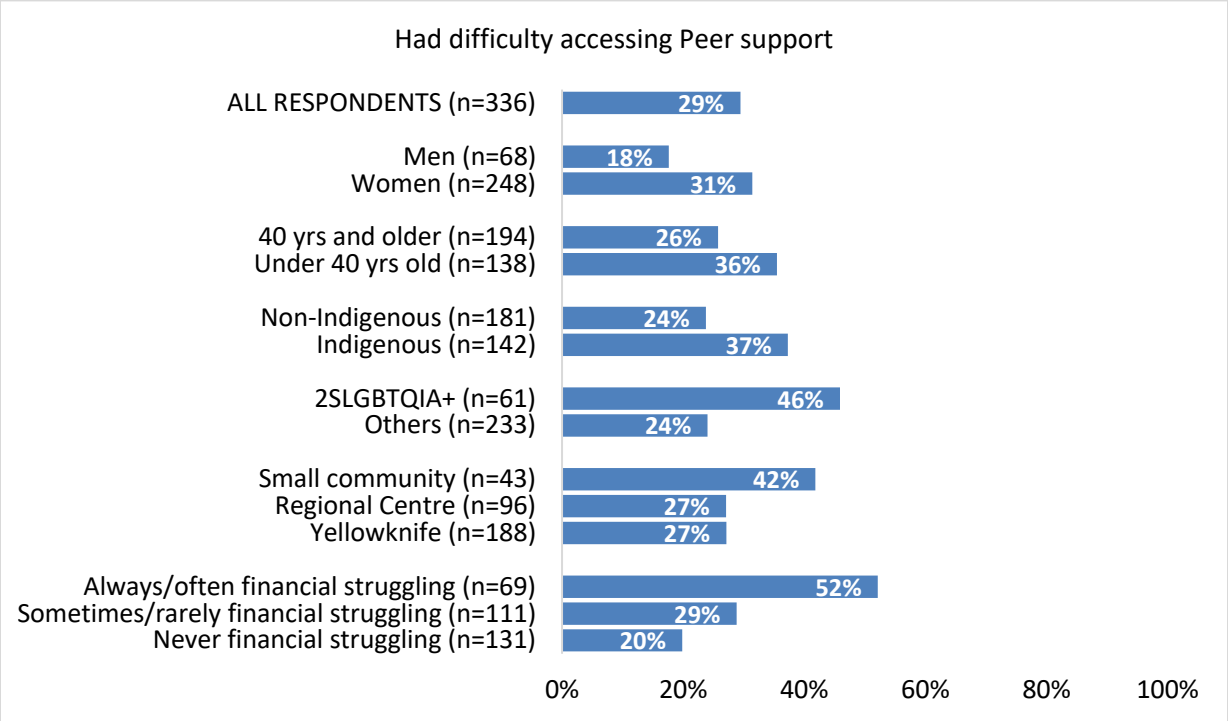


Figure 77. Difficulty accessing Community Based supports by gender, age, Indigenous Identity, 2SLGBTQIA identity, community type, and financial stability

