Healthy Communities Partnership

Middlesex-London: Community Picture

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Acknowledgements

Healthy Community Partnership Middlesex-London engaged in a community consultation that resulted in this community picture which includes demographics, health statistics and data, local policy review, focus group and community consultation results. The Executive Summary, a two page document, was submitted to the Ministry of Health Promotion and Sport identifying two action areas per priority area. These were further refined thanks to an additional community consultation and the Core Group. The selected two policy priority areas for Middlesex-London are Physical Activity and Mental Health Promotion.

A special thanks goes to the:

- stakeholders who participated in the community consultations, for dedicating their time and knowledge to move Healthy Communities Partnership Middlesex-London forward,
- community individuals and agencies that provided Middlesex-London Health Unit with reports, statistics and data, and
- community partners especially those who volunteered to be part of the Core Group.

Executive Summary

Healthy Communities Partnership Middlesex-London

Middlesex-London: Who are we?

Total population: 422,333

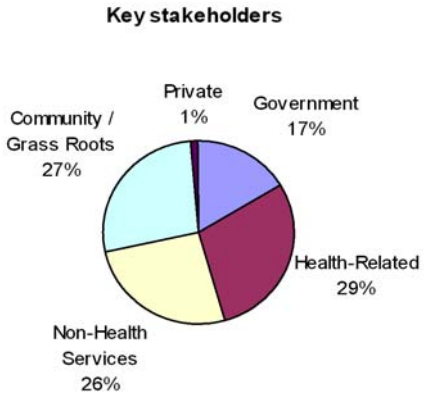
Middlesex County population: 69,938
City of London population: 352,395

Rural Population: 10.9% Urban Population: 89.1%

- Overall, the Middlesex-London population is aging, similar to trends seen for the rest of the province.
- Middlesex-London has more adults 20-29 years of age compared to the province, with a greater proportion of children and youth in the County compared to the City.
- 1.4% of the population are Aboriginal, living off-reserve.
- 12% of the population are visible minorities, with a higher number in the City compared to the County.
- New immigrants make up 15% of the total immigrant
- About 1 in 5 Middlesex-London residents' mother tongue is a language other than English or French.
- 1.4% report French as their mother tongue and 0.4% report French as the language spoken at home.
- Spanish is the most common non-official language spoken at home in Middlesex-London.
- 13% of individuals age 25-64 years in Middlesex-London, did not graduate from high school.
- 1 in 10 individuals in Middlesex-London are low-income earners, with a higher proportion of low-income earners in the City versus the County.
- 1 in 4 Middlesex-London families with children at home

The Ministry of Health Promotion and Sport's, Healthy Communities Fund Partnership Stream supports the work of the Middlesex-London Health Unit (MLHU) to identify local policy needs while engaging with the community. To that end the MLHU developed a strategy to consult with various individuals, groups and agencies to identify recommendations/actions for each of the six priority areas: physical activity, sport and recreation; healthy eating; tobacco use/exposure; injury prevention; substance and alcohol misuse and mental health promotion. The recommendations are not limited to policy but include education/awareness, program and services, capacity building and supportive environment.

This strategy has brought forward members from a wide cross-section of the community, with some aligned to specific priority areas, allowing for rich, knowledgeable exchange. It is important to note that Middlesex-London community members and agencies are passionate about their community as evidenced by the numerous initiatives currently underway.



Community stakeholders completed a Level of Involvement form to identify their level of interest in the Healthy Communities Partnership-Middlesex London (HCP-ML). From the interest expressed, several stakeholders formed the Core Group (CG) to help refine the community-identified recommendations for action. To identify two recommendations for each of the six priority areas, the CG reviewed surveillance data, current evidence and applied a decision-making framework with the following criteria: impact; capacity and feasibility; partnership and collaboration, and readiness. It is important to note that 2 overarching messages presented consistently in all consultations were the need for sustainable funding and access to all resources in both official/other languages.

Physical Activity

- Middlesex-London physical activity levels have decreased significantly since 2003.
- The 2009 *in motion*® Middlesex-London survey (self-reported or parent-reported) reveals only 35% of adults, 30% of youth, and 44% of children were physically active enough for health benefits.
- Direct measures (not self-reported) in Canadian studies indicate that these levels are actually lower, with only 15% of adults (Canadian Health Measures Survey) and 7% of children and youth in Ontario, ages 6-19 (Canadian Health Measures Survey) achieving recommended levels of physical activity.
- Levels for preschool children are unavailable.

Recommendations

1. Advocate for endorsement by all municipalities for a physical activity charter, ensuring that the charter is age friendly and addresses a life span approach.
2. Advocate at all levels for support and funds (including staffing) to go towards infrastructure (built environment and design) and programs that enable/enhance/increase physical activity in the community.

Healthy Eating & Healthy Weights

- Rates of fruit and vegetable consumption have decreased between 2003 and 2009; about 1 in 3 people eat 5+ vegetables and fruit per day which is somewhat lower than Ontario.
- Overweight and obesity rates in Middlesex-London rose from 48% to 54% between 2003 and 2009.
- A local study in 2001-2003 of children 6-12 years found 29% of boys and 28% of girls overweight or obese.

Recommendations

1. Advocate for policies at all levels that address healthy eating, always ensuring economic and cultural sensitivity. This could include policies related to healthy/local fresh food access, media & advertising, local foods, food subsidies, healthy food options in cafeterias, foods served during meetings, fundraising, and sodium levels.
2. Increase skill building opportunities to augment individual/community capacity for healthy eating. Focus attention on parents and other target groups (e.g. youth and seniors), ensuring cultural/age sensitivity.

Tobacco use and exposure

- Smoking rates decreased over the last decade and the current rate is 20% (16% daily, 4% occasionally).
- Highest tobacco use is among males, 20-34 year olds and those with a lower level of education.
- Younger people (12-19 years) are more likely to be exposed to environmental tobacco smoke or second hand smoke.
- In youth 12-19 years, the proportion of smokers was 14% in 2000/01 and 16% in 2003.

Recommendations

1. Expand smoking restrictions (private and public) in outdoor spaces/outside doorways and parks.
2. Advocate for all addiction treatment agencies and mental health agencies helping clients to quit smoking.

Injury Prevention

- Leading causes of unintentional injuries in Middlesex-London are motor vehicle traffic crashes and falls.
- Falls are the leading cause of hospitalizations in all age groups but are more prevalent among seniors age 65+.
- Numbers of motor vehicle collisions leading to injuries and fatalities have declined considerably since 1989, but are still the main cause of death due to unintentional injuries among those under the age of 65 years.
- Injuries are the leading cause of death in all children and youth.

Recommendations

1. Develop a large media campaign to change culture/norms and perception of injuries as “part of life” and reduce the stigma of asking for assistance related to injury prevention.
2. Advocate for policies that include the physical environment and safety (snow removal, cross walk signals, speed zones near schools, building codes for seniors’ housing), integrated into municipal Master plans.

Alcohol & Substance Misuse

- 15% of Middlesex-London residents monthly consume 5 or more drinks on one occasion; most common among males, younger age groups, and those with lower education.
- 1 in 4 people in Middlesex-London exceed recommended levels of alcohol intake (low-risk drinking guidelines).

Recommendations

1. Develop a comprehensive strategy related to sensitivity training for Health Care Providers for alcohol and substance misuse education, screening, and prevention.
2. Implement an education/policy initiative to increase understanding within families, guidance counsellors, and the community in order to decrease stigma for those with substance misuse issues and increase recognition of signs of addiction and heavy drinking.

Mental Health Promotion

- 95% of residents rate their mental health to be good, very good or excellent.
- 70% of residents experience a sense of belonging; however, 1 in 4 report feeling that most days in their life are quite a bit or extremely stressful.

Recommendations

1. Implement awareness and skill building for anti-bullying and to reduce aggression across the life span within the community.
2. Advocate for equitable access to mental health services for vulnerable populations including routine mental wellness assessments; support programs that help foster “sense of belonging”; linking existing initiatives, and ensuring that schools have daily coverage by either social worker and/or public health nurse. As well have enhanced training of health care workers/settlement workers to populations needs.

Next Steps

Following the identification of the two key recommended actions for each priority area by the Core Group, the top two policy priorities were to be selected by the community. On February 28th, 2011 community stakeholders were invited to hear a HCP-ML progress update but more importantly to select the two policy priorities for Middlesex-London. Through an anonymous voting strategy facilitated by Nancy Dubois the following two policy priorities were selected;

Mental Health and Substance Abuse- Policies that ensure access to mental health promotion resources and services, including those related to alcohol and substance abuse; and

Physical Activity, Sports and Recreation - Development and endorsement of a Physical Activity Charter based on the Global Call to Action at the 3rd International Congress on Physical Activity and Public Health (ICPAPH).

To that end, the Core Group will be submitting two Community Mobilization Work plans to the Ministry of Health Promotion and Sport with action steps that will lead to the above stated policy goals.

This Community Picture is a live, open ended document and will need to be periodically updated to reflect major health and demographic status changes in our community. It is noted that limited time frames for submission of this Community Picture did not allow original data analyses and more extensive data collection to be conducted. Therefore it will be imperative for the HCP-ML to continue to monitor local data e.g. demographic makeup, health status data, current initiatives and policies as part of the overall evaluation to measure the impact on the health and well-being of the Middlesex-London community.

1. Purpose of Report

The purpose of the Community Picture report is to provide a comprehensive profile of the Middlesex-London community, including demographic makeup, health status data, current initiatives and policies that have an impact on health and well-being. It is hoped that this report will be a useful tool to inform the work of community partners, municipalities and others in improving the health of the community and in particular those directly involved in the Healthy Community Partnership and will serve:

- To mobilize community partners around a common goal.
- To inform the Ministry of Health Promotion and Sports' Healthy Communities Fund grants project stream.
- To inform the allocation of other local funds or activities.
- To identify strategic and program priorities by local organizations.

The Community Picture report contains both quantitative and qualitative descriptions of the community's "current state" with respect to the provincial Healthy Communities Framework priorities and aims to capture the broader social, economic, political and environmental context that affects the health needs and concerns of Middlesex-London.

Through an extensive information gathering process, the Community Picture report identifies local priorities in the form of recommended actions across the six Healthy Communities priority areas:

- Physical Activity, Sport and Recreation;
- Injury Prevention;
- Healthy Eating;
- Tobacco Use/Exposure;
- Substance & Alcohol Misuse; and
- Mental Health Promotion.

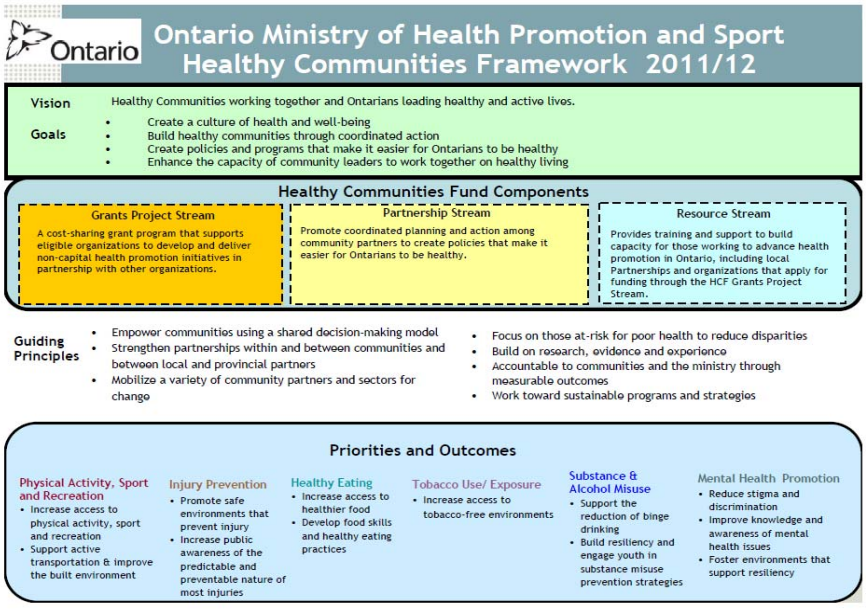


Figure
Source: Ministry of Health Promotion and Sport. (2011). Ontario Ministry of Health Promotion and Sport Healthy Communities Framework: 2011/12. Retrieved March 31, 2011, from http://www.mhp.gov.on.ca/en/healthy-communities/hcf/default.asp

2. Background

The Ontario Ministry of Health Promotion and Sport initiated the Healthy Communities Fund initiative in 2009. The Healthy Communities Fund (HCF) provides funding to community partnerships to plan and deliver integrated programs that improve the health of Ontarians. The Healthy Communities Fund plays a key role in helping the Ministry achieve its vision of *Healthy Communities working together and Ontarians leading healthy and active lives*.

The goals of the Healthy Communities Fund are to:

- Create a culture of health and well-being;
- Build healthy communities through coordinated action;
- Create policies and programs that make it easier for Ontarians to be healthy; and
- Enhance the capacity of community leaders to work together on healthy living.

The Healthy Communities Fund has three main components:

Grants Project Stream
A one-window approach to funding local, regional and provincial organizations to deliver health promotion initiatives that address two or more of the Ministry's priority areas - physical activity, injury prevention, healthy eating, mental health promotion, reducing tobacco use and exposure, and preventing alcohol and substance misuse.

Resource Stream
Provides training and support to build capacity for those working to advance health promotion in Ontario, including local partnerships and organizations that apply for funding through the HCF Grants Project Stream.

Partnership Stream
Promotes coordinated planning and action among community groups to create policies that make it easier for Ontarians to be healthy. Funding from the Partnership Stream supported the development of the Community Picture report.

The aim of the Partnership Stream is to create policies that make it easier for Ontarians to be healthy. To achieve this, community partnerships have been formed at the local level to:

- Engage community members, partners, networks, leaders and decision-makers;
- Assess the community and create a Community Picture that identifies local directions across each of 6 key Ministry health promotion priorities: physical activity and sport and recreation, injury prevention, healthy eating, mental health promotion, tobacco use and exposure, and substance and alcohol misuse.
- Mobilize community leaders, decision-makers and organizations to work together to build healthy public policy.

The Partnership Stream will link planning with community action by ensuring alignment between the communities' priority areas of focus and programs funded under the Grants Project Stream.

The Partnership Stream objectives are to:

- Identify key health priorities that are supported by community partners and individuals;
- Broaden the number of networks, community leaders, and decision-makers involved in identifying community priorities;
- Strengthen the capacity of communities by increasing the number of partners and sectors involved in coordinated planning to create supportive environments for health;

- Increase the quantity and impact of local, regional and provincial policies that support health and make it easier for Ontarians to be healthy;

- Increase the knowledge within the community of effective interventions that impact health and the role of policies in influencing health: and

- Empower communities to sustain health issues beyond time-limited funding.

Healthy Communities Partnership – Middlesex - London

The Middlesex-London community has a rich history of working in partnerships. Numerous City of London and Middlesex County departments and associated committees, non-government and not-for-profit organizations are in existence whose mandates address a variety of community health and well-being issues. A well-developed and interconnected network of community organizations, institutions, coalitions and private sector stakeholders also provide services, programs and resources to the community (Stakeholders List - Appendix 9.1).

Several community engagement activities took place between September 2010 and March 2011 (see Methodology section). A critical component of the community engagement activities was the formation of the Healthy Communities Middlesex-London Core Group which took responsibility for finalizing recommended actions for the community and developing the Operational Plan for submission to the Ministry of Health Promotion and Sport (Healthy Communities Partnership Middlesex-London Core Coordinating Committee: Terms of Reference, Appendix 9.1)

In November 2010 fifty-three community stakeholders completed the Healthy Communities Network Survey – Middlesex London. These completed surveys were developed by Health Nexus into a series of network maps based on the data generated by the survey. The network maps provided a snapshot of where existing partnerships existed and where additional partnership opportunities might be pursued. The maps provide a picture of 224 organizations with 2500 links. Overall, the Middlesex-London community has a good mix of sectors involved and connected with each other. All six Ministry of Health Promotion and Sport priority areas have community partners who are interested and engaged in the process of supporting a Healthy Community (Healthy Communities Partnership Middlesex-London: Network Maps, Appendix 9.2).

3. Methodology

Community Engagement Activities

Twenty one-on-one meetings took place with key community stakeholders between August 2010 and January 2011. These meetings continue on an ad hoc basis.

Facilitated community stakeholder meetings took place on November 1, 2010 and on February 28, 2011. Throughout the community consultation process, participants were asked to complete a Level of Involvement form (Appendix 9.3) to indicate their commitment to the overall project using the following categories; Core, Involved, Supportive, and Peripheral, with each subsequent category indicating a lower level of involvement. (Stakeholder Wheel, Appendix 9.4).

Invitations to participate in Focused Discussion Groups were sent to 150 potential participants. These discussion groups were held January 11 and 12, 2011 for each of the priority areas with the following attendance; Physical Activity, Sport and Recreation, Healthy Eating, Injury Prevention/ Substance and Alcohol Misuse, Tobacco Use/Exposure and Mental Health Promotion. A focused discussion group was also held with representatives from the Middlesex-London Francophone community on January 20, 2011.

The Core Group comprised of 22 representatives from various sectors and priority areas, met five times to develop Terms of Reference, explore a community framework, engage in a priority setting exercise by which the top two Recommended Actions were determined (Appendix 9.5) and to map out a one year Operational Plan.

The February 28, 2011 Community Stakeholder meeting brought community partners together for a full day meeting. Participants also took part in a small group priority setting exercise where the top policy actions for the Middlesex-London community were identified including implementation steps. A comprehensive overview of the Community Picture for Middlesex-London and progress-to-date was also presented.

In addition to preceding activities of gathering information about the Middlesex-London community, various community reports were reviewed along with community stakeholder strategic plans.

Epidemiological Data Presentation

The Community Picture was developed with the purpose of describing the people living in our community: their characteristics, the status of their health, and who is most affected by poor health. In order to create a baseline picture of the Middlesex-London population we aimed to gather local, current data. Where local data was not available or was too dated we reported on data that came from a larger geographical area that included Middlesex-London, i.e. the South West LHIN region. Sometimes the Ontario population was used in order to get samples big enough to generate reliable estimates over time. We gathered data for presentation in the following order of priority:

1. Local data for the City of London, Middlesex County and for the whole Middlesex-London region
2. South West LHIN region or larger regions including Middlesex-London
3. Provincial data
4. National data (and in some instances from other provinces than Ontario)

Considering the fairly short timeframe to put this community picture together we decided to summarize and present data and findings that had already been published in previous reports or was easily accessible and available online (e.g. Census data, and data from the Canadian

Community Health Survey from Statistics Canada). Thus, no original data analyses were conducted for this report.

The majority of the results in this report originated from three data sources:

- The 2006 Census (and comparisons to older Census data from 1996 and 2001)
- The Canadian Community Health Survey (CCHS)
- The Rapid Risk Factor Surveillance System (RRFSS)

Community profiles of Census data were downloaded from Statistics Canada[1] for Middlesex-London health unit region, the city of London, the eight County municipalities, and Ontario as a comparator. The Census takes place every five years in Canada and is a reliable source of information for population and dwelling counts as well as demographic and other socio-economic characteristics.

The Canadian Community Health Survey (CCHS) is a national population household survey of Canadians aged 12 years and older, providing cross-sectional information related to health status, health care utilization and health determinants. Before 2007 the survey was conducted every second year including approximately 130,000 respondents across Canada. Since 2007 data has been collected every year with about half the sample size compared to earlier cycles. The sample size for Middlesex-London in 2009 was 1,194. Unless otherwise referenced, the CCHS data presented originate from the CANSIM table 105-0501[2] generally including the estimates for the years 2003, 2005, 2007, 2008 and 2009.

Examples of other data sources used are:

- The Canadian Tobacco Use Monitoring Survey (CTUMS)
- Youth Smoking Survey (YSS)
- Canadian Campus Survey
- *in motion*® Middlesex-London Physical Activity survey
- Canadian Health Measures Survey
- Canadian Physical Activity Levels Among Youth (CAN PLAY) survey
- Ontario Student Drug Use and Health Survey (OSDUHS)
- Centre for Addiction and Mental Health (CAMH) Monitor
- The SmartMoves household transportation survey
- inTool, provided by the Institute for Clinical Evaluative Sciences (ICES) for data on chronic diseases
- local statistics of traffic crashes provided through personal communication
- details about the Ontario Disability Support Program and cases provided through personal communication

Detailed information on methodology for the original analyses of the survey data can be found in the respective sources referenced in the report.

The reporting of data has been kept as consistent as possible, but inconsistencies exist due to differences in reporting format for the original data. Estimates have been presented with one decimal place wherever available in the original data source. Since confidence intervals (CI) and p-values were not always available and for the sake of the readability of the document, these have not been presented, with the exception of some tables in Chapter 6, presenting prevalence rates of chronic diseases. However, comments about statistical differences between estimates for different groups have generally been made throughout the document. It is important to keep in mind that all survey data presented (with the exception of most Census data included) are estimates based on samples selected to represent the larger population of interest. These estimates always come with some degree of uncertainty, and estimates based on smaller samples come with a larger degree of uncertainty.

[1] http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E

[2] Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2007 boundaries) and peer groups, occasional. Retrieved from: http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&id=1050501&pattern=1050501&searchTypeByValue=1

Rates allow for comparisons between subgroups or populations. In this report, rates, as opposed to number of events or persons, have generally been presented, and unless otherwise stated the rate refers to a percentage. Where possible, comparisons have been made to the province as well as across geographical areas within the Middlesex-London region, between sexes, across age groups, and over time. Rates for some other population subgroups of interest, such as immigrants, Aboriginals and Francophones, have also been presented where available.

