

Mental Health and Addictions in Northern Ontario

Analysis of Policy Outcomes in the North West LHIN and North East LHIN using Socio-
Economic Determinants of Health

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1.0 INTRODUCTION

Local Health Integration Networks are an innovative, yet integral part of the modern evolution of the Ontario health care system. It has been five years since the passing of the Local Health System Integration Act, 2006 when the Ministry of Health and Long-Term Care (MOHLTC) divided the province of Ontario into 14 Local Health Integration Networks (LHINs). Each individual LHIN is responsible for funding, managing and integrating the health care services within their local region. Although LHINs are still relatively new, in this short time they have learned from the results of their previous actions and have used this knowledge to create a new set of goals. LHINs are now in their fourth year, operating under their second series of priorities. Over the last five years, knowledge has been gathered and obtained through community outreach to determine regional needs and the best means of achieving them as determined through the outcome of committees and meetings. In 2006, all Local Health Integration Networks in Ontario were responsible for designing Individual Health Services Plans (IHSPs) which would outline their health improvement goals for the next three years and outline the steps needed to achieve them. Each IHSP sets out the individual LHIN's three year plan which includes their goals and priorities for the upcoming years and the formula they will follow in hopes of achieving them. IHSP's contain both regional and local strategies for satisfying the purpose of the Local Health System Integration Act. These first IHSP's would outline the foundation of each LHIN's work from 2007-2010.

This paper will examine the differences in the ways in which mental health and addictions were addressed by the North West (NW) and North East (NE) LHINs in their 2007-

2010 IHSPs. The differences in their actions and results of decisions made in the NW and NE LHINs in respect to mental health and addictions are significant due to the similarities in these regions' geography, rural populations and economy. They both also have large populations of minorities. The NW LHIN has the largest population of Aboriginals in the province (Population Projections LHIN Summary Table, 2009), while the NE LHIN has the largest population with French language as their mother tongue (23.1% versus the Ontario average of 4.1%) (Ontario, NE LHIN Demographic and Health Profile: Summary Overview). Given these similarities it would not be unreasonable to assume that these two LHINs would also have similar health characteristics and therefore use similar means of addressing them. However, this is not the case. It is interesting to note the divergent methods these two LHINs chose to take in dealing with mental health and addictions in their 2007-2010 IHSPs.

In their 2007-2010 IHSP, the NE LHIN chose not to focus on specific health issues as the rest of the LHINs in the province had done. They chose instead to focus on system wide issues. The NW LHIN on the other hand designed an IHSP that focused on specific and individual health needs. They chose to take a similar action as the rest of the province and included mental health and addictions as specific priorities in their initial IHSP. Not surprisingly, the status of mental health and addictions rates and treatment methods now show different results. This paper will examine the differences and possible reasons for the unique outcomes, particularly in rural and remote areas, that emerged as a result of these decisions in respect to mental health and addictions.

The focus is on the challenges associated with treatment delivery and prevention of mental health and addictions in rural and remote Northern Ontario. Obvious disparities in the level of health of rural residents have gained increased attention in recent years. The overall

health status of these populations in Canada is statistically lower than the general urban population. Rural areas have a “disproportionately high proportion of long-term disabled people compared to the urban population” (CMA, 1992), higher rates of chronic disease, and a large number of work related injuries. It has become a challenge to promote the health and well-being of rural and remote populations in Ontario. Due in part to the high costs associated with maintaining small hospitals in the face of declining populations, many rural and remote populations in the province have been faced with the loss of health services centres and local physicians. Policy makers are challenged with developing new methods of maintaining the health of these small populations. Recent years have witnessed an upswing in support for new approaches to mental health and addictions in Ontario, at both the local and provincial levels. People, organizations and government agencies are all working together to find new methods of improving mental health within rural Ontario.

North Western Ontario and North Eastern Ontario have witnessed divergent patterns of mental health and addictions occurrences and treatment methods since 2006. This paper asserts that although the NW and NE LHINs have a similar geography and population spread, the reasoning behind both the differences in their 2007-2010 IHSP priorities and their current status of mental health and addictions issues is attributable to the social and economic characteristics of the populations and the impact of earlier mental health policy in North Eastern Ontario. This paper will review changes in Ontario’s approach to mental health and addictions services over the last decade and analyze how these changes have impacted the decisions made in rural Northern Ontario. To analyze these differences effectively a thorough understanding of the socio-economic determinants responsible for the health status of these regions is necessary. An assumption can be made that the reason behind the different treatment of mental health and

addictions in 2007-2010 is the result of socio-economic determinants. Variations in rates of illness and program use between the NW LHIN and the NE LHIN are not the result of the IHSPs themselves, but rather population characteristics, health determinants, attitudes and existing programs.

1.1 Methods

This paper will focus on the existence and treatment of mental health and addictions issues in the NW and NE LHINs. Although these two LHINs have a similar geography and population, they each demonstrate unique methods of dealing with mental health and addictions issues within their rural populations. Each LHIN has taken different approaches in their dealing with the different levels of mental health and addictions issues within their region.

For the purposes of this paper the terms North East and North West will refer to the area covered by their respective LHINs. North Eastern Ontario and NE LHIN will be used interchangeably. The same will be done with the terms North Western Ontario and NW LHIN. These terms will be understood to mean the same geographical location, population and economy respectively.

The terms mental health and mental illness will be used broadly and refer to all forms of mental health conditions and behavioural disorders. Mental health and mental illness will refer to individuals who have contacted health services with psychological conditions, mood disorders as well as age related disorders such as Alzheimer's disease and dementia.

Addictions will be used in reference to both substance addictions and process addictions. The term substance addiction is used to describe an addiction to the use of a substance such as a drug or alcohol while as the term process addiction or behavioural addiction, refers to an addiction to mood changing behaviours (McMurran, 1994). These include gambling, eating, spending and sexual activity. There will be a focus on the impacts of alcohol and substance addictions as well as problem gambling, and the steps taken by the LHINs in response to these issues.

This paper will employ socio-economic determinants of health to analyze the status of mental health and addictions in Northern Ontario and achieve a better understanding of the steps taken to deal with these issues in the two LHINs. It will then use this information to perform a comparative analysis of the 2007-2010 IHSP's of both the NE and NW LHINs and review suspected reasoning behind the current status of mental health and addictions in these two regions.

2.0 GEOGRAPHY OF NORTHERN ONTARIO

The North West and North East LHINs have the largest land masses of all LHINs in Ontario. Combined they represent over 90 percent of the province's total land area. The NW LHIN covers 458,010 km² (Ontario: North West LHIN, 2010) and the NE LHIN covers 400,000 km² (Ontario, NE LHIN Demographic and Health Profile: Summary Overview). However, despite their large geographic size, the two LHINs represented only 6 percent of the population of Ontario at the time they were created in 2006 (Statistics Canada, 2010). These two LHINs are sparsely populated with population densities in the NW LHIN of 0.5 persons/km² and in the NE

LHIN of 1.4 person/km². The NW LHIN has the largest rural and remote population with only 45.6 percent of the population living in the sole major urban area of Thunder Bay (Ontario: North West LHIN, 2010). The remainder the population of North Western Ontario is found in small scattered communities across the region. The general population of Northern Ontario is spread out leaving vast distances between urban areas. Settlement patterns in Northern Ontario create challenges for both the distribution of and access to healthcare services.

Rural Canada is home to unique challenges. Approximately fifteen percent of the national population lives in areas outside of urban centres (Statistics Canada, 2002). Only two percent of psychiatrists work outside of urban areas (Canadian Psychological Association (CPA), 1999). An unequal distribution of physicians (Government of Canada- Depository Services Program, 2002) means that residents in rural areas of Canada are faced with longer wait times for physicians, provider isolation and often have to travel long distances for referrals (Commission on the Future of Health Care in Canada, 2002). This trend can be found within the province of Ontario where a diverse population and large geography is causing a strain on the provincial availability to supply universal access to physicians.

Research into the disparity between rural and urban health is ongoing, however there is no clear universal definition as to what a rural community consists of. This lack of agreement about how to define “rural” is problematic. Different definitions of rural include different populations. Rural populations are often distinguished based upon their size, their distance from urban populations, and the transportation flow between their community and the nearest urban centre. Just as the term urban can be understood to mean a variety of communities such as city, metropolis and suburbs, so too can the term rural be divided into distinct categories. Rural communities possess unique identities pertaining to their individual geographical and social

conditions. The term rural is generally understood to define small populations and isolated communities. This definition is very broad however, as it limits our understanding of the term rural to a geographical concept.

Rural can also be identified as a “social representation” whereby it refers to the beliefs and attitudes of a community’s residents. The term is used to describe the residents’ values and lifestyles (Clarke & Miller, 1990). Rural communities often share unique beliefs, cultures, feelings of isolation from larger urban centres and feelings of both political involvement and neglect (Halfacree, 1993).

The third and most commonly used definition involves a statistical classification. Statistics Canada defines rural as any small town, village or any other area containing a population of less than 1,000 people with a population density of less than 400 people per square kilometre (Statistics Canada), and where continuous built up areas exceed 1km (DuPlessis, Beshiri, Bollman, & Clemenson, 2002). Using this definition one would assume that 20.6 percent of the Canadian population, or 6 262 154 individuals were considered to be residents of rural and small town Canada in 2006 (Community Information Database, 2007).

