Kenora-Rainy River Youth Justice Collaborative

Community Profile Report

Systems Improvement through Service Collaboratives

July 2015

Provincial System Support Program
Centre for Addiction and Mental Health

Contents

Background

Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy commits to the coordination of mental health and addictions services for children, youth, and adults. The Systems Improvement through Service Collaboratives (SISC) is one of 22 initiatives being implemented as part of this strategy. As the SISC project sponsor, the Centre for Addiction and Mental Health (CAMH) has established 14 geographically-based Service Collaboratives and 4 justice and health-related Collaboratives across Ontario. Service Collaboratives bring together stakeholders across multiple sectors and services to effect local system change to support coordinated services for children, youth, and adults. The Justice Collaboratives address coordination for individuals with mental health and addictions needs who come into contact with the criminal justice system, specifically at the transition or juncture points between the criminal justice, mental health and addictions systems.

Kenora Rainy-River Youth Justice Collaborative

The Kenora-Rainy River Youth Justice Collaborative (KRRYJC), which began on November 7, 2013, is a youth-focused community collaborative. The geographic boundary for the KRRYJC is the Census Districts of Kenora and Rainy River (including the Thunder Bay-Atikokan region, which is within the realm of the Kenora-Rainy River Youth Justice Collaborative; **see Figure 1**).

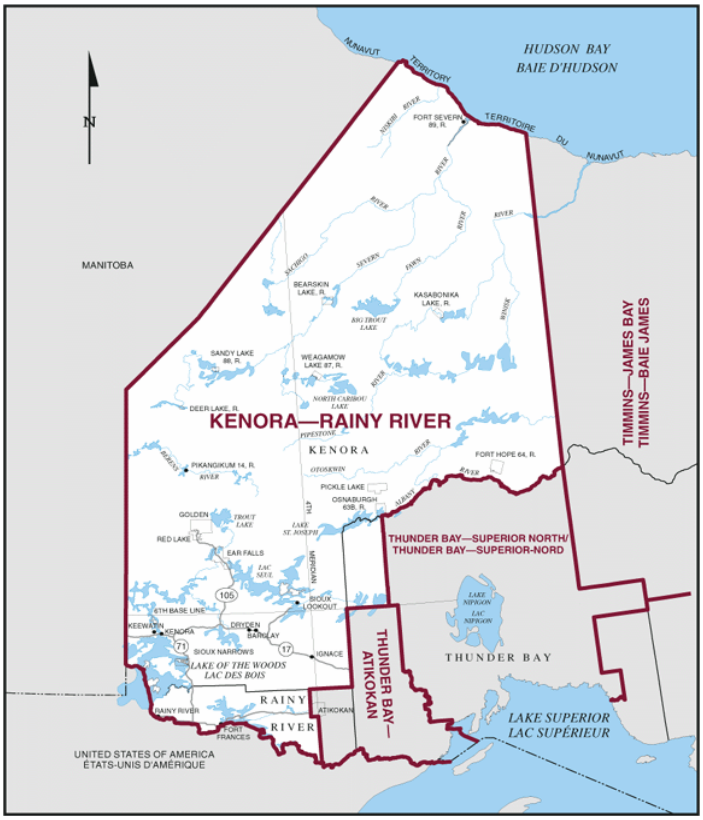

Figure 1. Census map of Kenora and Rainy River districts.

Objectives

The goals of the KRRYJC are:

- Improved service integration between sectors for youth with mental health and/or addiction issues within the justice system
- More seamless and timely access to appropriate services for youth living with mental health and/or addiction issues
- Enhanced experience and quality of service for youth within the mental health, addictions, and justice systems
- Better quality of life for youth with health and/or addiction issues and their families

The KRRYJC aims to effect system change focused on improved connections and coordination of services between the criminal justice, mental health and addictions systems by targeting key transition or juncture point of action with consideration to the unique needs of the community.

A Needs Validation and Strength Discovery process was undertaken by CAMH to identify the key transition or juncture points that are important for the Kenora-Rainy River community, as well as to identify the unique needs of the service users and service providers in Kenora-Rainy River. The purpose of this document is to share the findings of the Needs Validation and Strength Discovery process; provide information about the needs of the community; and to identify the gaps, issues and strengths within the local systems in order to help inform the KRRYJC members' decision-making processes.

Methods

The Needs Validation and Strength Discovery process was conducted in two phases. First, we conducted a literature review to develop a Community Health Profile of the areas served by the KRRYJC. Second, we interviewed local key informants in order to validate the findings from the Community Health Profile, and to identify any needs that may have been overlooked in previous reports.

The Community Health Profile was developed to bring together and demonstrate the needs of Kenora and Rainy River that have been identified in previous reports. To compile the Community Health Profile, we conducted an extensive literature review of various government and ministry reports, local agency reports, and community-based reports. We analyzed the data from these reports and produced a Community Health Profile with the most up-to-date and relevant information that was available.

In order to validate the findings in the Community Health Profile, as well as capture information that may not have been included in previous reports, we conducted interviews with local stakeholders to gain their perspectives on the needs and challenges in their area. We held key informant interviews with service providers and community leaders who live and/or offer services in the Kenora-Rainy River District and Northern First Nation and Métis communities. Interviews focused on getting first-hand accounts from people within the mental health and justice systems, specifically which areas work well and which areas need improvement.

The interviews were conducted in a one-on-one setting or as small discussion groups with colleagues. The interviews took approximately one hour to complete. We collected notes during each interview, which were then thematically analyzed to reveal common ideas that were prevalent across interviews.

Initially, we intended to complete 6-10 interviews with service providers across various Ministries, First Nation and Métis community members, and other local community representatives. We chose to expand the number of people interviewed to 16 in order to capture a diverse range of perspectives and avoid having only one or two individuals representing an entire Ministry or community.

Limitations

There are several limitations in this report that should be noted. For the Community Health Profile section, these limitations include:

- The evidence is limited by the reports that are available and their quality.
- Many of the reports use 2011 census data; this may not accurately reflect the current situation in the Kenora and Rainy River Districts.
- There is uncertainty about the quality of the 2011 census data in regards to the recent changes to the long-form census.
- Many reports are representative of a larger area in Northwestern Ontario (particularly for First Nations, Inuit, and Métis (FNIM) and Francophone populations); this may not accurately reflect the current situation in the Kenora and Rainy River Districts.
- Most of the previous reports do not provide data that is specific to children and youth.
- Census data does not adequately capture information about FNIM populations. Reasons for this include that the census relies on self-disclosure of Aboriginal identity and reserves are incompletely enumerated.
- There is a lack of comprehensive and consistent health data for FNIM populations. Health Canada collects data for on-reserve populations, but not for off-reserve populations. In contrast, some federal health surveys do not include on-reserve populations. Additionally, provincial data sets do not consistently collect information on FNIM identity.
- There is a lack of data on health status and service use among the Francophone population.

For the key informant interviews, the limitations include:

- The inability to interview everyone for which we sent invitations to. Issues such as scheduling conflicts, tight deadlines, and people's workload prevented us from conducting some interviews.
- Some respondents chose not to answer every question during the interview. This was particularly evident in the questions relating to the identification of critical transition points on the Justice Mental Health Systems Map. Some of those who chose not to answer these questions stated they did not feel knowledgeable enough to answer, while others simply declined.
- The perspectives of youth involved in the justice system were not included due to the laws preventing the identification of youth involved in the justice system, and collecting data from these youth.
- The answers are based on respondents' individual perspectives and experiences. They are not meant to be considered reflective of the community, but rather one perspective among many within the community.

Findings: Community Health Profile (Highlights)

The Community Health Profile focuses on the communities within the boundaries of the District of Kenora and the District of Rainy River. Since there are a myriad of ways in which these two districts are defined by different local and provincial organizations, we chose to use the boundaries that are defined by the Census Divisions. Using the Census Divisions boundaries allowed us to: a) use a constant and clearly defined geographic boundary that encompasses all regions that the KRRYJC is focusing on in the SISC initiative; and b) use data (e.g., general demographics, health data, etc.) that are specific to the Districts. Using a different geographic boundary would prevent us from doing this as the other geographic boundaries that were looked at either: a) did not encompass all of the areas that the KRRYJC is focusing on; and b) provide limited data on the regions that it does cover.

Note: A more detailed version of the Community Health Profile can be found in Appendix A. The full version of the Community Health Profile includes further information about the population, the planning areas and bodies, and the determinants of health in the Kenora and Rainy River Districts.

This region is located on the far west of Ontario's Manitoba border and includes the districts of both Kenora and Rainy River (**see Figure 1**). The District of Kenora covers 407,213.01 km^2 and the District of Rainy River covers 15,484.83 km^2, or approximately 47% of Ontario.

Population Overview

In 2011, the population for the Kenora District and the Rainy River District was 74,960, which was approximately 0.6% of the provincial population (12,851,821)[1]. The Kenora District had a population of 54,915 [1], and Rainy River had a population of 20,045 [1]. In total, males and females each made up 50% of the population [1].

First Nation, Inuit, Métis Population

In 2011, the FNIM population in the Kenora District was 19,985 people, approximately 36% of the District's population [1]. The FNIM population in the Rainy River District is 4485, approximately 22% of the District's population [1]. In comparison, the overall FNIM population made up approximately 2% of Ontario's population [1]. The FNIM population in the Kenora and Rainy River Districts made up approximately 12% of the overall FNIM population for the province [1].

Youth Population

In 2011, the population of youth for the Kenora District (24.6%) [1] and the Rainy River District (23.4%) [1] were slightly higher than the Ontario's youth population (20.3%) [1]. In Kenora, FNIM youth under 18 years of age made up 37.7% of the FNIM population, while youth under 25 years of age made up 50.1% of the FNIM population [2]. In Rainy River, youth under 18 years of age made up 35.5% of the FNIM population, and youth under 25 years of age made up 45.9% of the population [2].

Mental Health and Addiction Issues and Services

This section of the report looks at mental health, substance use, and service utilization statistics for the KRRYJC area. In some instances, it was difficult to find information that was specific to both Kenora and Rainy River, and also youth-specific. As such, it is important to note that, at times, some statistics may include geographic areas that surround Kenora and Rainy River, or adult statistics.

Mental Health Status

- **Perceived Well-being**
  - The percentage of people who perceived their health as very good or excellent, as reported by the Northwestern Health Unit (NWHU), was 55% [3], compared to the provincial average of 60.4% [3].
  - The percentage of people who perceived their mental health as very good or excellent, as reported by the NWHU, was 70% [3], compared to Ontario's average of 72.4% [3].
- **Mental health disorders/issues**
  - Results from the 2011 Ontario Student Drug Use and Health Survey (OSDUHS) indicated that the mental health of youth in Grades 9 to 12 in the North East and North West LHINs differ from the provincial averages in the following ways [4]:
    - Antisocial behavior (12.5% vs. 9.4%)
    - Fair/poor self-rated mental health (16.5% vs. 15.3%)
    - Elevated psychological distress (36.1% vs. 37.1%)
    - Symptoms of anxiety/depression (3.8% vs. 7.0%)
    - Suicide ideation (8.0% vs. 11.1%)
- **Mood disorders**
  - The percentage of the population aged 12 and over, as reported by the NWHU, who reported having been diagnosed by a health professional as having a mood disorder, such as depression, bipolar disorder, mania, or dysthymia (7.1%), was similar to the provincial average (6.8%) [3].
- **Suicide**
  - The percentage of deaths by suicide or self-inflicted injury (per 100,000 population), as reported by the NWHU, was 26.6% [3], as compared to Ontario's average of 7.7% [3].

Substances

- **Substance use**
  - Results from the 2011 OSDUHS indicated that youth in Grades 9 to 12 in the North East and North West LHINs had higher substance use rates than the provincial average. For example, they were more likely to report the following [5]:
    - Smoking (19.5% vs. 11.1%)
    - Binge drinking (39.0% vs. 29.3%)
    - Drunkenness (33.8% vs. 26.0%)
    - Hazardous/harmful drinking (31.1% vs. 23.4%)

- Cannabis (38.0% vs. 28.4%)
- Cocaine/crack (5.1% vs. 2.6%)
- Drug use problem (23.0% vs. 16.3%)

- **Ease of access**
  - The NWHU (2010) asked students (n=2263) about how easy it is to obtain alcohol, prescription drugs not prescribed to them, illegal drugs, and marijuana. The table below describes the findings in this report [6]:

Ease of Obtaining	Alcohol (%)	Prescription drugs (%)	Illegal drugs (%)	Marijuana (%)
Don't know	20.2	42.8	42.5	24.3
Very easy	28.9	6.3	4.7	25.5
Sort of easy	27.5	9.5	10.0	15.6
Sort of hard	12.6	12.8	11.8	7.8
Very hard	8.8	26.1	28.9	15.1
No response	2.0	2.5	2.0	1.7

Service Utilization

- Results from the 2011 OSDUHS indicated that youth in Grades 9 to 12 in the North East and North West LHINs (16.4%) were as likely to visit a mental health center as youth across the province (15.3%) [4]
- **Mental Illness Hospitalization Rate**[*]
  - According to Statistics Canada's Health Profiles for the NWHU, in December 2013, 808 per 100,000 population were hospitalized for mental illness [3], which is higher than the provincial rate of 442 per 100,000 population [3].
- **Repeat Hospitalizations**[†]
  - In 2014, the North West LHIN quarterly report indicated that repeat hospitalizations occurred for the following reasons [3]:
    - 35.5% for Schizophrenia and psychotic disorders
    - 17.8% for stress-related and neurotic disorders
    - 14.8% for mood disorders
    - 13.4% for other mental health disorders

[*] The mental illnesses selected for this indicator are: substance-related disorders, schizophrenia, delusional and non-organic psychotic disorders, mood/affective disorders, anxiety disorders and selected disorders of adult personality and behavior.

[†] Risk-adjusted percentage of individuals that had three or more episodes of care for a selected mental illness* over all those who had at least one episode of care for a selected mental illness in general hospitals within a given year.

  - The North West LHIN also reported that 9.4% of patients with repeat hospitalizations were for issues related to their mental illness [3], compared to the provincial average of 10.7% [3].
- **Readmission Rate**
  - The Statistics Canada Health Profiles for the NWHU indicated a 14.4% 30-day readmission rate for mental illness, compared to the provincial rate of 11.5% [3].
- **Mental Illness Patient Days**[‡]
  - The NWHU had a rate of 797 (per 100,000 population) of mental illness patient days compared to Ontario's 485 (per 100,000 population) [3].
  - Males' rates of patient days (1,049 per 100,000 population) in the NWHU are almost double that of females (534 per 100,000 population) [3].

Justice

- According to the Ontario Court of Justice (OCJ), there were 1,243 youth criminal cases received between April, 2013 and March, 2014 from the North West region of Ontario [8]. The breakdown of the nature of the offences is as follows [8]:
  - 27.7% were crimes against the person
  - 22.4% were crimes against the property
  - 26.7% were administration of justice (i.e., fail to appear, breach of probation, unlawfully at large, fail to comply with order, etc.)
  - 20.0% were from the federal statute offence group (i.e., drug possession, drug trafficking, etc.), of which 17.3% came under the Youth Criminal Justice Act
  - 2.7% were classified under other Criminal Code categories (i.e., weapons, prostitution, disturbing the peace, etc.)
  - 0.6% were traffic offences

[‡] The patient days rate is a partial measure of general hospital utilization. Patient-days are influenced by the number of hospitalizations and the length of stay.

Findings: Key Informant Interviews

In order to provide the Kenora-Rainy River Service Collaborative with the most up-to-date, meaningful, and relevant information to use for informing decision-making processes related to the SISC initiative, we conducted interviews with local key informants. Interviewing a diverse range of community members allowed us to capture unique information that has not been captured elsewhere; the most noticeable being the attitudes towards the justice and mental health systems. Capturing these attitudes allowed us to identify where some of the key gaps exist within the mental health/addictions and justice systems.

Purposeful sampling was used to select key informants for the interviews. That is, the key informants were invited to participate because we felt their work closely aligned with the SISC initiative. Once we began conducting interviews and met more people in the community, additional interviews took place.

Understanding the User

Throughout the interviews, First Nation and Métis youth from remote Northern communities were identified as having high levels of involvement in the mental health and justice system in the Kenora and Rainy River Districts. In fact, the majority of respondents answering the questions referenced this perspective.