Labels of "Southwest Ontario", "South West Ontario", "West Ontario", "East Ontario", or "Ontario" are found throughout this document, depending on the study's defined geographic aggregate boundaries from which data was collected. For example, the Ontario Student Drug Use and Health Survey (OSDUHS) gathered data regarding "mental health and well-being among youth, 2009" (Table 7.6.1) with the following geographic labels:

Region			
Grades 7-12		Grades 9-12	
West Ontario	Ontario	South West + Erie St Clair	Ontario

Policy Scan Validation Methodology

Ontario Heart Health Network (OHHN) Project

"The Ontario Heart Healthy Network (OHHN) Policy Work Group conducted a scan of policies across the 36 Ontario Heart Health Network-Taking Action for Healthy Living Community Partnerships in five areas:

1. Access to nutritious foods
2. Access to recreation and physical activity
3. Active transportation and the built environment
4. Prevention of alcohol misuse
5. Prevention of tobacco use and exposure.

The purpose of the scan was to create a baseline inventory of the policies that exist at the provincial level based on local data." (OHHN, 2009, p.2).

OHHN Policy Definition

The OHHN policy definition used was:

- A principle, value or course of action that guides present and future decision-making
- Can be implemented in a variety of settings, such as schools, worksites and communities
- Can be formal and informal, but it should specify expectations, regulations and guides to action
- Can provide more equitable access to determinants of health such as income, housing and education, and
- Can have a consequence for non-compliance and some method of enforcement.

OHHN Data Collection

"A protected, web-based data collection system that standardized the data collection of eleven consultants was designed and utilized. Data was collected between October 26, 2009 and December 13, 2009 by scanning publicly available web sites and/or contacting representatives via telephone or email using information provided by OHHN members."(OHHN, 2010, p.10).

Municipal data was collected from 9 Middlesex-London municipalities:
City of London, Strathroy-Caradoc, North Middlesex, Southwest Middlesex, Thames Centre, Lucan-Biddulph, Adelaide-Metcalfe, Middlesex Centre, Village of Newbury

School Board data was collected from:
Thames Valley District School Board and London District Catholic School Board

Additional Priority Area Policy Scan

There were three priority areas of the Ontario Ministry of Health Promotion and Sport, Healthy Communities Partnership stream that were not scanned for within

the Ontario Heart Health Network (OHHN) Policy Scan.

Thus, for the priority areas of Injury Prevention, Substance Misuse, and Mental Health, two Public Health Nurses at the Middlesex-London Health Unit created Policy Scan questions with advice from community partners that possess expertise for each priority area.

Middlesex-London Validation Process

Letters explaining the OHHN policy scan and a summary of Middlesex-London findings from the OHHN report were sent electronically to local partners with a request to validate/update their respective information. Through the validation process, partners identified the existence/non-existence of a policy. An opportunity to provide information about local policies related to the priority areas of Injury Prevention, Substance Misuse, and Mental Health policies were presented at the end of the survey.

However, this does not imply the policy is comprehensive, or in the case of municipalities that the policy is an existing by-law. Partners also provided anecdotal comments on policies to be reviewed in the future, as well as practice in place which are not formal policies.

A summary document of the Policy Scan Validation results in Middlesex-London is found in Appendix 9.6.

4. Socio-demographic Profile and Social Determinants of Health

Geography

Middlesex-London includes the City of London and the eight municipalities in Middlesex County. The City of London is the largest city in Southwestern Ontario. It was founded in 1826, and ten years later, in 1836, the City of London was separated from Middlesex. London was incorporated as a town in 1840 and as a city in 1855 (City of London, 2010a). The city's location as well as the amount and type of economic activity generated by the city create a significant impact on the surrounding County (Middlesex County, 2006). The County of Middlesex covers an area of approximately 284,464 hectares (2,824 square kilometres) and is situated in the centre of Southwestern Ontario (Figure 4.1). Agriculture is the predominant land use and economic mainstay in Middlesex County (Middlesex County, 2006).

Middlesex County borders Lambton in the West, Elgin in the South, Oxford to the East, Huron and Perth to the North and Essex-Kent to the Southwest (Figure 4.2). Middlesex County previously consisted of 21 different townships and municipalities but between January 1998 and January 2001 seven of the current eight municipalities (Village of Newbury excepted) were formed through amalgamations of smaller townships and municipalities. This amalgamation of townships makes comparisons over time challenging. The eight municipalities of Middlesex County are the following: the Townships of Adelaide Metcalfe and Lucan Biddulph, the Municipalities of Middlesex Centre, North Middlesex, Southwest Middlesex, Strathroy-Caradoc and Thames Centre, and the Village of Newbury.

According to the 2006 Census data 89.1% of the population in Middlesex-London lived in urban areas and 10.9% lived in rural areas. In comparison, Ontario as a whole had an urban population of 85.1%.

Figure 4.1. Map of Middlesex County in Southwestern Ontario

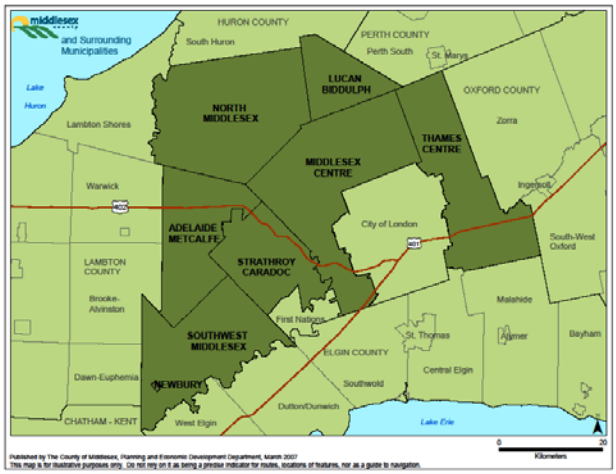
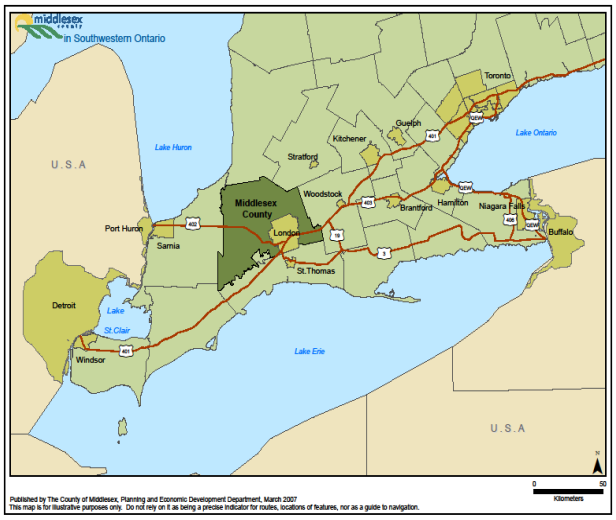
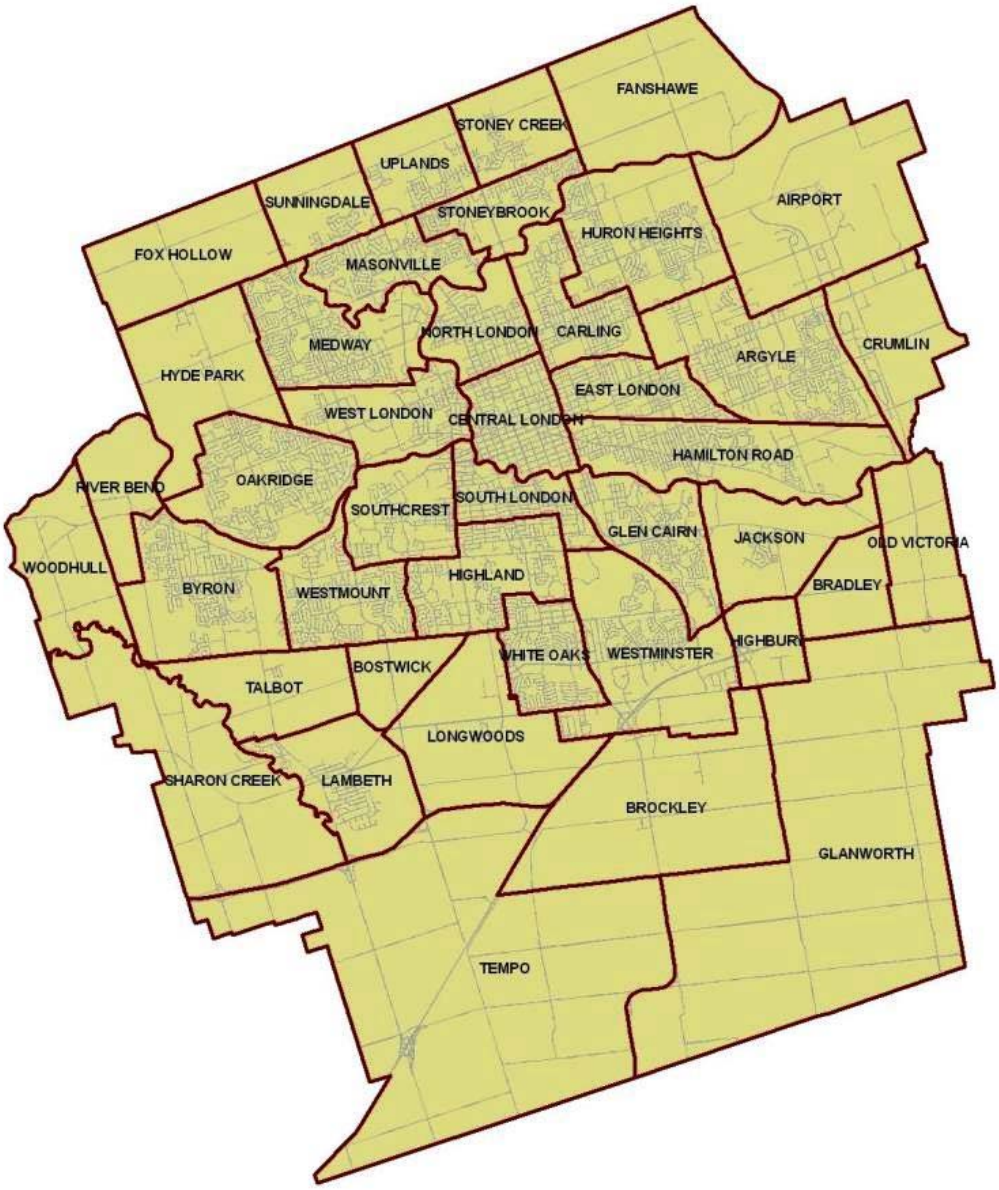


Figure 4.2 Map of Middlesex County and surrounding municipalities



A map of the City of London divided into 41 different neighbourhoods is shown in (Figure 4.3).

Figure 4.3. Map the City of London divided into 41 neighbourhoods (planning districts).



Population characteristics

A strong association between socio-economic factors and health has been established through the Whitehall studies (Marmot, 1978, 1991). Lower socioeconomic standing was persistently shown to be associated with poorer health outcomes in terms of mortality and morbidity from various chronic conditions and associated risk factors. This section provides a description of the socio-demographic profile of the population of the Middlesex-London area mainly at the time of the last Canadian Census in 2006. Some trends over time and comparisons to the census years of 1996 and 2001 will also be provided. It is important to understand the composition of the population and variations between municipalities in the region to get a better understanding of potential inequities and differential health outcomes resulting from the social determinants of health. The social determinants of health are important factors contributing to the health of individuals and populations. They include: income and social status; social support networks; education and literacy; employment/working conditions; social environments; physical environments; personal health practices and coping skills, healthy child development; biology and genetic endowment; health services, gender and culture (Public Health Agency of Canada (PHAC), 2010b). These are largely responsible for health inequities (World Health Organization (WHO), 2010a), and act independently of the amount of money that is spent on the health care system (Health Canada, 1999). Many of the social determinants of health will be described in this section.

Throughout this section the reader needs to bear in mind that the First Nations reserves are under federal jurisdiction and that the census data for the Middlesex-London census division includes the geographic areas of three First Nations reserves (Chippewas of the Thames First Nation, Munsee Delaware Nation and Oneida) and the population of two of these reserves (Chippewas of the Thames First Nation and Munsee Delaware Nation).

The size of the population in Middlesex-London in 2010 was estimated to be 457,116 people[3]. In 2006, Middlesex-London had a total population of 422,333 people, which is an increase of 4.7% (19,148 people) compared to 2001. This is a slower growth rate compared to Ontario as a whole, which grew by 6.6%. The City of London had a population of 352,395 and the eight municipalities in Middlesex County surrounding the City had a population of 69,024. The remaining 914 lived on First Nations reserves. Table 4.1 shows that there were differences in population change between the different municipalities, with Middlesex Centre demonstrating the highest rate of growth (9.5%), Adelaide Metcalfe and Lucan Biddulph remaining fairly stable, and North Middlesex and Southwest Middlesex decreasing in population size (-2.3% and -4.1%, respectively). Migration within the Middlesex-London region was very similar to that in Ontario as a whole, with 85.2% living at the same residence as they did one year earlier (Ontario: 86.6%), and 56.4% living at the same address as they did five years earlier (Ontario: 58.7%). Among the 172,350 who had moved within the past five years 14,515 (8.4%) had lived in a different country five years previously, 5,670 (3.2%) had lived in a different province or territory, 44,705 (25.9%) had lived in Ontario but in a different municipality, and 107,460 (62.3%) had moved within the same municipality.

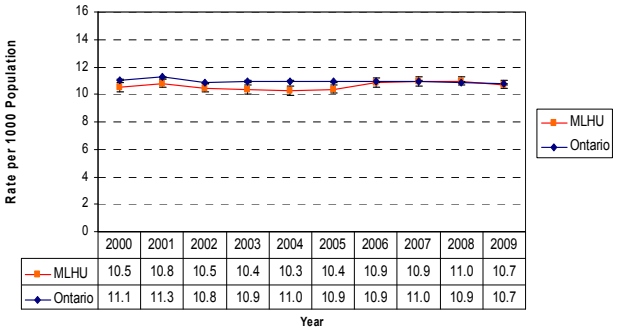
[3] Data Source: Population Projections County, (Statistics Canada) Intellihealth, MOHLTC; Description: Ministry of Finance Population Projections by County from 2009-2036, based on the 2006 Census

Table 4.1. Population characteristics

Area	Population size	Population change (2001-2006)	Population Density (people/km$^{2)}$	Land area (km^2)
Adelaide Metcalfe	3,117	0.3%	9.4	331.3
Lucan Biddulph	4,187	-0.3%	24.8	169.1
Middlesex Centre	15,589	9.5%	26.5	588.1
Newbury	439	4.0%	236.7	1.9
North Middlesex	6,740	-2.3%	11.3	597.9
Southwest Middlesex	5,890	-4.1%	13.8	427.9
Strathroy-Caradoc	19,977	4.3%	72.9	274.2
Thames Centre	13,085	4.9%	30.2	433.8
London	352,395	4.7%	837.9	420.6
Middlesex-London	422,333	4.7%	127.3	3,317.1
Ontario	12,160,282	6.6%	13.4	907,573.8

Source: Statistics Canada Census Data, 2006

Figure 4.4. Crude birth rate in Middlesex-London and Ontario, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
MLHU	10.5	10.8	10.5	10.4	10.3	10.4	10.9	10.9	11.0	10.7
Ontario	11.1	11.3	10.8	10.9	11.0	10.9	10.9	11.0	10.9	10.7

Note: Excludes births with birth weights < 500g.
Note: "MLHU" refers to the geographic region of Middlesex-London
Source: Inpatient Discharge Main Table, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [October 21, 2010].

The crude (live) birth rate in Middlesex-London was 10.7 (per 1,000) in 2009. Between 2000 and 2005 the rates in Middlesex-London were somewhat lower compared to the provincial rates, but have since converged (Figure 4.4).

Age

Reviewing the age structure shown in Table 4.2 we can see that the median age across the Middlesex-London region was 38.5, which is very close to the median age in the province (39.0). The residents of Southwest Middlesex had the highest median age of 42.2 years, and all the eight municipalities in Middlesex County, except Lucan Biddulph (37.3 years), showed a higher median age compared to the City of London (38.2 years). The proportion of people 18 years and younger was 22.9% in Middlesex-London, compared to 23.3% in Ontario. The City of London had a lower proportion of people in this age group (22.3%) compared to all of the eight municipalities in Middlesex County. The highest proportions are seen in Adelaide Metcalfe and North Middlesex (27.4%). Newbury had the largest proportion of residents aged 55 years and over (29.9%), compared to the whole Middlesex-London area and Ontario (both 24.7%).

In 2001, the median age in the Middlesex-London population was 36.8. Looking at the trend over time among City of London

residents the median age has gone up from 34.4 in 1996, to 36.6 in 2001 and 38.2 in 2006.

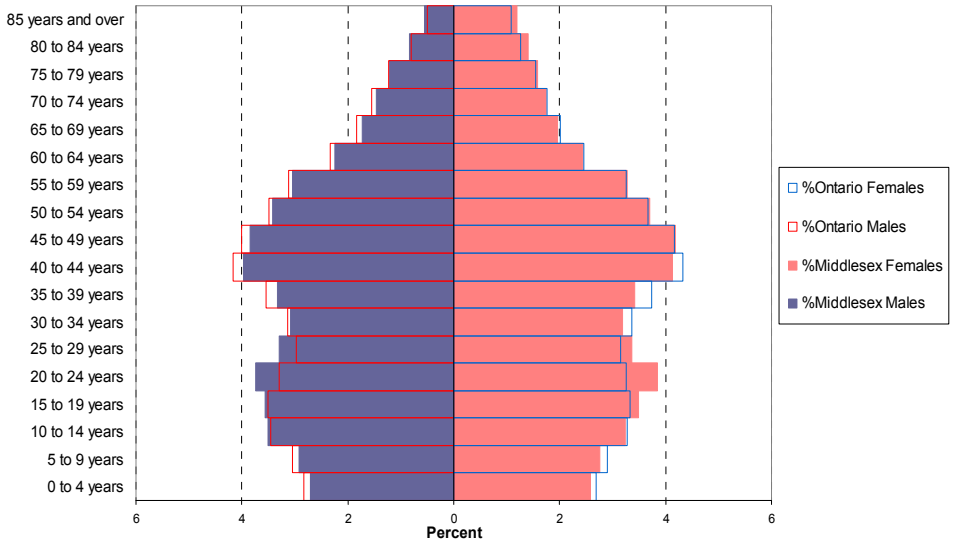
A breakdown of the population age-structure by gender for the Middlesex-London area, in comparison to the Ontario population, is illustrated in Figure 4.5. Middlesex-London had a comparatively larger proportion of people in the age-group 20-29.

Table 4.2. Median age and distribution of age groups in Middlesex-London

Area	Median Age	Age ≤18 (%)	Age 19-34 (%)	Age 35-54 (%)	Age 55+ (%)
Adelaide Metcalfe	39.3	27.4	17.0	29.9	25.7
Lucan Biddulph	37.3	26.8	19.9	31.2	22.1
Middlesex Centre	41.2	26.1	14.9	32.3	26.7
Newbury	39.8	24.8	16.6	28.7	29.9
North Middlesex	39.8	27.4	16.7	29.7	26.2
Southwest Middlesex	42.2	23.8	16.7	31.2	28.3
Strathroy-Caradoc	39.2	25.7	18.6	30.2	25.5
Thames Centre	41.0	25.8	16.2	33.4	24.6
London	38.2	22.3	23.5	29.7	24.5
Middlesex-London	38.5	22.9	22.4	30.0	24.7
Ontario	39.0	23.3	20.9	31.1	24.7

Source: Statistics Canada Census Data, 2006

Figure 4.5. Middlesex-London Age pyramid, 2006



Source: Statistics Canada Census Data, 2006

Table 4.3. Dependency ratios, Middlesex-London and Ontario, 2001 and 2006

	Overall ratio		Child (0-14) Dependency Ratio		Aged (65+) Dependency Ratio	
	2001	2006	2001	2006	2001	2006
Middlesex-London	0.48	0.46	0.29	0.26	0.19	0.20
Ontario	0.48	0.47	0.29	0.27	0.19	0.20

Source: Statistics Canada Census Data 2001 and 2006

The demographic dependency ratio measures the size of the "dependent" population in relation to the "working age" population. The higher the dependency ratio, the greater numbers of people who may be dependent on others, such as family, caregivers or government support. Changes in demographic dependency ratios highlight changes in the age structure of the population. The overall dependency ratio is calculated by adding the child dependency ratio (number of children under age 15 compared to the number aged 15 to 64) and aged dependency ratio (number of people age years 2001 and 2006. In 2006 the overall dependency ratio in Middlesex-London was 65 and older compared to the number between 15 and 64). Table 4.3 shows the dependency ratios in Middlesex-London and Ontario for the 0.46, compared to 0.47 in Ontario, and had decreased from 0.48 in 2001. The child dependency ratio in Middlesex-London was 0.26 in 2006, compared to the provincial ratio of 0.27, and had decreased from 0.29 in 2001. The aged dependency ratio changed from 0.19 in 2001 to 0.20 in 2006 in both Middlesex-London and Ontario.

According to population projections[1] of the Middlesex-London population the overall dependency ratio may increase to 0.51 in 2020 and to as much as 0.63 in 2030. The aged dependency ration may increase to 0.27 in 2020 and 0.37 in 2030.