The improvement of “rural” health requires a “rural” approach. It is imperative that consideration be given to the recognition of the differences between urban and rural health status. Allan Rock once said “Geography is no excuse for inequality” (Standing Committee on Health (HESA), 2009) . One must properly understand the health status and behaviours exhibited amongst the rural Canadian population before instituting any new policies or health programs in rural and remote Canada.

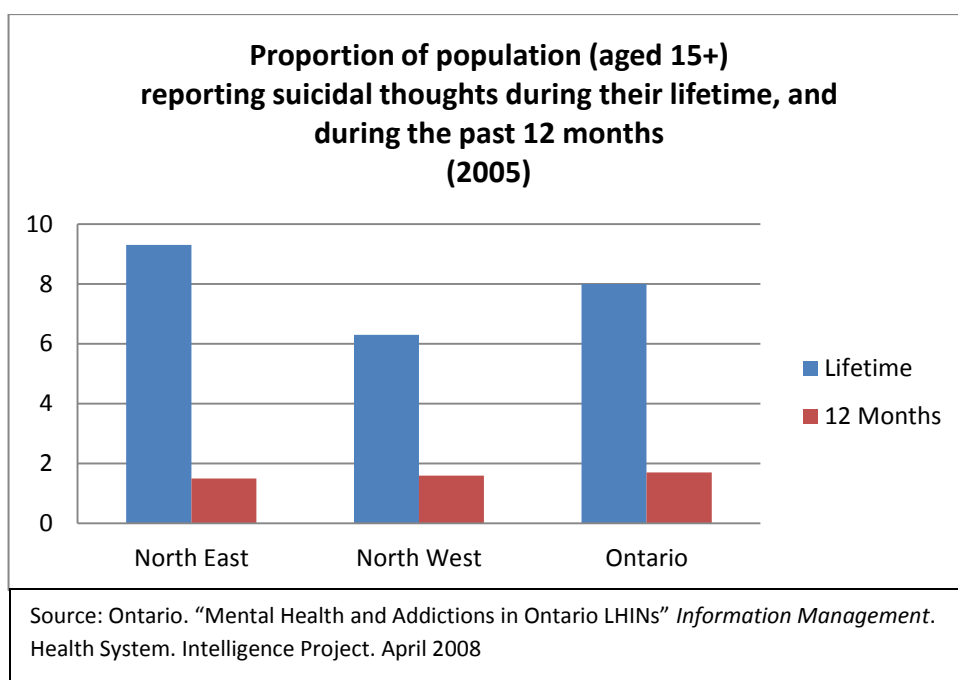
The paper will discuss the populations included in all three of these definitions. Regardless of whether areas in Northern Ontario are considered, rural, remote or isolated, they will all contain at least some similar characteristics.

3.0 MENTAL HEALTH AND ADDICTIONS STATISTICS

3.1 Mental Health Statistics

About twenty percent of all Canadians will experience some form of mental health issue over their lifetime. It is estimated that the other eighty percent of the population will know someone who is impacted by this issue (Health Canada, 2002). One in five children under the age of eighteen suffers from issues associated with a mental health disorder in Ontario. (Boydell, R, Voipe, Tileczek, Wilson, & Lemieux, 2004).

Figure 1.



Largely blamed on isolation, separation, and lack of confidence, suicide is a preventable but deadly reality for many rural and remote communities in Northern Ontario. Suicide is a community issue affecting the psychological status of a population. Figure 1 notes that there is a higher percentage of individuals in North Eastern Ontario reporting having thoughts of suicide in 2005. This statistic however, conflicts with the actual reality of suicide in Northern Ontario. In 2005, Statistics Canada reported that the rate of suicide in North Western Ontario was more than twice the provincial average, and significantly higher than the rate found in any other LHIN. In fact, the rate of suicide for males in this region is double the rate of the rest of the province, while the rate of suicide for females is four times the provincial average. The suicide rate for females is significant as it is three times the rate of any other LHIN (Ontario, 2008). Similarly, the rates of suicide for Aboriginal men and women who represent a large portion of the NW LHIN's population are two and three times the national rate. (Health Canada, 2002).

These differences in numbers reporting thoughts of suicide and the number of incidences signify a reporting issue in the North West LHIN. Either residents of North Western Ontario are failing to admit their suicidal thoughts to a practitioner, or many are unable to access their services. Reasons explaining high rates of suicide in the NW LHIN may be found in cultural differences, and the percentage of the population living in smaller towns. Just like there is a stigma behind mental health disorders in small towns, which will be discussed later, there may be a similar cultural occurrence in these Aboriginal populations (Health Canada). Another explanation may be found in the smaller number of mental health services found in rural North Western Ontario. Limited options and opportunity to seek help for mental health or addictions issues only logically means that smaller numbers will be reported.

The Aboriginal population in Ontario is subject to unique conditions and unique issues with regards to mental health and addictions when compared to the rest of the province. It has been found that “Aboriginal citizens bear a heavier burden of ill health than do most Canadians and, at the same time their communities have access to fewer physical, financial and human resources” (Minore & Katt, 2007). Suicide and self-injury are the leading causes of death for Aboriginal youths. In 2000, suicide accounted for 22 percent of all deaths among Aboriginal youth (aged 10 to 19 years) and 16 percent of all deaths among Aboriginal people aged 20 to 44 years (Health Canada, 2002). Suicide rates of Registered Indian youths (aged 15 to 24) are eight times higher than the national rate for females and five times higher than the national rate for males (Health Canada).

Mental health and addictions are related because many who suffer from one will also report being affected by the other in their lifetime. Approximately twenty percent of those affected by a mental health disorder will also have a co-occurring substance abuse problem (Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, 2008). Approximately one in every ten Canadians over the age of fifteen has an alcohol or illicit drug dependence (Statistics Canada, 2003).

As noted earlier, addictions issues are not solely linked to drug and alcohol dependence. It is possible to become addicted to certain behaviours or actions. Approximately 3.8% of adults in Ontario are reported to have a moderate to severe gambling problem (CSSA and Responsible Gambling Council, 2001). The largest percentage of the population claiming problem gambling issues exists within the 35-54 age category for both male and females. However, it is reasonable to assume that this age group be the largest category reporting addictions issues seeing it is the age where most people settle down, start making more money, and assuming more

responsibilities. These activities are known to cause both financial and family stresses. There has been a recent increase in the number of those seeking assistance for problem gambling issues (Wrigley & al, 2005). This is most likely due to the fact that there is also an increasing level of acceptance and acknowledgement of the necessity of this service. Wrigley et al. conclude that the reasons behind an individuals' attitude towards seeking help for a mental health issue is linked more to perceived stigma and causal attributions than that person's actual symptoms or disability. This increased participation rate could also be attributed to an increased recognition of addictions issues and an acceptance that these issues need to be treated.

Most estimates of mental health and addictions prevalence are based on service utilization records. However, it is widely accepted that statistics do not represent the total number of cases in an area. Statistics generally will only show the total number of treated cases. Due to the fact that many people do not go for treatment Kirmayer suggests we must recognize that these numbers represent only a “lower bound on the true prevalence of distress in the community, and at worst, serve to distort the picture due to inequities of access and availability of appropriate services” (Kirmayer, Laurence, et al., 1993, p. 12).

Care need is urgent, and we now know more than ever the number of people who are suffering from mental health and addictions issues. There is a new acknowledgement of these issues resulting from greater information and better assessment tools. Unfortunately, with this new recognition of the commonality of these issues, we also know that there are more people who need assistance than are currently receiving it. The numbers of those admitting themselves for mental health or addictions issues does not correlate with the existing evidence. For example, only one in six children who have mental health problems actually get treated (Centre for Rural and Northern Health Research, p. 1). Mental health and addictions strategies require a

whole of government approach as the field is so complex (Canadian Mental Health Association, 2011, p. 13).

3.2 Mental Health in Northern Ontario

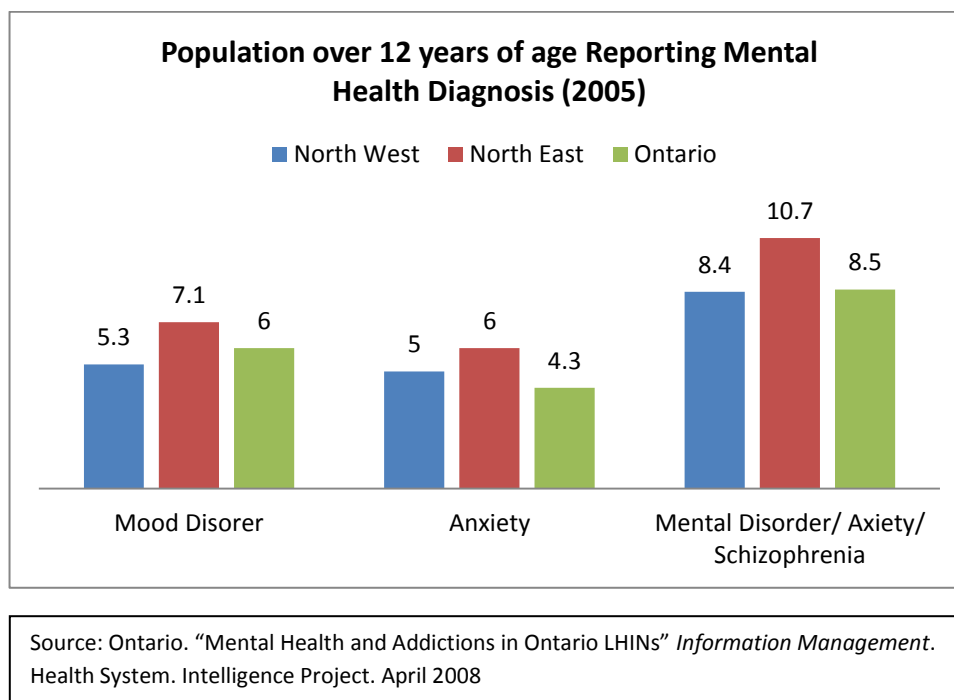
It is evident that mental health and addictions play a heavy burden on Northern Ontario. To illustrate the unique challenges and issues apparent in Northern Ontario, it is necessary to divide the problem into sections. An understanding is needed of both the prevalence rate of mental health and addictions issues as well as how and where these individuals seek treatment. An analysis of best practices is impossible without first appreciating the prevalence and current treatment patterns of the region.