It should be noted that when respondents spoke of issues facing First Nation and Métis youth from remote Northern communities, every key informant indicated that tensions from historical relationships, terms of the Treaty, jurisdictional realities, and the interruption of First Nation and Métis cultures, readily influenced the following demographic-related findings.

Socio-political Environment

Respondents frequently spoke of how the following injustices influence a youth's socio-political environment:

- Inter-generational trauma
- Historical and current political neglect/abuse
- Socio-political injustices

Respondents explained how these injustices have forced First Nation and Métis communities to experience:

- Instability
- Extreme poverty
- High exposure to violence, trauma, abuse, suicide, alcohol and drug use
- Lack of access to basic services

Mental Health and Addictions

For First Nation and Métis youth from remote Northern communities who also experience a mental health issue, respondents stated that these socio-political injustices are contributing factors in experiencing or exacerbating the following issues:

- **Concurrent disorders**
    - Difficult to state with certainty because of issues relating to assessment and diagnosis
    - Suspect the prevalence rate is very high
    - Mental health and addictions go hand-in-hand
    - It is highly unusual to see a youth with just an addiction issue
- **Mental health issues**
    - Difficult to determine prevalence because of issues related to diagnosis (no early diagnosis, issues with assessment/intake forms – assessments do not get completed, etc.)
    - Suspect/observe high levels of:
        - Complex mental health and addiction issues
        - Developmental issues (e.g., Fetal Alcohol Spectrum Disorder [FASD], brain injuries, etc.)
        - Anxiety
        - Depression
        - Suicide
    - FASD
        - Beginning to see suspected or confirmed second and third generation FASD youth (i.e., adults with FASD are beginning to have children with FASD)
- **Addictions**
    - Undiagnosed mental health issues are, in part, leading to alcohol and drug use/abuse as a coping mechanism
    - Drug use/abuse is worse/more prevalent than alcohol
    - Suspect/observe high rates of:
        - Solvent use/abuse
        - Prescription drug use/abuse
        - Need use/abuse
        - Marijuana use/abuse
        - Homebrew/alcohol use/abuse

Gender Differences

When discussing issues that youth from remote Northern communities face, respondents identified issues that are specific to males and females.

- **Males**
    - Engage in more violent crimes
    - The rate of violent crimes is increasing
    - Engage more in property damage
    - Less likely to ask for/seek services
- **Females**
    - May be starting to see an increase in females involved in the justice system
    - Engage more in bullying and harassment

- More likely to ask for/seek services
- High number of pregnant teenagers and young adults
- More likely to be victims of abuse
- Less specific services
- Targeted by human traffickers

LGBTQ2 Youth

Respondents also identified lesbian, gay, bisexual, transgender, transsexual, queer, questioning, and 2-spirited (LGBTQ2) youth as an important demographic to acknowledge when planning for the area. It is important to note that findings in this section are not necessarily specific to First Nation and Métis youth. It was not always clear if respondents were referring to LGBTQ2 First Nation and Métis youth, or LGBTQ2 youth in general.

- Seeing an increasing number of youth identifying as LGBTQ2 and an increase in questions about LGBTQ2 issues
  - Not sure of actual numbers – youth are still exploring and not sure of themselves
  - Males more likely to have questions
- Conflicting responses about safety of being LGBTQ2 in the North
  - Some stated it dangerous to self-identity due to lack of support, safe places, etc.
  - Others stated there is a lot of support, but that this support is mostly from youth. People who are harmful/negative/homophobic tend to be adults who may, or may not, have been raised with certain religious beliefs

The Mental Health System

We asked four questions about the mental health system in the Kenora and Rainy River Districts, relating to how youth access mental health services, youth's experiences when in the system, systemic barriers that exist, and systemic factors that facilitate access and use for youth.

1) **What kinds of services do youth access to meet their needs?**
   - **Access.** The most common theme across the interviews was the absence of services. Respondents noted that there was a lack of basic services in remote Northern communities, and also a lack of specialty services in the Kenora-Rainy River District. Local service providers must connect youth with clinical services based outside of the community, such as Dr. Stambrook, or telepsychiatry.
   - **First point-of-entry.** Respondents also discussed access in terms of how youth enter the mental health system. Police and the hospital emergency department were the two most commonly identified entry points.
2) **What is your understanding of youth's experiences when accessing these services?**
   - **Frustration**
     - Difficult system to navigate
     - Long wait times
     - Travel and distance
     - Financial costs
     - Assessment and intake issues

        - Language barriers, assessment forms are not youth-friendly, may be re-traumatizing, and/or are not applicable to First Nation and Métis cultures
    - Cyclical
        - Due to lack of support in their home community, youth often re-enter the system
- **Confusion**
    - Language barriers
        - May not speak English
        - May use concepts and terminology that are unfamiliar to youth
    - Youth may not receive an explanation as to why they are receiving these services
    - Developmental issues not being addressed

3) Have you identified any barriers to accessing mental health services?

- **Intake**
    - Lack of formal identification (birth certificates, health cards, etc.) can cause delays and confusion
    - Little-to-no information coming with the youth (personal history, medical history, etc.). This leaves staff with little information to work with.
    - Issues with assessment forms (may be re-traumatizing, are not youth/client friendly, are not relevant to First Nation and Métis communities and culture)
    - Language barriers
- **Travel/Geography**
    - Long travel times
    - Multiple trips are required
    - Separates youth from family (because of the lack of services in their community)
    - Costly
- **System**
    - Disjointed
    - Communication
        - Case files/information do not follow the youth
        - Unaware what happens when youth leaves services (no follow-up)
    - Frustrating system to navigate
    - Hard to build meaningful relationships with youth because they are constantly being moved across Northwestern Ontario
    - Single point-of-care does not work when youth are accessing services across Ministries
        - Some respondents have said that most youth tend to be multiple service-using youth

- **Services**
    - Not trauma-informed
    - Not developmentally appropriate
    - Age-specific restrictions

4) **Have you identified any factors that assist access and use of services?**
    - **Ingenuity and Partnerships**
        - Finding creative solutions to problems
        - Client-first attitudes
    - **Cultural services**
        - Use of traditional services and Elders in treatment
    - **Service/System**
        - Single point-of-care helps services providers know where to refer youth

The Youth Justice System

We asked three questions concerning the youth justice system in the Kenora-Rainy River District pertaining to youth's experiences within the system, systemic barriers that exist, and systemic factors that facilitate access for youth. Responses overlapped for the first two Youth Justice System questions. In order to avoid duplication, the themes for both questions will be listed together.

1) **What is your understanding of youths' experiences when accessing services?**
2) **Have you identified any barriers?**
    - **Lack of applicability**
        - Justice System does not reflect the social realities and cultural values of First Nation and Métis youth from remote Northern communities
            - Language barriers
            - Reintegration issues (no supports in communities results in a cycle where youth keep re-entering the system)
            - Youth do not understand the system – it's foreign to them
    - **Rural and remote communities**
        - Youth are entering the system in rural and remote communities
        - Band Council Resolutions (BCR)
            - Removes youth from rural and remote communities with BCR. This can result in a barrier in tracking youth who may, or may not, be able to return to their communities
        - Historical and current political neglect
        - Lack of resources
        - Lack of access to specialty resources in community
    - **Frustration**
        - Time spent travelling
        - Forced relocation
            - Forces youth to be away from their home, family, and culture

        - More cost- and time-efficient methods available for certain services
- **System**
    - Lack of communication between Ministries
    - Stigmatizing mental health within the justice system
    - Not enough time for mental health assessments
    - Frequent shuffling of youth throughout the Northwest
- **Relationships**
    - Hard to develop meaningful relationships with youth when they are being moved across the region
    - Lack of First Nation and Métis staff
    - Services need to use relationship-based/building models

Youth with Mental Health and Addiction Needs in Contact with the Justice System

The following five questions were designed to identify the unique gaps that exist when youth with mental health and addiction needs come in contact with the justice system. Respondents were also asked to identify specific juncture points between the criminal justice, mental health and addictions systems: the most critical, that which would have the greatest impact, that which is most easily addressed, and that which will pose the greatest challenge to the SISC initiative.

1) **What are the major gaps in the justice system when dealing with youth who have mental health and addiction needs?**
    - We are forcing youth to fit into the system, when we should be designing the system to fit the needs of youth
        - Court appearance
            - Youth often cannot make court appearances because of distance, costs, lack of transportation, etc.
    - No mental health screening done before going into court
    - Reintegration
        - Warehousing youth while in custody, no follow-up once they are done serving their term
        - No supports in community/no appropriate placements available at discharge
        - No contact/collaboration with reintegration workers
    - Assessments are not youth/client friendly, not relevant to First Nation and Métis youth, and may be re-traumatizing
    - High turnover rates of staff in custody/accessing services
        - Youth are frequently moved to different areas throughout the Northwest
    - Communication
        - Little-to-no communication with services from other Ministries
    - Community-police relationship
2) **What are the most critical gaps (see Appendix B)?**

- Pre-diversion (2 votes)
- Post-diversion (2 votes)
- First Contact (2 votes)
- Reintegration (1 vote)
- Community Supervision (1 vote)

3) Which is the most important juncture point (see **Appendix B**) in the youth justice and mental health systems for your community?

- First Contact (2 votes)
- Reintegration (2 votes)
- Community Supervision (2 votes)
- First Court Appearance (2 votes)

4) Which juncture point (see Appendix B) do you think can be addressed most easily and have the greatest impact?

- First Contact (6 votes)
    - Can lead to early diagnosis/assessments
    - Don't want youth to get lost in the system
    - Help with system navigation
- Reintegration (2 votes)
    - Detailed plans of care should be made and enacted long before youth are released

5) Which juncture point (see Appendix B) do you think will pose the greatest challenge?

- Reintegration (4 votes)
    - No supports in community
    - Appropriate placements not available at discharge
    - No contact/collaboration with reintegration workers
- Community Supervision (4 votes)

Bright Spots

Respondents were asked to identify what works well in their communities and helps meet the needs of youth with mental health and addiction issues. The following common themes were identified across all interviews:

- **Partnerships**
    - Collaborative work
    - Referrals
    - Justice System players work well together/are on the same page
    - Relationships with First Nations and Métis communities
- **Services**
    - More services than there used to be
    - Increased focus on FASD
    - Culturally sensitive and appropriate
    - Elders
    - Use of traditional/cultural approaches

Future Recommendations

The KRRYJC has decided to focus on developing a more trauma-informed youth justice system for the SISC initiative. This will be accomplished by cross-sectoral training and education in trauma-informed practice, adoption of a common mental health and addictions screening tool, and creation of system navigation map for service providers, clients, and families. The Service Collaborative will draft a protocol between youth justice serving organizations. This protocol will commit the organizations to the process of transitioning to a more trauma-informed youth justice system, and clarify service provider roles and responsibilities from all sectors. This intervention will focus on the Kenora area and expand to Rainy River and other communities in the region. The intervention will be responsive to the distinct and varying needs of youth justice clients, with particular attention to First Nation, Inuit, and Métis youth.

The KRRYJC would also like to make note of the following issues that future planning committees should focus their attentions on when trying to improve the mental health and/or justice system in Kenora and Rainy River:

- Fitting the mental health and justice system to the realities and experiences of FNIM youth living in Northern remote communities
    - Culturally-specific services and supports
    - Address language barriers
    - FNIM-friendly screening and assessment tools
- Have more custody facilities/beds in the region
    - Stop shuffling youth into different facilities across the Northwest
- Focus on prevention initiatives
- Have a shared data/information system and/or improve information sharing between Ministries
- Have/develop trauma-informed/developmentally appropriate services
- Increase focus on FASD
    - Screening
    - Diagnosis
    - Services

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Appendix A: Community Health Profile (Full)

The Community Health Profile focuses on the communities within the boundaries of the District of Kenora and the District of Rainy River. Since there are a myriad of ways in which these two districts are defined by different local and provincial organizations, we chose to use the boundaries that are defined by the Census Divisions. Using the Census Divisions boundaries allowed us to: a) use a constant and clearly defined geographic boundary that encompasses all regions that the KRRYJC is focusing on in the SISC initiative; and b) use data (e.g., general demographics, health data, etc.) that are specific to the Districts. Using a different geographic boundary would prevent us from doing this as the other geographic boundaries that were looked at either: a) did not encompass all of the areas that the KRRYJC is focusing on; and b) provide limited data on the regions that it does cover.

This region is located on the far west of Ontario's Manitoba border and includes the districts of both Kenora and Rainy River. The District of Kenora covers 407,213.01 km^2 and the District of Rainy River covers 15,484.83 km^2, or approximately 47% of Ontario.

Cities and Towns in the District of Kenora and the District of Rainy River

Kenora District: Dryden (City); Ear Falls (Township); Ignace (Township); Kenora (City); Kenora, Unorganized (Unorganized); Machin (Township); Pickle Lake (Township); Red Lake (Municipality); Sioux Lookout (Municipality); Sioux Narrows-Nestor Falls (Township)

Rainy River District: Alberton (Township); Atikokan (Township); Chapple (Township); Dawson (Township); Emo (Township); Fort Frances (Township); La Vallee (Township); Lake of the Woods (Township); Morley (Township); Rainy River (Township); Rainy River, Unorganized (Unorganized)

First Nation Communities in the District of Kenora and the District of Rainy River

Kenora District: Attawapiskat 91A; Bearskin Lake; Cat Lake 63C; Deer Lake; Eagle Lake 27; English River 21; Fort Albany 67; Fort Hope 64; Fort Severn 89; Kasabonika Lake; Kee-Way-Win; Kenora 38B; Kingfisher Lake 1; Kitchenuhmaykoosib Aaki 84; Kitchenuhmaykoosib Inninuwug; Lac Seul 28; Lake of the Woods 37; Lansdowne House; MacDowell Lake; Marten Falls 65; Muskrat Dam Lake; Neskantaga; North Spirit Lake; Northwest Angle 33B; Osnaburgh 63B; Peawanuck; Pikangikum 14; Poplar Hill; Rat Portage 38A; Sabaskong Bay 35C (Part); Sabaskong Bay 35D; Sachigo Lake 1; Sandy Lake 88; Shoal Lake 39A (Part); Shoal Lake 40 (Part); Shoal Lake 34B2; Slate Falls; Summer Beaver; The Dalles 38C; Wabaseemoong; Wabauskang 21; Wabigoon Lake 27; Wapekeka 2; Wawakapewin; Weagamow Lake 87; Webequie; Whitefish Bay 32A; Whitefish Bay 33A; Whitefish Bay 34A; Wunnumin Lake 1

Rainy River District: Agency 1; Big Grassy River 35G; Big Island Mainland 93; Couchiching 16A; Long Sault 12; Manitou Rapids 11; Neguaguon Lake 25D; Rainy Lake 17A; Rainy Lake 17B; Rainy Lake 18C; Rainy Lake 26A; Sabaskong Bay 35C (Part); Saug-a-Gaw-Sing 1; Seine River 23A; Seine River 23B

Population Overview

In 2011, the population for the Kenora District and the Rainy River District was 74,960, which was approximately 0.6% of the provincial population (12,851,821)[1]. The Kenora District had a population of 54,915 (see **Figure 1**), and Rainy River had a population of 20,045 (see **Figure 2**)[1]. In total, males and females each made up 50% of the population [1].