Dwelling

Examining dwelling characteristics in 2006, 54.8% of residential units were single-detached houses, which is close to the provincial percentage of 56.1. In the City of London only 49.6% of the units were single-detached houses, compared to much higher proportions in Middlesex County, ranging between 72.1% (Strathroy-Caradoc) and 99.0% (Adelaide Metcalfe). Whereas 19.4% of the residential units in the City of London were apartments in buildings over five stories, no such dwellings were found in Middlesex County. Only 0.9% of the total occupied dwellings were occupied by more than one person per room, compared to the provincial rate of 1.9%. The proportion of rented households was 34.3% in Middlesex-London, compared to the provincial rate of 28.8%. The City of London had the highest rate of rented households (37.7%), followed by Strathroy-Caradoc (19.6%) and Newbury (19.4%). In the rest of the County municipalities between 10.0% and 17.8% of the households were rented. Within the City of London the following neighbourhoods had the highest rates of rented dwellings: West London (75%), Central London (73%), Downtown (71%), Southcrest (61%), Carling (56%), and South London (53%).[4]

Selected household characteristics are shown in Table 4.4. The average number of persons living in Middlesex-London households was 2.4, ranging between 2.4 and 3.0 in the different municipalities, Households tended to be bigger in the County compared to the City on London. London and Newbury had the largest proportion of one-person households (30.0% and 31.4%, respectively), whereas Adelaide Metcalfe and Thames Centre show the lowest proportion (14.1% and 14.9%, respectively). The Middlesex-London region has a higher proportion of one-person households (28.2%) compared

[4] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

Table 4.4. Household Characteristics

Area	Average household size	% of one-person households	% of households containing a couple with children	% of households containing a couple without children
Adelaide Metcalfe	3.0	14.1	45.5	35.9
Lucan Biddulph	2.8	18.3	37.9	33.6
Middlesex Centre	2.9	13.5	41.7	36.4
Newbury	2.4	31.4	25.7	31.4
North Middlesex	2.8	17.8	39.0	34.3
Southwest Middlesex	2.6	22.0	31.0	36.5
Strathroy-Caradoc	2.6	21.3	35.1	31.8
Thames Centre	2.8	14.9	41.8	35.1
London	2.4	30.0	26.6	26.8
Middlesex-London	2.4	28.2	28.3	27.8
Ontario	2.6	24.3	31.2	28.3

Source: Statistics Canada Census Data, 2006

to the province of Ontario (24.3%). The average household size in the City of London has remained stable between the censuses of 1996, 2001 and 2006. However, the percentage of one-person households in London have increased from 27.6% in 1996 to 30.0% in 2001, at the same time as the percentage of couples with children has decreased over time from 29.4% in 1996 to 26.6% in 2006.

The average dwelling value in Middlesex-London in 2006 was $218,156, which was a considerable increase compared to $159,660 in 2001 and $156,379 in 1996, but significantly lower than the Ontario average of $297,479. Owner-occupied dwellings were accompanied with a median monthly payment[5] of $984, comparable to the provincial median of $1,046. Rented dwellings in Middlesex-London were on average $984 per month[6], which is 23% higher than the provincial average cost of $801. These average monthly payments were lower in the City of London compared to the rest of the Middlesex County and likely reflect the lower median age and smaller household sizes in the City compared to the surrounding municipalities. Among the

owner-occupied dwellings 72.0% were constructed before 1986, compared to 68.6% in the whole province.

Marital Status

In Middlesex-London 33.4% were single among those 15 years of age or older, compared to 31.6% across Ontario (Table 4.5). The proportion of people who were separated or divorced in Middlesex-London was fairly similar to the provincial rate (11.4% vs. 10.3%). The City of London had the highest rate of separation/divorce (12.0%) in Middlesex-London, and the highest rate of single people (34.7%). The latter may reflect the large number of students pursuing post-secondary education or urban/rural differences in life style. While 57.0% of the population in Middlesex-London was living with a spouse or common-law partner (Ontario: 58.9%) the remainder (41.9%) were effectively socially single as well as potentially financially single. Households relying on only one income are more financially fragile in the event of a job loss.

[5] Including all shelter expenses paid by households that own their dwellings
[6] Including the monthly rent and costs of electricity, heat and municipal services paid by tenant households

Table 4.5. Marital status

Area	Single (never married)	Married and not separated	In a common-law relationship	Separated or divorced
Adelaide Metcalfe	26.7	60.3	5.9	6.5
Lucan Biddulph	27.8	58.7	7.2	8.6
Middlesex Centre	24.1	63.5	4.7	6.6
Newbury	24.3	55.7	5.7	11.4
North Middlesex	26.5	59.0	5.5	7.3
Southwest Middlesex	27.4	55.2	9.0	10.3
Strathroy-Caradoc	26.4	57.3	7.2	9.8
Thames Centre	24.8	62.3	6.5	8.3
London	34.7	47.1	8.1	12.0
Middlesex-London	33.4	49.1	7.9	11.4
Ontario	31.6	51.9	7.0	10.3

Source: Statistics Canada Census Data, 2006

Unemployment

According to the London Labour Market Monitor the unemployment rate in the London economic region[1] decreased from 10.9% in August 2009 to 7.6% in December 2010 (Service Canada, 2010). As of January 2011 the unemployment rate in Ontario was 8.1% (Statistics Canada, 2011). The unemployment rate in Middlesex-London in 2006 was 6.1% and similar to the provincial level at 6.4% (Table 4.6). The highest unemployment rate was found in London (6.5%) followed by Strathroy-Caradoc (5.4%), and the lowest rates were seen in North Middlesex (3.1%) and Thames Centre (3.0%). The Middlesex-London region had an unemployment rate of 8.9% in 1996 and 6.5% in 2001.

Table 4.6. Labour Force characteristics (2006)

Area	Unemployment rate	Median income*	Family income**
Adelaide Metcalfe	3.9	$28,277	$72,658
Lucan Biddulph	4.6	$29,990	$70,731
Middlesex Centre	3.2	$34,695	$90,484
Newbury	4.9	$19,492	$43,444
North Middlesex	3.1	$27,834	$71,117
Southwest Middlesex	3.7	$25,700	$64,248
Strathroy-Caradoc	5.4	$26,854	$68,991
Thames Centre	3.0	$33,530	$87,187
London	6.5	$27,275	$53,684
Middlesex-London	6.1	$27,611	$68,728
Ontario	6.4	$27,258	$69,156

** Individual income before-tax among all persons 15 years of age and over, with income, for income year 2005*

*** Among all census families, before-tax*

Source: Statistics Canada Census Data, 2006

In the City of London the highest rates of unemployment in 2006 were found in the following neighbourhoods: Fanshawe (14%), East London (10%), Central London (9%), Carling (8%), Huron Heights (8%), and West London (8%).[7]

Income

Table 4.6 also presents median yearly income (individual and before-tax) for the income year 2005 among people 15 years and over. The median income for the whole Middlesex-London region was $27,611, with the highest incomes seen in Middlesex Centre ($34,695) and Thames Centre ($33,540), while the lowest rates could be found in Newbury ($19,492) and Southwest Middlesex ($25,700). Median income for private households in Middlesex-London was $55,435, which is lower than the provincial estimate ($60,455). Couples with children had a higher yearly median income in 2005 ($86,226) compared to couples without children ($66,532).

In the City of London the lowest median individual incomes could be found in the following neighbourhoods: Central London ($20,142), Carling ($22,229), East London ($22,322), West London ($22,747), and Southcrest ($24,165).[8]

Affordability

Statistics Canada bases their measure of housing affordability on the proportion of household income spent on housing costs. A household is considered to be at increased risk of financial hardship if the proportion of household income spent on housing is greater than 30%. Although this measure helps in assessing trends in housing affordability, it needs to be noted that not all households spending more than 30% on housing experience financial difficulties. Some may simply chose to spend more on housing than on other goods. There are 168,480 households in Middlesex-London and 25.8% of these spend more than 30% of their income on housing, compared to 27.7% in Ontario.

One-person households are most likely to spend 30% of their income on housing (44.5%), followed by lone-parent households (39.2%). The municipalities in Middlesex-London with the largest percentage spending 30% or more of their income on housing are London (27.2%) and Newbury (34.3%).[9]

Social housing

According to the City of London Housing Division the average market rent is too high for people earning minimum wage or those on social assistance, and for those with moderate incomes home ownership is gradually getting more out of reach (City of London, 2010b). Households owning their home earn 2.5 times more than tenant households. According to the London Community Housing Strategy a large proportion (45%) of tenant households spends 30% or more of their monthly income (before-tax) on rent. Meanwhile only 27% of all households in London and 1 of 6 homeowners spend 30% or more of their gross monthly income on rent. The number of community housing units in London was increased by 61 units to 939 units between 2006 and 2010. The target is to increase the number of units to 1,000 by 2015 (City of London, 2010b).

The Ontario Non-Profit Housing Association 2010 waiting-list survey shows that there were a total of 4,265 households on the waiting list for assisted housing in Middlesex-London as of January, 2010.[10] The number had increased by 11% from a total of 3,852 household being on the waiting list in January 2009. Of the households actively waiting for assisted housing in 2010, 384 were seniors, 2,175 were non-senior singles and 1,706 were families. Waiting times were not reported for this region.

[7] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

[8] Ibid.

[9] Source: Statistics Canada - 2006 Census. Catalogue Number 97-554-XCB2006039

[10] Numbers for London and area (Middlesex County) retrieved from spreadsheet available at: http://www.onpha.on.ca/AM/Template.cfm?Section=Waiting_Lists_2010

Homelessness

Reliable data on homelessness in London is very limited. However, most local experts agree that there may be up to 1,500 people without stable accommodation. London's emergency shelters can only accommodate up to 360 persons. The growing population of homeless people in London is partly a result of a migration of homeless people from other southwest Ontario communities lacking sufficient social services and emergency shelter services (London CAReS, 2007).

Household Food Insecurity

According to data from the Canadian Community Health Survey (CCHS) from 2007/08, 7.0% of the households in Middlesex-London reported moderate or severe food insecurity. This was not significantly different compared to Ontario as a whole (7.7%). About 3.0% experienced severe food insecurity, and 4.0% experienced moderate food insecurity.[11] Provincial data show that lone-parent households had the highest incidence of food insecurity (25.4%), and couples without children had the lowest rate (3.5%).[12]

The average weekly cost of a Nutritious Food Basket in Middlesex-London for a reference family of four was $160.85 in 2010, which was slightly below the cost in 2009 ($162.22). This has been attributed to many grocery store sales during the time of data collection. The provincial average cost was $169.17 in 2010 (Middlesex-London Health Unit, 2010, Appendix 9.7a). Between 1997 and 2008 there was an increase of over 25% in the average weekly food cost for a family of four (Middlesex-London Health Unit, 2009).

Measuring the cost of basic needs is done on a yearly basis in an effort to define the minimum resources needed for long term physical wellbeing. The items included in the cost of basic needs are food, shelter, transportation, personal care items and clothing. However, not included are items such as household furniture and supplies, monetary recreational activities, and communication expenses. These are items that would be needed for individuals to lead productive, financially stable and socially engaged lives.

When calculating the cost of basic needs there are four different scenarios used and an urban (London) and rural (Middlesex County) estimate[13] calculated for each of the four scenarios. Table 4.7 shows the discrepancy between income from Ontario Works and the estimated expenses to meet basic needs for the specified family or individual (see Appendix 9.7b for detailed description of calculations). Further, the Weekly Cost of a Nutritious Food Basket, 2010 is found in Appendix 9.7c.

Table 4.7. Monthly cost of basic needs in Middlesex-London, 2010, according to four different case scenarios

Case Scenario	Expenses		Income
	Urban	Rural	Urban & Rural
Family of four (male: 42 yrs, female: 38 yrs, boy: 14 yrs, girl: 8 yrs) as Ontario Works recipients	$2284.09	$2194.48	$2019.07
Single male: 26 yrs as Ontario Works recipient	$1097.97	$1327.36	$648.33
Single parent (female 35 yrs) and child (boy 11 yrs) as Ontario Works recipients	$1488.06	$1769.45	$1368.91
Single person (male 50 yrs) as Ontario Disability Support Program recipient	$1077.00	$1306.39	$1115.16

Source: Middlesex-London Board of Health Report No. 133-10, November, 2010.

[11] Source: Statistics Canada. Table 105-0547
[12] Source: Statistics Canada. Table 105-0545

[13] Rent is estimated to be higher in the urban setting, whereas transportation is estimated to be more expensive in the rural setting (where a car is needed for transportation).

The London Food Bank (serving London and surrounding area, borders unspecified) has one main site and five satellite sites in the City. The main site is open Mon-Fri 9am to 4pm, whereas the satellite sites are open one day per month. Clients are allowed to visit the food banks once per month and they generally get a three to five day supply of groceries, intended as emergency food. About 2% of all clients access the food bank as often as once per month.[14] The average number of visits per family in the year 2010 was 3.52. The average number of monthly visits (by household) to the London Food Bank was 3,044 in 2010, compared to 2,238 visits in the year 2000.[15] This represents an increase by 36% in a 10-year period. In addition, there are 17 other food banks serving different areas and groups; of which the two major food banks are the Salvation Army Centre of Hope, and the Daily Bread Program through St. Paul's cathedral. There are also 32 different community agencies (primarily faith based organizations) that facilitate monthly community meals.

Free charity meals for individuals and families in need are served throughout the year at a multitude of places in the City of London. The February, 2011 meal calendar is used as an example (see Appendix 9.7d), although variations occur throughout the year and places serving meals rotate. To summarize the meal calendar for February, 2011 there are 17 opportunities for breakfast weekly, 8 opportunities for lunch and 40 opportunities for dinner. Furthermore, at an additional three locations in London youth (16 to about 25 years of age) are offered breakfast (5 opportunities/week), and dinner (11 opportunities/week). The Salvation Army Emergency Services Vehicle serve light suppers one day per week, the Ark Aid Mission serves supper as posted (Monday – Saturday and Sundays) and St. Joseph's Hospitality Centre serves breakfast and lunch (Monday to Friday) for a nominal fee.

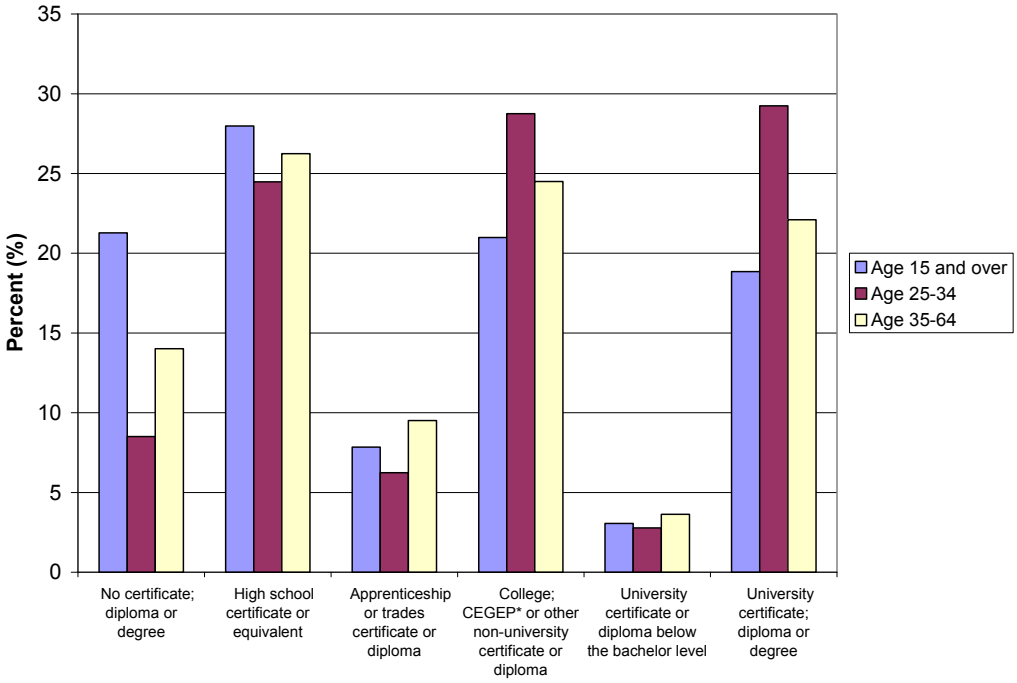
Education

The major post-secondary institutions in Middlesex-London are the University of Western Ontario and Fanshawe College.

A breakdown of residents in Middlesex-London in the age groups 15 and over, 25-34 and 35-64 by the highest level of education received is shown in Figure 4.6. Among Middlesex-London residents aged 25-64 years 23.8% had a university certificate at or above the bachelor level. This is just slightly lower than the provincial rate at 26.0%. Among females 24.6% had an educational attainment at this level, compared to 22.9% among males. A larger proportion of 25-34 year olds had a college or other non-university certificate or diploma (28.7%), or had a university certificate, diploma or degree above the Bachelor's level (29.2%) compared to the older age group of 35-64 year olds, among whom 24.5% had a college or other non-university certificate or diploma and 22.1% had a university certificate, diploma or degree above the Bachelor's level. Trades and apprenticeship training tended to be more common among 35-64 year olds compared to 25-34 year olds (9.5% vs. 6.2%). Among 25-64 year olds in Middlesex-London in 2006, 25.8% had high school as their highest level of education, and 12.7% had not completed high-school (Table 4.8). Lacking complete high-school education was most common in Southwest Middlesex (19.2%), North Middlesex (18.3%) and Strathroy-Caradoc (18.0%), and least common in Middlesex Centre (7.5%). In comparison, 13.6% of all Ontario residents had not completed high-school. In Middlesex-London the proportion of individuals not completing high school was somewhat higher among males compared to females (13.8% vs. 11.6%).

[14] Personal communication with Mary Ann McDowell, operations coordinator at the London Food Bank, January, 2011.
[15] Statistics retrieved from: http://web.ca/~londonfb/LFB-statistics.htm

Figure 4.6. Educational attainment by age group in Middlesex-London, 2006



Source: Statistics Canada Census Data, 2006
** collège d'enseignement général et professionnel, which is equivalent to general or vocational college*

Table 4.8. High School Completion Rates

Area	% People aged 25-64 who did not complete high-school
Adelaide Metcalfe	16.5
Lucan Biddulph	13.7
Middlesex Centre	7.5
Newbury	37.2
North Middlesex	18.3
Southwest Middlesex	19.2
Strathroy-Caradoc	18.0
Thames Centre	13.3
London	12.3
Middlesex-London	12.7
Ontario	13.6

Source: Statistics Canada Census Data, 2006

The most common field of study among Middlesex-London residents with post-secondary education were: 1) Business, management and public administration (19.4%), 2) Architecture, engineering, and related technologies (19.3%), and 3) Health, parks, recreation and fitness (17.3%).

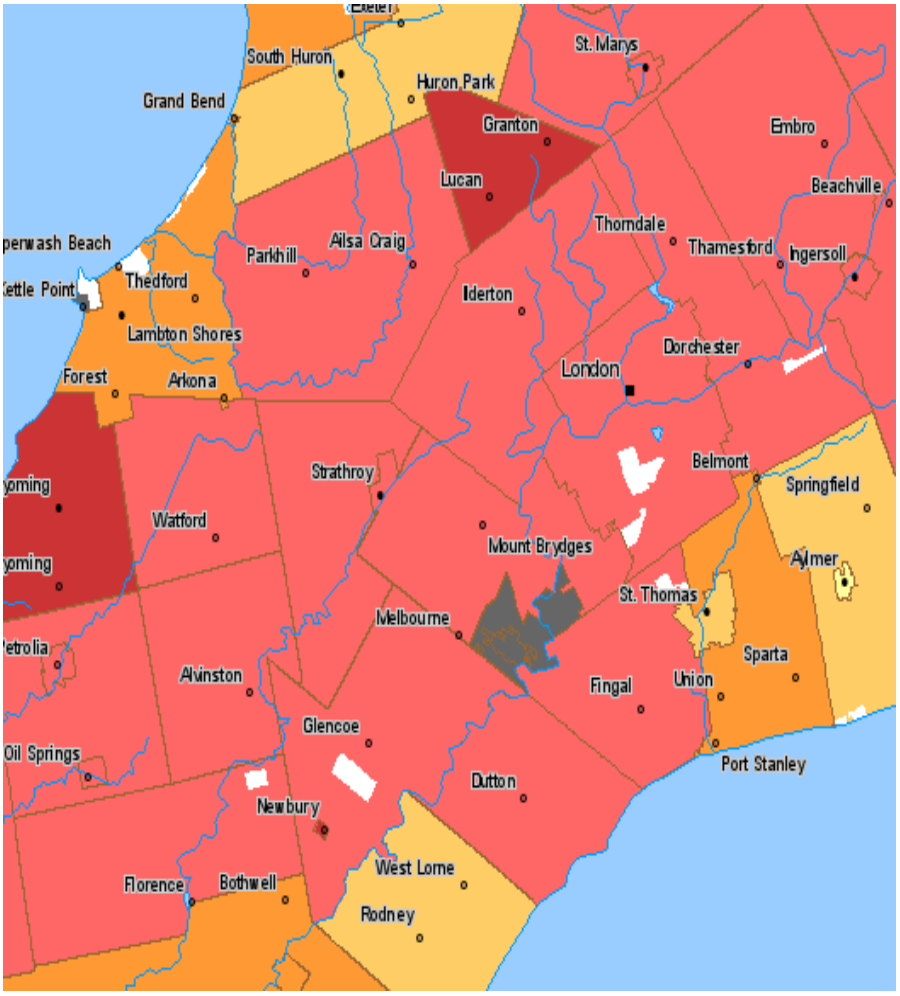
Highlights from the 2003 International Adult Literacy and Skills Survey (IALSS) show that Ontario had average scores for document literacy, prose literacy, numeracy, and problem solving that were about the same as the Canadian national average (Statistics Canada, 2005a). The scores dropped somewhat for document and prose literacy in Ontario between 1994 and 2003, but the decrease was not statistically significant (Statistics Canada, 2005b). Among Canadian adults aged 16 to 65 about 42% scored below Level 3 in prose literacy, which is considered the threshold level for managing well in the knowledge society we live in (Statistics Canada, 2005a). When including those above 65 years of age this rate increased

to 48%. About one in five were functioning at the lowest level of literacy. Lower literacy levels were found among Francophones, Aboriginal people and immigrants (Statistics Canada, 2005a). The Literacy Atlas (Figure 4.7) shows that adults age 16 and over in Middlesex-London scored in the second highest quintile (dark pink) in Canada for prose literacy, with the exception of those in Lucan-Biddulph, who performed in the highest quintile (red).