The first step in understanding the steps that the NW and NE LHINs took in dealing with mental health and addictions in their first IHSP, is acknowledging the prevalence of the illness' in their regions at that time. As Figure 2 notes, North Eastern Ontario was home to the highest percentage of individuals seeking treatment for mental health in the North in 2005. North Eastern Ontario was home to the greatest number of reported cases of mood disorder, anxiety and schizophrenia.

Alcohol is the largest substance abuse issue in Ontario, by a landslide, with cannabis placing second. The rates of cocaine and crack usage in the province are declining, while there has been a steady increase in the usage of prescription drugs in Ontario. Contrary to most beliefs, there is now a higher hospital intake of individuals suffering from addictions to prescription drugs than either crack or cocaine (Drug and Alcohol Treatment Information System, 2010). North Western Ontario is following this trend. The NW LHIN has the largest percentage of individuals being admitted for issues related to alcohol addictions in the province

and the lowest numbers for both crack and cocaine (Drug and Alcohol Treatment Information System, 2010).

Figure 2.



The Ontario Student Drug Use and Health Survey (OSDUHS) run by the CAMH is an important tool for determining changes in Ontario students' patterns of drug use. Surveys have been conducted every two years since 1977. The results from these surveys demonstrate that students in Northern Ontario from grades 7 to 12 are more likely than the rest of the province to smoke cigarettes, drink alcohol, binge drink, use cannabis, methamphetamine, OxyCotin for non-medical purposes, as well as stimulants pills non medically (Paglia-Boak, Mann, Adlaf, & Rehm, *Drug Use Among Ontario Students 1977-2009: Detailed OSDUHS Findings* (CAMH Research Documents Series No. 27), 2009). However, comparison between rates of most drug and alcohol use has been declining steadily since 2004. But, while these rates have dropped for the majority,

due to the short timeline, no compelling explanation for this correlation can be made. It is possible that the reasons for these differences lay in fact that there are just different respondents.

Although the NE and NW LHINs both report average rates of mental health disorders as the rest of the province, they also had the lowest percentages of OHIP-billed visits to Ontario physicians for mental health in 2005/2006. The NE LHIN accounted for 2.7 percent of Ontario's visits, while the NW LHIN accounted for only a mere 0.6 percent (Ontario, Mental Health and Addictions in Ontario LHINs, 2008, p. 13). It is important to keep in mind however the small populations of these LHINs. These low numbers are to a large part attributable to the characteristics of the population.

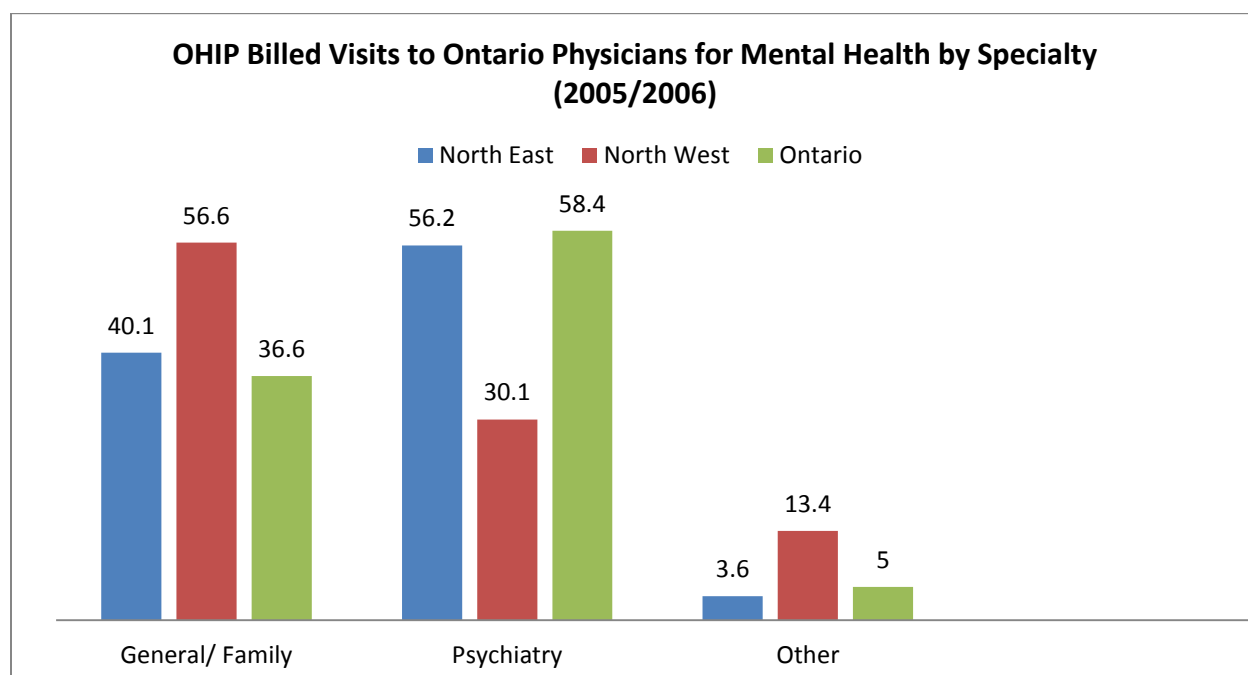
A better method of examining the treatment of mental health and addictions in Northern Ontario is through a comparison of treatment methods and providers. Knowledge of how individuals seek and are provided treatment in the NE and NW LHINs is needed before one can properly assess the situation.

In both the NE and NW LHINs, the majority of treatment for mental health issues is sought using traditional methods. In 2006, the Canadian Institute for Health Information Discharge Abstract Database (CIHI-DAD) reported that the NE LHIN had the highest percentage of individuals over the age of fifteen who were re-admitted to the hospital for depression (Lin & al, 2009). In over half of the LHINs including the NE LHIN, more women returned to the hospital for aid with their depression issues. The NW LHIN was in the minority group where the percentage of men fifteen and older returning to the hospital for assistance was greater.

In the NE LHIN, the most popular source of assistance for mental health issues is through psychiatry, followed by physicians. Just over 56 percent of those seeking assistance visit a psychiatrist, 40.1 percent seek help from a general practitioner and 3.6 percent report

using other methods. This pattern however is not followed in the NW LHIN. The NW LHIN has the lowest usage rate of psychiatrists for mental health issues. Only 30.1 percent of reported treatments for mental health issues in the NW LHIN were done through psychiatrist visits. Most reported cases of mental health in the NW LHIN are treated by general practitioners. An interesting figure is the high percentage of treatments being provided through “other” means. The NW LHIN’s percentage of 13.4 using other means to treat mental health is the highest in the province. This could be attributable to the focus on community level treatment in the North West, particularly amongst Aboriginal populations. The NW LHIN also had the lowest total number of visits for mental health issues as compared to the rest of the province (only 22% of the next lowest amount) (Ontario, Mental Health and Addictions in Ontario LHINs, 2008).

Figure 3.



Source: Ontario. “Mental Health and Addictions in Ontario LHINs” *Information Management*. Health System. Intelligence Project. April 2008

Figure 4

Contacts with the Drug and Alcohol Registry of Treatment, Mental Health Service Information Ontario, and the Ontario Problem Gambling Helpline, 2006/2007						
LHIN of Residence	Drug and Alcohol Registry Treatment	% of ON total	Mental Health Service Information Ontario	% of ON total	Ontario Problem Gambling Helpline	% of ON total
NW LHIN	610	2.4	75	1.6	55	1.7
NE LHIN	1160	6.6	286	6	112	3.5
Ontario	25044	100	4756	100	3181	100

Source: Ontario. "Mental Health and Addictions in Ontario LHINs" *Information Management*. Health System. Intelligence Project. April 2008

While the NE LHIN rates about average with other LHINs in the province for patients with substance abuse admitting a mental health problem, the NW LHIN is much lower. Approximately only half the numbers of those receiving treatment for substance abuse have also been diagnosed medicated or hospitalized for emotional, behavioural, psychiatric, or other mental health problem as compared to the rest of the province (Drug and Alcohol Treatment Information System, 2010). Looking at this data one would surmise that there are only half as many people with mental health problems in the NW LHIN compared to the NE LHIN; however we know this to be very inaccurate. This leads us to question the rationale behind these

disparities. Is the number so low because of the under reporting, poor data, or are people just not either looking for or receiving the mental health help they need in the NW LHIN?

Statistics show that although there is a high percentage of individuals in the NW LHIN reporting addictions issues, the rate of those actually seeking assistance is low (ConnexOntario, 2007). The NW LHIN admits the lowest number of individuals to drug and alcohol treatment in Ontario, and the participation rate accounts for only 2.4 percent of the provincial total. The NW LHIN accounts for only 1.6 percent of the provincial total number of utilizers of Mental Health Service Information Ontario and 1.7 percent of those who call the Ontario Problem Gambling help line. These statistics illustrate a usage issue, because although the NW LHIN has the smallest population in the province, it also has relatively the same percentage of mental health and addictions as the rest of the province. Why is it that the NW LHIN uses such a small percentage of addictions services?