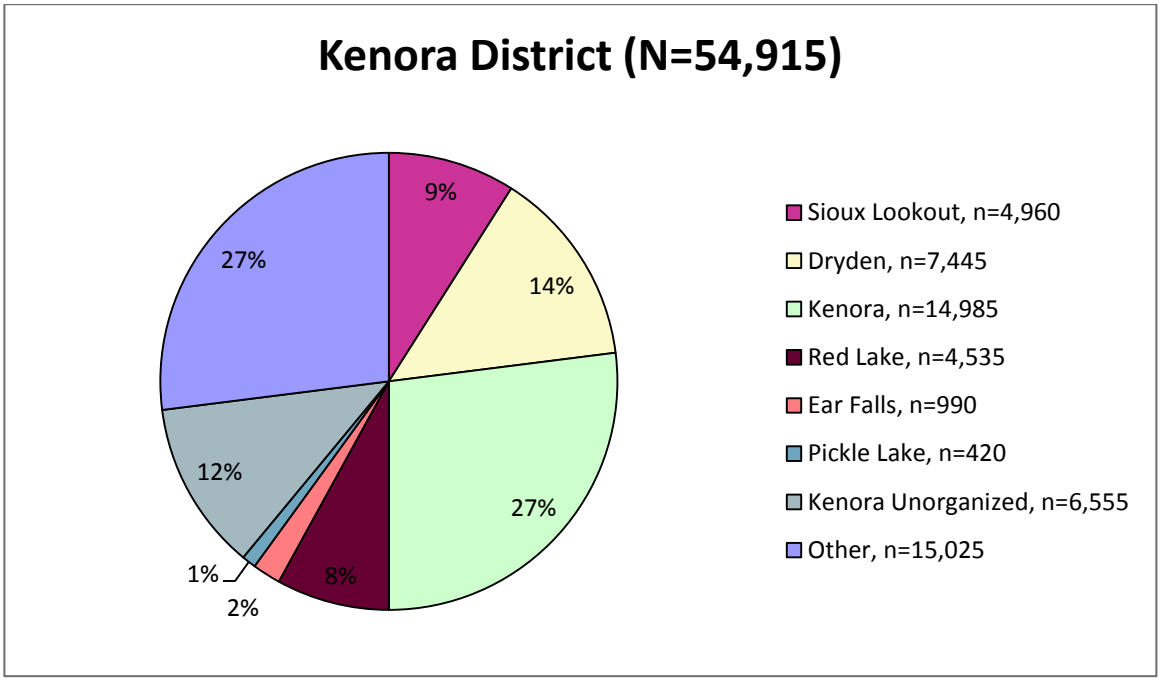

Figure 1. **Kenora District population per city/town** [1]

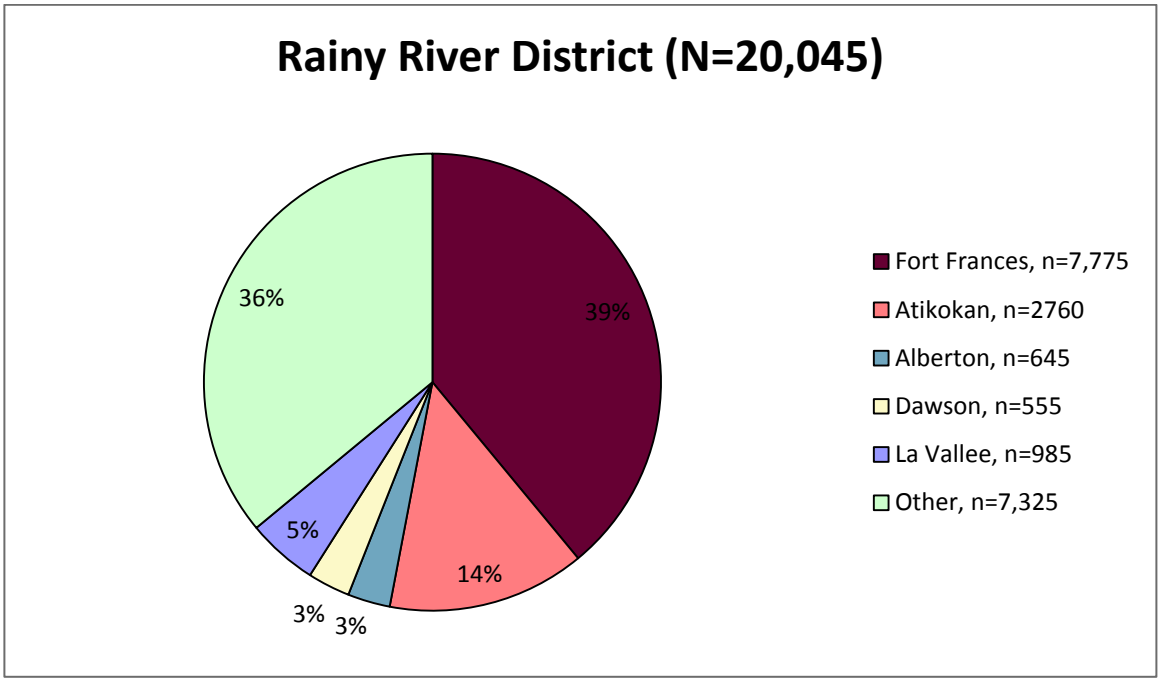

Figure 2. **Rainy River District population per city/town** [1]

First Nation, Inuit, Métis Population

In 2011, the FNIM population in the Kenora District was 19,985 people, approximately 36% of the District's population (see **Figure 3**) [1]. The FNIM population in the Rainy River District is 4485, approximately 22% of the District's population (see **Figure 4**) [1]. In comparison, the overall FNIM population made up approximately 2% of Ontario's population [1]. The FNIM population in the Kenora and Rainy River Districts made up approximately 12% of the overall FNIM population for the province. Of the total FNIM population in Kenora and Rainy River, males and females each make up 50% of the population [1].

There are a total of 53 First Nation communities in the District of Kenora, 43 of which are affiliated with various political territorial organizations, and 10 of which are Independent and not affiliated with any other Tribal Councils. There are 11 First Nation communities in the District of Rainy River. Combined, they make up 31% of the First Nation communities in Ontario.

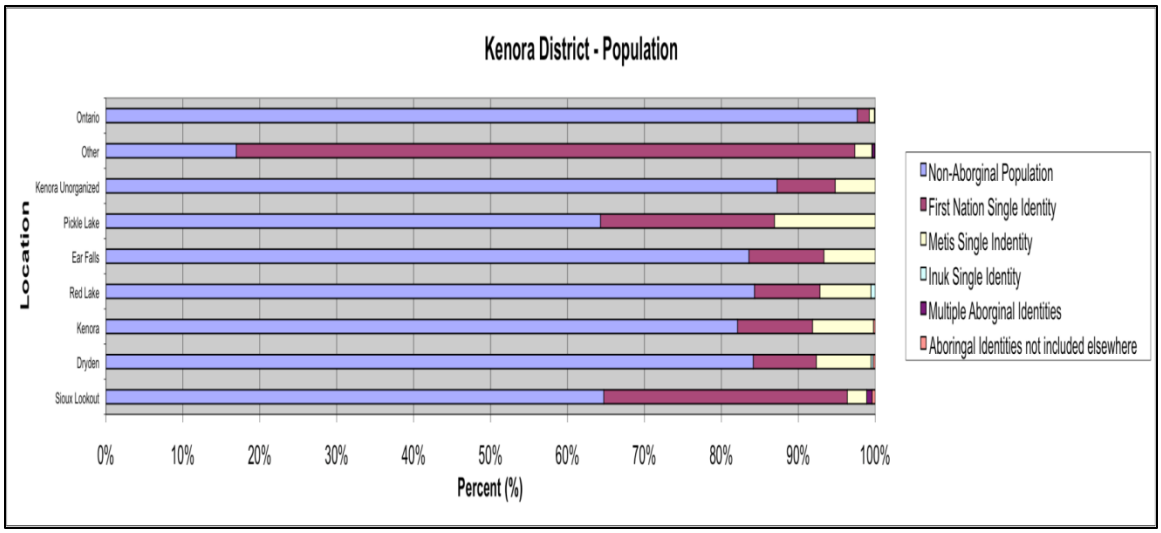

Figure 3. **Kenora District FNIM population per town/city** [1]

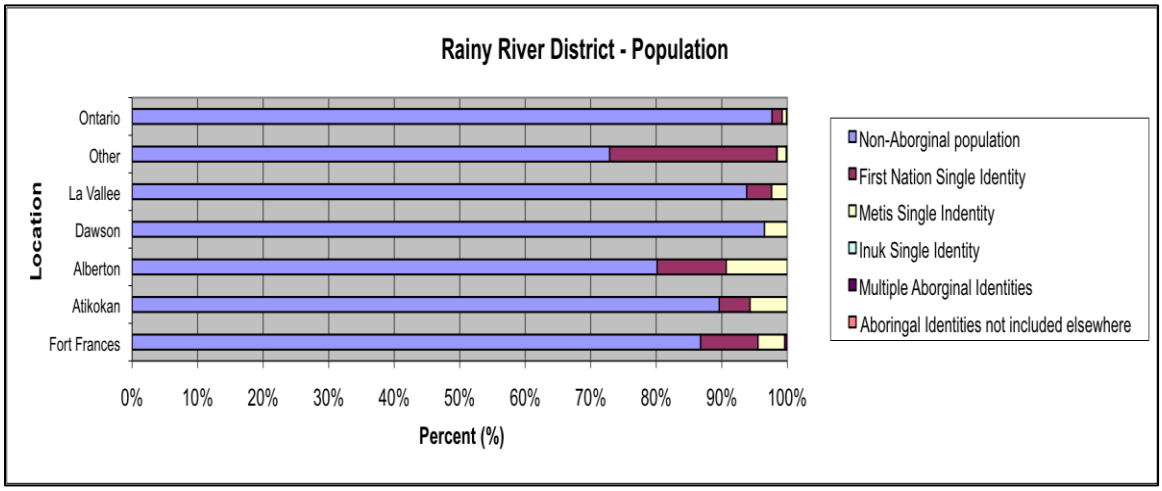

Figure 4. **Rainy River District FNIM population per town/city** [1]

Youth Population

In 2011, the population of youth for the Kenora District (24.6%) and the Rainy River District (23.4%) were slightly higher than the Ontario's youth population (20.3%; see **Figure 5**)[1]. Of the total youth population for the region, males and females each made up 50% of the population [1].

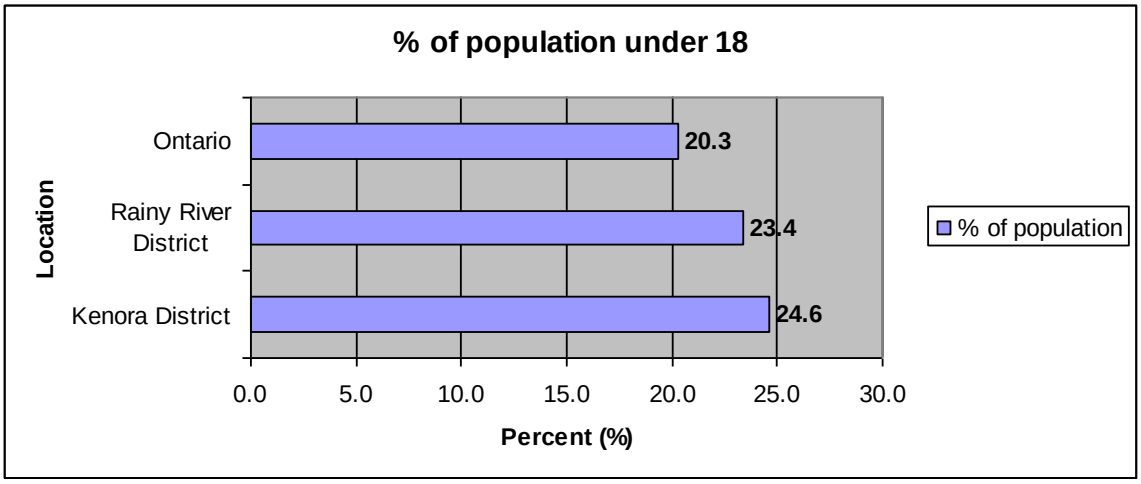

Figure 5. **Population of youth (under 18 years of age)** [1]

In 2011, FNIM youth under 18 years of age made up 37.7% of the FNIM population, while youth under 25 years of age made up 50.1% of the FNIM population (see **Figure 6**) [2]. In Rainy River, youth under 18 years of age made up 35.5% of the FNIM population, and youth under 25 years of age made up 45.9% of the population (see **Figure 6**) [2].

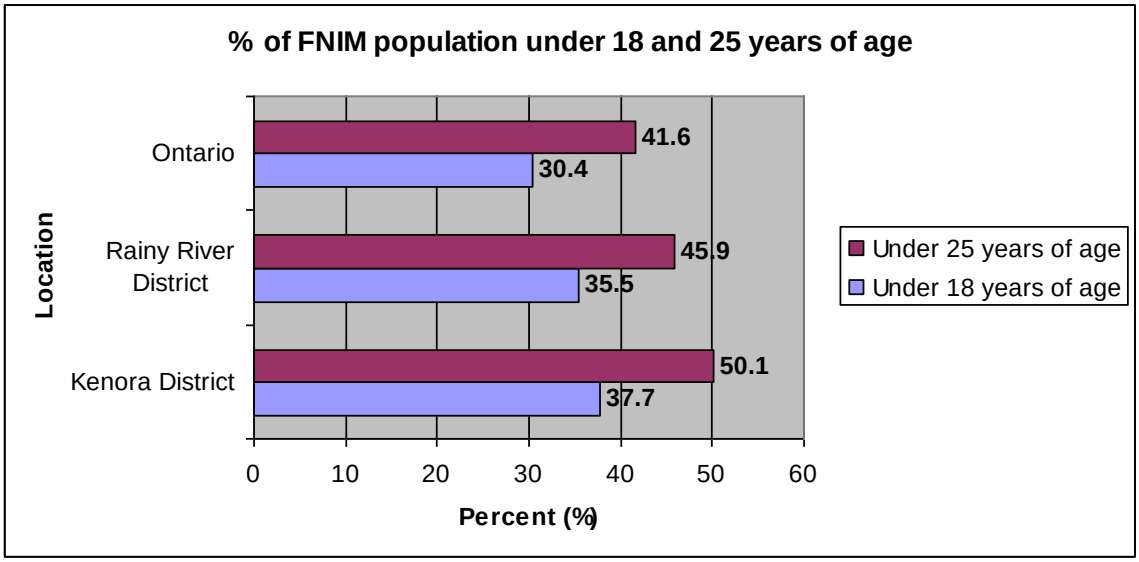

Figure 6. **Population of FNIM youth (under 18 years and 25 years of age)** [2]

Planning Area

This section highlights the different planning areas and bodies that operate within the jurisdiction of the Kenora-Rainy River Youth Justice Collaborative, including those for the delivery of health services, justice services, education services, and social services, as well as FNIM governing bodies/organizations that service youth in the region.

Health

The **North West Local Health Integration Network Division (NW LHIN)** is a planning body that works with agencies and community members in Northwestern Ontario "to set priorities and plan health services." [9] The NW LHIN also allocates funding for hospitals, Community Care Access Centres, community support service organizations, long-term care homes, community health centres, and community mental health and addictions agencies [9].

The NW LHIN has the largest land mass of all LHINs: 458,010 square kilometers, equivalent to 47% of the province [9]. Approximately 1.9% of the entire population of Ontario resides within the catchment of the NW LHIN. Within the NW LHIN there are 4 sub-area regions which include: The districts of Thunder Bay, and Rainy River; most of the Kenora District; and the City of Thunder Bay (see **Figure 7**) [9].

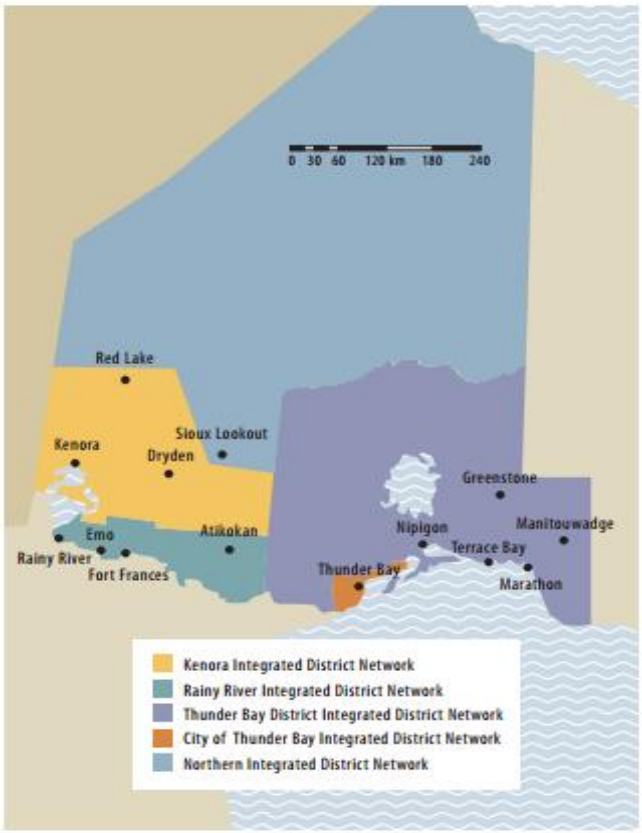

Figure 7. **NW LHIN Jurisdiction**

Many communities within the NW LHIN region are rural and remote, which creates significant challenges for the delivery of health care services. These challenges include: "limited access to care, limited health human resources, need for extensive travel and higher costs per capita." [9] The North West LHIN also notes that there are challenges to delivery and access to care for those living on-reserve or in remote areas. There are resource and capacity restraints experienced by these communities due to their remoteness, such as challenges in retaining and recruiting front-line staff and other health service providers [9].