Clear associations were seen between literacy and employment, and between literacy and physical health; those who were unemployed and those reporting poor health had lower average literacy scores (Statistics Canada, 2005b).

About one in three children aged 8-14 did not meet expected provincial standards for reading, writing, and mathematics in 2006/7. School age children and youth in Middlesex County generally scored higher on literacy compared to London students (United Way, 2007).

Figure 4.7. Atlas of prose literacy in the Middlesex-London area (2003).



Source: Natural Resources Canada (2006)

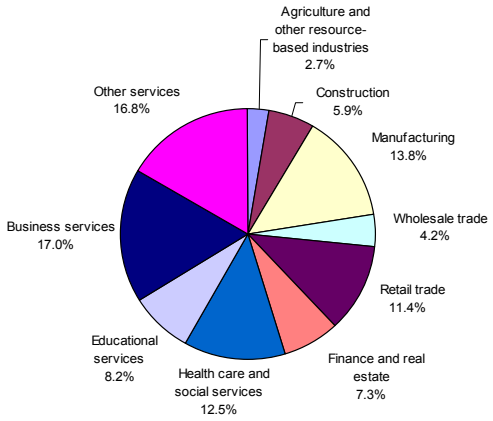
Occupation

A breakdown of occupations by industry in Middlesex-London is shown in Figure 4.8. The most common job was in the service industry (54.5%) which includes health care and social services, educational services, business services and other services. This corresponds exactly with the provincial proportion (54.5%). The second and third most common job is in manufacturing (13.8%) and retail trades (11.4%).

Of those who had a usual place of work 78.9% were working in the same municipality in which they lived, and 11.2% worked in a different municipality but still within the Middlesex-London region. Commuting outside of the Middlesex-London region for work was a fairly uncommon practice in 2006 (9.9%, including those commuting out of the province), compared to 24.4% in Ontario (Table 4.9). The municipalities where most residents commuted out of the region for work were Lucan Biddulph (25.4%), North Middlesex (24.5%) and Southwest Middlesex (23.0%). Residents in the City of London were least likely to commute (8.8%) followed by Strathroy-Caradoc residents (9.4%).

The rest of the employed labour force were working from home (6.8%), were working outside of Canada (0.4%), or did not have a fixed workplace address (9.0%).

Figure 4.8. Occupations by Industry in Middlesex-London, 2006



Source: Statistics Canada Census Data, 2006

Table 4.9. Commuting out of Middlesex-London for Work

Area	Commuters %
Adelaide Metcalfe	10.4
Lucan Biddulph	25.4
Middlesex Centre	10.0
Newbury	25.0
North Middlesex	24.5
Southwest Middlesex	23.0
Strathroy-Caradoc	9.4
Thames Centre	21.3
London	8.8
Middlesex-London	9.9
Ontario	24.4

Source: Statistics Canada Census Data, 2006

5. Specific Demographic Subsets

A priority population may be defined as those "that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level" (Ontario Ministry of Health and Long-Term Care (MOHLTC), 2008). The Ontario Ministry of Health Promotion and Sport has identified the following groups of people as priority groups in the Healthy Communities Ontario Framework: children and youth (18 and under), aboriginal populations, ethnic communities, francophone populations, low-income populations, older adults (55 years and over), persons with disabilities, and women and girls. The following section reports the proportion of these priority populations in Middlesex-London and how they compare to the province. The way these groups fit into each priority area will be explained in more detail under each heading.

Children and Youth (≤18)

In Middlesex-London 22.9% of the population was made up of children and youth 18 years of age and under (Table 5.2), which was comparable to the provincial rate of 23.3%. The City of London had a lower proportion of people in this age group (22.3%) compared to all of the eight municipalities in Middlesex County. The highest proportions were seen in Adelaide Metcalfe and North Middlesex (both 27.4%).

In the City of London the following neighbourhoods (for neighbourhood reference map see Figure 4.3) had the largest proportion of children and youth (age 0-19): Fox Hollow (36%), Hyde Park (35%), Woodhull (32%), Jackson (30%), Sharon Creek (30%), Uplands (30%), Argyle (29%), and White Oaks (29%).[16] The largest number of children and youth were found in the neighbourhoods of Argyle, White Oaks, Medway, Highland, Huron Heights, Westmount, Glen Cairn, Oakridge and Carling.

Aboriginals

The aboriginal off-reserve population made up 1.4% of the total population in Middlesex-London (Table 5.1). However, when including the two Indian reserves that participated in the Census 2006 the regional percentage increased to 1.6, which was below the provincial proportion of 2.0%. There were a total of 5,680 people with Aboriginal identity living off-reserve in the region. The highest proportions of Aboriginal persons were found in Newbury (2.3%) and Southwest Middlesex (1.8%), and the lowest proportions were found in Adelaide Metcalfe (0.3%), Lucan Biddulph (0.4%) and Thames Centre (0.6%). By far the largest population of people with Aboriginal identity was to be found in the City of London, with a community of 5,040 people.

Table 5.1. Aboriginal Population in Middlesex-London, 2006

Area	Aboriginal Identity	
	N	%
Adelaide Metcalfe	10	0.3%
Lucan Biddulph	15	0.4%
Middlesex Centre	90	0.6%
Newbury	10	2.3%
North Middlesex	50	0.8%
Southwest Middlesex	105	1.8%
Strathroy-Caradoc	275	1.4%
Thames Centre	85	0.6%
London	5,040	1.4%
Middlesex-London (incl. Indian reserves)	6,580	1.6%
Middlesex-London (excl. Indian reserves)	5,680	1.4%
Ontario	242,490	2.0%

Source: Statistics Canada Census Data, 2006

[16] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

In the City of London the following neighbourhoods (for neighbourhood reference map see Figure 4.3) had the highest proportion of Aboriginal persons: Bostwick (8%), Central London (3%), East London (3%), Hamilton Road (3%), and Tempo (3%). In terms of numbers Argyle, Hamilton Road, White Oaks, Huron Heights, Carling, Central London, Glen Cairn and East London had the largest Aboriginal populations.[17]

The Aboriginal community of Ontario is younger than the general population, with 50% of the Aboriginal population being below the age of 25, compared to 33% of the general population (Ontario Trillium Foundation (OTF), 2010). Among off-reserve Aboriginals in 2001, 26% had incomes below the low income cut-off, compared to 12% among non-Aboriginals. The unemployment rate was twice as high among Aboriginals as among non-Aboriginals (14% vs. 7%). High school education was attained by 56% of female and 57% of male off-reserve Aboriginals, compared to 70% of female and 71% of male non-Aboriginals. Moderate to severe food insecurity was experienced by almost four times as many off-reserve Aboriginals (33%) as non-Aboriginals (8.8%) in 2004. Life expectancy among Aboriginals is about five to 14 years shorter than among non-Aboriginal Canadians. Infant mortality rates are between 1.5 and four times higher in the Aboriginal population compared to the general Canadian population (Mikkonen & Raphael, 2010).

The top health and chronic conditions among Aboriginals as identified by the key stakeholders of the First Nations in South West were diabetes, heart disease, and mental health issues. Other important issues identified were kidney disease and asthma (Perry, 2010).

Ethnic Groups

Ethnic diversity can be measured and expressed in different ways. It can be examined from the view of mother tongue, immigration and generation status, visible minority status, or by ethnic origin.

Visible Minorities

The Employment Equity Act defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour". The proportion of the population identifying themselves as belonging to a visible minority group in the Middlesex-London region was 11.7% in 2006, compared to 22.8% across Ontario (Table 5.2). The most common visible minorities in Middlesex-London were Black (16.3%), Latin American (16.0%), Arab (15.9%), Chinese (13.2%) and South Asian (12.8%). The vast majority of visible minorities lived in the City of London, with 13.8% identifying themselves as belonging to a visible minority group. Much lower percentages were seen across Middlesex County, ranging between 0.3% and 2.3%. Over time the visible minority group in the whole region increased from 7.7% in 1996 and 9.3% in 2001. In the City of London this population increased from 8.9% in 1996 and 10.9% in 2001. Across Ontario this group grew from 15.8% in 1996 and 19.1% in 2001. The visible minority group in Middlesex-London grew by 11,660 people from 2001 to 2006, and, given that the reporting of visible minority status remained constant between censuses, visible minorities accounted for 61% of the population growth in that 5-year period (Statistics Canada Census Data, 2006).

Table 5.2. Visible minority status in Middlesex-London, 2006

Area	%
Adelaide Metcalfe	0.3
Lucan Biddulph	1.1
Middlesex Centre	1.9
Newbury	2.3
North Middlesex	0.8
Southwest Middlesex	2.1
Strathroy-Caradoc	1.3
Thames Centre	1.2
London	13.8
Middlesex-London	11.7
Ontario	22.8

Source: Statistics Canada Census Data, 2006

[17] Ibid

In the City of London the highest rates of visible minorities were found in White Oaks (26%), Uplands (23%), Huron Heights (21%), Sunningdale (21%), Medway (20%), and Westmount (20%).[20]

According to projections made by Statistics Canada for the London Census Metropolitan area[18] the visible minority group could double from 11% in 2006 to 22% in 2031 (Statistics Canada, 2010a).

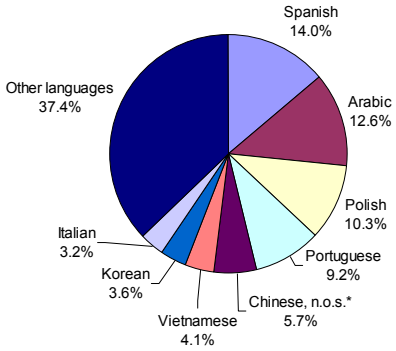
Ethnicity

Ethnic origin is difficult to summarize since respondents often report multiple ethnic origins. The most commonly reported (in single or multiple responses) ethnic origins among the Middlesex-London population were the British Isles origin (53.5%) and Canadian origin (26.0%). Among those aged 15 years and over 55.6% identified as being third generation or more Canadian, 20.1% as second generation, and 24.3% first generation Canadian (Statistics Canada Census Data, 2006).

Language

In terms of mother tongue, defined by Statistics Canada as the first language learned at home in childhood and still understood by the individual at the time of the census, 18.8% of the Middlesex-London population had a different mother tongue than English and French in 2006 (Ontario: 27.2%). This proportion grew from 16.1% in 1996 and 17.2% in 2001. Of the non-official languages the most common mother tongues were Spanish (10.5%), Arabic (9.6%) and Portuguese (9.3%) (Statistics Canada Census Data, 2006). In their home 9.0% were speaking a non-official language, among which Spanish, Arabic and Polish being the most frequently reported (Figure 5.1). Only 1.1% of the population had no knowledge of either English or French.

Figure 5.1. Non-official languages spoken most often at home in Middlesex-London

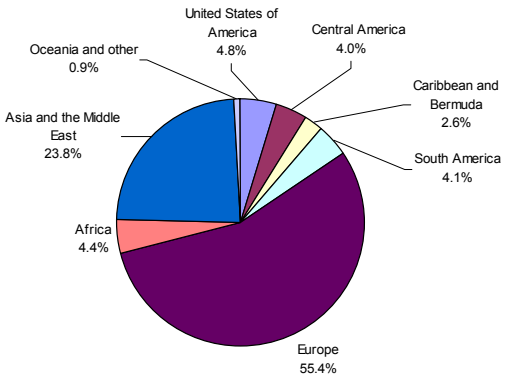


Source: Statistics Canada Census data 2006
The 2006 category 'Chinese, n.o.s. (not otherwise specified)' includes responses of 'Chinese' as well as all Chinese languages other than Cantonese, Mandarin, Taiwanese, Chaochow (Teochow), Fukien, Hakka and Shanghainese.

New Canadians

Immigrants made up 20.0% of the Middlesex-London population in 2006, compared to 28.3% in Ontario as a whole. The immigrant population in the City of London was 21.7% of the total population in 2006. Figure 5.2 shows the distribution of all immigrants by place of birth. Among all immigrants the most common place of birth was Europe (55.4%), and Asia and the Middle East (23.8%).

Figure 5.2. Total immigrant population in Middlesex-London by place of birth.



Source: Statistics Canada Census Data, 2006

[18] This area does not correspond with the borders of the Middlesex-London area

In the City of London in 2006 the largest concentration of immigrants (foreign born) could be found in the following neighbourhoods (for neighbourhood reference map see Figure 4.3): Fanshawe (35%), Uplands (31%), White Oaks (30%), Talbot (29%), Jackson (27%), and Masonville (27%).[19]

The picture for new immigrants (immigrated between 2001 and 2006), however, looks very different. New immigrants made up 15.0% of the 2006 immigrant population in the Middlesex-London region (compared to 16.2% in London and 17.1% in Ontario, Table 5.3), and 3.0% of the total population (compared to 3.5% in London and 4.8% in Ontario). The vast majority (97.7%) of the 12,530 new immigrants in Middlesex-London in 2006 were living in the City of London. The City neighbourhoods where the highest proportions of new immigrants were living were: Glen Cairn (12%), Uplands (7%), Argyle (6%), Carling (6%), Medway (6%), and White Oaks (6%). The largest numbers of new immigrants were found in Glen Cairn, Argyle, White Oaks, Medway, Carling, Highland and Westmount.[20]

Compared to 1996 the percentage of new immigrants in the Middlesex-London population did not change. New immigrants made up 15.3% of the immigrant population and 3.0% of the total population in the region in 1996.

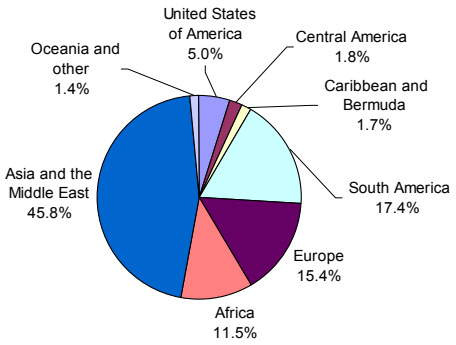
Table 5.3. New Immigrants in Middlesex-London

Area	% of immigrant population
Adelaide Metcalfe	0.0
Lucan Biddulph	4.0
Middlesex Centre	4.6
Newbury	0.0
North Middlesex	0.2
Southwest Middlesex	0.0
Strathroy-Caradoc	0.1
Thames Centre	4.8
London	16.2
Middlesex-London	15.0
Ontario	17.1

Source: Statistics Canada Census Data, 2006

New Canadians were most likely to come from Asia and the Middle East (45.8%), and the second largest group consisted of immigrants born in South America (17.4%, Figure 5.3). Of all residents in Middlesex-London 1.1% did not know either one of the two official languages. This was a greater concern in the City of London compared to Middlesex County (1.2% vs. 0.6%).

Figure 5.3. New immigrants (immigrated between 2001 and 2006) in Middlesex-London by place of birth.



Source: Statistics Canada Census Data, 2006

According to combined data from the Canadian Community Health Survey for the years 2005 and 2007/08, the immigrant population (age 12+) in Ontario was slightly older (average age 46.8) compared to the Canadian population (40.9) (MOHLTC, 2010). Table 5.4 shows the age distribution among Canadian-born and immigrants in Ontario and in the South West LHIN region. In summary, recent immigrants (immigrated 20 years ago or more recent), in both Southwestern Ontario and the whole province, tended to be younger than both the Canadian-born population and established immigrants. In turn, established immigrants tended to be older than the Canadian-born population.

[19] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

[20] Ibid.

Table 5.4. Age distribution in the South West LHIN and Ontario population (%)

Region & Age	Canadian-born	Immigrant	Recent immigrant	Established immigrant
Ontario				
12 to 17	11.8	4.3	8.0	n/a
18 to 44	47.0	43.1	64.7	18.0
45 to 64	28.6	34.2	22.6	47.7
65 +	12.5	18.4	4.8	34.3
Southwest				
12 to 17	11.1	3.7[E]	8.6[E]	n/a
18 to 44	44.1	37.3	67.7	14.9
45 to 64	30.2	35.8	23.2	45.0
65 +	14.6	23.3	F	40.1

F Too unreliable to be published (Data with a coefficient of variation greater than 33.3% suppressed due to extreme sampling variability or sample size too small)

[E] Use with caution (Data with a coefficient of variation between 16.6% to 33.3%).

n/a Not applicable

Immigrants in the South West region were significantly more likely to have post-secondary education (59.2%) compared to those in the region who were Canadian-born (47.5%), and this counts for both recent and established immigrants (60.1% and 58.5%, respectively). However, recent immigrants tended to have a lower income compared to the Canadian-born population. In Ontario a significantly higher proportion of recent immigrants had a yearly income of less than $20,000 (43.2%) compared to the Canadian-born population (32.7%), and a significantly lower proportion had a yearly income of $60,000 and more (13.0%) compared to those who were born in Canada (22.9%).

Francophones

Different statistics about the language of the population can be found in the Census Data: mother tongue, knowledge of official languages, and language spoken most often at home. In Middlesex-London 1.4% reported French as their mother tongue in 2006, and another 0.2% reported both French and English as their mother tongues (compared to 4.1% and 0.3%, respectively, in Ontario). The proportion reporting French as the language spoken most often at home was 0.4% (2.4% in Ontario), and even fewer claimed that French was the only language that they knew (0.1%, compared to 0.4% in Ontario). All of the 275 individuals who only knew French resided in the City of London (Statistics Canada Census Data, 2006). This population doubled between 1996 (n=130) and 2006 (n=275).

In the City of London the highest concentration of Francophones could be found in neighbourhoods with small populations (n<900). In Glanworth 8% had French as their mother tongue and 6% spoke French at home. In Riverbend 4% had French as their mother tongue and 2% spoke French at home. In Talbot 4% had French as their mother tongue and 3% spoke French at home. In Longwoods 8% had French as their mother tongue. The largest Francophone populations were found in Argyle (560 had French as mother tongue and 170 spoke French at home), Medway (330 had French as mother tongue and 185 spoke French at home) and Huron Heights (350 had French as mother tongue and 155 spoke French at home) in 2006 (for neighbourhood reference map see Figure 4.3).[21]

Despite the fact that Canada is officially a bilingual country, only 11.6% claimed knowledge of both English and French across Ontario in 2006. In Middlesex-London the percentage was even smaller (7.1%, Table 5.5). The knowledge of both English and French varied between 3.0% (in North Middlesex) to 7.7% in the City of London. Over time knowledge of both English and French remained fairly stable (6.6% in 1996[22] and 7.0% in 2001).

[21] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

[22] Profile of Census Divisions and Subdivisions, 1996 Census, 2001: Knowledge of Official Languages - Cat. No. 97F0024XIE2001003

Table 5.5. Knowledge of official languages among residents of Middlesex-London

Area	Knowledge of both English and French
Adelaide Metcalfe	3.5%
Lucan Biddulph	3.5%
Middlesex Centre	5.8%
Newbury	6.8%
North Middlesex	3.0%
Southwest Middlesex	3.6%
Strathroy-Caradoc	4.7%
Thames Centre	4.1%
London	7.7%
Middlesex-London	7.1%
Ontario	11.5%

Source: Statistics Canada Census Data, 2006

There are currently seven schools providing elementary and secondary education in French only in London. A total of 1,594 children were enrolled in these schools (JK-12) in 2009/2010. In addition to French only schools there are 11 elementary French Immersion schools in the Middlesex-London area. A total of 4,014 students were enrolled in these schools in 2010/2011.[23] Three secondary schools in Middlesex-London provide French Immersion programs.

In 2006, a regional report by Réseau franco-santé presented some socio-demographic and health related information about the Francophone population in Southern Ontario (Réseau franco-santé du Sud de l'Ontario, 2006). According to the 2001 Census the Southwest region[24] of Ontario was home to approximately 35,000 Francophones, mainly concentrated in Essex and Middlesex counties and the municipality of Chatham-Kent. Francophones in this region constituted 2.5% of the total population and 6.3% of the province's total Francophone population. In Southwest the Francophone population had a higher average age compared to the general population. However, Middlesex County was an exception with its younger Francophone population. The highest numbers of Francophone visible minorities were found in Middlesex and Essex counties. Among Francophone racial minorities in Southwest there was a higher unemployment rate (16.8% vs. 4.9%) and lower total income than among the general Francophone population in the region. Francophones in the Southwest region were less likely to have completed grade 9 compared to the general population (15.3% vs. 8.4%). Compared to Francophones in the Southwest region those in Middlesex County had a higher income. Language retention among Francophones in Southwest was the lowest in the whole province. In 2001 the language retention was 26.9%, which was a drop from 29.6% in 1996. The high rate of exogamous unions (marrying outside of the Francophone community) in the region (82.2%), likely has a negative effect on language retention.

Low-Income

Low-income cut-offs are used as a measure of those who are relatively worse-off financially, and not as an absolute measure of poverty. This measure reports the income level at which a family may be in financial difficulty because they will have to spend a greater proportion of their household income on food, clothing and shelter than the average family of a similar size. The cut-offs vary by family size and by size of community (Statistics Canada, 1999). In 2005 the prevalence of low income after-tax in Middlesex-London was 7.3% for all economic families (Ontario: 8.6%), 21.9% for lone-parent families (same percentage in Ontario), and 10.4% among all persons aged 15 and over (11.1% in Ontario). The prevalence in the region ranged between 2.2% in North Middlesex and 11.8% in the City of London (Table 5.6).