3.3 Economic Impact of Mental Health and Addictions

Mental health and addictions place a heavy burden on both the economy and society in Canada. These illnesses place an economic strain on the healthcare systems, as well as mental and social pressure on those affected. It is estimated that the human and economic burden on society is an estimated \$51 billion/year in Canada, while the social and human costs are far greater (Canadian Mental Health Association, 2011, p. 6). The economic burden of mental health and addictions can be divided up into dollars spent and dollars lost. Money is needed to pay for the direct medical costs associated with assessment and treatment. While this places a strain on the Ontario healthcare budget, it is estimated that these dollars spent on mental health and addictions will help to ensure higher output. A report in 2009 estimated that every \$1 spent on mental health and addictions saves \$7 in health costs and \$30 in lost productivity (Ontario,

Every Door is the Right Door, Towards a 10-Year Mental Health and Addictions Strategy: A discussion paper, 2009).

3.4 Methods for Treatment of Mental Health and Addictions

Two arguments emerge over the proper treatment of mental health and addictions issues in Ontario. Opinions differ over whether the best form of treatment is done using a whole of population approach or if it is better to treat individuals. A whole of population approach decrees that one should aim to treat the problem and not the person. It is important to recognize the determinants of each issue and try to resolve them on a large scale. It can also be argued that the best form of treatment is done at the individual level. In using this approach one would look at the individual's environment, economic position, as well as their individual social and health behaviours in trying to determine the causes of their issues.

Mental health and addictions are similarly rooted in that they both are resultant from and related to a variety of sociological, cultural, biological, genetic and life experiences. (Addressing Integration of Mental Health and Addictions, 2010). Recent practice has discovered that it is important to ensure that the treatment of mental health and addictions be integrated as it is the best preventative step for future issues.

4.0 SOCIO-ECONOMIC DIFFERENCES

In everyday conversations it is often difficult for the general public to dissociate health from healthcare, specifically hospitals, numbers of doctors and the services afforded them. Although sometimes difficult it is imperative to broaden the lens through which you view determinants of health in society. This is especially true when taking on the task of formulating

or analyzing health policy. In order to accomplish this, the health of a population can be studied using a more holistic approach, incorporating the multiple social and economic determinants of health. These include but are not limited to understanding the impacts of external factors such as wealth and environment.

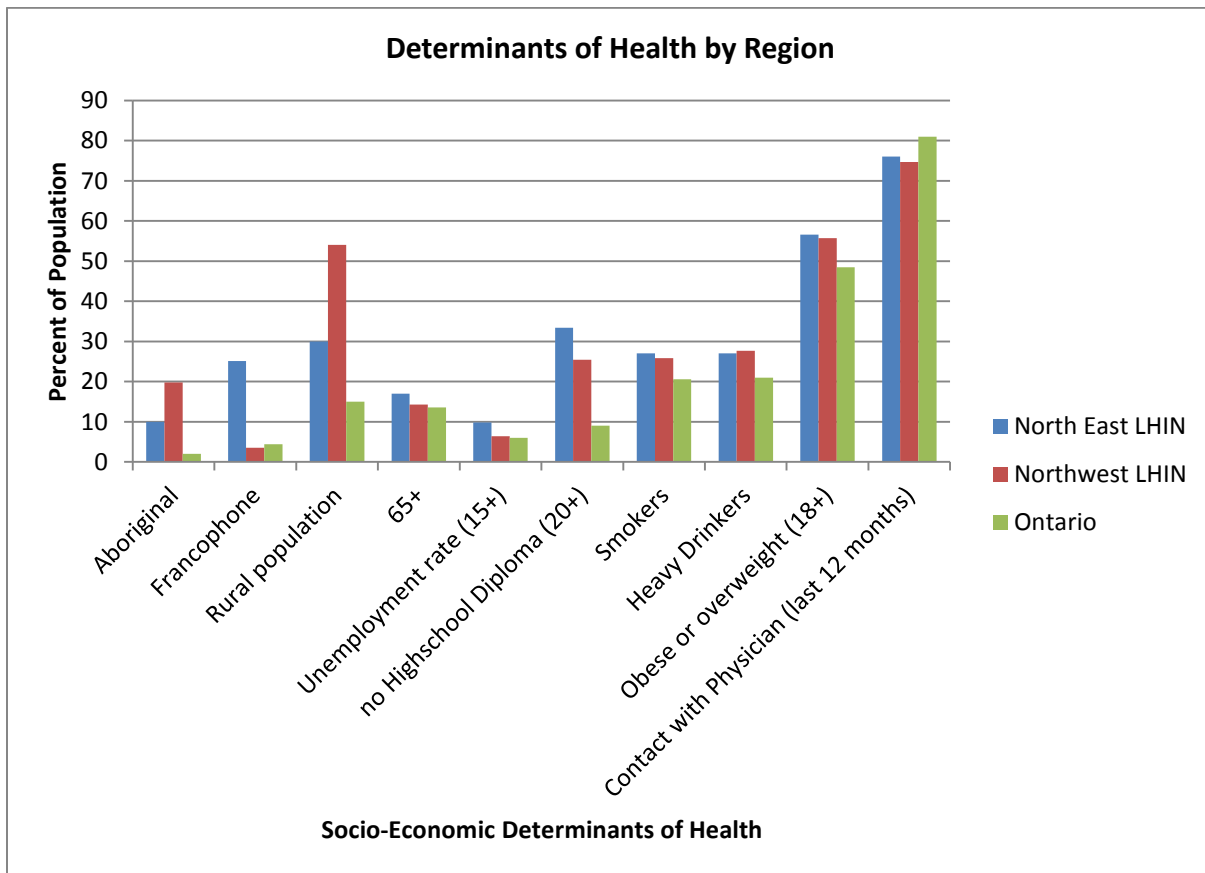
The focus on community and recognition of socio-economic determinants coincides with a broader recognition of the problem of mental health and addictions. In order to fully understand the prevalence of mental health and addictions in an area, or devise community treatment plans, one must first recognize the characteristics related to that population and its environment.

The residents of rural Northern Ontario face a vast number of socio-economic challenges. In general, the profiles of communities within these rural areas are different from that of urban Ontario. An aging population, economic difficulties and geographic isolation are all contributing factors to the specific health vulnerabilities existing in these regions. The World Health Organization classifies health as a “resource” in society (World Health Organization, 1986). Good health is essential for the sustainability of a society because it ensures the well-being of almost every aspect of living.

The health of a society can be understood by a variety of socio-economic determinants. These include the “conditions in which people are born, grow, live, work, and age. In their turn, poor and unequal living conditions are the consequence of poor social policies and programs, unfair economic arrangements, and bad politics” (CSDH, 2008). Canada’s Chief Public Health Officer, Dr. David Butler-Jones released a report in 2008 listing what he believed to be the top social and economic factors responsible for determining the health and well-being of the modern Canadian population. In it he lists income, employment and working conditions, social support

and individuals' sense of connectedness to the community, their health behaviours and access to healthcare as the top social and economic factors responsible for the health and well-being of Canadians (Public Health Agency of Canada, 2008). This paper will use these five determinants of health to analyze the health behaviours of the residents of rural Northern Ontario and the impact these factors have on mental health. The thorough analysis of these factors can also contribute to a better understanding of the reasons for and reactions to LHIN policy decisions.

Figure 5.



Source: NW IHSP, NW IHSP and Statistics Canada

While the Canadian population as a whole maintains a relatively high level of good health when compared internationally, this pattern is not reflected evenly across the whole country. On

average, the health status of the population of rural Canada is falling below that of their urban counterparts. Rural Canada is subject to lower levels of health as indicated by higher rates of morbidity, cardiovascular disease, obesity and work related injuries specifically in primary-sector occupations.

An effective examination of current LHIN efforts at dealing with mental health and addictions issues is not complete without first providing an outline of the current issues. The Mental Health Commission of Canada has labelled the situation in rural Ontario to be worse than the rest of the population. Populations in rural and remote areas of the province are subject to a level of service that is lower than the rest of the province (Mental Health Commission of Canada, 2009).

4.1 Income

Income is a socio-economic determinant of mental health because wealth can determine security, nutrition, education and access, which can create stress. Income is important because it can help to determine quality of life. In both the NW and LE LHINs, a noticeable number of individuals admitted for mental health issues receive their income from government benefits. Northern Ontario has the highest percentage of residents living off of government benefits than any other region (Drug and Alcohol Treatment Information System, 2010). This is a growing trend in the region as the percentage of those individuals with mental health issues who admit earning an income through employment is decreasing.

4.2 Employment and Working Conditions

Employment, like income is a determinant of health in that it can help to provide an individual with financial security. The stress of getting a job, keeping a job, earning sufficient wages, and dealing with the working conditions of that job can play a role in the health of an

individual. Since 2006 unemployment has been highly correlated with addictions admissions. The number of employed individuals entering rehabilitation centres has decreased and the number who are not working (retired, disabled or students) has remained relatively stable (Drug and Alcohol Treatment Information System, 2010). In 2009, 35 percent of clients admitted for substance abuse in Ontario were unemployed.