Further, the **Northwestern Health Unit** (NWHU) is the public health unit that provides the following programs: health promotion, health protection, environmental health, family services, and equity access programs [10]. The NWHU covers the districts of Kenora and Rainy River and covers 166,514 km^2, or approximately one-fifth of Ontario [10]. There are 19 municipalities, 53

First Nations and two unincorporated or "unorganized" territories - Kenora Unorganized (part) and Rainy River Unorganized in the catchment area [10]. The NWHU operates 14 offices in the Kenora-Rainy River District located in Kenora (two offices), Dryden, Fort Frances, Sioux Lookout, Red Lake, Atikokan, Ear Falls, Emo, Ignace, Machin, Rainy River, Sioux Narrows-Nestor Falls, and Pickle Lake [10].

FNIM health services planning

The North West LHIN's Aboriginal Health Programs and Services Analysis and Strategy (2010) project describes that health services are offered to FNIM peoples living on-reserve or off-reserve in the North West by a myriad of service providers [11]. Some of these service providers are governed by FNIM governing bodies such as: "Provincial Tribal Councils, Health Planning Authorities, the Métis Nation of Ontario, Ontario Native Women's Association, Aboriginal Health Access Centres, Aboriginal Family Health Team, and Aboriginal Friendship Centres." [11] Health services are also offered to FNIM peoples through non-FNIM governing bodies, which include: "hospitals, public health units, Cancer Care Ontario, Community Care Access Centres, Family Health Teams, and Women's Shelters/Transition Houses." [11]

Comprehensive Mental Health and Addiction Strategy

Ontario's Comprehensive Mental Health and Addictions Strategy (2011) is aimed at providing services and supports to youth and their families, such as "fast access to high-quality services, early identification and support, and helping high-risk children and youth with unique needs." [12] One of these support systems is Aboriginal Mental Health and Addiction Workers, who will provide culturally appropriate services to Aboriginal children and youth in Aboriginal communities across the province [12].

Children and Youth

Ministry of Children and Youth Services

Kenora and Rainy River Districts are part of the Ministry of Children and Youth Services' (MCYS) Northern Regional Office, located in Sudbury [13]. The MCYS offers, funds, and/or monitors a wide range of services for children and youth in Ontario, which include: early childhood development services; adoption services; Children's Aid Societies, services for youth with special needs; services for youth involved with the justice system [13].

Child and Youth Welfare Organizations

Kenora-Rainy River Districts Child and Family Services provides services to children and families within the Northwest region of Ontario. Tikinagan Child and Family Services, Anishinaabe Abinoojii Family Services, and other independent agencies run through individual First Nation communities provide child welfare services for First Nation communities within the area.

Education

Ministry of Education

Five Ministry of Education School Boards operate within the districts of Kenora and Rainy River. They include:

- **Rainy River District School Board** – operates 14 schools in the service collaborative region [14].
- **Northwest Catholic District School Board** – operates 6 schools in the service collaborative region [15].
- **Kenora Catholic District School Board** – operates 5 schools in the service collaborative region [16].
- **Keewatin Patricia District School Board** – operates 14 schools in the service collaborative region [17].
- **Conseil scolaire de district catholique des Aurores boréales** - operates 3 schools in the service collaborative region [18].

Schools in First Nation Communities

Band Councils are responsible for the education of children and youth in First Nation Communities. Some bands operate schools on the reserve while others purchase education services from public schools through tuition agreements [19]. Métis children are not recognized under the Indian Act, and therefore fall under provincial jurisdiction for education.

Justice

The **Human Services and Justice Coordinating Committee** (HSJCC) are province-wide inter-Ministerial committees that aim to coordinate services, ease system navigation, increase communication, and to more effectively plan for specialized clients involved in the justice system in a given geographical location [20]. The **Northwest HSJCC** covers the same geographical boundaries as the NW LHIN, and is comprised of two local committees (Kenora and Thunder Bay) [20]. The local HSJCCs assist regional HSJCCs by providing specialized planning within local jurisdictions [20].

Youth Justice Services

Youth Justice Services provides a range of programming with the aim of rehabilitating youth and reintegrating them back to the community [21]. For First Nation Youth, **the Youth Justice Services in Ontario** provides youth with access to "41 Aboriginal Community based programs that focus on alternatives to custody, prevention, Extra-Judicial Measures and Sanctions, Attendance Centres, Restorative Justice and Reintegration *[sic]*." [21] These programs incorporate traditional and cultural practices as part of its life skills programming [21].

Aboriginal Justice Strategy

The **Aboriginal Justice Strategy** (AJS), a federal government initiative, aims to: 1) "contribute to a decrease in the rates of victimization, crime and incarceration among Aboriginal people in communities operating AJS programs"; 2) "assist Aboriginal people to assume greater responsibility for the administration of justice in their communities"; 3) "provide better and more timely information about community justice programs funded by the AJS"; and 4) "reflect and include relevant Aboriginal values within the justice system." [22]

Gladue

Gladue is a right designated to Aboriginal People that requires judges, when sentencing or setting bail for FNIM peoples, to "consider "all available sanctions other than imprisonment that are reasonable in the circumstances, with particular attention to the circumstances of Aboriginal offenders." [23] Gladue "attempts to deal with the crisis of overrepresentation /inequities of Aboriginal Peoples in custody, to the extent possible, through changing how judges sentence." [23]

Jordan's Principle

Jordan River Anderson was a First Nation child living on reserve in Norway House First Nation in Manitoba, born with complex medical needs and required hospitalization for the early part of his life to treat his medical issues [24]. Jordan passed away while waiting to return home, which was delayed by the provincial and federal government to agree on who was financially responsible for his medical costs [24]. **Jordan's Principle** requires that debates over jurisdiction be delayed "in order to ensure First Nation children receive the same care available to non-First Nation children." [25] Jordan's Principle was adopted in the House of Commons in December 2007, but remains to be fully implemented [26].

First Nation Tribal Councils

Tribal Councils are a grouping of bands with common interests who voluntarily join together to provide advisory and/or program services to band members. The **First Nation Councils** included in the Kenora and Rainy River catchment area include:

- Independent First Nations Alliance
- Anishinaabeg of Kabapikotawangag Resource Council Inc.
- Windigo First Nations Council
- Pwi-Di-Goo-Zing-Ne-Yaa-Zhing Advisory Services
- Keewaytinook Okimakanak/ Northern Chiefs Council
- Bimose Tribal Council
- Shibogama First Nations Council

Treaties

The **Treaties** covering the Kenora and Rainy River Districts (see **Figure 8**) include:

- Grand Council Treaty 3 (1873) [27]
- Treaty 5 (1875) [27]
- Nishnawbe-Aski Nation: Treaty 9 (1905) [28]

Figure 8. Geographic boundaries of Treaties in Northern Ontario (the different colour location markers represent the Tribal Councils that each First Nations community belongs to).

Representative First Nation Political Territorial Organizations

These organizations undertake, as one of their main functions, all or some of the following: consultations and workshops; communications; public education; public awareness; policy or program development; and design and research on behalf of its members [29]. For the area of Kenora and Rainy River, these organizations include:

- Grand Council Treaty 3
- Independent
- Nishnawbe Aski Nation
- Union of Ontario Indians

Determinants of Health

This section of the report looks at the Determinants of Health (DoH) for the Justice Collaborative area. The DoH are the living conditions experienced by people (e.g. place of birth, where they live, work, etc.) and the health and social services they receive (see **Figure 9**) [30]. The DoH are a critical component of the Public Health Agency of Canada's (PHAC) Population Health Approach. The Population Health Approach recognizes that health is influenced by a broad range of non-medical factors known as the DoH. These factors interact to influence the health over one's lifespan [31]. Inequities in access to the DoH contribute to the health disparities seen between groups of people within a population [31]. These circumstances, in turn, are shaped by a wider set of forces: economics, social policies, and politics [30].

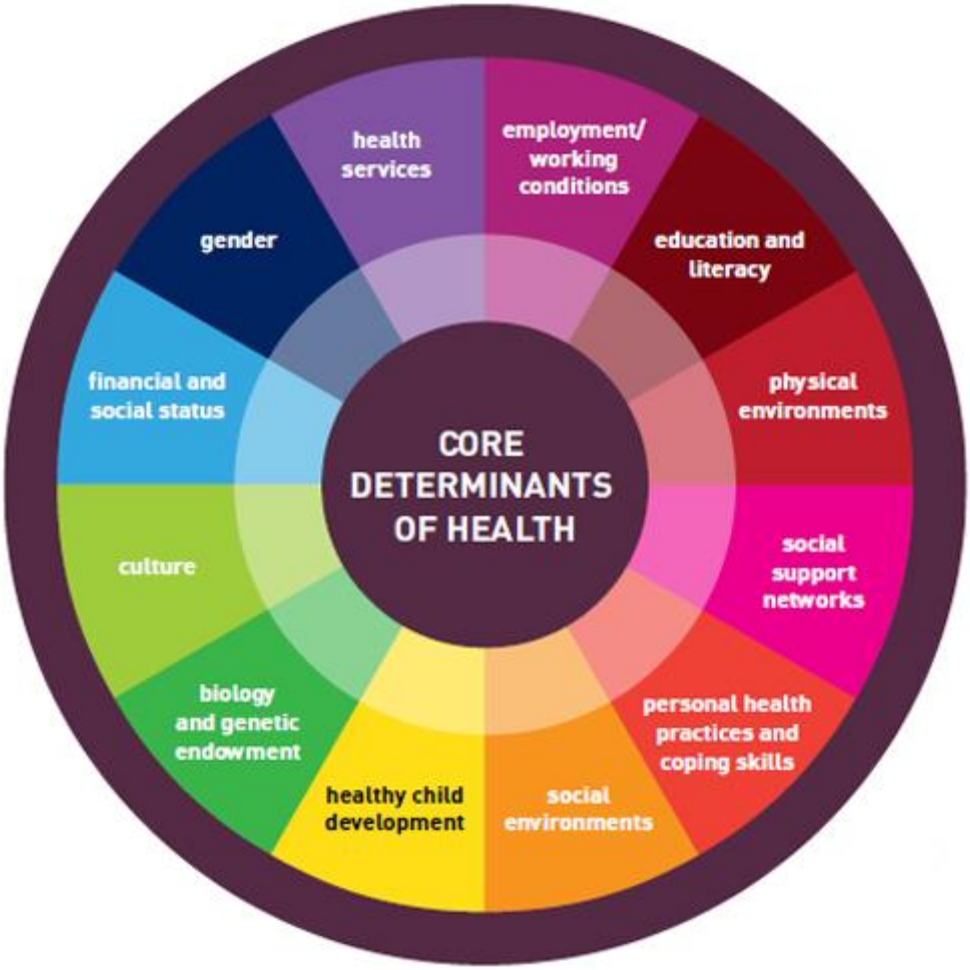

Figure 9. The core determinants of health.

The National Aboriginal Health Organization (NAHO) includes 8 additional determinants of health specific to Aboriginal populations, including: colonization, globalization, migration, cultural continuity, access, territory, poverty and self- determination [32]. It is important to include these historical determinants in order to better understand current health status for First Nations people, because social determinants of health are often influenced by both political and historical events [32].

The following information on the DoH does not focus specifically on children and youth. It does, however, provide an indication of the DoH for children and youth in the region as the following determine the social and economic situation of children and youth until they are able to support themselves: Income and Social Status, Social Support Networks, Education & Literacy, Employment & Working Conditions, Social Environments, Personal Health Practices & Coping Skills, Biology & Genetic Endowment, Physical Environments, Healthy Child Development, Health Services, Gender and Culture, Colonization, Globalization, Migration, Cultural Continuity, Access, Territory, Poverty and Self-Determination.

Income and Social Status

In 2010, the average after-tax income for residents in the Kenora District ($32,377) and the Rainy River District ($31,998) are slightly lower than the provincial average ($35,249; see **Figure 10**) [1]. On average, women in Kenora earned $8,942 less than men [1]. Women living in Rainy River earned $7,959 less than men [1]. This discrepancy in income between genders is less than the provincial average ($11,134) [1].

> "Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth."- *Public Health Agency of Canada, 2010*

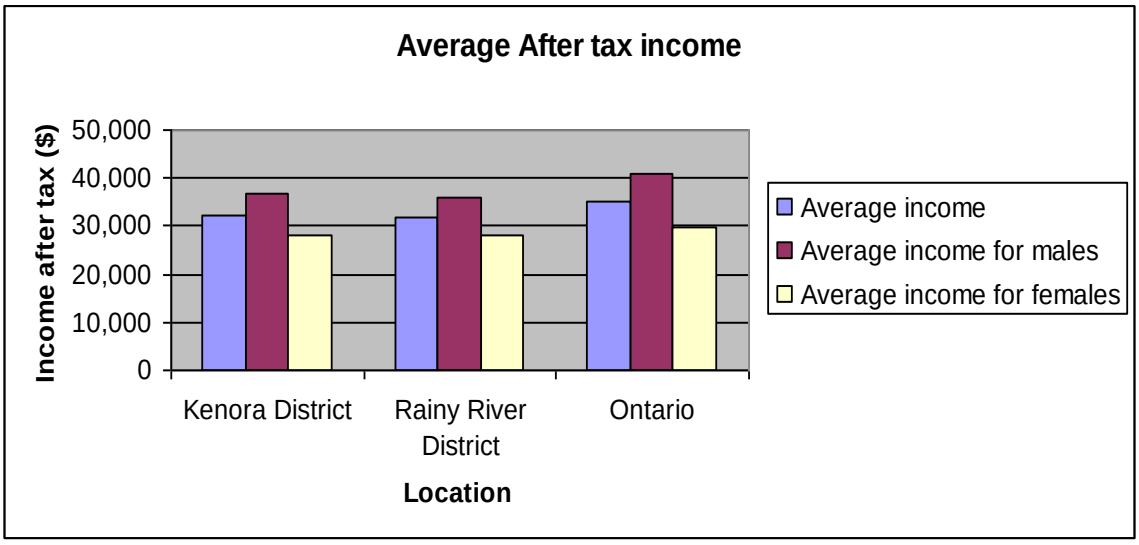

Figure 10. Average after-tax income in the Districts of Kenora and Rainy River [1].

During the same time period, the average income for FNIM peoples in the District of Kenora and the District of Rainy River was $6,000-$9,000 less than in the general population. In Kenora, the average income for FNIM peoples was $23,135, just slightly more than the average income for FNIM peoples in Rainy River ($23,000; see **Figure 11**)[2]. On average, FNIM women make, on average, $269 more than FNIM males in Kenora, while FNIM males in Rainy River make, on average, $2,517 more than FNIM women [2].

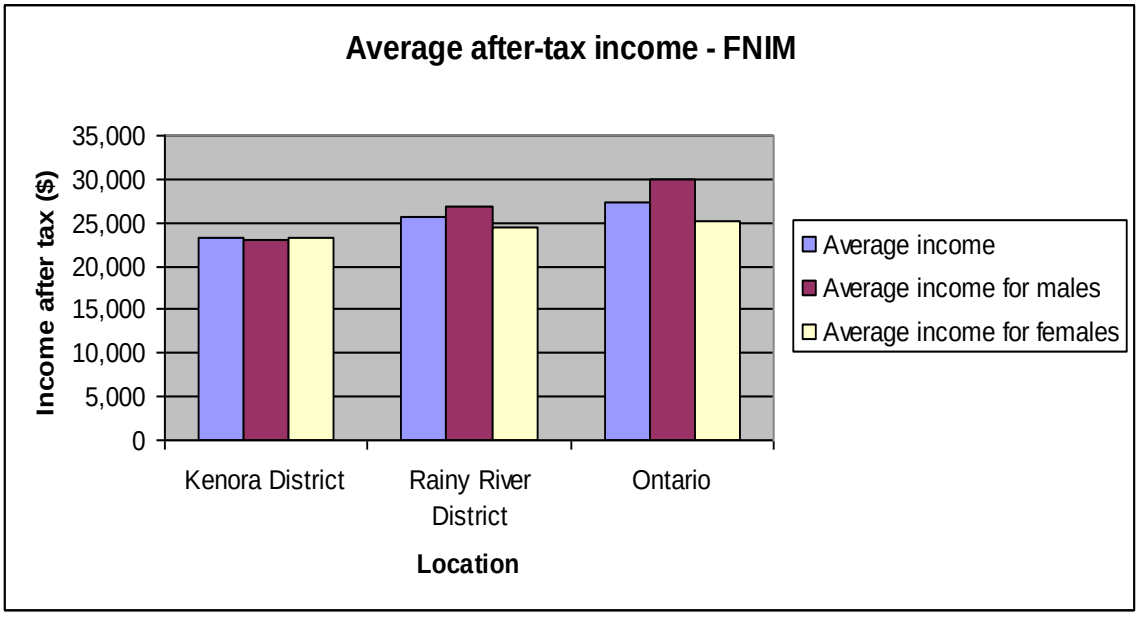

Figure 11. Average after-tax income for FNIM peoples in the Districts of Kenora and Rainy River [2].