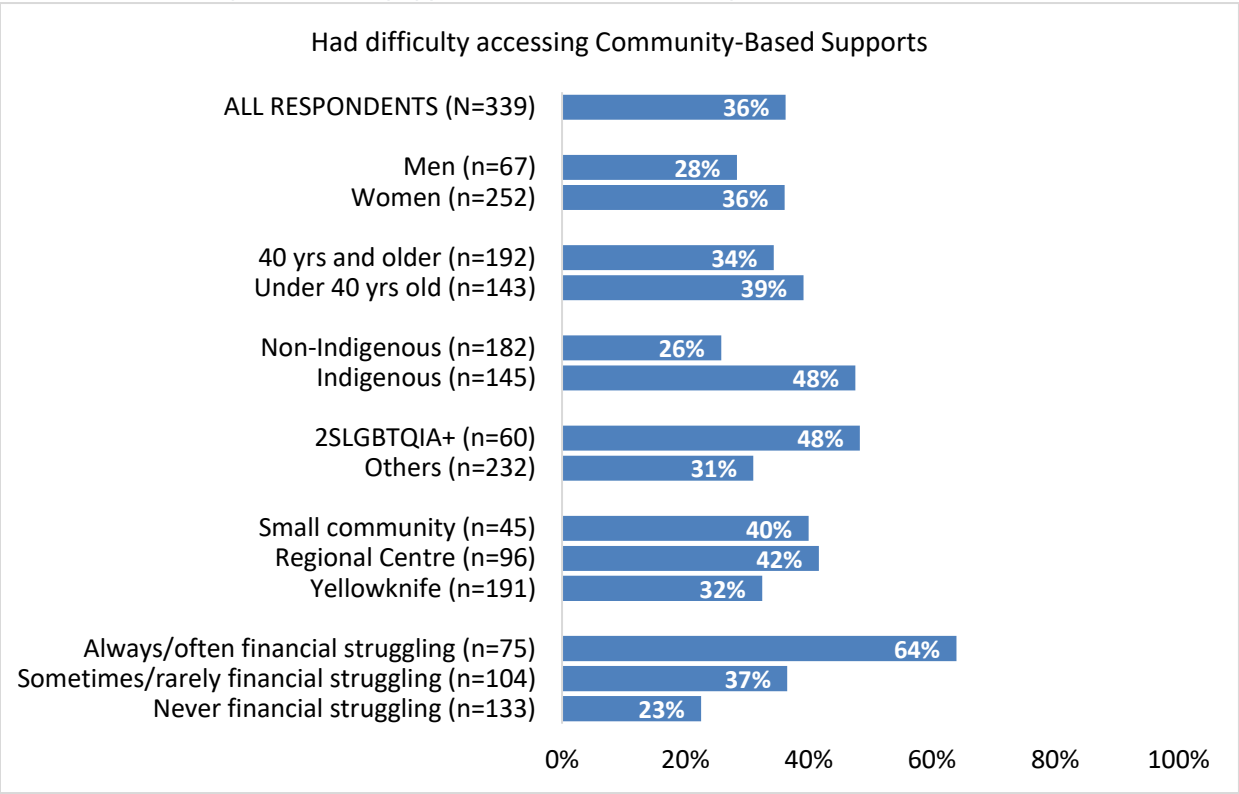
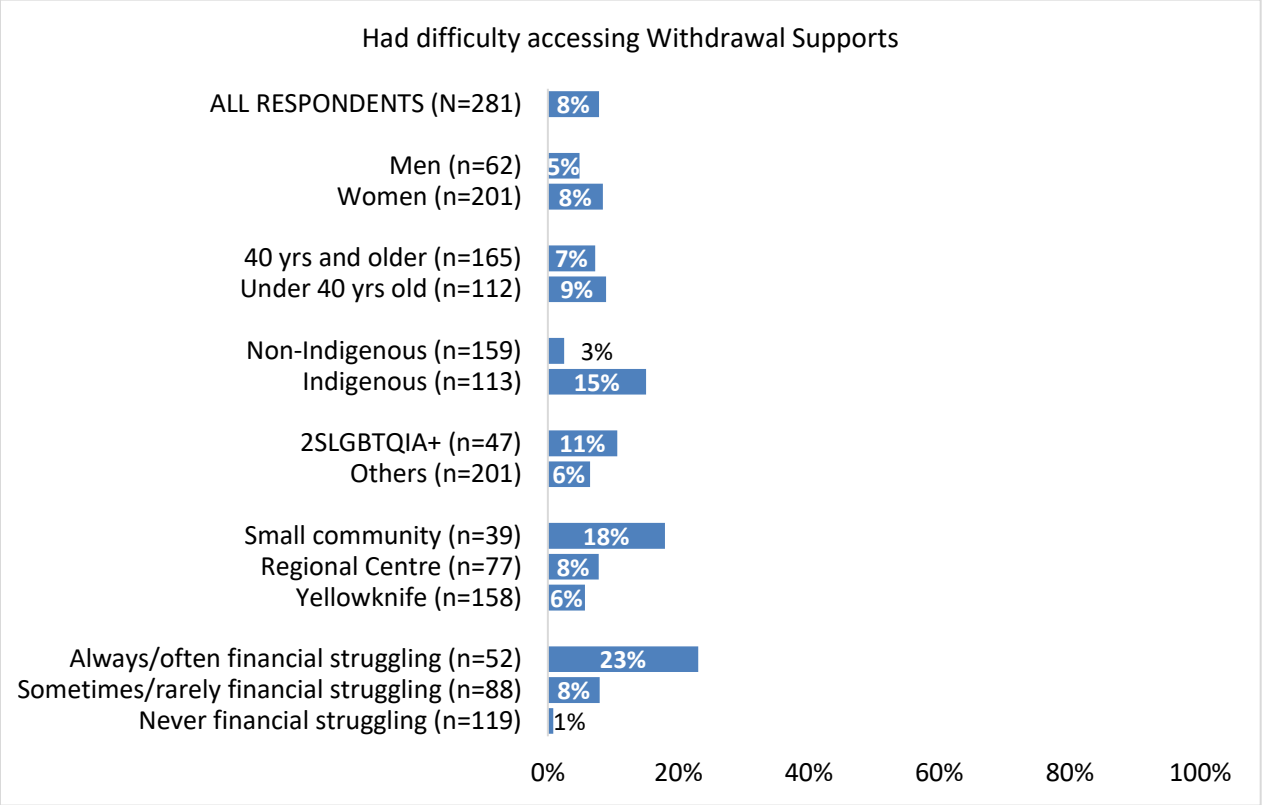