Rural residents are less likely than those in urban areas to obtain a higher level of education limiting job opportunities for many. A large number of rural Northern Ontario residents hold positions that require only one specific skill. These individuals often lack the experience and education required to obtain a new job if they lose theirs. Many of these positions are found within the primary sector such as agricultural work, industrial work, mining and forestry.

A difference is reported between the numbers entering treatment for addictions issues in the NE LHIN and the NW LHIN in 2010. The number of unemployed entering treatment in the NW LHIN is almost double that in the NE LHIN. The number of unemployed entering treatment in the NE LHIN is only slightly larger than the employed (Drug and Alcohol Treatment Information System, 2010). These numbers indicate that there is a higher likelihood of individuals in the NW LHIN developing and requiring treatment for a mental health issues resulting from the stresses of being unemployed.

4.3 Social Support and Sense of Connection to the Community

Social support networks and good social relations at home, work and in the community can contribute to good mental health. The World Health Organization acknowledges that belonging to social networks helps to make individuals feel cared for and valued which has an enormous impact on mental health. They argue that those who not receive an adequate level of

social or emotional support from others are more likely to become depressed and engage in risky behaviours (Wilkinson & Marmot, 2003).

An individual's sense of connectedness to their community is an important factor in their likelihood of acquiring a mental health or addictions issue, and whether they feel comfortable enough to seek treatment. The sense of belonging to interpersonal relationships is an integral characteristic of social significance. A sense of connectedness can help to influence mental health. When someone does not feel connected to their environment they are more likely to experience emotional distress, which can cause them to turn to substances as a means of dealing with this problem, and increased thoughts of suicide.

Residents of small towns are often times more encouraged to participate in society. It is more important to ensure a strong sense of connectedness to the community. There are both positive and negative aspects to this. A strong sense of community can help to discourage mental health and addictions issues brought on by disconnectedness, but it may also at the same act negatively against those who wish to seek help for their problem but fear stigmatization. This is true in many Aboriginal communities where in most cases, assistance is provided through the community. It is unlikely that people will seek help from the people from whom they intend to keep their condition a secret.

Rural residents who live far away from their closest city centre, or even from their nearest neighbour are more likely to become depressed due to feelings of isolation.

North Western Ontario claims to have a greater sense of connectedness when compared provincially (Ontario: North West LHIN, 2010). In 2007 74.8 percent of the NW LHIN population over the age of twelve reported feeling a sense of community. When compared to the

provincial rate of 63 percent, one notices a greater sense of connectedness amongst the population.

4.4 Health Behaviours

Personal behaviour and lifestyle have an incredible impact on the development of mental health and addictions issues. Behaviours such as nutrition and food choices, levels of physical activity, body weight and tobacco smoking are all known determinants of health.

The lifestyle choices one makes can help with the mental stresses of living. An example of this is the rate of tobacco smoking. Smoking is largely correlated with mental health. A study done in 2003 found that women who smoke reported poorer mental health than men who smoke (Cohen & Maclean, 2003). This may be resultant from mental health conditions such as stress leading to smoking.

Residents of the NW LHIN have a higher prevalence of modifiable risk factors that are associated with mental health and addictions. Individuals aged twelve and older are more likely to have poor diets, smoke and be heavy drinkers. Evidence from 2007 (Bains, Dall, & Hohenadel, 200) suggests that 59.9 percent of the population consumes less than five servings of fruit or vegetables in a day while the provincial average is 53.8 percent. The rate is even higher in the NE LHIN who reported that 64 percent do not consume a sufficient amount of fruit or vegetables a day (Ontario, Population Health Profile: North East LHIN, 2004). A poor diet can lead to unhealthy weight, increased risk of type 2 Diabetes and decreased self-esteem. The percentage of residents reporting having more than five drinks on at least twelve occasions in a year is 6.5 percent higher in the NW LHIN than the provincial average, while the rate of daily or occasional smokers is 4.9 percent higher in North Western Ontario.

4.5 Culture and language

A discussion on the health of Northern Ontario cannot be complete without mentioning its unique demographic profile. Culture and language are barriers to the optimal provision of health service in Northern Ontario due to large Aboriginal and Francophone populations in both the NW and the NE LHINs. Issues of language and cultural attitudes contribute to communication issues and barriers to optimal health service delivery. These populations are at a higher risk of experiencing language and interpretation barriers when attempting to access health care. It is often difficult to apply and adapt provincial and mainstream mental health and addictions programs to make them culturally appropriate for Aboriginal communities due to the fact that Aboriginal and non-Native concepts of health and healing are different. It is important to recognize these differences when considering conceptions and methods of healing.

North Western Ontario is home to the largest population of self-reported Aboriginals in the province. One third of the on-reserve Aboriginal population of Ontario and one quarter of the off-reserve population of Canadian Aboriginals resides in the NW LHIN. It is also the location of a little over half of all Indian Reserves and Indian Settlements in Ontario (Population Projections LHIN Summary Table, 2009). The proportion of Aboriginals residing in the NW LHIN is an estimated 19.2 percent (Ontario: North West LHIN, 2010), while the population of the NE LHIN consists of 9.2 percent self-identifying Aboriginals (Ontario, NE LHIN Demographic and Health Profile: Summary Overview). Aboriginal populations in Northern Ontario are subject to issues of access to health services. This access problem is defined as language and cultural barriers and inadequate transportation to health service locations. (Government of Ontario, (1994), Aboriginal Health Policy: Executive Summary)

Another commonly discussed barrier to service is the low Aboriginal participation in the planning of health services. The perceived inability to contribute to the planning of health priorities and decision making results in a health plan that does not respond to the immediate health concerns of the community.

The debate over Aboriginal healthcare often includes the mention of specific barriers to the provision of adequate services. It is argued that several factors are responsible for the poor health status of the First Nations. A lack of co-ordination among Aboriginal communities is problematic because it is seen by some as a deterrent of equitable funding amongst Aboriginal populations in the country. A second barrier to the improvement of health is a believed emphasis on treatment opposed to wellness (Ontario, Aboriginal Health Policy: Executive Summary, 1994).

The NE LHIN's 2007-2010 IHSP recognizes the rights and unique health care challenges associated with the Aboriginal population living in their region. However, they make a point to note that the need to deliver Aboriginal/First Nations/ Métis health services in the community must be a component of and measured against all other IHSP priorities (Ontario, North East LHIN Integrated Health Service Plan: 2010-2013, 2010).

An important point of comparison is the differences in the proportion of French language speakers in the NE LHIN as compared to the North West LHIN. One of the defining characteristics of the NE LHIN is its large proportion of residents who report French as their mother tongue. Although the concentration of Francophone populations does differ throughout the region, they combine to equal almost a quarter of the total population of the NE LHIN. In 2006, 23 percent of North Eastern Ontario reported French as their first language (Ontario, NE LHIN Demographic and Health Profile: Summary Overview). The story in the NW LHIN,

however is very different. The proportion of residents who are Francophone in North Western Ontario is much lower. In fact, the Francophone population as a percentage is lower in the North West LHIN (3.5 percent) than the proportion of Francophone residents in Ontario as a whole (4.4 percent) (Ontario: North West LHIN, 2010). Although normally, a statistic so close to the provincial average would not be significant, this critical difference from the North Eastern demographic is our first major difference between the North West and NE LHINs. North Eastern Ontario's large Francophone population faces issues of access. It is important that service providers acknowledge the language barrier that still exists in certain communities.

Issues of access between the NW LHIN's Aboriginal population and the NE LHIN's Franco-Ontarian population differ greatly however. While both being an Aboriginal and being a member of the Francophone community are in themselves social determinants of health, Franco-Ontarians are supported in that any language barrier is inconsistent with the law. The Ontario government has a legal and constitutional obligation to the French community to provide services for the linguistic minority as part of Ontario's French Language Services Act of 1990 (Ontario, French Language Services Act. R.S.O. 1990, Chp F 32, 1990). There is no such law protecting the rights of Aboriginals in Ontario to have their health services provided in their own language.

4.6 Education

The attainment of good population health can be found through increasing levels of educational success. Education is a determinant of health in that greater education of health can result in the practice of better health behaviours. Higher education is normally correlated with greater employment, increased wages and better physical, monetary and health security.

Education level is correlated with rates of substance abuse in Northern Ontario. Both the NE LHIN and the NW LHIN have the highest percentage of individuals entering treatment with only a primary school education, as well as the smallest numbers of post-secondary graduates entering treatment (Drug and Alcohol Treatment Information System, 2010).

4.7 Access to Services

Access to services is a determinant of health; however there are two different types of access: physical distance and availability of services in the area. The geography of rural Northern Ontario is a challenge for service providers due to the challenges of distance, language and culture. Access to services impacts the treatment of mental health in rural Northern Ontario due to distance, system capacity, availability of services, transportation issues and economic barriers. Of the various reasons reported for unmet need in Ontario, the most commonly cited include: lack of knowledge of where to get assistance, stigmatization, low motivation (amongst those with substance abuse disorders), and dissatisfaction with previous service experiences (Urbanoski & al, 2008). Improving the access to healthcare in rural communities involves reducing geographical barriers to services as well as creating options for service delivery.