In 2011, trends in family income for Kenora and Rainy River were similar to the province as a whole. Couples with children earned more than families with no children and lone-parent families, and lone-parent families earned the least of the three family types (see **Figure 12**).

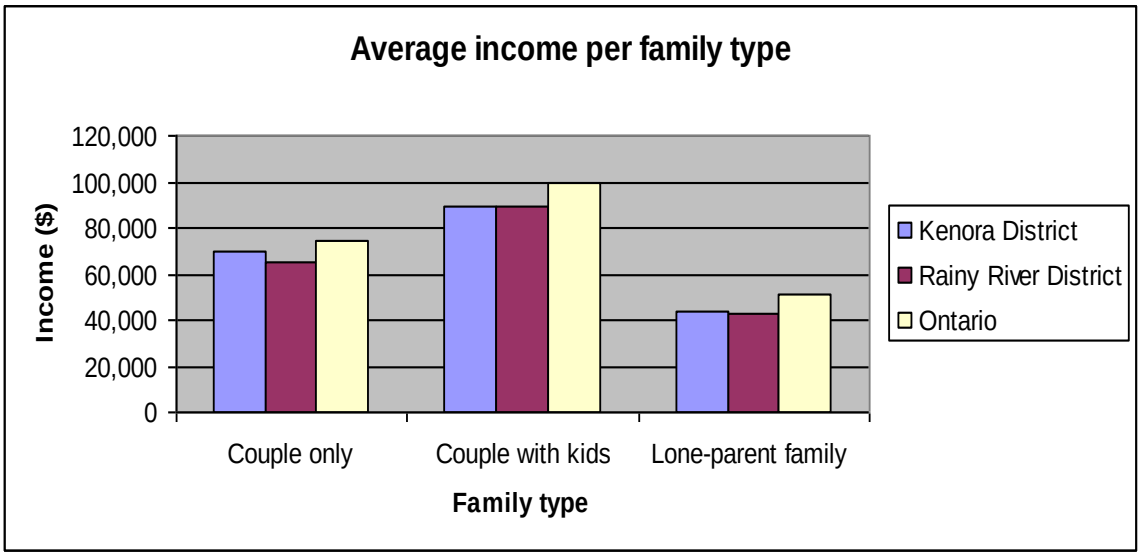

Figure 12. Average family income per family type [1].

Poverty

> "Poverty is… linked to social exclusion, low social cohesion and increased crime. In the case of Aboriginal peoples, social exclusion in turn, prevents individuals from pursuing education and training. More profound perhaps is the lack of control poverty creates, with resulting anxiety, insecurity, low self-esteem and feelings of hopelessness...The accumulation of these psychosocial stressors often leads to poor mental health and increased vulnerability to infection, as well as diabetes, high blood pressure, and depression." – *National Collaborating Centre for Aboriginal Health, 2009*

The percentage of youth living in low income in Kenora and Rainy River are similar to that of Ontario (see **Figure 13**) [1].

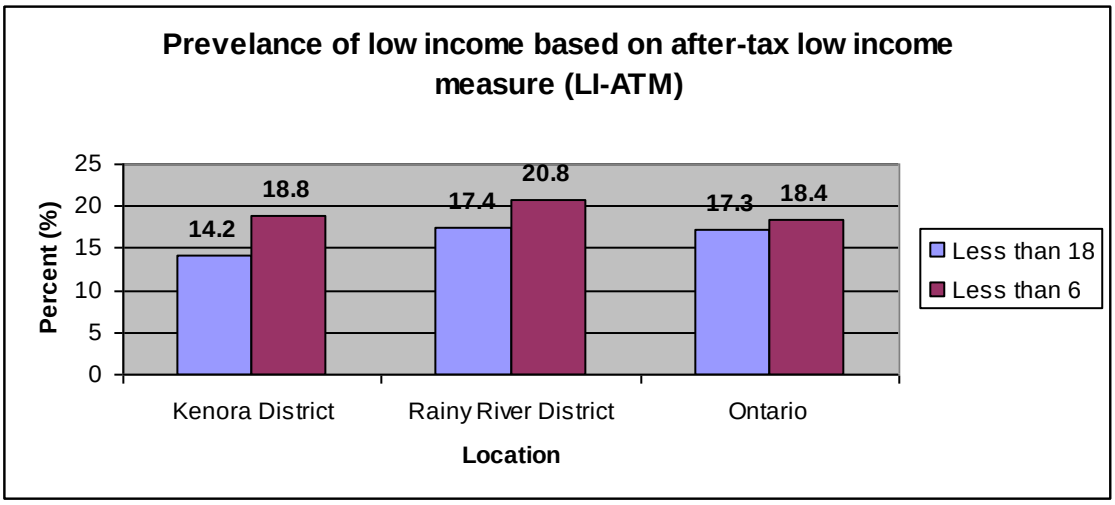

Figure 13. Youth living under the poverty line in Kenora, Rainy River, and Ontario [1].

Off-reserve FNIM youth living in the Districts of Kenora and Rainy River have higher rates of living in low income compared to the general population [2]. The percentage of off-reserve FNIM youth living in low income in Kenora and Rainy River is similar to the provincial average for off-reserve FNIM youth across the province (see **Figure 14**) [2].

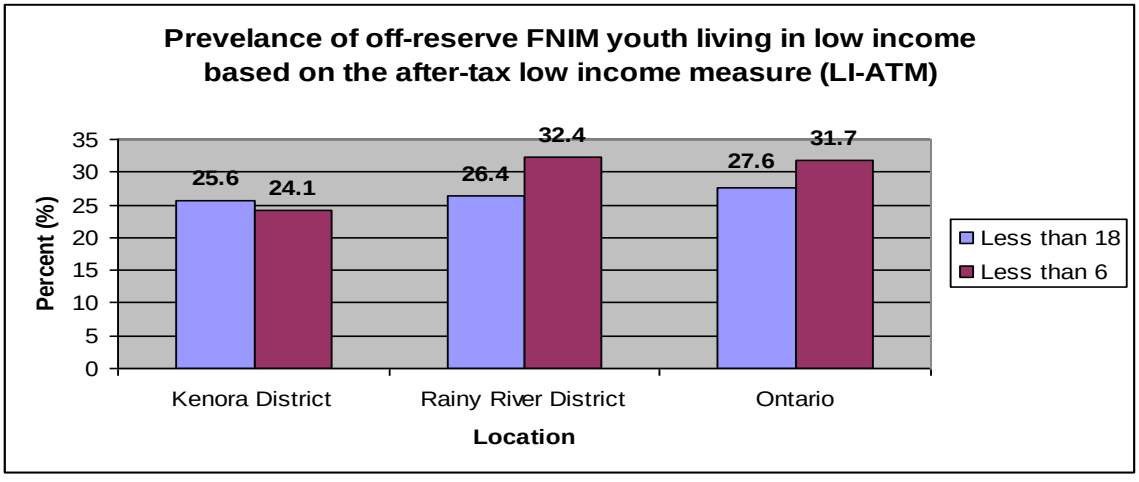

Figure 14. FNIM youth living under the poverty line in Kenora, Rainy River, and Ontario [2].

Food Insecurity

Food insecurity has been identified by the Mamow Sha-way-gi-kay-win (a collaboration between philanthropic organizations, universities, and private citizens in Southern Ontario and thirty remote First Nations communities in northwestern Ontario) as a major issue for FNIM peoples in the Northwest [33]. The high cost of food and high levels of poverty have resulted in food insecurities in FNIM communities in the North West [33]. In some communities grocery bills are double what they are in large urban centers like Toronto [33].

According to the Ministry of Health Promotion, the region has the highest Cost of Nutritious Food Basket [34], which compares the cost of basic healthy eating with average food purchase in the province, at $212 per week [35]. This rate is higher than the average cost of food ($178) per week for a family of four in Ontario [36].

Social Environment

The sense of community-belonging is higher in the Northwestern Health Unit jurisdiction (82.3%) compared to Ontario (67.5%)[3]. According to Statistics Canada (2013), "research shows a high correlation of sense of community-belonging with physical and mental health" [3].

> "The array of values and norms of a society influence in varying ways the health and well-being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health." - *Public Health Agency of Canada, 2010*

The Northwestern Health Unit's life satisfaction rate (population aged 12 and over who reported being satisfied or very satisfied with their life in general) is 91.6%, consistent with provincial average (91.5%) [3].

Lone parent families

According to Statistics Canada's Health Profile for the Northwestern Health Unit, the total percentage of lone parent families is greater than the rest of Ontario [3]. In the Northwestern Ontario, the total for this characteristic is 18%, compared to 16.3% for the rest of Ontario [3]. The Northwest LHIN Environmental scan indicates that the percentage of lone parent families is 29.9% in Kenora and 24.9% in Rainy River, compared to 15.8% for the rest of Ontario [37].

Of the 18% of families headed by a single parent in the NWHU, 73.3% (or 13.2% of all families) were headed by females [3]. In comparison, 26.7% of single parent families (or 4.2% of all families) in the NWHU were headed by a male [3].

Census data from the 2011 National Household Survey shows similar results in lone parent families for the FNIM population in Kenora and Rainy River. In Kenora, 72.6% of single parent families were headed by females compared to 27.1% for males [2]. In Rainy River, 80% of FNIM lone parents were headed by females compared to 20% headed by males [2].

Colonization

The colonization of FNIM peoples in Canada has led to FNIM peoples to incur "historical trauma including Indian Residential Schools effects and Post Traumatic Stress Disorder" and "unresolved intergenerational grief due to historical trauma." [38] These two issues have and continue to affect FNIM peoples' mental health and well-being in the North West [38].

> "Colonialism impacts the health of Aboriginal peoples by producing social, political and economic inequalities that 'trickle down' through the construction of unfavorable intermediate and proximal determinants. The specific mechanisms of colonialism occur in diverse domains such as environmental relationships, social policies and political power." – *National Collaborating Centre for Aboriginal Health, 2009*

Migration

> "Increased urbanization of Aboriginal Canadians from reserves and home communities can result in a disconnection from lands and traditional practices that are tied to maintaining Indigenous knowledge systems. Complementary changes to regimes around nutrition and activity levels have translated into elevated levels of diabetes. The on-reserve/ off-reserve migration applies only to First Nations, although relocation patterns in Inuit and Métis are similar in scope and rationale for moving to more urban locations." –*Interagency Coalition on AIDS and Development, 2009*

When considering the population, it is important to take into account how people move within and between communities. Movement from one residence to another, due to social and economic reasons or housing and employment needs, provides insight to the population growth in a region, or its decline [39]. In the Kenora District, 89% of the population in 2011 lived at the same address five years ago (see **Figure 15**)[1]. In 2006, 67% of the population lived at the same address five years ago [1]. These trends also reflect the FNIM population in the District of Kenora (see **Figure 16**)[2].

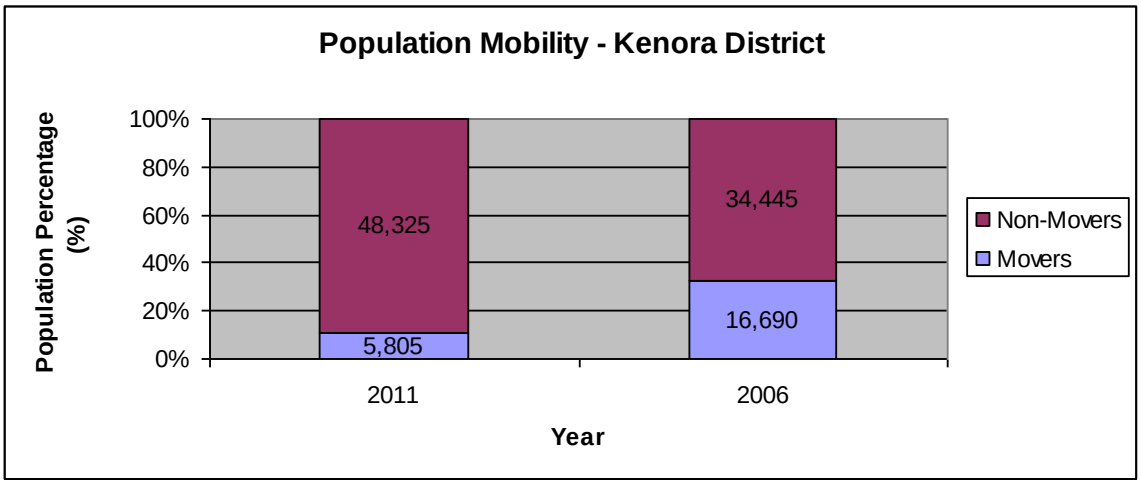

Figure 15. Kenora District – Population Mobility in 2006 and 2011 [1].

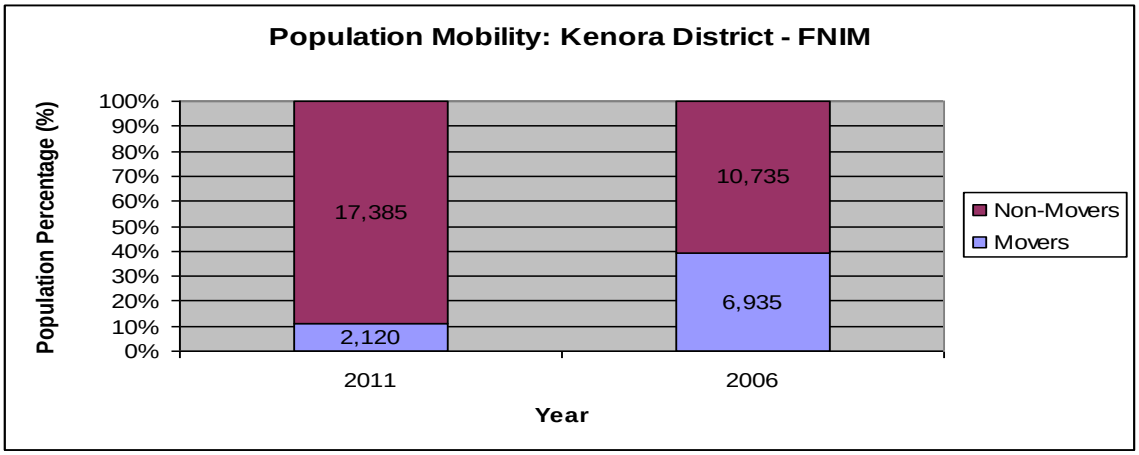

Figure 16. Kenora District – FNIM Population Mobility in 2006 and 2011 [2].

In the District of Rainy River, 91% of the population in 2011 lived at the same address they did 5 years ago (see **Figure 17**)[1]. Similar trends are mirrored in the mobility statistics for FNIM peoples living in the region (see **Figure 18**)[2].

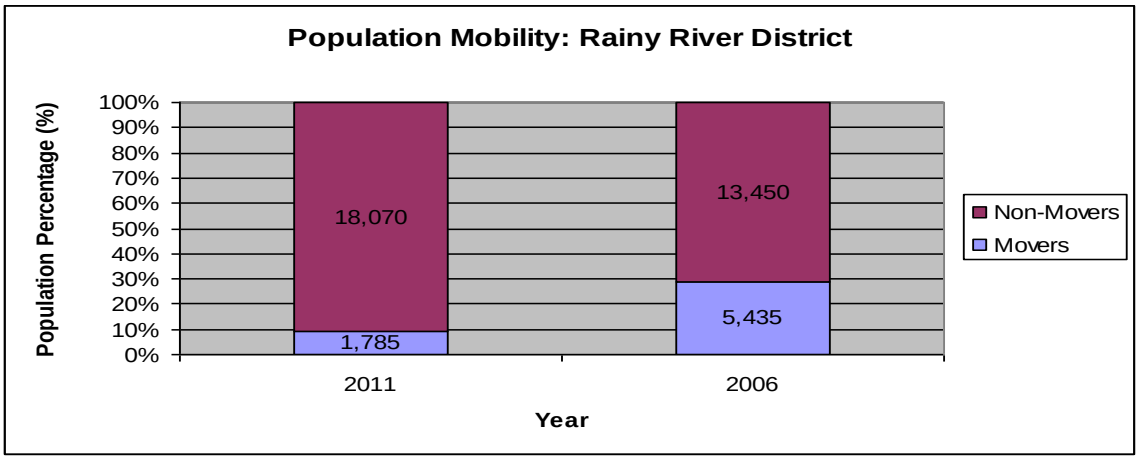

Figure 17. Rainy River District – Population Mobility in 2006 and 2011 [1].