[23] Data retrieved through personal communication with Janice Graham (secretary for the superintendent) at Thames Valley District School Board and from the following web sites:
http://www.tvdsb.ca/schools.cfm?subpage=3826
http://www.tvdsb.ca/Elizabeth.cfm?subpage=351
http://www.ldcsb.on.ca/schools/anthony/
http://www.ldcsb.on.ca/schools/john/

[24] Including the LHIN regions of South West and Erie St. Clair

Table 5.6. Prevalence of low-income after-tax among all persons 15 and over in Middlesex-London, 2006

Area	%
Adelaide Metcalfe	2.4
Lucan Biddulph	4.1
Middlesex Centre	2.2
Newbury	6.9
North Middlesex	2.2
Southwest Middlesex	3.8
Strathroy-Caradoc	3.8
Thames Centre	3.0
London	11.8
Middlesex-London	10.4
Ontario	11.1

Source: Statistics Canada Census Data, 2006

Among persons 15 and over not in economic families (single-person household) 26.1% were in the low-income bracket after-tax (Ontario: 27.0%). Statistics Canada recommends using the after-tax measure for low income. The number of people falling below the low-income tax bracket is generally lower when using the after-tax measure compared to using the before-tax measure. However, the after-tax measure for low income was not used in earlier censuses. In Figure 5.4 low-income before-tax is shown in 1996, 2001, and 2006 for selected municipalities with populations of over 5,000 people. The percentage of persons in low-income decreased over time in all of these geographical areas

In 2005 in Middlesex-London 10.6% of the total income came from government transfers, compared to 9.8% in Ontario (Table 5.7). The municipalities with the highest dependence on government income were Newbury (21.6%) and Southwest Middlesex (13.6%), and those least reliant were Middlesex Centre (7.0%) and Thames Centre (7.6%). It's important to bear in mind that different forms of government transfer income include Old Age Security, Guaranteed Income Supplement, retirement income plans for seniors, Employment Insurance, disability income and Ontario Works.

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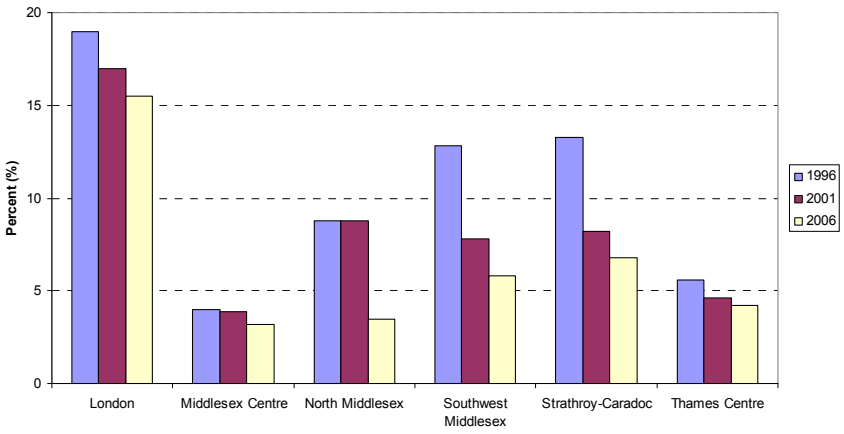
Figure 5.4. Percentage in Low-Income Cut-Off group before-tax



Source: Statistics Canada Census Data 1996, 2001, 2006

Table 5.7. Percentage of income from government transfers in Middlesex-London

Area	%
Adelaide Metcalfe	8.6
Lucan Biddulph	9.3
Middlesex Centre	7.0
Newbury	21.6
North Middlesex	11.6
Southwest Middlesex	13.6
Strathroy-Caradoc	12.2
Thames Centre	7.6
London	10.8
Middlesex-London	10.6
Ontario	9.8

Source: Statistics Canada Census Data, 2006

Older adults (55+)

The population across Canada is aging, and with that comes increasing health problems. There were a total of 104,270 adults 55 years of age and over in Middlesex-London in 2006, which represents 24.7% of all residents (Table 1.2). This corresponds exactly with the percentage of this age group in the Ontario population. The highest proportion of people 55+ in 2006 was found in Newbury (29.9%) and the lowest in Lucan Biddulph (22.1%). In 1996 this age group made up 20.6% of the Middlesex-London population, and in 2001 it made up 22.1% (Statistics Canada Census Data 1996, 2001). People over 65 years of age, who are generally above working age, constitute 13.7% of the Middlesex-London residents. This age group is projected to constitute 17.9% of the Middlesex-London population in 2020 and 22.6% in 2030.[25]

In the City of London in 2006, 14% of the population was 65+, and the highest rates of seniors were found in the neighbourhoods of Bostwick (40%), West London (27%), Glanworth (19%), Southcrest (19%), Sunningdale (19%), Stoneybrook (18%), and Tempo (18%).[26]

The neighbourhoods with the highest number of seniors (>18,000) were West London, Westmount, Southcrest, Oakridge, Highland, Huron Heights, Hamilton Road, Medway, Carling, Byron and Glen Cairn (for neighbourhood reference map see Figure 4.3).

Seniors' facilities were available in the following neighbourhoods: Byron, East London, Hamilton Road, Huron Heights, Lambeth, Southcrest, South London (2), West London, Westminster, Westmount, and White Oaks (2).[27] Thus, four areas with a high number of seniors that did not have a seniors facility could be identified: Carling, Glen Cairn, Highland and Medway.

Persons with disabilities

Disabilities are difficult both to define and to measure. As defined by the World Health Organization, "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives" (WHO, 2010b). There is likely a large proportion of hidden disabilities since some people may not perceive of a disability they have as being a disability, or may not report or acknowledge their disability for different personal and social reasons.

Due to lack of more accurate disability measures proxy measures have been reported. One such proxy measure is receiving social assistance due to disabilities. The Ontario Disability Support Program (ODSP) provides assistance for people with physical and mental disabilities. Approximately half of ODSP is for physical disabilities and half is for mental disabilities. In September,

[25] Data Source: Population Projections County, (Stats Can) Intellihealth, MOHLTC; Description: Ministry of Finance Population Projections by County from 2009-2036, based on the 2006 Census

[26] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

[27] Ibid.

2010, the total number of cases in 77.9% of single people without children, 7.8% of couples without children, 5.8% of couples with children and 8.5% of single people with children. The average monthly caseload for ODSP in the City of London in 2007 was 8,267 cases (including a mix of sole supporters, couples, couples with dependents and singles), which was an increase by 6.5% from the previous year. In 2006 the Participation and Activity Limitation Survey conducted by Statistics Canada suggested a disability rate of 15.5% in Ontario, which indicates that roughly 65,500 people in Middlesex-London experienced disability in daily activities.

In 2005 in Middlesex-London, 29.9% of those 12 years and over reported some participation and activity limitation.[28] The rate increased with age and as many as 59.6% among those 75 years and over reported some limitation or disability.

Good to full functional health[29] was reported by 80.3% of the Canadian Community Health Survey (CCHS) respondents in Middlesex-London in 2009, indicating that 19.7% had moderate to poor functional health.[30]

Pain or discomfort that prevents activities was reported by 12.8% of the population 12 years and over in Middlesex-London in 2009, according to findings from the CCHS. Numbers were too small to make comparisons across sub-groups and over time in this local population. However, looking at provincial estimates the rate increased from 10.5% in 2003 to 13.2% in 2009, which is a statistically significant change. Females were more likely to Middlesex-London was 10,725, including report pain or discomfort that prevents activities (15.3%), than males (11.0%) in 2009. The rate also increased with age from 7.4% among those 20-34 years of age to 22.4% among those 65+.

Women and girls

Unlike the other priority groups described in this section, women and girls do not constitute a minority group. However, there may still be inequities in social determinants of health affecting the health of this group negatively.

Among Middlesex-London residents 15 years of age and over, the yearly median individual income before-tax (for the year 2005) was $12,014 lower among females compared to males (Statistics Canada, Census 2006). This, however, may reflect that more women chose to work part-time compared to males and not just that males have higher paid jobs or are paid more for the same jobs.

In Middlesex-London in 2006, 16.5% of all Census families were lone-parent households, and 26.7% of families with children at home were lone-parent families (slightly higher than in Ontario: 24.5%). About 82% or the lone-parent families were headed by a single mother. Table 5.8 shows the distribution of lone-parent families across the region. London had the highest rate of both female and male lone-parent families (23.7% and 5.1%, respectively). The lowest rate of female lone-parent families was found in Adelaide Metcalfe (3.9%).

Table 5.8. Percentage of Lone-Parent Families in Middlesex-London (among all census families with children at home)

Area	Female %	Male %
Adelaide Metcalfe	3.9	3.9
Lucan Biddulph	14.8	3.4
Middlesex Centre	9.6	2.8
Newbury	15.4	0
North Middlesex	9.9	4.7
Southwest Middlesex	16.3	4.0
Strathroy-Caradoc	17.1	3.5
Thames Centre	9.6	3.6
London	23.7	5.1
Middlesex-London	21.9	4.8
Ontario	20.0	4.5

[28] Statistics Canada, Canadian Community Health Survey, Table 105-04171

[29] Population aged 12 and over reporting measures of overall functional health, based on 8 dimensions of functioning (vision, hearing, speech, mobility, dexterity, feelings, cognition and pain). A score of 0.8 to 1.0 is considered to be good to full functional health; scores below 0.8 are considered to indicate moderate to poor functional health. Otherwise known as the Health Utility Index (HUI), this index, developed at McMaster University's Centre for Health Economics and Policy Analysis, is based on the Comprehensive Health Status Measurement System (CHSMS).)

[30] Statistics Canada. Table 105-0501

Source: Statistics Canada, 2006 Census of Population, Statistics Canada catalogue no. 97-553-XCB2006009.

As a proportion of all households, lone-parent families were most commonly found in the following neighbourhoods in the City of London (for neighbourhood reference map see Figure 4.3): Glen Cairn (27%), Argyle (24%), Carling (24%), East London (24%), and Hamilton Road (23%). Neighbourhoods with the largest number (>1,000) of lone-parent families were Argyle, Glen Cairn, Carling, White Oaks, Highland and Huron Heights.[31]

The prevalence of low income after-tax was somewhat higher among females (24.1%) in Middlesex-London (Ontario: 23.9%), compared to male lone-parent families (21.9%).[32] Furthermore, female lone-parent families reported an average income before-tax in 2005 of $14,652 less than male lone-parent families.

[31] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

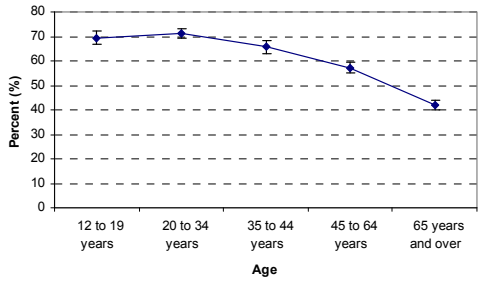
[32] Source: Statistics Canada, 2006 Census of Population, Statistics Canada catalogue no. 97-563-XCB2006040

6. Health Status

Overall Health

The majority (61.2%) of residents in Middlesex-London (age 12+) perceived their health as being very good or excellent in 2009, which was the same as the provincial estimate. In Ontario the rate went up from 57.3% in 2003. There was no significant difference between males and females either in the Middlesex-London sample or the provincial sample. Perceived health among Ontarians dropped with increasing age, from about 70% among 12-34 year olds to 42.0% among those 65+ (Figure 6.1).

Figure 6.1. Proportion of Ontario population with very good or excellent perceived health in 2009



Source: Canadian Community Health Survey, Statistics Canada

Among students in grades 9-12 in 2009, poor self-rated physical health was reported by 16.2% in the South West and Erie St Clair LHIN regions, and by 16.8% of Ontario students (Paglia-Boak et al., 2010). Among students in grades 7-12 poor physical health was reported by 14.7% of West Ontario[33] students (grades 7-12) and by 14.5% of Ontario students. Females were more likely than males to report poor physical health (18.5% vs. 10.8%). Poor physical health also increased with grade from 6.3% in grade 7 to 19.8% in grade 12, and increased over time from 8.9% in 1999 to 14.5% in 2009.

Based on data from the Canadian Community Health Survey (CCHS) in 2000/01 Francophones in Southern Ontario (including Central and South West) have a poorer perception of their health than Anglophones. Francophone females have poorer health compared to Francophone males (Réseau franco-santé du Sud de l'Ontario, 2006).

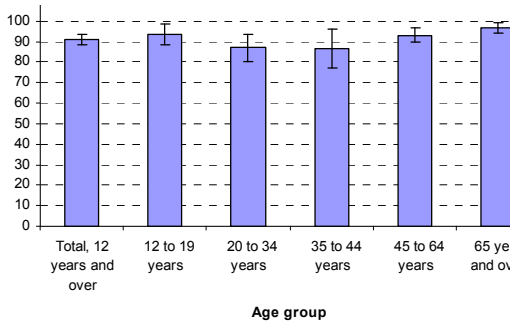
According to combined CCHS data from the years 2005 and 2007/08 the immigrant population in South West were less likely to report that their health was very good or excellent (55.9%) compared to the Canadian-born population in South West (63.1%). Recent immigrants, who immigrated 20 years ago or more recently, were as likely as the Canadian-born population to rate their health as very good or excellent, whereas only 50.6% of more established immigrants rated their health this high (MOHLTC, 2010). This could be affected by the fact that the more established immigrants were older.

Having a Medical Doctor

In 2009, 91.1% of the Middlesex-London residents reported having a medical doctor, which is similar to the provincial rate of 91.5%. The rate had not changed significantly since 2003. Provincially, females were more likely to indicate having a medical doctor (93.5%) compared to males (89.4%). The same pattern was seen in Middlesex-London but the difference was not statistically significant. Figure 6.2 shows differences in proportions across age groups. People who were most likely to have a medical doctor were those in the age groups 12-19 (93.6%) and 45+ (93.2-96.6%). Those aged 20-34 were least likely to report having a medical doctor (87.0%).

[33] Including Peel District, Dufferin County and farther west, excluding North Ontario

Figure 6.2. Proportion of Middlesex-London residents who reported having a medical doctor in 2009



Source: Canadian Community Health Survey, Statistics Canada

According to combined CCHS data from the years 2005 and 2007/08 recent immigrants in South West Ontario were less likely to have had contact with medical professionals at least once in the past year (71.9%), compared to those in the region who were Canadian-born (79.8%) and compared to recent Ontario immigrants (80.6%). Recent immigrants in South West were also less likely to have a regular medical doctor (79.0%) compared to the Canadian-born population in South West (90.7%) and compared to recent Ontario immigrants (87.6%) (MOHLTC, 2010).

Physical Health Doctor Visits Among Youth

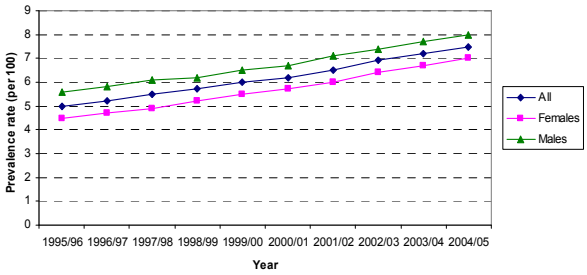
In the LHIN regions of South West and Erie St Clair in 2009, 30.1% of the students in grades 9 to12 had not visited a medical doctor for their physical health in the past 12 months, not even for a check-up. The rate among Ontario youth was slightly higher at 33.6% (Paglia-Boak et al., 2010). Among grade 7-12 students the rates were 33.2% in West Ontario and 33.6% in Ontario. Males were more likely than females to report no doctor visits (39.3% vs. 27.2%).

Prevalence of Specific Chronic Disease Conditions

The estimated prevalence of *arthritis* in the Middlesex-London population (age 12+) based on self-reported CCHS data was 17.9% in 2009, which is not statistically different from the provincial estimate of 16.8%. The rate was stable between 2003 and 2009. In Ontario, females were significantly more likely to report arthritis (20.7%), compared to males (12.7%), and the provincial rate increased dramatically with increasing age, from 2.0% among 20-34 year olds to 46.4% among those 65+ (2009 estimates).

Diabetes rates in Middlesex-London increased steadily from 5.0% (95% CI: 4.9-5.1) in 1995/96 to 7.5% (95% CI: 7.4-7.6) in 2004/05 and a similar rate of increase was seen among both males and females (Figure 6.3). Males were consistently more likely to have diabetes compared to females (Table 6.1) and in 2004/05 the prevalence rate was 8.0% among males and 7.0% among females. Overall diabetes was slightly more prevalent in Middlesex-London compared to South West (7.2%) but less prevalent compared to the provincial rate at 8.4%. Although age-specific rates were not available for Middlesex-London, both South West and Ontario rates show an increasing prevalence rate with increasing age among both males and females.

Figure 6.3. Prevalence rates (percent) of diabetes in Middlesex-London between 1995/96 and 2004/05



Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010.

Table 6.1. Age- and sex- adjusted prevalence rates (percent) for diabetes (2004/05)

	MLHU		South West		Ontario	
	%	95% CI	%	95% CI	%	95% CI
All	7.5	7.4-7.6	7.2	7.2-7.3	8.4	8.3-8.4
Males	8.0	7.8-8.1	7.6	7.5-7.7	8.8	8.8-8.8
Females	7.0	6.8-7.1	6.9	6.8-7.0	7.9	7.9-8.0

Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010

In 2009, 5.8% of Middlesex-London residents reported having diabetes (based on CCHS data). Provincially the likelihood of reporting diabetes was lowest among 20-34 year olds at about 2% and highest among those aged 65 years and older at 19.3%.

The age-standardized prevalence rate of diabetes was three to five times higher among First Nations people than in the general Canadian population in 1997 (Health Canada, 2001).

Ontario immigrants were more likely to report having been diagnosed with diabetes than Canadian-born Ontarians (7.1% vs. 4.7%), based on 2005 and 2007/08 data from the CCHS (MOHLTC, 2010).

The overall *asthma* prevalence in Middlesex-London (11.3%) was similar to that in South West (11.5%), but was lower compared to the provincial rate at 13.7%. Overall, the prevalence rates in Middlesex-London have increased significantly since 1996/97 (6.5%). This increase was seen in all age groups except the youngest (0-4 years) where the rate decreased slightly from 11.8% in 1996/97 to 10.1% in 2006/07. Overall, asthma was more common among females than males, but among children and youth (0-19 years) the asthma rates were higher among males. The highest asthma rates could be found among those 5-19 years of age (Table 6.2).

Table 6.2. Age- and sex- adjusted prevalence rates of Asthma (percent) in Middlesex-London (2006/07)

	%	95% CI
Age		
0-4	10.1	9.7-10.5
5-9	16.0	15.5-16.5
10-19	18.7	18.4-19.1
20-39	11.1	10.9-11.3
40-64	8.3	8.1-8.4
65+	9.0	8.7-9.2
All ages	11.3	11.2-11.4
Males	10.5	10.3.10.6
Females	12.0	11.9-12.1

Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010.

Based on 2000/01 data from the CCHS a larger proportion of Francophones in South West Ontario have asthma compared to non-Francohpones (Réseau franco-santé du Sud de l'Ontario, 2006).

In the immigrant population in South West Ontario the asthma rate was significantly lower (3.9%) compared to the Canadian-born population (8.3%) in the years 2005 and 2007/08 (MOHLTC, 2010).

Overall, the prevalence rate of *Chronic Obstructive Pulmonary Disease (*COPD*)* in Middlesex-London was 3.5% in 2006/07 (Table 6.5). This was comparable to the provincial rate at 3.6%, but somewhat lower than the South West rate at 4.1%. COPD was more common among males than females and rates increased significantly with increasing age. In 2009, the prevalence of COPD (based on self-reported data from the CCHS) was 3.5% in Middlesex-London.

Table 6.3. Age- and sex- adjusted prevalence rates of COPD (percent) in Middlesex-London (2006/07)

	%	95% CI
Age		
35-49	1.1	1.1-1.2
50-64	3.1	2.9-3.2
65-74	7.3	7.0-7.6
75-84	10.4	10.0-10.9
85+	11.5	10.6-12.4
All ages (35+)	3.5	3.4-3.5
Males	3.8	3.7-4.0
Females	3.2	3.1-3.3

Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010.

In the immigrant population in Ontario the rate of COPD was significantly lower (1.0%) compared to the Canadian-born population (1.5%) in the years 2005 and 2007/08 (MOHLTC, 2010).

High blood pressure was self-reported by 17.2% in 2009, both locally and provincially (based on results from the CCHS). Provincially the rate increased from 14.8% in 2003. In Middlesex-London the increase in high blood pressure rates between 2003 and 2009 was smaller and not statistically significant. No statistically significant difference between males and females was noted either locally or provincially. In the adult population the prevalence increased drastically with age, from 2.3% among 20-34 year olds to 48.8% among those 65 and over (provincial estimates from 2009).

According to combined CCHS data from the years 2005 and 2007/08, hypertension was more common among immigrants in South West Ontario (20.9%) compared to the Canadian-born population in the region (16.6%) (MOHLTC, 2010).

Among Middlesex-London residents age 20 and over the prevalence of *Ischemic Heart Disease* was 5.1% in 2006/07 (Table 6.4). The rate was considerably higher among males (6.6%) compared to females (3.8%), and rates increased significantly with increasing age. The overall rate in Middlesex-London was about the same as in South West (5.2%), but lower than the provincial rate (6.2%). Males in Middlesex-London were more likely to have Ischemic Heart Disease than South West males (6.6% vs. 6.1%), but less likely compared to males in Ontario (7.2%). Females in Middlesex-London had a lower prevalence rate compared to females in both South West (4.2%) and Ontario (5.2%).

Table 6.4. Age- and sex- adjusted prevalence rates (percent) of Ischemic Heart Disease in Middlesex-London (2006/07)

	%	95% CI
Age		
20-34	0.3	0.3-0.3
35-49	1.3	1.3-1.4
50-64	6.2	6.0-6.4
65-74	15.7	15.3-16.2
75-84	24.0	23.3-24.7
85+	26.7	25.4-28.1
All ages (20+)	5.1	5.0-5.2
Males	6.6	6.5-6.8
Females	3.8	3.7-3.9

Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010.

Based on 2000/01 data from the CCHS a higher percentage of Francophones in South Ontario (including Central and South West Ontario) had cardiovascular disease compared to non-Francophones (Réseau franco-santé du Sud de l'Ontario, 2006).