The population of Northern Ontario is challenged with vast distances between urban centres, as well as cultural differences. Small populations are located throughout the expanses of the large geography of the area. This distance creates healthcare access issues as services are generally not found in every town. This results in the need to travel to reach service providers. Access issues are visible in Figure 5. This figure illustrates that Northern Ontario has greater socio-economic determinants of disease, yet its population is visiting the doctor less than the provincial average. Aboriginal and Francophone populations residing in rural and remote areas

of the province often have difficulty in accessing adequate levels of services. Although services in Aboriginal languages and French exist in Northern Ontario, these services are generally designated to certain populations rather than offered universally. This means that these services are available for these populations, individuals just have to find a means of accessing them. These language and distance barriers are responsible for limiting access to treatment in the area. Northern Ontario is home to a larger population who is over the age of 65, unemployed, living without a high school education, smoking, drinking and obese or overweight than the general provincial population. Despite the recognition of this issue, there fewer residents of this region are seeking assistance, due to issues of access.

In attempts at resolving the distance barrier to treatment in Northern Ontario, the MOHLTC presented a possible solution to the economic barriers to treatment associated with service distance. As of October 1, 2007, the MOHLTC afforded residents who have to travel at least 100 kilometres to see a medical specialist the opportunity to have part of their travel related costs alleviated. The Northern Travel Grants (NHTG) (Ontario, Northern Health Travel Grant Program, 2007) provide individuals with 41 cents per round trip kilometre, if the one way trip distance is over 100 kms, with a deductible of the first 100 kms. The NHTG also provides an accommodation allowance of \$100.00 for those whose one way trip distance is at least 200 kilometres. Patients are eligible provided they reside in Northern Ontario and there is no specialist closer than 100 kilometres away. This travel grant is beneficial for those rural residents who have to travel long distances to see a practitioner for their mental health problem, however, in order to get the grant you first have to be referred to that doctor. To get referred to a mental health specialist, one first must be assessed. There is no money provided for those who

have to travel great distances to be assessed. The grant also does not cover lost wages, child care costs, or time.

The filing for NHTG grants can be time consuming and people find themselves having to pay the travel costs up front and remembering to keep all receipts. Another downfall of the NHTG is that it is not advertised enough. Those rural residents who live closer to urban areas are used to travelling to the city for work and entertainment. Due to this fact, despite the benefits provided, many would never think to seek compensation for their additional trips.

Barriers to treatment in rural areas not only include distance to providers and distance to assessment centers but also the stigma attached to mental health disorders. Smaller communities mean that there is a higher chance that others will find out about your mental health issue (Centre for Rural and Northern Health Research).

As previously mentioned, stigma is a barrier to access. When someone is perceived to be different, we may sometimes inadvertently view him or her in a negative or stereotypical manner. This is most common in cases where these differences are recognized as negative in society. Stigma is a reality for many people with mental illness due to inaccuracies and misconceptions of mental health in society. Society's view of mental health and mental illness has been distorted through social media who has portrayed mental illness as a feature attributable to dangerous and unpredictable behaviour (Centre for Addiction and Mental Health, 2011).

Stigma reduces the likelihood of an individual seeking assistance for a mental health or addictions issue. Many will be unlikely to ask for the time off of work, seek child care or find transportation because they do not want to admit their health issue. Given the nature of small towns, even if a mental health or addictions service is provided within that town, the likelihood of an individual utilizing it is reduced due to fear of others finding out.

Moderate mental health issues are considered a silent disease. Mental health and addictions do not discriminate. Diagnosing a person with mild or moderate mental health issues is often difficult. It is for this reason that the responsibility of obtaining help is most often in the hands of the individual. Without assistance moderate mental health issues can worsen and become major health concerns. The best method of ensuring more people receive help involves the reduction of stigma currently attached to mental health issues and addictions, the education of the public on the symptoms and causes of mental health issues as well as increasing the access to and utilization of existing services. People residing in more remote areas might need special attention and specific mental health problems and addictions might have to be targeted (Pong, Desmeules, & Lagacé, 2009). People need to be informed about available options for treatment. This requires better funding for the education of both what mental health is and the services available in the community.

5.0 LOCAL HEALTH INTEGRATION NETWORKS AND WORK ON MENTAL HEALTH AND ADDICTIONS IN NORTHERN ONTARIO

Socio-economic factors are determinants in the development of and accessibility of treatment for both mental health and addictions issues. It is important to understand the structure that is in place to deal with these factors and the policies which have been developed to deal with them.

5.1 History of LHINs

The last decade has witnessed a need to redesign the Ontario healthcare system as a means of dealing with its growing inefficiencies. At the turn of the century, the healthcare

system began to pose numerous issues for the Ontario government. The cost of delivering healthcare services was steadily increasing at the same time as access to healthcare services began to decline. There are three common arguments as to what the causal factors are: an aging baby boomer population demanding better healthcare services, a growth in healthcare technologies, and the increasing cost associated with these new services and medications (Ontario, Long-Term Sustainability of Ontario Public Services, 2010). These increasing demands began to strain the budget for direct and indirect healthcare employment creating a social and economic problem where growing healthcare costs accounted for nearly half of the Ontario budget. Despite the strain on the financial capabilities the Ontario government now possessed, the public continued to expect the latest treatment and technology innovations from their healthcare system.

Health care technologies were continuing to grow and with it the price of health products such as medications, prostheses and medical technologies. This increased price of medical technologies created a strain on the healthcare budget for both direct and indirect healthcare employment. The public continued to demand more from the Ontario healthcare system which they saw as lacking in their service provision. In 2003, the rising costs of healthcare services were “threatening to crowd out many important social, environmental and economic priorities” (Fenn, 2006). Recognizing the growing issue, while also acknowledging their inability to remove supports from other social services, the Ontario government decided that a structural change was needed if they wanted to sustain their ability to properly fund public health services.

Adding to this issue was the argument Health Canada’s Special Advisor on Rural Health made regarding the problems associated with Canada’s population spread. He described many of the inefficiencies in the Canadian health care system as resulting from a two-tiered, urban versus

rural system (Government of Canada- Depository Services Program, 2002). Despite rural Canada's growing health demands as compared to its urban counterparts, the range of health care providers has not increased to accommodate their need.

Changing demographics, economic inefficiencies, and a shortage of doctors, created increased pressure on the Ontario health care system. The Ontario government was challenged with devising a way of managing this. It was clear that something needed to be done to ensure the sustainability of the Ontario public health care system. The passing of the Local Health System Integration Act was intended to do just that. In March, 2006 the Ministry of Health and Long Term Care divided Ontario into fourteen regions that were afforded the responsibility to fund, plan and integrate local healthcare services starting as of April 1, 2007. The division of Ontario into this regionalized system of healthcare was done with the goal of solving the growing inadequacies within the provincial healthcare system. Aimed at creating a healthcare system that would be more apt to meet the healthcare needs of communities and the patients they serve, LHINs represent the idea that the most effective healthcare system is one in which integration, community engagement and accountability are necessary components. LHINs were founded based on the concept that the healthcare system will be more sustainable, efficient and accountable if managed at a local level, so as to allow for more community input and enhanced co-ordination. LHINs were designed to provide better integrated care that resulted from local planning designed for a defined geography and population (The Change Foundation, 2008). The goal was to renew community engagement in the healthcare process, improve the health status of the province, ensure equitable access- regardless of location, and improve the quality and sustainability of the system.

The Government of Ontario argued that LHINs would be beneficial because in handing the power to regional bodies, the government was allowed the opportunity to step back and focus on their long term goals for the provincial healthcare system. Devolving the responsibility onto local authorities provided the opportunity to escape the challenges and stresses involved in the local politics of healthcare. As difficulties emerged from regional differences, the division of the province into regional authorities presented the opportunity for decisions to be made based on local demands. Because of this, LHINs are thought to be more efficient and effective (Barker, 2077).

LHINs were designed to take over key MOHLTC responsibilities in an effort to manage at a local level. These new responsibilities included the planning, funding and monitoring of hospitals, home care, community support services, community mental health and addictions services as well as long term care. These public health service providers include public hospitals, divested psychiatric facilities, Community Care Access Centres, community mental health and addictions agencies, community support services organizations, community health centres and long term care facilities. It is important to note that despite their high level of responsibility, LHINs are not in charge of issues related to public health, doctors, medicines, ambulances, laboratories, provincial networks and programs, dentists, chiropractors or optometrists (Ontario. MOHLTC, 2006). Each individual LHIN is responsible for promoting the integration of local services within their individual region and identifying, planning and recommending the health services funding needs. This is to be performed as the result of thoroughly monitoring, evaluating and reporting local needs.

It is the responsibility of each LHIN to devise an individual IHSP that is consistent with the healthcare goals as set out by the province. These IHSPs will contain the goals, priorities,

vision and the strategic directions under which the LHIN would like for their health service provider so work. It will also contain the framework under which the LHIN shall follow to achieve their mandated goals (Bhasin & Williams, 2007).

5.2 Integration:

Integration is a key feature of any LHIN and requires a cohesive strategy (Canadian Mental Health Association, 2011, p. 13). There are three ways in which LHINs can integrate health systems. The first method is through the allocation of funds. LHINs can choose to either provide or change the funding delivered to a service provider. The second method of integration is the integration of services amongst providers. The third, and most obvious form of ensuring the integration of health services lies in the power LHINs hold to determine the longevity of a service. LHINs can make formal decisions regarding integration which can include the transfer of a service to another location, an increase or decrease in the volume of patients admitted to a service in one area or they can altogether stop a service in an area.