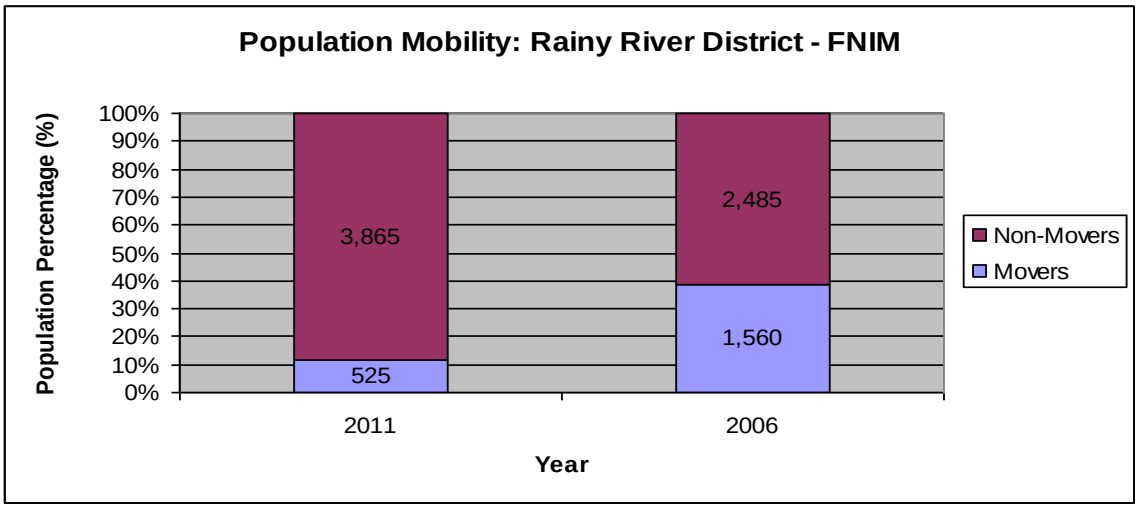

Figure 18. Rainy River District – FNIM Population Mobility in 2006 and 2011 [2].

Language

Census data from the 2011 National Household Survey (NHS) indicates that 7465 people in Kenora and 600 people in Rainy River spoke an FNIM language (see **Figure 19**) [1].

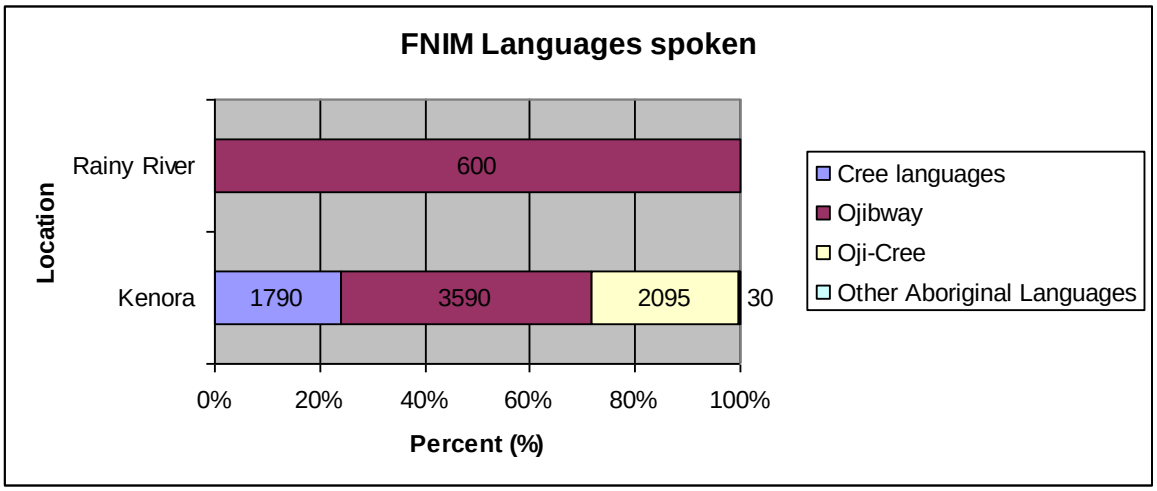

Figure 19. Number of people in Kenora and Rainy River speaking a traditional language [1].

Education and Literacy

"Health status improves with level of education. Education is closely tied to socioeconomic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy." *–Public Health Agency of Canada, 2010*

Populations of the Kenora and Rainy River Districts mirror the educational attainments of the province as a whole, with two exceptions (see **Figure 20**). The first discrepancy is that Kenora (16.7%) and Rainy River (21.0%) have a lower rate of post-secondary attainment when compared to the provincial average (33.0%)[1]. The second discrepancy is that Kenora has a higher percentage of people without a high school diploma (23.2%), compared to the province as a whole (11.2%) [1].

"Inadequate education often includes poor literacy, which affects one's ability to acquire information about proper nutrition or healthy food preparation. Insufficient education also diminishes the skills one might have to offer the labour market, often resulting in low paying jobs. The ensuing poverty and social exclusion, both disproportionately experienced by Aboriginal peoples, increases the risk of family instability, which often manifests in divorce and single parenthood." – *National Collaborating Centre for Aboriginal Health, 2009*

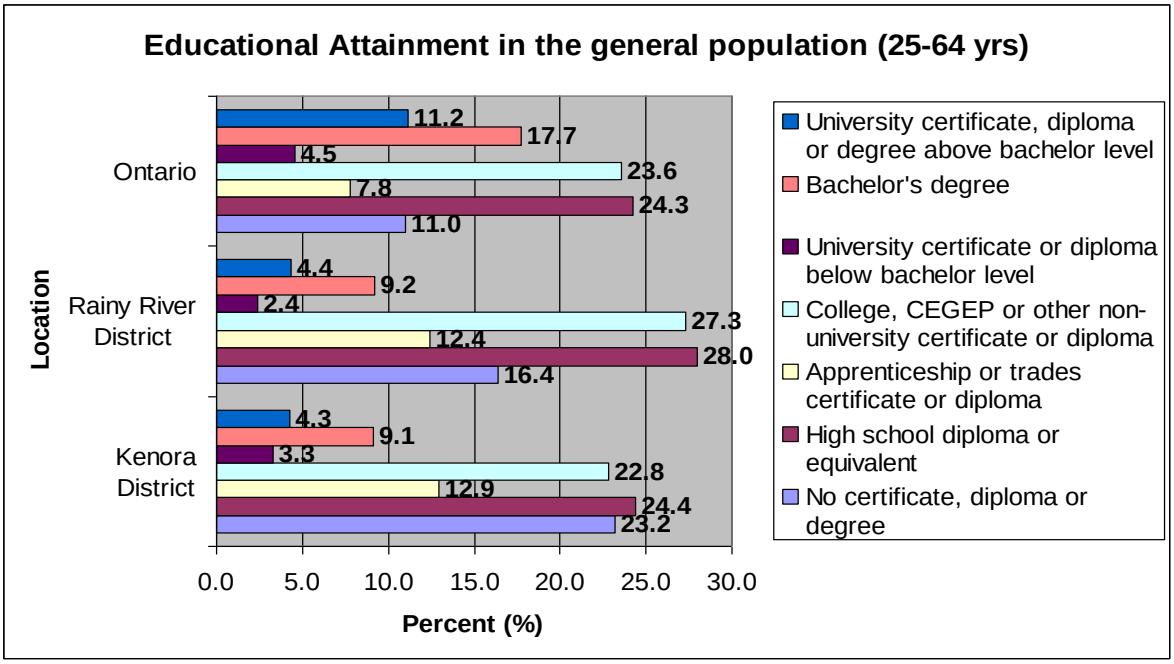

Figure 20. Educational attainment for the general population in the Districts of Kenora and Rainy River [1].

FNIM populations living in the Districts of Kenora and Rainy River show similar rates of educational attainment when compared to the general population with three exceptions (see **Figure 21**)[2]. The first exception is that the percent of FNIM from Kenora without a high school degree is almost double that of the general population of Ontario [2]. The final discrepancies are that FNIM from Kenora are less likely to have college or a university degree when compared to the general population of Ontario [2].

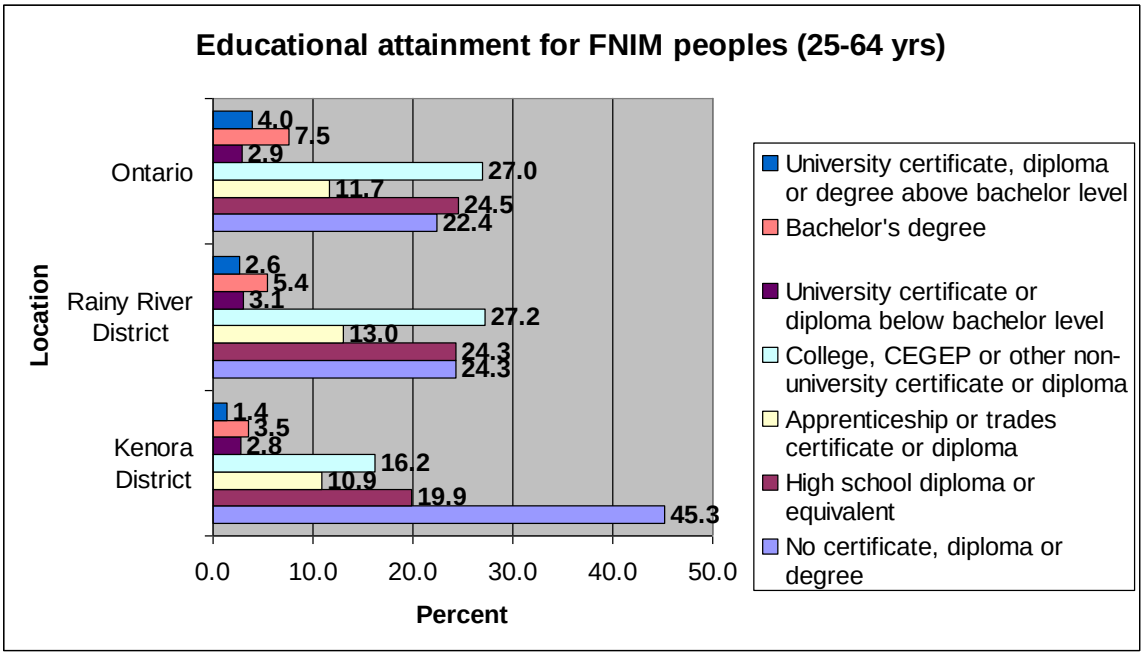

Figure 21. Educational attainment for FNIM peoples in the Districts of Kenora and Rainy River [2].

Employment and Working Conditions

According to the Health Profile from 2011 census information, residents in the Northwestern Health Unit (NWHU) experience similar unemployment rate and long-term unemployment compared to the provincial levels.

"Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities." – *Public Health Agency of Canada, 2010*

Unemployment Rates	Northwestern Health Unit	Ontario
Unemployment (%) "Proportion of the Labour force aged 15 and over who did not have a job during the reference period." [3]	8.1%	7.8%
Long-term unemployment (%) [3]	5.5%	4.8%

While there was no information available for NWHU for FNIM unemployment rates, the Aboriginal Population Profile from Statistics Canada (2011) states the unemployment rate for FNIM was 19.1% in the District of Kenora and 14.2% in the District of Rainy River [2]. There were no statistics on long-term unemployment for either region.

Physical Environments

"The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being." –*Public Health Agency of Canada, 2010*

Population Spread

The majority of the population in the NWHU lives in remote and rural communities. Having a population spread over a large geographic area isolates the population from health services, which in turn increases the cost to access services [40].

Population Density and Rural Population	**Northwestern Health Unit** [3]	**Ontario** [3]
Small population centre: area between 1,000 and 29,999 km^2.	45.1 %	9.2 %
Rural area population: Population centers are defined as "an area with a population of at least 1,000 and a density of 400 or more people per square kilometer. All areas outside population centers continue to be defined as rural areas." [3]	54.9 %	14.1 %
Population density (persons per km^2): "The calculation for population density is total population divided by land area. Land area is the area in square kilometers of the land-based portions of standard geographic areas." [3]	0.44 %	14.14%

Unintentional Injuries and Deaths

Unintentional injuries, deaths (per 100,000 population) "is described as external causes of unintentional injuries, which includes: transport accidents, falls, poisoning, drowning and fires, but not complications of medical and surgical care." [3] In the NWHU, the rates for the region (51.2%) are more than double the provincial average (23.4%) [3].

Housing

The average shelter costs for Kenora and Rainy River are lower than the provincial averages for both home owners and renters (see **Figure 22**).

"Among Aboriginal peoples, physical environments that are largely detrimental to health have been imposed through historic dispossession of traditional territories, as well as current reserve or settlement structures... Lack of affordable housing has created situations of overcrowding in First Nation and Inuit communities, as well as homelessness for Aboriginal people living in urban areas. Many on-reserve homes are overcrowded and lack appropriate ventilation, resulting in excessive mold, which has been implicated in several health problems including severe asthma and allergies among Aboriginal children." *– National Collaborating Centre for Aboriginal Health, 2009*

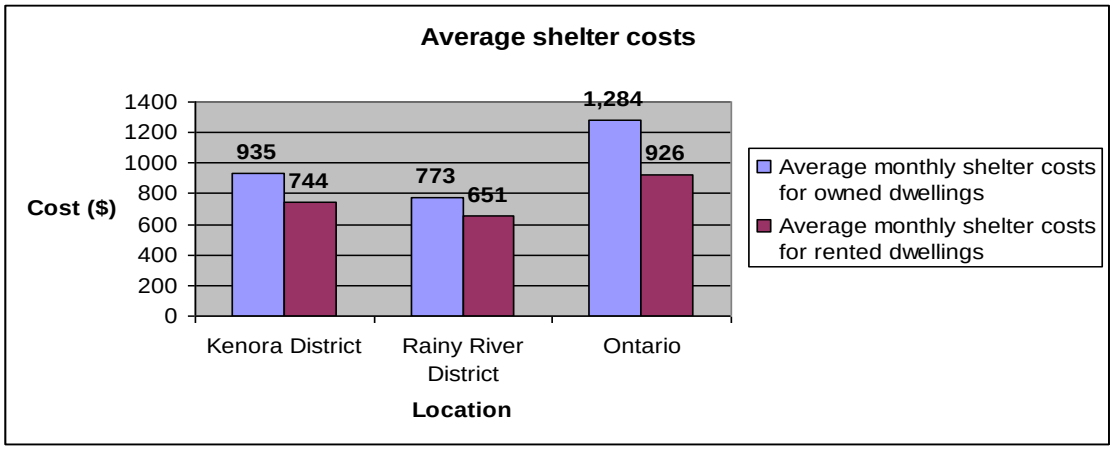

Figure 22. Average shelter costs in the Districts of Kenora and Rainy River [3].

The average shelter costs for FNIM living in the Districts of Kenora and Rainy River are similar to the general population with the exception of shelter costs for owned dwellings in Kenora (see **Figure 23**). The average costs for FNIM peoples who own their own dwellings are $112 more expensive than the general population [2].