Immigrants in Ontario were more likely to suffer from heart disease compared to Canadian-born Ontarians (5.6% vs. 4.6%), according to combined CCHS data for the years 2005 and 2007/08 (MOHLTC, 2010).

The prevalence rate of *Cerebrovascular Disease* was 2.1% among Middlesex-London residents aged 20+ in 2006/07 (Table 6.5), which was similar to the South West rate at 2.0% and Ontario rate at 1.9%. The rate increase with increasing age and was slightly higher among males (2.3%) compared to females (2.0%) in Middlesex-London. However, this gender difference was not reflected in the South West and Ontario populations.

Table 6.5. Age- and sex- adjusted prevalence rates (percent) of Cerebrovascular Disease in Middlesex-London (2006/07)

	%	95% CI
Age		
20-34	0.2	0.2-0.2
35-49	0.7	0.7-0.8
50-64	2.2	2.1-2.3
65-74	5.7	5.4-6.0
75-84	10.4	10.0-10.9
85+	14.3	13.3-15.3
All ages (20+)	2.1	2.1-2.2
Males	2.3	2.2-2.4
Females	2.0	2.0-2.1

Source: inTool, Institute for Clinical Evaluative Sciences (ICES), accessed in January, 2010.

Cancer Incidence and Mortality in Ontario

Cancer relates to many of the priority areas in this report. Obesity, poor nutrition, lack of physical activity, alcohol use and tobacco use are all risk factors for different cancers.

An increasing number of new cancers have been diagnosed in Ontario, and this is mainly due to population growth and an aging population. Between 1982 and 2006 the number of new cancers diagnosed per year doubled (Cancer Care Ontario, 2010a). Provincially, the top three cancers being diagnosed in 2006 among males were prostate, lung and colorectal cancer, and among females the top three cancers were breast, lung and colorectal cancer (Table 6.6).

Rates of overall cancer mortality have been decreasing since the 1980s, reflecting improved treatment and earlier diagnosis for many types of cancer (Cancer Care Ontario, 2010a). Lung cancer was the leading cause of cancer death in 2006 (27% among males and 24% among females), followed by colorectal and prostate cancer (12% and 11%, respectively) in males, and by breast and colorectal cancer among females (16% and 12%, respectively) (Table 6.7).

Table 6.6. Most commonly diagnosed cancers, by sex, Ontario, 2006

Male			Female		
Site	**# Cases**	**%**	**Site**	**# Cases**	**%**
All sites	*31,954*	*100*	***All Sites***	*29,224*	*100*
Prostate	9,617	30	Breast	7,942	27
Lung	4,212	13	Lung	3,601	12
Colorectal	4,096	13	Colorectal	3,398	12
Non-Hodgkin lymphoma	1,390	4	Thyroid	1,615	6
Bladder	1,323	4	Body of uterus	1,605	5
Melanoma	1,199	4	Non-Hodgkin lymphoma	1,202	4
Leukemia	1,068	3	Ovary	1,140	4
Kidney	983	3	Melanoma	1,031	4
Stomach	712	2	Leukemia	766	3
Pancreas	635	2	Pancreas	633	2

Source: Cancer Care Ontario. (2010a).

Table 6.7. Most common cancer deaths, by sex, Ontario, 2006

Male			Female		
Site	**# Cases**	**%**	**Site**	**# Cases**	**%**
All sites	*13,124*	*100*	***All Sites***	*11,845*	*100*
Lung	3,548	27	Lung	2,822	24
Colorectal	1,634	12	Breast	1,839	16
Prostate	1,384	11	Colorectal	1,392	12
Pancreas	609	5	Pancreas	625	5
Leukemia	519	4	Ovary	602	5
Non-Hodgkin lymphoma	478	4	Non-Hodgkin lymphoma	419	4
Stomach	464	4	Leukemia	395	3
Bladder	458	3	Body of uterus	286	2
Esophagus	456	3	Stomach	259	2
Liver	416	3	Myeloma	228	2

Source: Cancer Care Ontario. (2010a).

From the early 1990s prostate cancer incidence rates rose while mortality rates decreased (Cancer Care Ontario, 2010a). The incidence rates for breast cancer stabilized from the early 1990s and mortality rates decreased from the late 1980s. Colorectal cancer incidence and mortality rates have declined for both sexes. Lung cancer incidence and mortality in males have decreased since the early 1980s. In females, these rates increased till the late 1990s and then leveled off. The long-term decline in lung cancer incidence rates in males and the recent stabilization in females reflects differences in smoking trends between the sexes.

Oral cancers (combined) were the 10th most common cancers diagnosed among Ontario males between the years 2003 and 2007, whereas they only ranked 15th among females (Cancer Care Ontario, 2010b). Incidence rates among both males and females fell between 1982 and 2007. Tobacco use and alcohol consumption are the major known risk factors for oral cancers.

A survey among Ontarians[34] in 2008 showed that cancer was a real concern for them, even more so than heart disease and diabetes (Canadian Partnership Against Cancer, 2009). About six in ten said that cancer was the disease causing the greatest personal concern, followed by heart disease (19%) and diabetes (10%), and about three-quarters thought there was some risk they would be diagnosed with cancer some day. When asked whether specific health practices would help prevent cancer 37% said stopping smoking would, 20% said exercising would, 12% said changing diet in general would, 9% said eating healthier food would, and 9% said eating more fruits and vegetables would. Almost two-thirds (62%) reported they were currently doing specific things to reduce their risk of getting cancer. In terms of cancer information, only 17% were actively seeking out information on cancer, but an additional 70% were interested in information on cancer prevention when coming across it. About 85% said they were somewhat (50%) or very (35%) interested in learning more about factors that cause cancer. When asked what would motivate them to change their lifestyle, the majority (66%) said they would be more likely to change if the person telling them to change was stressing the benefits of healthy living, and 23% would be more motivated by someone stressing the risks of unhealthy living. Being too busy or not having enough time were, by far, the most common barriers to both exercising (64%) and eating healthy (52%). Another barrier to healthy eating was not being able to afford as much healthy food as they would like (15%). Thirteen percent responded they were physically unable to exercise more than they currently did.

[34] Part of a national survey

7. Priority Areas

The Ministry of Health Promotion and Sport have identified six priority areas for the Healthy Communities Ontario Framework: Physical Activity, Sport and Recreation; Healthy Eating; Injury Prevention; Tobacco Use and Exposure; Substance and Alcohol Misuse; and Mental Health Promotion. In this section, data and trends will be presented to help determine the health status of the Middlesex-London population as it pertains to these specific priority areas. Where available and applicable, data will also be presented for specific demographic subgroups of particular interest.

7.1 Physical Activity, Sport, and Recreation

7.1.1. Data

Physical activity is a well recognized strategy in promoting well being, reducing stress, achieving a healthy body weight, reducing all-cause mortality and reducing the risk of developing numerous chronic diseases such as cardiovascular disease, stroke, hypertension, osteoporosis, diabetes, and some cancers (Warburton et al., 2010; Brownson et al., 1998; Bouchard et al., 1994). Insufficient physical activity has been blamed for an estimated 35% of deaths from coronary heart disease (Brownson et al., 1998), as well as for many chronic conditions, such as 36% of coronary artery disease, 28% of osteoporosis, 20% of stroke, hypertension, colon cancer and type 2 diabetes, and 11% of breast cancer in Canada (Katzmarzyk et al., 2000).

Among older people, weight-bearing physical activity decreases bone loss associated with osteoporosis, and regular physical activity helps to maintain strength and flexibility, balance and coordination, as well as reducing the risk of falls (Stevens et al., 1997). Physical inactivity is largely to blame for increased limitation in the ability to carry out basic activities of daily living associated with aging (Wagner & Lacroix, 1992).

In January, 2011, the Canadian Society for Exercise Physiology (CSEP) released new Canadian Physical Activity Guidelines for apparently healthy children, 5-11 years of age (CSEP, 2011a), youth, 12-17 years of age (CSEP, 2011b), adults, 18-64 years of age (CESP, 2011c), and older adults, 65 years and older (CESP, 2011d) to receive health benefits.

Table 7.1.1. summarizes the guidelines for each age group. The more daily physical activity that people participate in, the greater the health benefits will be experienced.

When evaluating estimates of physical activity it is important to keep in mind that self-reported measures may not be reliable and that the measurement method may significantly affect the observed levels of physical activity.

A review study showed low-to-moderate correlations between self-report and direct measures among adults. No clear pattern emerged; self-report measures of physical activity were both higher and lower than levels measured directly (Prince et al., 2008). Parental reports of their children's physical activity tend to overestimate physical activity levels (Adamo et al., 2009).

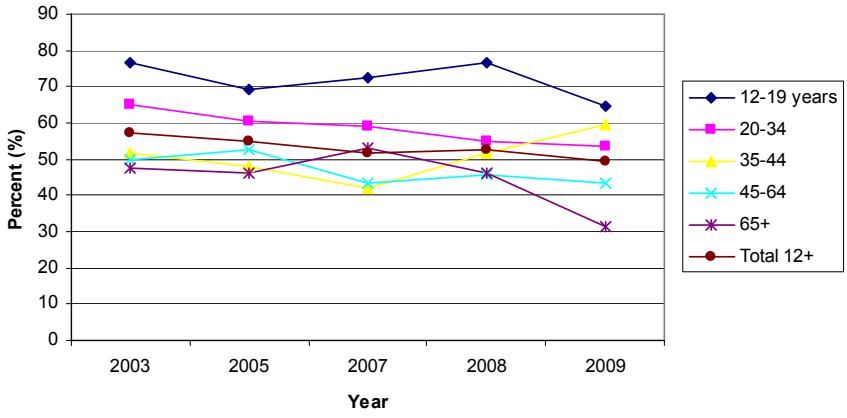
Data from the Canadian Community Health Survey (CCHS) show that self - reported physical activity in Middlesex-London decreased significantly between 2003 and 2009 (among people 12 years and over). The proportion of people being moderately active or active was 57.3% in 2003 and decreased to 49.4% in 2009 (Figure 7.1). In individual age groups there was generally a decrease over timeexcept for the age group 35-44. However, none of the changes in these individual age groups were statistically significant. Physical activity also

decreased with increased age: 64.6% of 12-19 year olds were moderately active or active in 2009, compared to only 49.4% among those 65+. Males tended to be more physically active (54.2%) than females (44.9%), but the difference was not statistically significant.

Table 7.1.1. Summary of Canadian Physical Activity Guidelines, 2011

Children (age 5-11)	Youth (age 12-17)	Adults (age 18-64)	Older adults (age 65+)
Accumulation of at least 60 minutes of moderate- to vigorous- intensity physical activity *daily* Moderate activities cause children and youth to breathe harder and to begin to sweat a little. Vigorous intensity physical activity causes children and youth to sweat and be 'out of breath'. Vigorous-intensity activities and physical activities that strengthen muscle and bone should be performed at least three days a week.		Accumulation of at least 150 minutes of moderate-to vigorous-intensity aerobic physical activity in bouts of 10 minutes or more, *every week* Muscle and bone strengthening activities at least two days per week	
Moderate physical activities include bike riding and playground activities. Examples of vigorous intensity activities are swimming or running.	Examples of moderate intensity physical activities are bike riding and skating. Vigorous intensity activities include running or rollerblading.	Moderate intensity physical activities include brisk walking or bike riding. Examples of vigorous intensity activities are jogging and cross country skiing.	Those with poor mobility should participate in physical activities to enhance balance and prevent falls.

Figure 7.1.1 Proportion of people being moderately active or active during leisure time, Middlesex-London, 2003-2009



Source: Canadian Community Health Survey, Statistics Canada

Combined data from the CCHS in 2005 and 2007/08 show that physical inactivity was more common among immigrants in the South West LHIN region (53.7%), and especially among recent immigrants (60.2%), compared to Canadian-born (46.4%) (MOHLTC, 2010).

Physical Activity Among Children And Youth

In the *in motion*® survey conducted in Middlesex-London in 2009 (Middlesex-London Health Unit, 2009b) parents of children between the ages of 5 and 12 years were asked to complete a survey on behalf of their child. Youth between the ages of 13 and 18 years either completed the survey by themselves with permission from a parent, or had a parent complete the survey for them. The weighted results[35] indicated that 87% of children and 77% of youth exercised regularly. However, only 44% of children and 30% of youth were considered physically active enough to receive health benefits[36]. About 55% of children and 42% of youth believed that they were more physically active than they were two years ago. Among children 79% engaged in at least one hour of moderate to vigorous exercise a day and 44% engaged in at least 90 minutes of exercise. Among youth 52% reported being physically active at least one hour a day and 30% at least 90 minutes daily (Middlesex-London Health Unit, 2010a).

No difference was seen in physical activity by area (City vs. County). Girls were twice as likely to meet the recommended level of physical activity compared to males among children, whereas, males were twice as likely to meet the recommended levels in the youth group. Parental education and physical activity levels in children and youth were not significantly related. The most commonly reported recreational activities for children were swimming, walking/hiking, biking, and organized team sport. Youth most commonly reported walking/hiking, swimming, jogging/running, and organized sports. When asked how much time they had spent either walking or bicycling to school, to work, or on errands 88% reported walking and 58% reported biking in the past seven days. Children were twice as likely to bicycle as youth (76% vs. 36%). All children and youth spent some time each day watching TV, and/or playing computer games. Interestingly, those who spent an average of less than two hours doing this on weekdays and weekends were twice as likely to be involved in 90 minutes of moderate to vigorous physical activity per day, compared to those who had two or more hours of screen time daily. A maximum of two hours of television watching per day for children is recommended by the Canadian Paediatric Society (2003).

About 8% of the children and youth (age 5-19) had a disability or chronic health problem that had been diagnosed by a medical doctor, according to the *in motion*® survey. The most commonly reported conditions were breathing problems such as asthma or bronchitis (4.7%). Chronic health problems or disabilities were reported to limit 6.6% of children and youth in their ability to participate in physical activities.

According to the 2009 Ontario Student Drug Use and Health Survey (OSDUHS) daily physical activity (≥60 mins.) was self-reported by 20.7% of West Ontario students and 20.8% of Ontario students in grades 7 to 12 (Paglia-Boak et al., 2010). Males were more likely to report daily physical activity compared to females (26.2% vs. 15.2%). Daily physical activity also decreased with grade from 28.2% in grade 7 to 14.1% in grade 12.

Being inactive in the past week (no days of physical activity ≥60 mins) was reported by 7.1% of grade 9-12 students in the South West and Erie St Clair LHIN regions, and 9.0% of Ontario students (Paglia-Boak et al., 2010). Among grade 7-12 students this was reported by 8.3% of students in West Ontario and 8.5% of Ontario students. Grade 12 students were most likely to report inactivity (11.4%).

[35] Data was weighted to adjust for the oversampling of rural residents (Middlesex County).
[36] For youth and children this was defined as an energy expenditure of ≥ 8 kilocalories per kilogram per day

Sedentary behaviour (≥7 hrs of screen time per day) in the past week was reported by 7.9% of grade 9-12 students in South West and Erie St Clair, and 11.0% of Ontario students (Paglia-Boak et al., 2010). Among grade 7-12 students this was reported by 8.7% of students in West Ontario and 9.7% of Ontario students. Males were more likely to spend at least seven hours in front of a TV or computer daily, compared to females (11.4% vs. 7.8%). Sedentary behaviour also increased with grade from 4.9% in grade 7 to 12.8% in grade 12.

As a contrast to these indirect measures of physical activity it is interesting to make a comparison to the findings from the Canadian Physical Activity Levels Among Youth (CAN PLAY) survey, which uses directly measured pedometer data. According to these survey results only 14% of children and youth (age 5-19) in Ontario in 2007-2009 were getting at least 90 minutes of moderate to vigorous physical activity (MVPA) per day, and only 32% were getting at least 60 minutes of MVPA per day (Active Healthy Kids Canada, 2010). Even lower physical activity levels were found in the Canadian Health Measures Survey in 2007-2009 (Colley et al., 2011b). Among Canadian children and youth (age 6-19) only 6.7% (4.1% of girls and 9.0% of boys) accumulated at least 60 minutes of MVPA at least 6 days a week. The same study shows that Canadian children and youth spent 8.6 hours per day or 62% of their waking hours in sedentary activities. Girls averaged 47 minutes of daily MVPA and boys 61 minutes. Scores for flexibility and muscular strength obtained in the 2007 to 2009 Canadian Health Measures Survey were lower compared to 1981 scores, regardless of age or sex (Tremblay et al., 2010).

In conclusion, levels of physical activity among children and youth vary widely according to these different data sources and measurement methods. Much higher levels of physical activity were self-reported in the *in motion*® survey, with more than half of children and youth getting at least 60 minutes of MVPA per day. However, when using direct measures of physical activity in a Canadian sample of children and youth it was shown that as little as 7% may be getting the 60 minutes of MVPA per day as recommended by the newly released physical activity guidelines.

Physical Activity And Environmental Influences Among Youth

In 2007 a focus group study with 7th and 8th grade students (n=60 in nine focus groups) in London was conducted to investigate how youth perceive that their physical activity behaviour was affected by environmental influences in their neighbourhood (Tucker et al., 2008). The discussions of places influencing physical activity mostly revolved around their school, parks and structures around their homes. The school grounds were seen as both providing the space to play sports, but also to discourage physical activity if they lacked structural opportunities or an inviting environment. There was also frustration about not getting access to existing school resources and equipment. Parks were commonly identified as a place that facilitated their physical activity, and other places were recreation facilities, school grounds, yards, driveways and streets. However, they also pointed out aspects about these parks and recreation options that hindered their opportunities for being active, such as not being designed for all age groups, safety issues, and too much litter. A particular value was placed on their yard or streets around their home for encouraging physical activity, but there was also concern raised about the amount and speed of traffic on their streets, and lack of safety in some neighbourhoods.

A study among 811 students in grades 7 and 8 in 21 elementary schools throughout London found that subjective (parent report) and objective measures of access to recreational opportunities were associated positively with physical activity (Tucker et al., 2009).

Children's Travel to School

Another local study among students 11 to 13 years old from 21 schools throughout London looked at whether children's

mode of travel to and from school was influenced by different aspects of the social and physical environment (Larsen et al., 2009). The results showed that among children who lived within one mile of their school, 62% walked or biked to school and 72% walked or biked from school to home. Active travel to school was more likely for shorter trips, among boys, in areas with higher land use mix, and where street trees were present. Additionally, walking or biking home from school was associated with lower neighbourhood incomes and lower residential densities. The authors suggest empowering and targeting girls and their parents when developing new strategies to increase active travel.

Young Children: Parks and Parents/Guardians Preferences

Parks are important outdoor recreational facilities for children. Playing outdoors encourages their involvement in physical activity and facilitates gross motor activity and free play. However, young children rely on their parents or guardians to take them to a park. When creating attractive parks it is thus important to understand and take into consideration parents' preferences. A qualitative study conducted in London in 2005 and 2006 examined parent's preferences regarding city parks (Tucker et al., 2007). The main amenities that were found to be important to parents/guardians were water facilities, sufficient shade, swings and other equipment, overall cleanliness, and picnic areas. The study only included people who were using the parks, thus it does not provide information about what would have made parks more attractive to those residents who were not using them. About half of the respondents visited the park closest to them and for them location was the most important factor. The other half travelled further to get to parks because of the amenities they desired.

Physical Activity Among Adults

Data on self-reported physical activity level of Middlesex-London residents (age 18+) was collected through the Rapid Risk Factor Surveillance System (RRFSS) and the most recent reported data were for the period 2004 to 2007 (Middlesex-London health Unit, 2008). A high or health-enhancing level of physical activity[37] was reported by 58.9% of the adult population (age 18-69) in 2007, and had not changed since 2004. Males were more likely to report a high level of physical activity compared to females (64.8% vs. 54.3% in 2007). The difference between age groups was not very pronounced and not statistically significant. A slightly higher likelihood of high physical activity was seen among those aged 25-44 compared to younger and older age groups in 2005-2007. Physical activity was not found to be related to level of education.

Weighted results[38] from the 2009 *in motion*® Middlesex-London Physical Activity survey indicate that 70% of adults (age 20+) exercised regularly. (Middlesex-London Health Unit, 2009b However, only 36% of adults were considered to be enough physically active to receive health benefits.[39] About 28% believed that they were more physically active than they were two years ago (Middlesex-London Health Unit, 2010a).

More males than females were active enough to receive health benefits. The proportion receiving physical benefits decreased with increasing age (20-35: 51%; 35-64: 35%; 65+: 32%). No difference was seen between Middlesex County and the City of London. Level of physical activity was shown to be strongly related to education; with physical activity levels increasing with level of education. The lowest level of health-enhancing physical activity was found among those earning between $20,000 and $40,000 per year. The most common physical activities reported among adults were: walking for exercise, bicycling, jogging or running, and yard work/gardening. Chronic health problems or disabilities diagnosed by a medical doctor had limited the ability to participate in physical activities among 11.1% of the respondents. Muscle, bone

[37] Defined as ≥1 hour/day of at least moderate-intensity activity, or 0.5 hours/day of vigorous-intensity activity

[38] Data was weighted to adjust for the oversampling of rural residents (Middlesex County).

[39] Ibid.

or joint problems was the most common condition reported (11.2%), followed by heart and circulation (3.4%), high blood pressure (3.2%), and diabetes (2.9%). Canadian estimates based on accelerometer results from the 2007 to 2009 Canadian Health Measures Survey (Colley et al., 2011a), show that only 15.4% of adult Canadians (age 20-79) accumulated 150 minutes of moderate to vigorous physical activity (MVPA) per week, and consequently met Canada's new physical activity recommendation. Furthermore, the data showed that men were more active than women and that MVPA decreased with increasing age and adiposity.