LHINs are powerful, but there are still restrictions placed on them regarding where and how they can integrate services. The largest condition is the agreement to follow their IHSP. If the integration of any services will not help to reach the goals listed in their IHSP the LHIN does not have the power to do so. LHINs are restricted to integrating solely the services that they themselves are responsible for funding. LHINs also must make certain not to use any property that belongs to a charity, or attempt to force any religious organization to provide services for the community which are against their beliefs. Individual health service providers retain the right to challenge any integration decisions proscribed to them within a thirty day time frame. Following this deadline, the decision is considered final and no further appeals can be made. Individual

health services providers have the right to integrate their services with another service provider on their own; however it is mandatory that they provide their LHIN with sixty days' notice. If the LHIN does not approve of this integration they have the right to prevent it. The LHIN will always have the final say.

6.0 ACTIONS TAKEN BY THE NORTH WEST LHIN AND THE NORTH EAST LHIN IN DEALING WITH MENTAL HEALTH AND ADDICTIONS

Yes, the development of Local Health Integration Networks has aided in creating a healthcare system better designed to attend to the needs of local communities throughout Ontario, but how do these LHINs respond to the continued challenges inherent in the prevention and treatment of mental health and addictions issues in rural populations? As previously stated, despite their similar social, economic and geographic similarities, the NW and the NE LHINs took unique approaches in their dealing with mental health and addictions in their 2007-2010 IHSPs. A formal analysis of the two LHINs' priorities can help to better understand the different outcomes resulting from their individual selection of priorities. This following section will outline these differences along with the individual actions each LHIN took during this time period.

One of the most important differences between the NE LHIN and NW LHIN's initial IHSP's is their diverging beliefs on how best to focus treatment delivery in their regions. While the NE LHIN emphasizes the importance of access and the treatment of individuals, the NW LHIN's IHSP has special emphasis on community.

6.1 North West LHIN

In 2006, the NW LHIN recognized the current access to mental health and addictions services as being inadequate for the region. Mental health affects the residents of the NW LHIN both economically and socially. The NW LHIN reports the highest population percentage with limited activity levels due to their physical or mental condition (37.5% vs. 29.4 ON) (Ontario, Healthier people, a strong health system- our future, 2007). Access issues were reported to be the most problematic in areas outside of Thunder Bay and Kenora (Ontario, North West LHIN Integrated Service Report: 2007, 2007). Most communities outside of the major urban centres reported issues accessing both specialized and children's' mental health and addictions services.

The NW LHIN's first IHSP was completed in October 2006. In it were listed seven priorities for the Northwest. These included Access to Care- of which mental health and addictions services was listed as a sub priority; long-term care services, integration of services along the continuum of care, engagement with Aboriginal People, ensuring French Language services, the integration of e-Health and the development of a regional health human resources plan (Ontario, Healthier people, a strong health system- our future, 2007).

Suggested methods of relieving the barrier to care associated with distance include the increased use of telehealth and increasing attempts at bringing care closer to where people are, whether this be through visiting clinics or visiting physicians. These two methods do not always prove successful as not all specialists will use telehealth, and it is difficult getting physicians to travel to remote locations. Various mental health conditions require constant or readily available services. Due to this fact, these two methods of treatment are not beneficial for optimal treatment.

The NW LHIN argues that health status cannot adequately be understood if one chooses to rely solely on the analysis of the health of individuals. The health of a population cannot

successfully be determined by choosing to solely examine the health outcomes of individuals. It is imperative that a deeper and more thorough understanding be obtained. This can be done by successfully analysing the environment in which those individuals live along with any factors that may have contributed to their issues. It is only in doing this that one can determine the necessary steps needed to prevent these issues from reoccurring in the future. Understanding and acknowledging the various health risks that can potentially be associated with these socio-economic conditions is important. It may be possible to use these markers to explain the existing patterns of health care use (Ontario. MOHLTC, 2006).

Various key issues are addressed in the NW LHIN's IHSP as critical for the success of mental health and addictions. Improving access is critical to addressing the needs of crisis care, mental health services for the elderly, improving in-patient services, withdrawal management programs, supportive housing, safe-beds, walk-in mental health services as well as the provision of services for children and youth (Centre for Addictions and Mental Health, 2007). Through the integration of these services using enhanced communication and co-ordination, the NW LHIN hoped to increase access to an adequate supply of services. The NW LHIN hoped to improve mental health and addictions in their region through the horizontal integration of services and increased communication between health sectors.

The NW LHIN has placed an emphasis on the importance of community involvement in the designing and development of their health service plans. This method follows parallel with CMHA Ontario which recommends that input from people with lived experiences is beneficial and a must (Canadian Mental Health Association, 2011, p. 6) at all levels of planning. Due to the vast geographic area and wide population spread, online tools have been determined to function as the most effective means of obtaining the largest participation rate from the

community in public planning. Community involvement was necessary if they were to develop ways of improving access to mental health and addictions services for residents living in remote areas.

Although the NW LHIN contains only 2% of the population of Ontario, its residents make up 10% of the province's substance abuse and problem gambling clients. (Ontario, North West Local Health Integration Network Environmental Scan). In North Western Ontario, mental health inpatients are more likely to be represented in substance-related disorders than the rest of the province. While the provincial average is 15.1%, the rate in North Western Ontario is 27.6%. Substance-related disorders account for the highest percentage (45%) of mental health visits to the emergency department (vs. 27.5% in the province) (Ontario. MOHLTC , 2010-2013).

The NW LHIN's decision to use a community centred approach to mental health and addictions is significant. The NW LHIN's large rural and remote population makes it difficult to provide equitable services throughout the region. It is not economical or efficient to place medical centres in small towns with a small service population. For these reasons a community based approach to mental health and addictions treatment sounds like the best option. However, as mentioned above, there is still stigma surrounding mental health and addictions which might prevent individuals from seeking help from someone they know. This could be one of the reasons behind the NW LHIN's inability to decrease addictions issues, or increase treatment for mental health issues. If one in every five people with an addiction also suffers from a mental health issue, there is no reason why there should be such a large difference in reported numbers of instances in the NW LHIN. There should not be so few reported cases of mental health issues compared to the addictions incidence rate. It is odd that the number of reported instances of

individuals with both addictions and mental health issues is not as high in the NW LHIN as the rest of the province knowing this statistic. Now that we know the actual incidence rate, there should also not be such a low rate of reported feelings of suicide in the NW LHIN as compared to other LHINs.

6.2 North East LHIN

The priorities listed in the first IHSP produced by the North East LHIN were established by input resulting from a series of community consultations, a priority setting workshop in 2004 and feedback from community stakeholders. These priorities included: Aboriginal health services, chronic disease management and prevention, coordinated information and technology systems and information management, French language health services, health human resources needs, primary care reform and reduced wait times (Ontario, The Local Vision, 2006).

The NE LHIN was the only LHIN in the province to not specifically choose mental health and addictions as a priority or sub priority in their 2007-2010 IHSP. Although not listed directly as a priority, the NE LHIN does make mention of additional resources for mental health and addictions, prioritizing enhanced programming for those individuals suffering from both mental health and an addiction (Ontario. MOHLTC, 2006).

The NE LHIN made the choice to take a system level and integrative approach (Ontario, The Local Vision, 2006) and tackle issues such as long wait times as a means of improving access to mental health services. Why did the NE LHIN choose not to follow in the same steps as the rest of the province and include mental health and addictions in their IHSP? How did this impact their dealing with mental health and addictions issues?

The perceived benefits of using a systems approach in the North East included improved access and awareness for health care consumers, quality enhancement (as a result of shared staffed and expertise), staff growth, development and education, recruitment and retention of health professionals using shared strategies, and improved efficiencies and more resources for direct care through program and administrative savings. The NE LHIN 2007-2010 IHSP focuses on the benefits of the integration of mental health and addictions services as a result of enhanced equity and access in the region. This method was flawed however in that choosing to focus solely on integration left issues of access and service delivery sometimes overlooked.

In order to understand the reasoning behind the decision to take a systems approach to their 2007-2010 IHSP it is necessary to look at the context. The decision to not specifically include mental health and addictions as a priority in their 2007-2010 IHSP can be explained through the previous acknowledgement of the necessity of integrating service found in *The Time for Change is Now* (2002), the *NE LHIN Integration Priorities Report* (2004) and the findings from the *We All Belong Campaign* which lasted from 2001-2005.

Although *The time for change is now: building a sustainable system of care for people with mental illness and their families in the North East region* (North East Mental Health Implementation Task Force, 2002) focused solely on adult mental illness, the report noticed the necessity to integrate services and supports ‘into a continuum of care’ as it is important for the individual, their care giver and their family. In their report they noted their belief that the creation of multidisciplinary teams using shared care models would result in more efficient service delivery and treatment, closer to home. What is interesting was their goal of developing a system to assess individual’s mental health problems and needs. The NE is now the only LHIN that uses the Ontario Common Assessment of Need (OCAN).

The report concluded that there needed to be a shift in the care of mental health in North Eastern Ontario. There needed to be a larger focus on more accessible services. This report however focused mainly on treating the individual and not helping to prevent the issue from occurring in the community. The individualized focus did not take into account the contributing socio-economic factors that would lead to the onset, although innovative in its acknowledgement of the benefits of integrating service providers, of many mental health issues. It also did not mention supports for addictions which are now widely acknowledged as complementary issues.