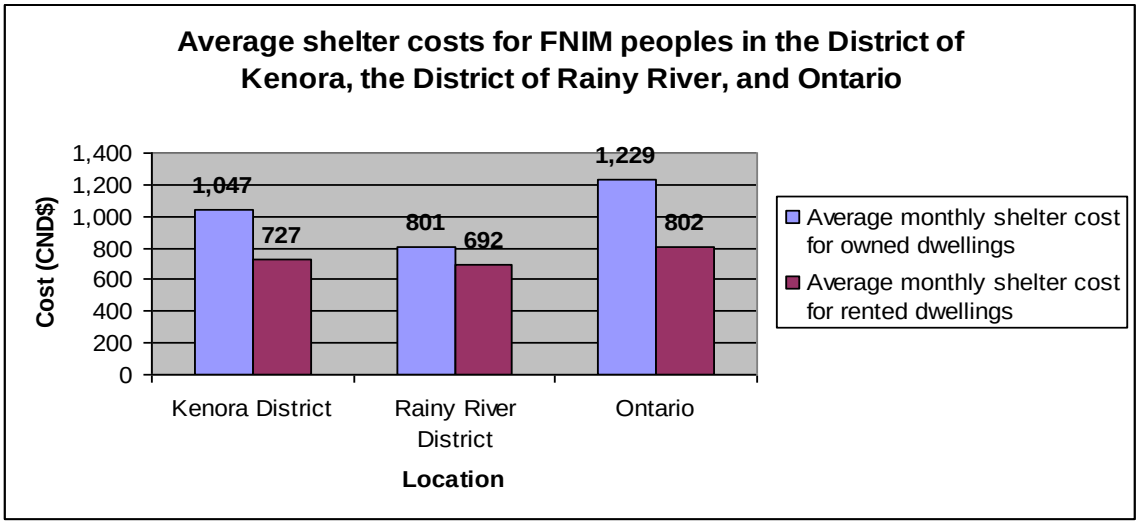

Figure 23. Average shelter costs for FNIM peoples in Kenora, Rainy River and Ontario [1]**.**

Percent of income spent on shelter costs

There were fewer residents living in Kenora and Rainy River who spent more than 30% of their income on shelter costs compared to the provincial average (see **Figure 24**) [1]. There were also fewer residents living in Kenora and Rainy River who spent less than 30% of their total income on shelter costs compared to the provincial average [1].

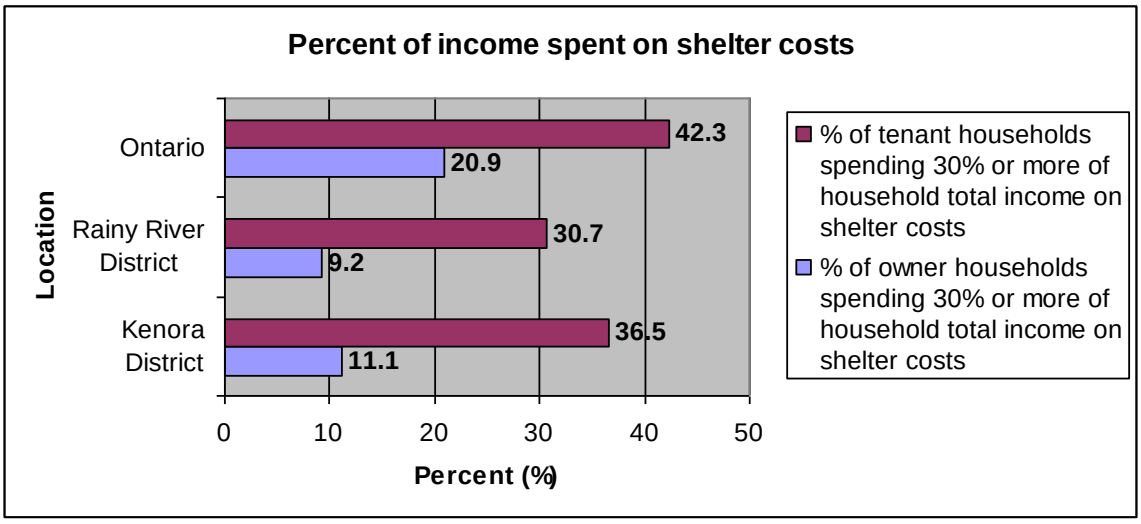

Figure 24. Percent of income spent on shelter costs

FNIM homeowners showed similar spending rates of homeowners spending more than 30% of their total income on shelter costs as the general population in Kenora and Rainy River (see **Figure 25**)[2]. FNIM renters, on the other hand, pay more than renters in Kenora and Rainy River compared to the general population [2].

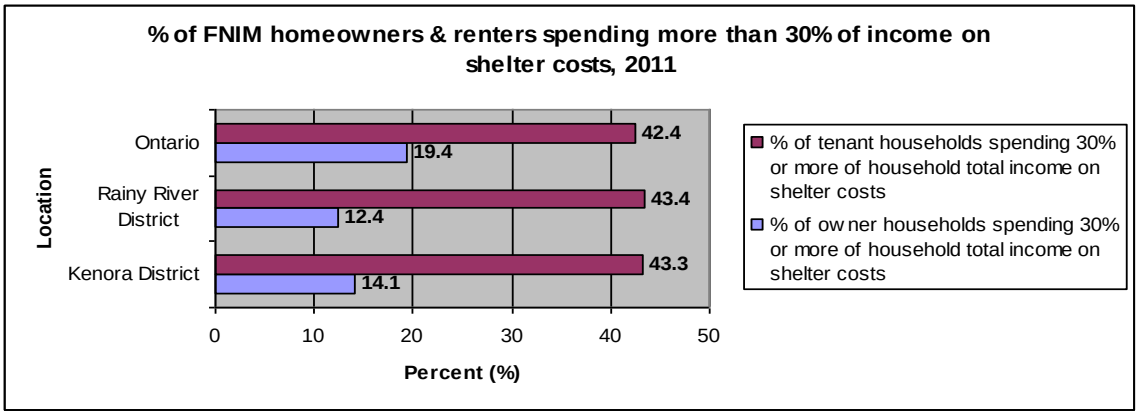

Figure 25. Percent of total income for FNIM spent on shelter costs [2].

Subsidized Housing

Statistics from the 2011 National Household Survey indicate that a higher percentage of residents in Kenora and Rainy River lived in subsidized housing compared to Ontario as a whole (see **Figure 26**)[1].

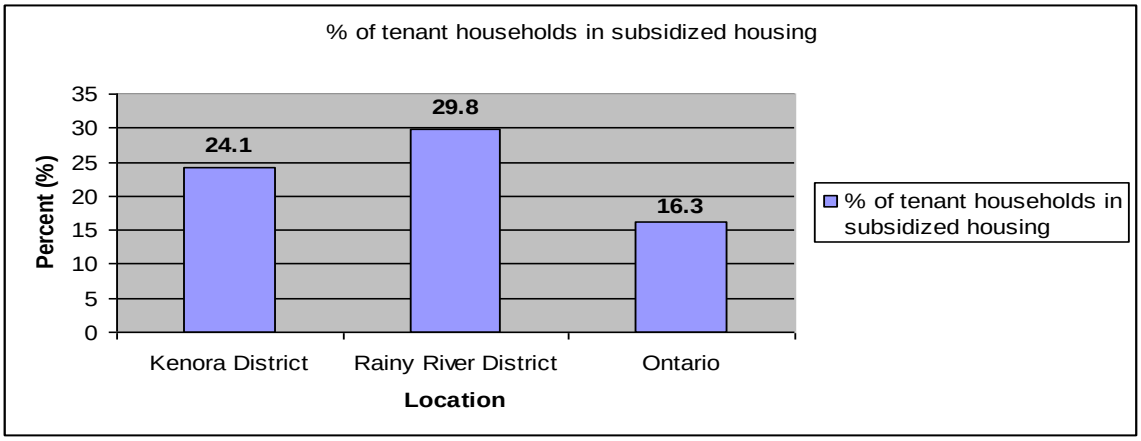

Figure 26. Percentage of tenants residing in subsidized housing [1].

The proportion of FNIM tenants in subsidized housing is similar to those in the general population in the Districts of Kenora and Rainy River (see **Figure 27**)[2].

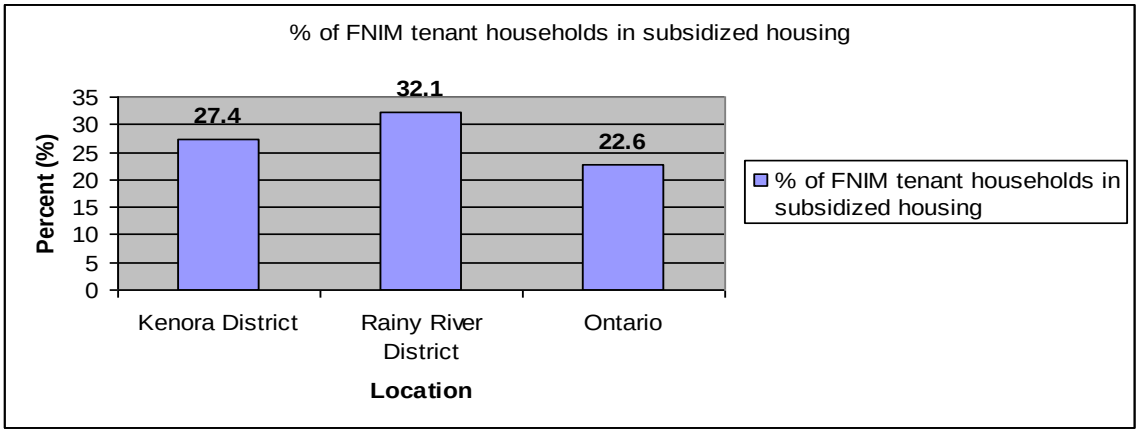

Figure 27. Percentage of FNIM tenants residing in subsidized housing [2].

The Kenora District Services Board (KDSB) examined the wait list for families to receive affordable housing and found that on average families had to wait 209 days before receiving affordable housing [41].

Homelessness

The KDSB also surveyed people who were or are currently homeless to find out the reasons they became homeless. The KDSB found that a large portion of those who became homeless did so as a result of a family crisis and were homeless for 1-6 months [41]. Forty percent of the participants stated that they experienced homelessness for the first time when they were 20 years of age or younger [41].

Healthy Child Development

"New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care." *–Public Health Agency of Canada, 2010*

Infant Health

According to Statistics Canada (2013), the infant mortality rate for the Northwestern Health Unit is nearly double compared to the provincial average [3]. The life expectancy of a person in the Northwestern Health Unit jurisdiction is 4 years lower than a child born elsewhere in Ontario [3].

	Northwestern Health Unit			**Ontario**		
Infant Health	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Infant mortality (per 1,000 live births) "Infant mortality corresponds to the death of a child under one year of age. Expressed as a rate per 1,000 live births." [3]	9.1	11.2	7.0	5.1	5.5	4.6
Life expectancy at birth (years) "Life expectancy is the number of years a person would be expected to live, starting from birth on the basis of the mortality statistics for a given observation period." [3]	77.4	75.8	79.1	81.5	79.2	83.6

Access to Health Services and Professionals

According to Statistic Canada's Health Profiles for the Northwestern Health Unit and Ontario, the physician-to-population rate is similar for both [3]. In terms of availability of specialists, on average, residents of Ontario have access to specialists within their home communities at a rate that is seven times higher than residents in the Northwestern Health Unit jurisdiction (see **Figure 28**)[3].

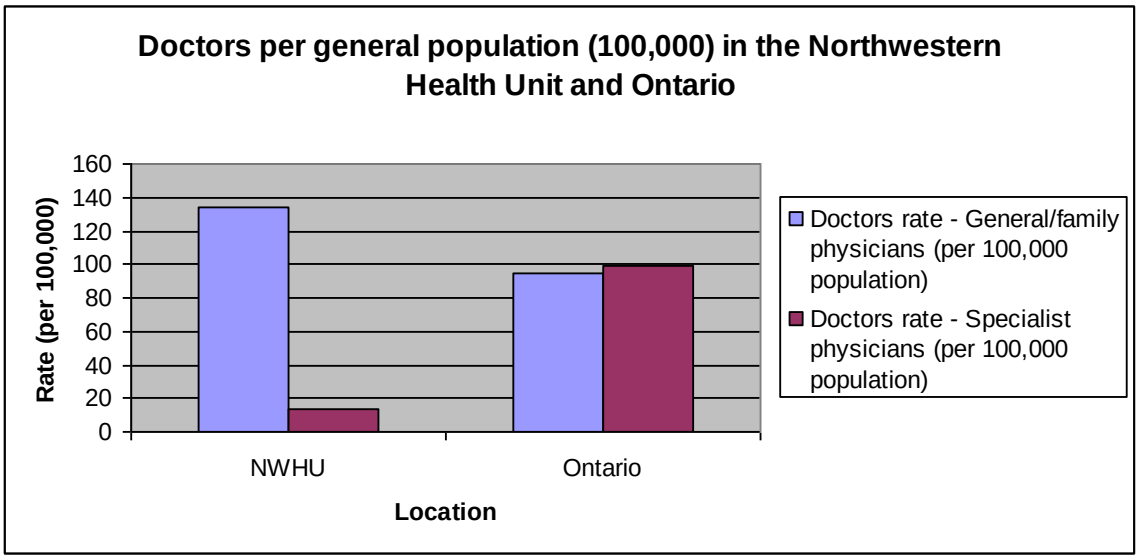

Figure 28. Doctors per population in the Northwestern Health Unit and Ontario [3].

Mental Health Issues and Services

This section of the report underlines mental health, substance use and service use statistics for the Service Collaborative area. It was difficult to find information on mental health, substance use, and service use that was specific to both the Kenora and Rainy River, and youth. Information for this section, at times, had to be taken from studies that merged Kenora and Rainy River with other surrounding geographic areas. For example, the 2011 Ontario Student Drug Use and Health Survey (OSDUHS) does not measure Kenora and Rainy River separately, but rather, it combines the statistics from Kenora and Rainy River with statistics collected from other cities and towns in the North East and North West LHINs. At other times, youth-specific data was not available, and thus, was combined with adult statistics. For example, Statistics Canada only reports data on suicides for people 15 years of age and above.

Mental Health Status

Perceived Well-being

The percentage of the population 15 years of age and above who perceived most days in their life to be stressful in the NWHU jurisdiction was 22%, compared to the provincial average of 24% [3].

The percentage of people who perceived their overall health as very good or excellent in the NWHU jurisdiction was 55%; the provincial average was 60.4% [3].The percentage of people who perceived their mental health as very good or excellent in the NWHU jurisdiction was 70%; the provincial average was 72.4% [3].

Mental Health Disorders/Issues

Results from the 2011 Ontario Student Drug Use and Health Survey (OSDUHS) indicated that the mental health of youth in Grades 9 to 12 in the North East and North West LHINs differ from the provincial averages in the following ways [4]:

Higher than average	**Similar to the average**	***Lower than average***
• Antisocial behaviour (12.5% vs. 9.4%)	• Fair/poor self-rated mental health (16.5% vs. 15.3%) • Elevated psychological distress (36.1% vs. 37.1%)	• Symptoms of anxiety/depression (3.8% vs. 7.0%) • Suicide ideation (8.0% vs. 11.12%

Mood Disorders

The percent of the population aged 12 years and above in the NWHU jurisdiction who reported having been diagnosed by a health professional as having a mood disorder, such as depression, bipolar disorder, mania or dysthymia (7.1%) is similar to provincial average (6.8%) [3].

Suicide

Suicides , self-inflicted injuries, and deaths (per 100,000 populations) are higher in the NWHU jurisdiction than the provincial average [3] :

	Northwestern Health Unit			Ontario		
Deaths	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Suicides and self-inflicted injuries, deaths (per 100,000 population) "Age-standardized rate of death per 100,000 population."[3]	26.6	31.0	22.2	7.7	11.9	3.8

Substance Use

The NWHU (2010) asked students about how easy they think it is to obtain alcohol, prescription drugs not prescribed to them, illegal drugs and marijuana. The table below describes the ease of obtaining drugs reported by students [6]:

Ease of Obtaining Drugs	**Alcohol** **% (n = 2263)**	**Prescription drugs** **% (n = 2263)**	**Illegal drugs** **% (n = 2263)**	**Marijuana** **% (n = 2263)**
Don't know	20.2%	42.8%	42.5%	*24.3%*
Very easy	28.9%	6.3%	4.7%	*25.5%*
Sort of easy	27.5%	9.5%	10%	*15.6%*
Sort of hard	12.6%	12.8%	11.8%	*7.8%*
Very hard	8.8%	26.1%	28.9%	*15.1%*
No response	*2%*	*2.5%*	*2%*	*1.7%*

Results from the 2011 OSDUHS indicated that youth in Grades 9 to 12 in the North East and North West LHINs had higher substance use rates than the provincial average. For example, they were more likely to report the following [5]:

- Smoking (19.5% vs. 11.1%)
- Binge drinking (39.0% vs. 29.3%)
- Drunkenness (33.8% vs. 26.0%)
- Hazardous/harmful drinking (31.1% vs. 23.4%)
- Cannabis (38.0% vs. 28.4%)
- Cocaine/crack (5.1% vs. 2.6%)
- Drug use problem (23.0% vs. 16.3%)

Service Utilization

Results from the 2011 OSDUHS indicated that youth in Grades 9 to 12 in the North East and North West LHINs (16.4%) were as likely to visit to a mental health centre as youth across the provincial (15.3%) [5].