The same survey also measured physical fitness among Canadian adults through direct measurement and found that muscular endurance and muscular strength declined at older ages (Shields et al., 2010). Higher scores for aerobic fitness, muscular endurance and muscular strength were found among males, whereas females had higher scores for flexibility. Compared to estimates from 1981, muscular strength and flexibility among Canadian adults had decreased.

Physical Activity Among Older Adults

Among the senior respondents (65+) in the *in motion*® study in 2009, 72% reported exercising regularly, 69% reported having been exercising regularly for at least six months, and 17% reported not exercising and having no intention to start within the next six months. No difference was seen across gender, age group, income level, retirement status or single household. Those living in households with children and those living in London were less likely to exercise. Among those who reported exercising, 81% reported doing light effort activities, 53% reported doing moderate effort activities and 14% reported doing vigorous effort activities. About 13% of seniors believed that they were more physically active than they were two years ago.

A high percentage reported having a disability or chronic health condition (44%), and 11.8% reported that such a condition had limited their physical activity. As many as 73% of those with a chronic health condition reported that their condition prevented them from being as physically active as they would like to be.

Healthy Eating and Active Living (HEAL) Awareness

Awareness of the key HEAL messages, i.e., the benefit of physical activity, healthy eating and energy balance, was measured among adults in seven Ontario health units in 2008/09 through the RRFSS. The data showed that almost everyone was aware of the health benefits of daily physical activity (He et al., 2010a). However, only 23.7% in the overall sample and 33.2% in Middlesex-London could correctly identify the amount of daily physical activity recommended by the old Canada's Physical Activity Guide (60 minutes of physical activity per day, or 30 minutes of moderate activity 4 days a week), which are different from the new guidelines specified in Table 7.1. Knowledge of the recommendations was significantly more common among females than males, and was positively related with income and level of education. In addition, older adults (60-69 years) were less likely to know the recommendations compared to younger age groups, and those who were overweight or obese were less likely to know them compared to those with lower BMI. In Middlesex-London 60.4% felt they were getting enough daily physical activity to maintain health, and 53.8% intended to increase their daily physical activity over the next year. Furthermore, among those who felt they didn't get enough physical activity 78% intended to increase their daily physical activity over the next year.

Public Transit and Active Transportation

Among employed members of the labour force 7.6% of Middlesex-London residents used active transportation (walking or biking) to work according to the 2006 Census (Table 7.1.2). A slightly higher proportion of people in Middlesex-London used active transportation to work compared to Ontarians (6.8%). Active

transportation to work also varied across the different municipalities and was highest in the City of London (8.2%) and lowest in Newbury (0%).

Use of public transit is highly dependent on availability of public transit and the City of London is the only municipality in Middlesex-London with public transit. Among residents in the City of London 8.6% used the bus to get to work. The small proportion of public transit users in Middlesex-London (varying between 0 and 1%) was likely represented by people commuting to the City.

In the City of London the neighbourhoods with the highest rates of active transportation to work were Downtown (42%), Central London (29%), North London (19%), South London (17%), East London (12%), Bostwick (11%), and West London (10%). Neighbourhoods where no one used active transportation were the following: Fanshawe, Fox Hollow, Glanworth, Jackson, Sharon Creek, Talbot, Tempo, and Woodhull.[40] These are in general less centrally located neighbourhoods with small populations (for neighbourhood reference map see Figure 4.3).

The SmartMoves household transportation survey was conducted in the fall and winter of 2009/10 and surveyed residents in the City of London and outlying areas (including non-resident students) 15 years of age and older (City of London, 2010c). From 2002 to 2009 there was a 33% increase in transit ridership. The survey results show

that 8.0% of the daily trips within the City on a typical day were made using active transportation modes, and 8.5% were made by transit. Almost half of daily transit users in the City were represented by post secondary students. About 10.5% of the transit trips were made by choice riders (who own a car but choose to walk, bike or use public transportation), and about 37.8% of reported bicycle trips and 18.7% of reported walking trips were made by choice riders. Among residents living in the outlying areas surrounding the City of London only 2.3% of the trips were made by public transit, and 4.8% were made by active transportation. The degree of satisfaction with different travel modes generally declined between 2002 and 2009. The largest decline was found among cyclists (from 26% to 11%) and transit users (from 35% to 18%). However, the latter result may have been affected by the labour unrest taking place during the data collection.

Trails And Walkways

The City of London has developed a multi-use pathway along the Thames River: the Thames Valley Parkway. At the end of 2010 this system of paths, extending into neighbourhoods, was 39.5 kilometres long.[41] The paved, broad pathways allow for two-way use. There are plans to eliminate road crossings and further improve neighbourhood connections (City of London, 2009). "London's Bike & Walk Map" has been distributed since 2001.[42] The Thames Valley Trail (TVT) is a 128 km hiking trail running through the Middlesex-London area, including 102 km of main trail and 26 km of side trails (Thames Valley Trail Association, 2008). The TVT links with the Elgin Trail in the south and the Avon Trail in the north.[43] Other trails in Middlesex-London can be found on the Middlesex County web site.[44]

Knowledge and use (anytime in the past 12 months) of recreational trails among residents in Middlesex-London was surveyed through the RRFSS and presented for the years: 2001, 2002, 2003 and partly for 2008 (Middlesex-London health Unit, 2008). Knowledge of recreational trails increased significantly

[40] Statistics Canada 2006 Census data specific for the City of London retrieved from: http://www.london.ca/d.aspx?s=/About_London/infoabout_neighborhood.htm

[41] Personal communication with Dianna Clarke, parks and recreation manager at the City of London, and verified by the Parks Planning Division at the City of London, February 2, 2011.

[42] Available at: http://www.london.ca/d.aspx?s=/Transportation/bikepage.htm

[43] http://www.thamesvalleytrail.org/trail.html

[44] http://www.county.middlesex.on.ca/EconomicDevelopment/MGN/maps.asp

from 80.6% in 2001 to 87.9% in 2008, but use of trails remained fairly unchanged over time. 63.1% reported using the recreational trails in Middlesex-London in 2008. Respondents aged 65+ were least likely to know about and use recreational trails between 2001 and 2003 and those aged 25 to 44 were most likely to know about them and to use them. Throughout the period 2001 to 2003 those without high school education were significantly less likely to use the recreational trails compared to those with higher education.

Table 7.1.2. Proportion of employed members of the labour force in Middlesex-London using active transportation or public transit to work

Area	Active transportation %	Public transit %
Adelaide Metcalfe	3.3	0.0
Lucan Biddulph	3.5	1.0
Middlesex Centre	4.1	0.7
Newbury	0.0	0.0
North Middlesex	5.9	0.0
Southwest Middlesex	5.1	0.6
Strathroy-Caradoc	6.3	0.4
Thames Centre	3.8	0.2
London	8.2	8.6
Middlesex-London	7.6	7.2
Ontario	6.8	12.9

Source: Statistics Canada Census Data, 2006

Mapping Of Public Recreation Facilities

Provision of public recreation opportunities for children and youth in urban neighbourhoods in London was mapped in another local research study (Gilliland et al., 2006). Although 'recreational deserts' could be identified in specific areas of the urban core and the rural-suburban fringes, the study found no systematic relationship between prevalence or density of public recreation spaces and socioeconomic distress. Updated maps of public recreation opportunities in the City of London as of February 2011 are provided in Appendix 9.7f.

Table 7.1.3. shows which neighbourhoods of the City had three or four, one or two, or no sport and recreational facilities, according to maps of sport and recreational facilities in different neighbourhoods in the City of London (for neighbourhood reference map see Figure 4.3)[1].

Most of the neighbourhoods with one or more of these facilities have large populations, whereas the areas with none of these facilities tend to be located on the outskirts of the City and have small populations. The major exceptions to this are Masonville and Westmount, which have populations of 9,000 and 18,795, respectively.

Table 7.1.3. Number of sport and recreational facilities in different City of London neighbourhoods

3-4		1-2	
Byron	Medway	Argyle	North London
Carling	Oakridge	Central London	Stoneybrook
Glen Cairn	Southcrest	East London	West London
Hamilton Road	South London	Highland	Westminster
Huron Heights		Lambeth	White Oaks
None			
Bostwick	Glanworth	Masonville	Sunningdale
Crumlin	Highbury	Old Victoria	Talbot
Downtown	Hyde Park	River Bend	Tempo
Fanshawe	Jackson	Sharon Creek	Uplands
Fox Hollow	Longwoods	Stoney Creek	Westmount
			Woodhull

7.1.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies, Programs, and/or Legislation:

Municipality Related:
Federal, Provincial, and Territorial (FPT) Ministers of Health and of Health Promotion/Healthy Living have endorsed the 2010 *Pan-Canadian Healthy Living Strategy*, which is a framework that aims to "obtain a 20 per cent increase in the proportion of Canadians who are physically active, eat healthily, and are at healthy body weights, by 2015", by aligning and coordinating work efforts to counter risk factors of chronic disease including physical inactivity and unhealthy eating (http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/ipchls-spimmvs-eng.php).

The Public Health Agency of Canada endorses Canada's new *Canadian Physical Activity Guidelines*, released January 2011, by the Canadian Society for Exercise Physiology (CSEP) (http://www.csep.ca/english/view.asp?x=804).

Also at a federal level, the *Children's Fitness Tax Credit* allows parents to "claim up to $500 per year for eligible fitness expenses paid for each child who is under 16 years of age at the beginning of the year in which the expenses are paid" (http://www.cra-arc.gc.ca/whtsnw/fitness-eng.html).

School Board Related:
Provincially, there is a policy issued by the Ontario Ministry of Education, for a minimum of 20 minutes of *Daily Physical Activity (DPA)*, in Ontario elementary schools, grades 1-8 (http://www.edu.gov.on.ca/eng/teachers/dpa.html).

Another policy issued by the Ontario Ministry of Education is the *Community Use of Schools* initiative, where "funding is being provided to all school boards so they can make school space more affordable for use after hours. Both indoor and outdoor school space is available to not-for-profit community groups at reduced rates, outside of regular school hours." In addition, "not-for-profit groups have free after-school access at 175 priority schools" (http://www.edu.gov.on.ca/eng/general/elemsec/community/). This funding allows greater usage of school facilities for Physical Activity, Sport, and Recreation.

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, Middlesex-London municipal and school board policies related to Physical Activity are well represented. Additional review and development of policies are currently underway within Middlesex-London municipalities, particularly with respect to *Active Transportation and the Built Environment.*

The following scans of policies depict existing and developing policies that were examined by the Ontario Heart Health Network (OHHN) policy scan (see Methodology for more information).

Policies that were scanned for and that do not exist in Middlesex-London could be considered for development and implementation by municipalities and school boards in the future.

Municipal Policies:

Access to Recreation and Physical Activity – Key Findings (Table 7.1.4)

- Middlesex-London municipal policies related to *Access to Recreation and Physical Activity* are captured in three of nine municipalities who have a Parks Master Plan and Recreation Master Plan.
- Three of nine Middlesex-London municipalities have policies to ensure people living on low income have access to recreation and sport programs to promote *Access to Recreation and Physical Activity.*
- Thames Centre has Interim Land Use and Vacant Lots policies to address lack of open space for recreation and for public use of private land and city-owned vacant lots to promote *Access to Recreation and Physical Activity.*

Table 7.1.4. Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Access to Recreation and Physical Activity: Municipalities

Access to Recreation and Physical Activity									
Policy	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
Policies to ensure people living on low income have access to municipal recreation/sport programs	✓	✓*		✓*					
Policies related to intramurals and sport programs to ensure opportunity for everyone (e.g. "no cut" intramurals, "no cut" from team sport policies)									
Interim Land Use policies to address the lack of open space for recreation					✓				
Vacant lots policies for public use of private land and city-owned vacant lots					✓				
Is there a municipal Parks Master Plan	✓				✓			✓	
Is there a municipal Recreation Master Plan	✓				✓			✓	

** Asterisk indicates policy scan validation response differed from initial Ontario Heart Health Network (OHHN) Scan policy scan results.*

Active Transportation and the Built Environment – Key Findings (Table 7.1.5)

- *Active Transportation and Built Environment* policies are largely reflected in Middlesex-London municipal Official Plans. All Middlesex-London municipalities validated they have an Official Plan.

- Within municipal Official Plans:
  - Five of nine incorporate active transportation policies
  - Four of nine identify plans for infrastructure that support active transportation (e.g. sidewalks, bike lanes, shared-use paths)
  - Three of nine have mixed land-use/priority land-use policies that incoportate active transportation
  - Two of nine have risk management policies to support and encourage physical activity

- Two of nine municipalities have a "sector" Transportation Demand Management Plan that incorporates active transportation.

Table 7.1.5. - Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Active Transportation and the Built Environment: Municipalities

Active Transportation and the Built Environment									
Policy	City of London	Strathroy -Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide -Metcalfe	Middlesex Centre	Village of Newbury
Is there a municipal public transportation system	✓								
Is there a municipal Official Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓
Does the Official Plan incorporate active transportation policies	✓	✓	✓	✓	✓				
Are there risk management policies to support and encourage physical activity in municipal Official Plans?	✓		✓						
Does the Official Plan "Have mixed land-use/priority land-use policies that incorporate active transportation?"	✓	✓	✓*						
Does the Official Plan "Identify plans for infrastructure (e.g. sidewalks; bike lanes; shared-use paths) that support active transportation?"	✓	✓	✓		✓				
Is there a "sector" Transportation Demand Management Plan that incorporates active transportation	✓	✓*							

** Asterisk indicates policy scan validation response differed from initial Ontario Heart Health Network Scan policy scan results*

.

School Board Policies:

Access to Recreation and Physical Activity – Key Findings (Table 7.1.6)

- Ontario's Ministry of Education initiative *Community Use of Schools* allows for mixed use of school grounds in both Middlesex-London school boards (http://www.edu.gov.on.ca/eng/general/elemsec/community/).
- Neither Middlesex-London school board has policies that reduce sedentary screen time while on school property

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Table 7.1.6- Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Access to Recreation and Physical Activity: School Boards

Access to Recreation and Physical Activity		
Policy	Thames Valley District School Board	London District Catholic School Board
Policies for mixed use of school grounds	**Community Use of Schools**	**Community Use of Schools**
Policies that reduce sedentary screen time while on school property	No policy	No policy

7.1.3 Assets and Opportunities

On January 11, 2011, from 9:30 to 11:30am, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority areas of Physical Activity, Sport, and Recreation. The purpose of the session was to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: City of London, Child & Youth Network, London Intercommunity Health Centre, London Public Library, Middlesex-London Health Unit, Ontario Early Years Centre, Ontario Osteoporosis Strategy, SEARCH Mental Health Services, Southwest Ontario Aboriginal Health Access Centre, Settlement Health Worker, St. Joseph's Health Care, Southwest Middlesex, SportsXpress, Thames Region Ecological Association, Thames Valley Children's Centre, Thames Valley District School Board, YMCA of Western Ontario

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within

Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies/Initiatives

- *in motion*® awareness campaign related to Physical Activity and Healthy Eating
- *YMCA* programs (subsidy programs)
- Seniors' centres (subsidy programs)
- Churches have programs, especially Middlesex County youth, children, older adult
- *Ontario Early Years Centre* programs

- *Victorian Order of Nurses (VON)* older adult exercise programs and rural programs
- Grass-roots walking, running, biking sports groups, and social networks
- Municipal facilities
- *Middlesex-London Health Unit (MLHU)* promotes pregnancy and exercise via new DVD. [*Move for Two, Physical Activity and Pregnancy DVD,* developed in partnership with Dr. Michelle Mottola, Director of the Exercise and Pregnancy Lab at University of Western Ontario. Free for residents of Middlesex-London.]
- *Aboriginal Friendship Centres* and Aboriginal health centres with free activities
- *University of Western Ontario* and *Fanshawe College* are conducting research regarding physical activity and healthy eating.
- New *YMCA* location at Sunningdale has 80% family memberships.
- *Thames Valley Trails Association* Saturday Morning walking program
- Libraries
- Community centres
- Neighbourhood resource centres
- Neighbourhood hub programs
- Many community agencies/ initiatives that want to make a difference to increase physical activity
- *United Way* has mental health and physical activity priorities
- Service clubs fund initiatives
- *Middlesex County schools* are enhancing their after school programs for physical activity.
- *London's Child and Youth Network*
- London's *Age Friendly initiative*/ working group
- *London's Strengthening Neighbourhood Strategy*
- *Healthy Communities Fund, Grant Project Stream (Ontario Ministry of Health Promotion and Sport)*

Programs/Activities

- Many organized sport groups
- Bike festival
- Neighbourhood sport initiatives e.g. *Carling Athletic Soccer Association.*
- *Active and Safe Routes to School Committee and School Travel Planning Project*
- City of London *Spectrum* programs
- Trail development
- A variety of subsidized sports are offered through municipalities, for example *Kid Sport* (Canadian Tire), *All Kids Can Play* (Middlesex County), *Optimist* programs, *Tim Horton's Sponsorship Program*
- *Ontario Ministry of Health Promotion and Sport* after school programs and grants, such as CATCH Kids Club after school
- Schools' *Daily Physical Activity (DPA)* 20 minutes per day, plus regular Physical Education (few times per week) are free.
- Mall walking programs
- *Bike and Walk Map* (City Of London)
- *Car Free Sunday* (City Of London)
- Low cost organized sports (e.g. soccer)
- Awareness information that physical activity is important
- Modified exercise programs for individuals with limitations for physical activity
- *Middlesex County "Can I Play Too"* program for children from low-income families. Applications are received via local recreation departments.
- Resources for skill development

Opportunities

Organizations/Agencies/Initiatives

- There is willingness for several agencies to make a difference.
- The technology industry is coupling physical activity and technology to attract users.
- Teach why lifelong physical activity is important in schools. Emphasize walking and the concept of active living, as every little thing we do contributes to health. Focus on maintaining

physical activity throughout the life span.
- London's *Ending Poverty initiative* may allow more low-income families to participate in recreational physical activity. Parents consider the cost of physical activity versus the need to spend on basic necessities.
- *Small municipalities in Middlesex County* understand opportunities for recreational physical activity are important (e.g. physical activity within rural communities will not be enhanced solely by road repairs, as there are no sidewalks and high speed limits).

Policy
- If cost is a barrier to physical activity, use incentives, for example, tax incentives for private businesses to fund programs such as seniors' programs.

Summary of Identified Assets and Opportunities

Middlesex-London is rich in **organizations, agencies, and partnerships** that provide opportunities for physical activity, sport, and recreation. Assets range from a region-wide physical activity awareness campaign; to subsidy programs; to children, youth, and older adult recreation and exercise programs; to grass-roots walking running, biking sport, and social groups; to skill building and rural outreach programs. A new recreation facility recently opened and recorded registrant numbers that exceeded expectations. Other organizations and agencies provide venues for physical activity and recreation, including (but not limited to) *YMCA* locations, seniors' centres, churches, *Ontario Early Years Centres*, municipal facilities, *Aboriginal Friendship Centre*, libraries, community centres, neighbourhood resource centres, neighbourhood hub programs, many community agencies, service club funding, schools, and mental health and physical activity initiatives. Opportunities identified were a willingness among local organizations and agencies to make a difference; the harnessing of technology to provide innovative physical activity opportunities; and building on an existing vision of promoting "lifelong physical activity" via promotion of active living skills (e.g. walking, everyday activities, etc.).

There are also many **programs, activities, and initiatives** in Middlesex-London for physical activity, sport, and recreation. Assets include many organized sports and neighbourhood sports initiatives. There are *Active and Safe Routes to School* programs, a *City of London Car Free Sunday* event, and a bike festival that increase awareness and promote active transportation across the lifespan. The *City of London Bike and Walk Map* as well as trail development further promote active transportation and recreation opportunities. Subsidized sports and recreation opportunities for children and across the lifespan enable populations with low-income to participate in physical activity. Modified exercise programs also allow physical activity opportunities for populations with limitations. Middlesex-London has resources for distributing information and promoting awareness about benefits of being physically active. Opportunities exist in the form of collaborative initiatives in Middlesex-London, including London's *Ending Poverty initiative* that may allow more low-income families to participate in recreational physical activity. Small municipalities in Middlesex County understand that opportunities for recreational physical activity are important and recognize the need for built environments that are conducive to pedestrian travel.

A **policy** opportunity may be to use incentives (for example, tax incentives) for private businesses to fund programs such as seniors' programs if cost is a barrier to physical activity.

7.1.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Physical Activity, Sport, and Recreation within Middlesex-London were identified. There

may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Access/Equity to Physical Activity

- High fees associated with most programs, e.g. Family on hot day summer has to pay each time they go to the pool. Even low fees are a barrier to physical activity for low income families.
- Need to consider cost barriers to physical activity.
- Schools' *Daily Physical Activity (DPA)* 20 minutes per day, plus regular Physical Education (few times per wk) are free, but doesn't necessarily happen every day.
- Ontario Ministry of Education's policy regarding *Daily Physical Activity (DPA)* is not perceived as working well. Challenges are believed to be related to academic demands competing with the *DPA* time, and physical activity is valued less than academics, so *DPA* is replaced with academic obligations. Physical activity is viewed as being a leisure activity, and therefore is not as necessary as meeting academic obligations.
- Workplaces need to allow a healthy balance of work and time to engage in physical activity. Follow example of countries like Holland and Japan with physical activity policies. Could have subsidized athletic memberships for employees.
- Cost and transportation to engage in physical activity is a barrier especially for those with mental health issues.
- Language interpreters are needed when working with newcomers.
- There are also cultural barriers that must be understood to effectively promote physical activity.
- There is a parental and societal desire for children to be in organized sports versus non-organized activities.
- It is perceived to be easier for parents to place children in front of the television, versus doing something active with them. This may be especially true for single parent families who may have child care issues. It may be difficult to do an activity with one child but have to care for another.
- Identify other ways of being physically active besides organized sports.
- There are many "one-time events" versus making a commitment to increase long-term incidence rates of physical activity with sustainable changes.
- Organized sports should be accessible via active transportation (e.g. walking/biking to the location) rather than travelling by car.
- Cost of using a school for after hours physical activity/recreation should be free with no additional insurance costs/requirements (open schools for use by young adults, adults) within neighbourhoods.