The *NE LHIN Integration Priorities Report* mentions that the integration of mental health and addictions services is necessary as it would result in expanded community treatment and help to ensure more equitable access (Northeast LHIN Integration Priorities Work Group, 2004). In this report, the work group recognized the ability to enhance mental health and addictions services through the integration and collaboration of related populations such as seniors, HIV/Aids and Acquired Brain Injury (Northeast LHIN Integration Priorities Work Group, 2005). They also recognized the necessity of integrating the administration of mental health and addictions horizontally, vertically and intersectoral noting that the “the impact of mental illness and addictions on other health issues calls for the entire health care system to be able to identify and respond to those who are at risk and who have a problem” (Northeast LHIN Integration Priorities Work Group, 2005, p. 35). The workgroup also suggested that a universal method of screening for early intervention of mental health and addictions be incorporated (Northeast LHIN Integration Priorities Work Group, 2005) . This report focused more on bettering the treatment of specific populations as a means of improving the mental health and addictions rates of the community.

The *We All Belong Campaign* which ran from April 2000 to March 2005 in North Eastern Ontario by the North East Mental Health Implementation Task Force was a public education campaign about the need for mental health reform in Ontario (Canadian Mental Health Association). The main objectives and goals of this project were to increase the awareness of mental health, the need for early detection and access, reduction of stigma and the benefits of adding to the existing knowledge of effective public education campaigns. The goal was to help re-shape the public attitude towards mental health in North Eastern Ontario. This pilot mental health education project was successful as it demonstrated the importance and value of increasing public awareness of mental health (Champlain District Mental Health Implementation Task Force, 2002).

The fact that this campaign was carried out in North Eastern Ontario, prior to the development of the NE LHIN's first IHSP is significant for numerous reasons. It can be surmised that this project not only helped to educate the population of this region about mental health, but it also helped to advance the progress of integration. It is possible that the early education of the public, caregivers, patients and stakeholders played a role in determining the responses received by the NE LHIN in both 2004 and in consultations that followed. It is likely that the furthered education of the community helped to better shape mental health and addictions programs in the area.

While mental health and addictions were not listed specifically on the 2007-2010 IHSP, it was already recognized in the NE LHIN that these issues should be a top priority due to their prevalence and impact on other sectors. This is important as it can help to explain the reasoning behind the NE LHIN's decision not to include mental health or addictions specifically in their 2007-2010 IHSP. It had been previously established that the best way of managing mental

health and addictions was to include all related populations and partners in the process. Mental health and addictions are related and could not be separated from other sectors of the healthcare system. The NE LHIN's 2007-2010 IHSP indicates their desire to integrate mental health services because it will help to create better links with other services that are involved with mental health issues and services such as housing, income, employment and social supports. Under this logic, the quality of services provided will be improved because staff will be shared. Both program funding and service provision need to be integrated.

Despite their early recognition of this interconnected relationship, the mental health and addictions policy making in the NE LHIN has had to endure a long history of failed and frustrating attempts to move the system away from the hospital and move it more towards a community centred practice. Following the release of their 2007-2010 IHSP, the NE LHIN went out into the community and asked the public, patients, stakeholders and health service providers for their input. Six consultations and committees resulted in the development of a new set of priorities and policies (Ontario, North East LHIN Integrated Health Service Plan: 2010-2013, 2010).

7.0 POLICY BETWEEN FIRST AND SECOND IHSPS

It is important to recognize the changes in mental health and addictions policy in Ontario following 2006. The knowledge gained from practices as set out in the 2007-2010 IHSPs of both the NE LHIN and NW LHIN have assisted in the further development of mental health and addictions acknowledgement and action plans. New provincial and regional priorities have been made as a result from both increased recognition of the issue and community engagement.

The Regional Advisory Panel on Addictions (RAP), which was implemented in 2009, is co-chaired by the NE LHIN and the North East Mental Health Centre (NEMHC). It was designed to help better co-ordinate mental health providers within the LHIN. The objective was to get both regional and local service providers to work together to help assist in the planning and overall functioning of mental health and addictions services within the NE LHIN. The panel of highly qualified individuals from throughout the region works through task forces. These task forces cover relevant issues in the region and acknowledge service challenges. In priority order these task forces are: the siting of 31 specialized regional mental health beds, access to specialized regional mental health beds, discharge solutions for Alternative Level of Care mental health patients, addictions and mental health system capacity balancing and investment priorities, education and training and determining the mental health and addictions system resource reallocation needs and options (Northeast Mental Health and Addiction System Regional Advisory Panel, 2009).

The NE LHIN was presented with the idea of using the OCAN in 2009 as a tool for the regional assessment of mental health issues. The OCAN is a standardized decision making tool that helps to assess the symptoms of the individual and assist with mental health recovery. It allows individuals to express their own concerns and goals using a standard form. The OCAN is designed to help identify individual needs, match those needs to existing services in the area and then expose any existing gaps in service (Community Mental Health Common Assessment Project (CMH CAP)). The use of the OCAN allows individuals to speak their minds about the services they receive and would like to receive. The OCAN is beneficial because it allows for a non-intrusive and less intimidating way of expressing health concerns with a practitioner. It also provides important information as to where services should be directed. The goal of the OCAN is

to eventually establish a standardized system of measurement for the province. Currently the NW LHIN is not using the OCAN. It would be beneficial for the NW LHIN to look at using the OCAN for establishing a best system of practice for mental health issues.

In attempts at addressing the rising issue of mental health and addictions in Ontario, the Ontario government set out to develop a long term strategy for the provision of mental health and addictions services. A Select Committee on Mental Health was formed in 2009 by the Legislative Assembly of Ontario with goals of determining the mental health and addictions needs of vulnerable populations, finding innovative methods of delivering services, focusing on opportunities for integration, better access and more efficient social services. This Committee would focus on people with mental illnesses, substance abuse issues and problem gambling, as well as the impact these issues have on both the individuals' family and their community. In their final report *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (Select Committee on Mental Health and Addictions, 2010) released in August 2010, the Committee recommended that a new organization be designed to coordinate and design all mental health and addictions policy in Ontario. This new "umbrella organization" which they entitled Mental Health and Addictions Ontario would be responsible to the Ministry of Health and Long-Term Care for the running and over-seeing of all mental health and addictions services and programs, in all regions of the province. The committee recognized the importance and benefits of integrating mental health services and suggested that the best way to start would be from the provincial level.

Recognizing that further work was needed in this field the then Ontario Minister of Health and Long-Term Care, David Caplan, created a Minister's Advisory Group on Mental Health and Addictions (Minister's Advisory Group on the 10 Year Mental Health and Addictions

Strategy, 2010). It was assumed that the research done by this new group would be used along with the work from the Select Committee on Mental Health and Addictions to establish a new long-term mental health and addictions strategy for Ontario. On December 10, 2010, the Committee presented their recommendations for a new mental health and addictions strategy for Ontario. In following their recommendations the Committee predicts that Ontario will benefit by witnessing shorter wait times for mental health services, a lower number of hospital admissions and readmissions, a decreased demand on emergency departments, fewer suicides and suicide attempts, and an overall better economic and social quality of life for those living with mental health and addictions issues (Minister's Advisory Group on the 10 Year Mental Health and Addictions Strategy, 2010).

8.0 CONCLUSION

Mental health and addictions issues are prevalent in Northern Ontario impacting the community more than any other health concern. The NW LHIN and the NE LHIN are interesting points of comparison in that they demonstrate how small policy differences in seemingly similar regions can produce different outcomes.

The NE LHIN did not directly list mental health and addictions as a priority in their 2007-2010 IHSP. However, they still demonstrated an effective reduction in rates of addictions and have an increased participation and usage rate of mental health and addictions services as compared to the NW LHIN who prioritized access to these services. The differences in their success lies in the manner in which these LHINs chose to organize their health services plans. While the NW LHIN chose to focus more specifically on individual health concerns in their region, the NE LHIN decided to use a systems based approach in which they aimed to tackle the

broader issues. The NW LHIN chose to look at individuals as part of a community, while the NE LHIN looked at individuals within in a community and how that community could be better serviced through the integration of health services.

It is not enough however, to say that this small difference in the wording of the IHSP's of the NW and NE LHINs is responsible for the observed variation in mental health and addictions levels. Differences in population characteristics including language, culture, health behaviours, employment and senses of connectedness are determinants of mental health characteristics for each region. Higher rates of unemployment in the NW LHIN have created higher stress levels resulting in greater addictions levels. It can also be argued that the greater sense of social connectedness reported in the NW LHIN is responsible for lower reported rates of mental health in rural areas due to stigma.

In conclusion, variations in the prevalence of mental health and addictions issues in the NW LHIN and the NE LHIN are the result of not only policy decisions, but also due to socio-economic status. Because it is not possible to improve the long term health of a population at the individual level it is important that a community approach be taken. However, when doing so, it is important to recognize the differences inherent in the communities within each region. Different communities present their own unique challenges to policy makers. Depending on the acquired social behaviours of individuals within each community and their economic status, it will be important for policy makers to develop and facilitate unique health action plans for each community. However, one cannot look solely at community contributors just as one must make sure not to focus only on the individual.

In order to better the delivery of services in rural Ontario, we need to begin focussing less on the determinants of disease in these areas and more on the ways in which the current

healthcare structures are designed. There needs to be less emphasis on what it is that makes the citizens of rural less healthy than the rest of the population and more on what can be done to rectify the flaws within the system. In following this belief it also means that there should be less emphasis on the economics of the rural healthcare system with an increased attention paid to the demand for sustainability.

It can be concluded that the reasons for differing policy decisions in 2006 between the NW and the NE LHINs are the result of different cultural and language barriers, access issues and population spreads. Mental health and addictions treatment in Northern Ontario is the result of socio-economic differences, and the use of unique knowledge and health structures acquired through past practices. These factors are responsible for both the events leading up to the creation of each LHIN's IHSPs as well as the different outcomes resulting from the unique policy decisions.

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