Mental Illness Hospitalization Rate[*]

According to Statistics Canada's Health Profiles for the NWHU, in December 2013, 808 per 100,000 population were hospitalized for mental illness [3], which is higher than the provincial rate of 442 per 100,000 population (see **Figure 29**) [3].

Repeat Hospitalizations[†]

In 2014, North West LHIN quarterly report indicated that repeat hospitalizations (requiring the client to be readmitted to the hospital within 30 days) occurred for the following reasons: 35.5% for schizophrenia and psychotic disorders, 17.8% for Stress-related and neurotic disorders, 14.8% were for mood disorders, and 13.4% for other mental health (see **Figure 29**) [3].

Hospitalizations for Mental Health Issues

In 2014, the North West LHIN also reported that 9.4% of patients with repeat hospitalizations are for issues related to their mental illness [3]. This is comparable to the provincial average of 10.7% as reported in Statistics Canada's (2013) Health Profile for the Northwestern Health Unit [3].

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[*] The mental illnesses selected for these indicators are: substance-related disorders, schizophrenia, delusional and non-organic psychotic disorders, mood/affective disorders, anxiety disorders and selected disorders of adult personality and behavior.

[†] Risk-adjusted percentage of individuals that had three or more episodes of care for a selected mental illness* over all those who had at least one episode of care for a selected mental illness in general hospitals within a given year.

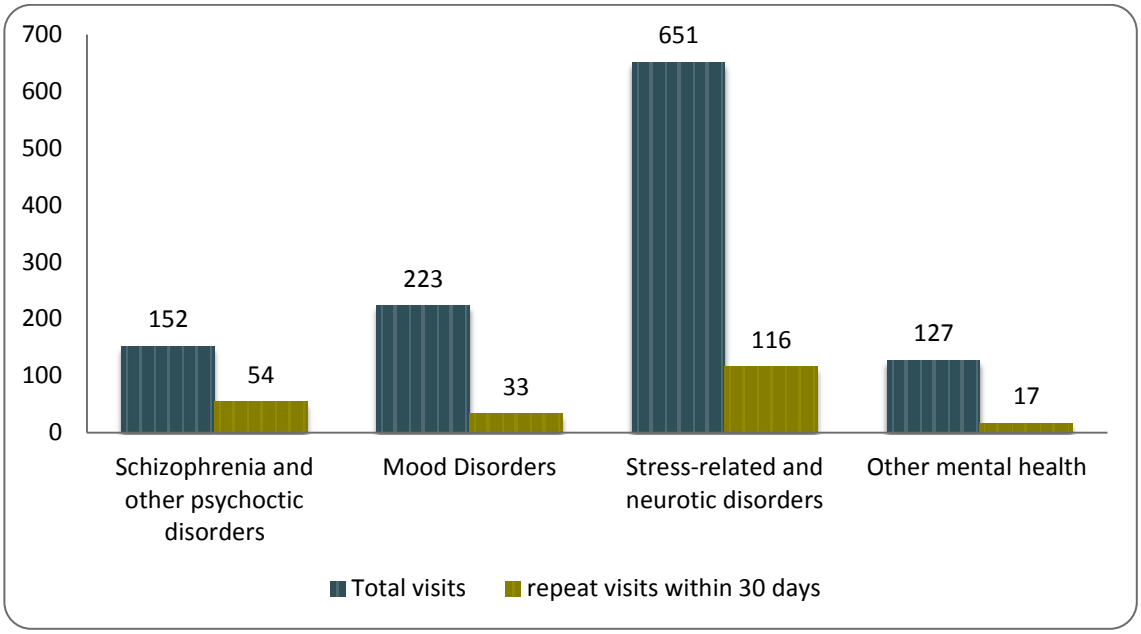


Figure 29. Hospitalizations for Mental Health issues [3].

The table below describes the repeated unscheduled emergency visits for the NW LHIN and hospitals situated at or near Kenora and Rainy River [3]:

Hospital	**2012/13 Q3**	**2012/13 Q3**	**2012/13 Q4**	**2013/14 Q1**	**2013/14 Q2**
Wilson Memorial General Hospital	21	35	28	<5	0
Atikokan General Hospital	38	18	20	32	12
McCausland Hospital	7	12	10	11	21
Riverside Health Care Fac-Laverendrye	86	91	78	86	78
Riverside Health Care Fac-Emo Site	0	0	<5	<5	<5
Riverside Health Care Fac-Rainy River	9	8	21	11	11
Manitouwadge General Hospital	10	17	11	20	20
Sioux Lookout Meno-Ya-Win Health Centre-Zone	95	111	119	141	141
Red Lake Marg Cochenour Memoiral Hospital (The)	30	15	17	12	12
Lake-of-the-Woods District Hospital	82	88	77	97	97
Dryden Regional Health Centre	81	75	62	85	85
Total	1,116	1,141	1,094	1,186	1,186

Readmission Rate

According to Statistics Canada, readmission to inpatient care may be an indicator of relapse or complications after inpatient stay [3]. Inpatient care for people living with a mental illness aims to stabilize acute symptoms: "once stabilized, the individual is discharged, and subsequent care and support are ideally provided through outpatient and community programs in order to prevent relapse or complications. High rates of 30-day readmission could be interpreted as a direct outcome of poor coordination of services and/or an indirect outcome of poor continuity of services after discharge."[3]

The Statistics Canada Health Profiles for the Northwestern Health Unit indicate a 14.4% 30-day readmission rate for mental illness versus an 11.5% 30-day readmission rate for mental illness for the province of Ontario [3].

Mental Illness Patient Days[‡]

The North West Health Unit has rate of 797 (per 100, 000 population) of mental illness patient days compared to Ontario's 485 (per 100,000)[3]. When looking into further rates of this indicator in both females and males, it is notable that males' rates of patient days (1,049) in the North West Health Unit are almost double that of females (534)[3].

[‡] The patient days rate is a partial measure of general hospital utilization. Patient-days are influenced by the number of hospitalizations and the length of stay.

Justice

Overview

According to the Ontario Court of Justice (OCJ), there were 1,243 youth criminal cases received between April 2013 and March 2014 from the North West region of Ontario (see **Figure 30**)[8]. The breakdown on the nature of the offences is as follows[8]:

- 27.7% were crimes against the person
- 22.4% were crimes against the property
- 26.7% were administration of justice (i.e., fail to appear, breach of probation, unlawfully at large, fail to comply with order, etc.)
- 20.0% were from the federal statute offence group (i.e., drug possession, drug trafficking, etc.), of which 17.3% came under the Youth Criminal Justice Act
- 2.7% were classified under other Criminal Code categories (i.e., weapons, prostitution, disturbing the peace, etc.)
- 0.6% were traffic offences

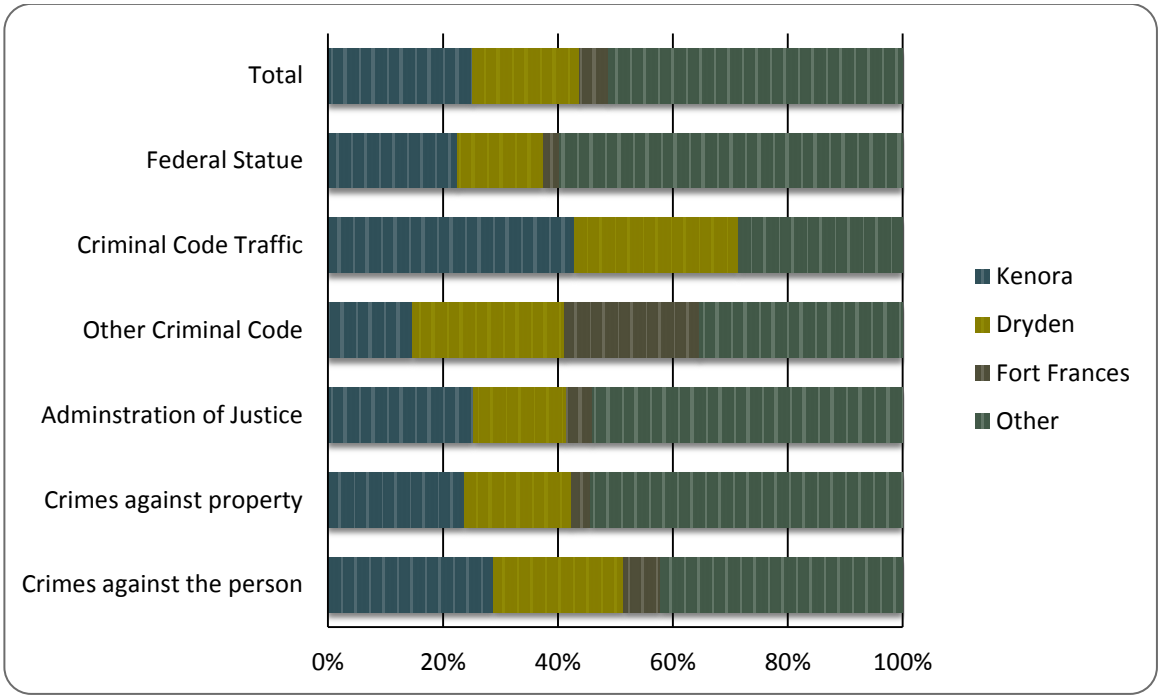


Figure 30. Criminal offences committed by youth in the North West region of Ontario [8].

Disposition Rates

The graph below shows the disposition rate, length of time or the number of appearances for cases where all charges on the case were completed for Youth Criminal Cases, from April 2012 to March 2014 for the Kenora Rainy River area (see **Figure 31**)[42].

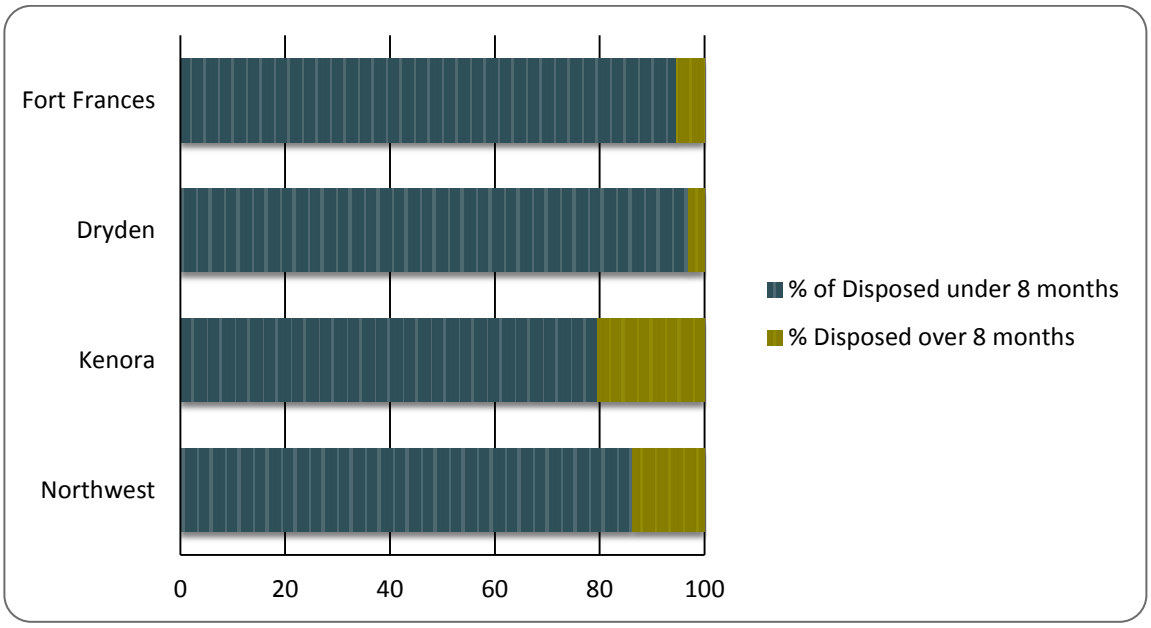
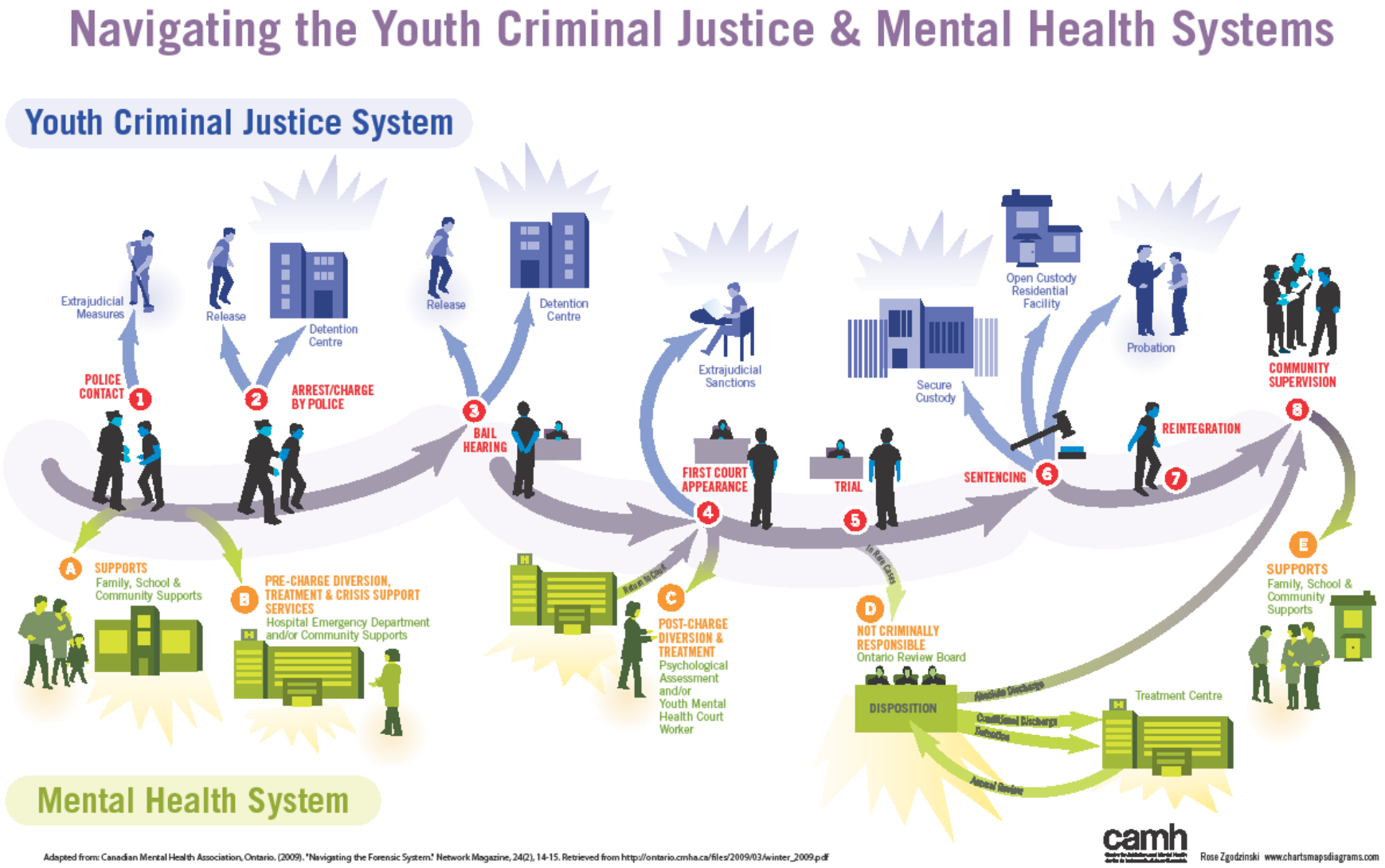


Figure 31. Disposition rates of youth in the North West region of Ontario [42].

Appendix B: Justice System Navigation Map



Adapted from: Canadian Mental Health Association, Ontario. (2009). "Navigating the Forensic System." Network Magazine, 24(2), 14-15. Retrieved from http://ontario.cmha.ca/files/2009/03/winter_2009.pdf