Figure 78. Difficulty accessing Withdrawal supports by gender, age, Indigenous Identity, 2SLGBTQIA identity, community type, and financial stability



Conclusion

Awareness and accessibility

Mental health and substance use / addictions recovery support awareness (i.e., the respondent knew about the service before the survey) varied widely across programs and population groups. The CCP was the most well-known with 61% (N=664) of respondents reporting that they had known about the program before the survey. However, CCP offices were one location targeted for promotion, so CCP service users are overrepresented in the survey compared to the general NWT population. Awareness of the CCP was lower among men and older adults. Awareness of other supports like FBAT (35%, N=664), Mental Health Helplines (53%, N=664) and E-Mental Health supports (40%, N=664) were lower overall, especially among men, those who experienced frequent financial difficulty or had lower education, Indigenous respondents, and racial minorities.

The CCP also had the highest reported barriers to access, with 46% (n=524) of respondents reporting difficulty accessing CCP (i.e., they would have liked to access the service but had a hard time accessing it or were not able to access it all). A higher proportion of people who identified as 2SLGBTQIA+ had difficulties accessing the CCP (63%, n=72), as well people who most frequently faced challenges meeting their basic financial needs (59%, n=93). FBAT and E-Mental Health supports had similar access issues, particularly for those in small communities, 2SLGBTQIA+ individuals, and lower-income respondents. Helplines were somewhat more accessible but still presented challenges for some groups.

Satisfaction and outcomes

Most respondents had positive experiences, particularly in feeling cared for and respected by their service provider. Respondents gave the CCP an overall 83% (n=213) satisfaction rate, with high ratings (79-83%) for the type of session they were offered (virtual vs. in-person), appointment location, and hours of operation. However, booking and wait times were common areas of dissatisfaction for respondents while staffing constraints and turnover impacted service availability and service user choice for how and when they received services. While 64% (n=224) of respondents felt the CCP helped them build skills to address their concern, and 70% (n=224) said it improved their overall well-being, these outcomes were less commonly reported among 2SLGBTQIA+ respondents, First Nations respondents, people under 40, and those facing financial hardship.

Among those who accessed FBAT, 90% (n=39) of respondents said it helped them develop skills, and 92% (n=39) reported improved health and well-being. Satisfaction with living conditions (82%, n=39) and overall experience was high (82%, n=39) among respondents, though only half (51%, n=39) were satisfied with aftercare information, and many (39%, n=46) were dissatisfied with having to leave their home community for treatment.

Use of Helplines and E-Mental Health supports was more limited, but most respondents reported positive outcomes. Around two-thirds of respondents felt these supports helped them build skills

and improve their well-being. Satisfaction was also tied to feeling respected, involved in decision-making, and supported.

Implications

Across all areas of awareness, accessibility, satisfaction, and outcomes, respondents from certain equity-deserving groups consistently reported facing greater barriers and fewer positive experiences. These included men, First Nations and other Indigenous respondents, 2SLGBTQIA+ individuals, people with lower income or education, younger people, and those living in small communities. These findings point to a clear need for more inclusive, culturally safe, and targeted approaches to mental wellness and substance use health / addictions recovery supports. Prioritizing the needs and voices of these groups in program design, outreach, and service delivery will be essential to improving equity and ensuring that supports are accessible and effective for all.