Built Environment/Healthy Places

- Seniors need trails that are accessible, proper length (currently they are too long), and with safe surface types (not loose rocks, etc.). Seniors also need knowledge of where proper trails are located, as not all seniors may be familiar with Internet searching.
- Need to make families feel safe in neighbourhoods, for example, with lighting in parks. This will encourage use of these facilitates and increased physical activity.
- Technology is attractive to youth. Need to explore a way for parents to build physical activity into kids' lifestyles, even though children are surrounded and attracted by technology.
- Toboggan hills, golf courses, etc. are no longer available for public use. Some parks are used more than others.

Availability and Use

- City of London has a number of parks, trails, splash pads, etc., that people are not fully using. Why are people not using these? There is a need to link people with what is already available.
- Secondary school students are only required to have one physical activity credit to graduate. There should be a further reward for engaging in physical activity courses in school, such as physical activity being mandatory for each year to graduate.
- Many people don't know what programs are available. For example, the Ontario Ministry of Education's subsidy for *Community Use of Schools* opens schools for organized non profit organizations and agencies. Stipulations such as need to show proof of $1 million liability insurance present additional barriers for benefiting from this initiative.
- There is a subsidy for physical activity programs for children from low-income families in rural areas. Organizations may not know the subsidy exists, or there may be stigma associated with using the subsidy. There should be confidentiality about who uses the subsidy within the municipality.
- There is a gap between people who engage in physical activity for health and those who exercise solely for looks.
- Need opportunities, particularly for adults, to build skills. *Spectrum Programs* are an example of those who do this, as all of the programs state whether they are introductory level to teach recreation skills.
- Preschool children require opportunity for active play (to use their imagination). This may be difficult when society's focus is on organized sports.
- Behaviour change takes time (e.g. Tobacco use and subsequent legislation; Daily Physical Activity or Municipal Master Plans)

Research/Surveillance

- Need comprehensive geriatric population data regarding physical activity levels (young, old & mid old, old-old 85+ yr olds).

Summary of Identified Gaps and Needs

Barriers to physical activity largely relate to issues of **access to opportunities to participate**. Program fees at recreation facilities, regardless of whether the fees are high or low, present obstacles for participating in physical activity for families with low income. Transportation is another barrier to access for rural populations and vulnerable populations including individuals with low income, physical limitations, or mental health issues. Organized sports and recreational opportunities should be accessible by active transportation (e.g. walking/biking to the location) rather than travelling by car. Accessible facilities such as schools should cover costs for use, allowing use of facilities within local neighbourhoods. Opportunities for physical activity in schools with *Daily Physical Activity* may not occur as mandated by the Ontario Ministry of Education, which may in part be due to physical activity viewed as a leisure activity and therefore not as necessary as meeting academic obligations. Secondary school students are only required to have one physical activity credit to graduate and could be further rewarded for engaging in physical activity courses in school, such as mandatory physical activity credits each year to graduate. Middlesex-London schools are noted as attempting to encourage physical activity to be embraced by society. Similarly, social norms may influence parents' enrolment of children in organized sports versus encouraging non-organized activities such as active lifestyles and active transportation. There is a need to highlight various forms of physical activity, which includes active lifestyles versus sedentary behaviour, instead of merely focusing on exercise or organized sports. Preschool children may not have an opportunity for active play (to use their imagination) with society's focus on organized sports. Parents might find it

easier to allow children to watch television versus doing something active with the child and this may be especially true for single parent families who may have child care issues. For example, it is difficult to do an activity with one child but have to care for another. At workplaces, a shift in culture is necessary to allow a healthy balance of work and time to engage in physical activity, such as policies for subsidized athletic memberships for employees.

The **built environment/healthy places** may also present obstacles for physical activity. Trails that are too long or not properly maintained may present risks for use among the older adult population. Parks, trails, and other available facilities are not observed as receiving maximum use. Neighbourhood safety can influence physical activity levels and strategies such as increased lighting in parks should be implemented to encourage use of free/available facilities and spaces to promote active lifestyles. Children and youth are surrounded by technology which is linked with sedentary behaviour, and ways to build physical activity into the lives of children and youth need to be explored.

Funding for physical activity programs/initiatives may be short-term, not well known, or may have onerous stipulations such as large liability insurance to receive the funding. Subsidized programs may present obstacles for those with low income due to stigma attached for participants using the subsidy, and care should be taken to protect confidentiality. There is a need for more opportunities for learning team sport skills in a non-threatening environment, such as *Spectrum* sports that identify whether programs are introductory, recreational, art, literacy, etc. Behaviour change toward increased physical activity takes time, so use of policy such as *Daily Physical Activity*, Municipal Master Plans, etc. should be explored and utilized.

In order to **track changes in physical activity levels**, there is a need for comprehensive population data across the lifespan (e.g. preschool and older adults 85+ years), where data is currently lacking.

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Physical Activity, Sport, and Recreation were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.1.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community stakeholders the following recommended actions emerged:

Advocate at all levels for Support and Funds to go towards Infrastructure (human resources, built environment, and design) and Programs that enable/enhance/increase physical activity in the community.

- Ensure every park and walking trail is lit up after dusk, to increase safety of physical activity.
- Promote awareness that recreation is important among politicians, City and County staff, engineers.
- Implement a tax for unhealthy beverages to offset cost associated with funding programs.
- A tax credit for seniors and all age groups for being physically active.
- Advocate provincially for sustained funding for physical activity programs for improved infrastructure of physical activity programs.

- Implement employee wellness programs that include benefits for not only drugs, but also for gym memberships. Lobby the federal government to push for a gym membership tax break.
- Enable the community by asking them about their needs so that the appropriate needs are met. This will provide necessary equipment, skills, transportation costs, etc. for physical activity.
- Improve policy regarding primary prevention to strengthen policy that prevents chronic disease. For example, policies that enable healthier prenatal development are linked to lifelong health benefits for the mother and her child. As such, need to advocate for a subsidy during pregnancy for active lifestyles and physical activity. Identify other key life times to target physical activity promotion (pregnancy, preschool, retirement, etc).
- Provide new immigrant outreach by sending a representative to "English as a Second Language" classes, to advocate physical activity opportunities.
- Adapt existing events to also include physical activity demos that allow individuals to try out and play activities in a non-competitive and relaxed environment.
- Provide physical activity opportunities at other events such as *London Community Educational Interactive Day*, *Car Free Sunday*, Fanshawe College (which has an event day to show people how to do activities through *City and SportXpress*), or *London Community Sports Day* in the fall.
- London housing units have a summer camp and could extend this to have a year long fitness leader that works with the community, or visits identified neighbourhoods 1 day per week.
- Complete streets (walkable)
- Education, funding for programs, community based, cultural change
- Enforcement / reinforcement of existing policies in schools, and the federal fitness tax credit
- School curriculum to include families

Advocate for Endorsement of a Charter for Middlesex-London municipalities (making a commitment to certain municipal standards), similar to Toronto Physical Activity Charter, ensuring that the charter is age friendly and addresses life span approach.

- Promote London's *Child and Youth Network* "Open door day" for trying physical activities. Open doors to London gyms, recreational facilities, etc. for free recreational opportunities.
- Have a unified social marketing campaign, beginning at the federal and provincial level. For example, *Thames Valley District School Board (TVDSB)* is guided by an understandable vision to ensure focus of physical activity initiatives: "Promote life-long physical activity". *TVDSB* channels all activities through that vision, as should the nation and province.
- Implement a marketing strategy that details "how to" initiate and sustain physical activity and active living, so as to overcome disconnect between awareness and doing.
- Market a culture change or shift in thinking, from reactive physical activity to being proactive. Market the benefits of preventive physical activity, for example improved academic learning, healthier body, decreased risk of drug use, etc.
- Age friendly community declaration. Declaration for youth.

Research and surveillance

- Participation and promotion of physical activity has been around for 40 years. Find an efficient way to collect data that assesses whether being active actually does improve fitness. Have baseline and benchmark measures to compare data against in order to measure improvement. Need to benchmark health status longitudinally, not

just short term. For example, track all grade 1 students' physical activity levels over 10 years to examine whether a particular approach has worked over a long period of time. Another example could be examining whether fewer sick days were taken if employees exercised regularly, using longitudinal data.

7.1.5 a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Physical Activity".

I. Advocate for endorsement by all municipalities for a physical activity charter, ensuring that the charter is age friendly and addresses a life span approach.

- Address issues of access, such as champions/trained fitness leaders to work with communities (e.g. within housing complexes or small communities).
- Include an age friendly community declaration, building upon the official World Health Organization (WHO) "age friendly city" status of the City of London.
- Community based culture change regarding physical activity.
- Include a declaration for youth.
- Learning from Food Charter development (of Child and Youth Network) will be of assistance.

II. Advocate at all levels for support and funds (including staffing) to go towards infrastructure (built environment and design) and programs that enable/enhance/increase physical activity in the community.

- Develop champions/trained fitness leaders to work with communities (e.g. within housing complexes or small communities).
- Advocacy for "complete streets" design (walkable communities).
- Advocacy for education.
- Advocacy for funding of programs.
- Reinforcement of existing policies (such as in schools), of the federal Fitness Tax Credit, etc.

7.2 Healthy Eating

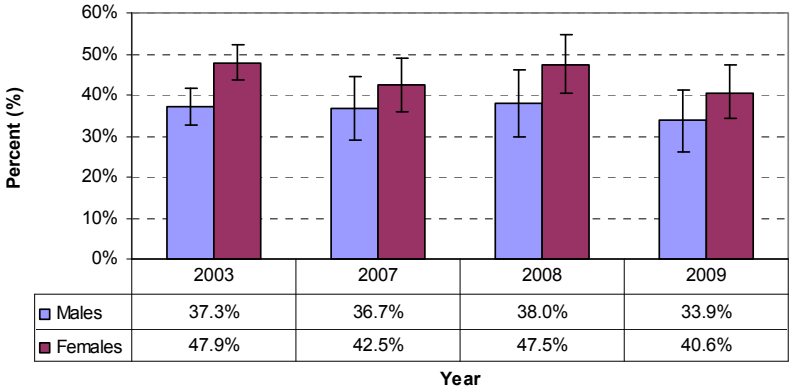
7.2.1 Data

Fruit and Vegetable Consumption

A substantial amount of research findings indicate that a higher intake of fruit and vegetables is associated with lower incidence of cardiovascular disease (Padayatti & Levine, 2008; Joshipura et al., 2001). Fruit and vegetables contain many vitamins, minerals, antioxidants and phytochemicals, such as vitamin C, potassium, flavonoids and carotenoids, which might play roles in preventing and controlling diseases. In addition, fruit and vegetables may change gut flora and increase roughage and fibre intake (Padayatty & Levine, 2008). Because most fruit and vegetables are low in calories, consumption can play a role in obesity prevention simply by displacing the consumption of energy dense foods (Padayatty & Levine, 2008). A diet rich in fruit and vegetables may also help to prevent heart disease and some cancers (Block et al., 1992; Steinmetz & Potter, 1996; Ness & Powles, 1997; WHO, 2009) and evidence suggests that fruit and vegetable consumption is a reasonable proxy for good eating habits (Garriguet, 2009). For teens and adults (14 years and older) Eating Well with Canada's Food Guide recommends a daily intake of 7 to 10 daily servings of fruit and vegetables, depending on age and sex (Health Canada, 2007). The public health goal has been to increase the proportion of individuals in the population consuming five or more daily servings of fruit and vegetables to 75% by the year 2010 (Ministry of Health, 1997).

Based on data from the Canadian Community Health Survey (CCHS), consumption of five or more servings of fruit and vegetables per day was reported by 37.3% of Middlesex-London residents in 2009. A higher intake was reported by females compared to males, (Figure 7.2). Data from the Rapid Risk Factor Surveillance System (RRFSS) between the year 2001 and 2007 showed that 35.1% of people in Middlesex-London had five or more fruit and vegetables per day. There was a consistent and statistically significant difference between males and females each individual year, with higher likelihood of consuming ≥5 servings/day of fruit and vegetables among females compared to males (Middlesex-London Health Unit, 2008). Figure 7.2.1. furthermore illustrates a decreasing trend in fruit and vegetable consumption among both males and females between 2003 and 2009. Females in Middlesex-London were significantly less likely to report eating five or more servings of fruit and vegetables per day (40.6%), compared to Ontario females (49.1%) in 2009. Males in Middlesex-London were also less likely to eat five or more servings of fruit and vegetables per day than males in all of Ontario, but this difference was not statistically significant.

Figure 7.2.1. Proportion of people (age 12 yrs +) reporting consumption of five or more servings of fruit and vegetables per day, by gender, Middlesex-London 2003, 2007, 2008 and 2009



Source: Canadian Community Health Survey, Statistics Canada, table 105-0501.

The RRFSS data for Middlesex-London (2007) indicate that older adults (65+) were significantly more likely to have ≥5 servings of fruit and vegetables daily compared to younger age groups (Middlesex-London Health Unit, 2008). These data also show that the likelihood of consuming ≥5 servings/day increased with higher education. In 2007 37.3% of those with post-secondary education had this much fruit and vegetables per day compared to 26.9% among those who had not completed high school (not a statistically significant difference).

Results from the *in motion*® Middlesex-London survey conducted in 2009 show that more than half (57.9%) of the adults (age 20+) reported eating one to four servings of fruit and vegetables daily, and 41.1% reported eating five or more servings. Fruit consumption was higher among those who believed in the health benefits of fruit and vegetable consumption, among females, and among those with higher income and higher education. No statistically significant differences were noted among age groups. Overall, 69% strongly agreed with health benefits of eating fruit and vegetables, and an additional 15% agreed somewhat. Believing in these health benefits increased with both education and income.

In conclusion, the majority (60-65%) of the population in Middlesex-London consume less than five fruit and vegetables per day, and over time we seem to be getting further away from the public health goal of 75% of the population eating this much fruit and vegetables by 2010.

In 2008/2009 only 27.5% in Middlesex-London could identify the minimum number of daily fruit and vegetables recommended in the previous Canada's Food Guide[45] or the current version[46] (He et al., 2010a). Many more could correctly identify the recommendations from the previous Canada's Food Guide (22.4%) compared to the current Food Guide (5.1%). Females were more likely to know the recommendations than males. Furthermore, knowledge of the recommendations increased with increasing education and household income. Those who were overweight or obese were not more or less likely to know the recommendations compared to those with lower BMI. Approximately 70% felt they were eating enough fruit and vegetables daily to maintain health and 36.2% planned to increase their daily fruit and vegetable consumption over the next year. Females were more likely than males to intend to increase their fruit and

[45] ≥5 servings
[46] 7 to 10 servings depending on age and sex

vegetable intake. Intention to increase daily fruit and vegetable intake decreased with increasing age. Among those who felt they were not eating enough fruit and vegetables daily in the full sample, as many as 63.9% planned to increase their daily intake over the next year. Almost everyone in Middlesex-London (99.8%), (2010b) was aware of the health benefits of daily fruit and vegetable intake.

Consumption of Sweetened Beverages
A survey among residents in the City of London in 2010 showed that 71.6% consumed one or more sweetened beverages per day (Statistics Canada). Those 18-29 and 30-39 years of age were most likely to consume one or more sweetened beverages per day (over 80%) and those 65+ were least likely (about 46%). Education and income were related to consumption. Those with a university education and those with high income (>$80,000 per year) tended to be less likely to drink sweetened beverages daily (Statistics Canada, 2010b).

Sodium Intake
Sodium consumption in Canada is considerably over the recommended maximum daily intake (ranging between 1,000 and 1,500 mg depending on age). Based on 24-hour dietary recall data gathered through the Canadian Community Health Survey in 2004 the daily average intake was estimated to be 3,092 mg among Canadians, compared to a significantly lower intake of 2,871 mg among Ontarians (Garriguet, 2007).

Food/Nutrition Literacy
Similar to health literacy, nutrition literacy can be defined as 'the degree to which individuals can obtain, process, and understand the basic nutrition information and services they need to make appropriate nutrition decisions' (Silk et al., 2008). One component of nutrition literacy is reading and processing of nutrition labels. Data on this topic was collected in a local survey in the City of London in 2010 (Statistics Canada, 2010b). The survey results show that 76.0% of London residents always or sometimes read nutrition labels before purchasing food products; females more so than males. The rate increased with education and income (Statistics Canada, 2010b).

Almost three quarters (73.8%) indicated they had good or excellent understanding of nutrition labels. The lowest rate of understanding was found among those 65 years of age and over. No gender difference was seen for understanding. University graduates tended to be more likely to understand nutrition labels compared to those who only graduated from high school (Statistics Canada, 2010b).

Among those who read nutrition labels 92.6% agreed these labels strongly or somewhat influenced their food purchasing decisions. The age groups most likely to be influenced by nutrition labels were those 30-49, and those least likely were 18-29 year olds. A slight increase was seen by education and income level (Statistics Canada, 2010b).

The nutrition items that affected food purchasing decisions most among London residents were carbohydrates (59.0%), fat (58.8%) and sodium (47.5%). Those 50 years of age and over were most likely to be affected by sodium content. Seniors (65+) tended to be less affected by fat content, compared to younger age groups. Males were more likely to be affected by protein content compared to females. Fat content affected people's food purchasing more as the level of education of respondents increased. Those with less than high school education were least likely to have food purchasing be affected by level of carbohydrates compared to people with higher education (Statistics Canada, 2010b).

Food Insecurity
According to 2004 data from the CCHS 9.2% of Canadian households had experienced not being able to afford the foods needed for a healthy, balanced diet at least once in the previous 12 months. Food insecurity was reported by 48.3% of households with a low income (yearly household income <$10,000 in a household of one to four people), and by 29.1% of lower-middle income households

(yearly income of $10,000 to $19,999 in a household of three or four people). Higher than average levels of food insecurity were experienced among those relying on social assistance, lone-parent families, off-reserve Aboriginals, and families with three or more children (Health Canada, 2004).

Student Nutrition Programs

There are several different organizations that facilitate nutrition programs to schools in Middlesex-London (either through funding or direct distribution):

- the Ontario Student Nutrition Program (OSNP),
- the Children's Nutrition Network (CNN),
- the May Court Club of London,
- Breakfast for Learning,
- the Breakfast Clubs of Canada, and
- the Elementary School Milk Program.

The Ontario Student Nutrition Program (OSNP) provides funding from the Ministry of Children and Youth Services (MCYS) to assist schools across the province in implementing a healthy snack, breakfast or meal program for students in their school community. OSNP funded programs must adhere to the Student Nutrition Program Guidelines set forth be the MCYS in 2008. For example, a snack program must serve two food groups with at least one serving from the fruit and vegetables food group. A meal must consist of at least three of the four food groups and at least one serving from the fruit and vegetables food group and at least one serving from the milk and alternatives food group. In the current school year (2010/2011), the OSNP funds 76 schools in Middlesex-London. Of these schools, 36 are elementary schools (ten of which are County schools), and 23 are secondary schools (three of which are County schools). The Children's Nutrition Network (CNN) administers snack/meal programs for another five elementary schools (two of which are County schools) and four secondary schools (two or which are County schools). The May Court Club of London purchases and distributes vouchers to area schools to support existing student nutrition programs and buy food for emergency purposes to support children who may need food for breakfast or perhaps lunch. A May Court committee runs this program, members deliver the vouchers to the schools, and teachers monitor the need. This program currently provides 87 schools (all in the City of London) with vouchers, 76 of which are elementary schools and 11 of which are secondary schools.[47]

Adolescents and Environmental Influences

In 2007 a focus group study with 7th and 8th grade students in London was conducted to investigate how youth perceived that their eating habits were affected by environmental influences in their neighbourhood (Tucker et al., 2008). Overwhelmingly, students reported on numerous convenience stores, as well as fast- and slow-food restaurants[48] within easy access from home or school. Students would visit these places on their way home from school, on weekends or with their family, and talked about the availability of less healthy snack options compared to the options provided at home.

Food Deserts

Socially disadvantaged areas of cities with poor access to healthy food are referred to as 'food deserts'. Mapping of locations of grocery stores in 1961 and 2005 was conducted by a group of local researchers (Larsen & Gilliland, 2008), and their study described the evolution of food deserts in the inner-city neighbourhoods of Central and East London (Old East). East London was also shown to have poorer access to grocery stores by public transit than other areas, which makes the effect of the food desert even worse (Larsen & Gilliland, 2008). Another local study, looking at the effect of introducing a farmers' market in this urban area, found that the average price of a healthy food basket in Old East dropped by 12.2%

[47] Statistics provided by Lisa Nixon, Community Partners Coordinator, Investing in Children & Coordinator For Children's Nutrition Network and Ontario Student Nutrition Program

[48] As defined in the research paper slow-food restaurants provide meal service at the table, whereas food orders at fast-food restaurants are processed from a counter.

between 2005 and 2008, whereas the price increased overall by 9.1% in London (Larsen & Gilliland, 2009). They also found that some fruit and vegetables on the healthy food basket list that were not available in 2005 were all available in 2008. With the introduction of the farmers' market the authors argued that Old East was not a food desert anymore (Larsen & Gilliland, 2009).

Updated maps (as of February 2011) of location of and proximity to grocery stores in both Middlesex County and the City of London can be found in Appendix 9.7e.

Community Gardens

Community Gardens can provide a host of benefits such as local opportunities for increased food security, access to fresh, nutritious, and locally grown produce, skill development, community building, recreation, physical activity, cross-cultural participation and improved air quality. There are currently 21 community gardening sites in the City of London and approximately 600 garden plots (London Community Resource Centre, 2010a). Five new sites were added and one site closed down in the year 2009-2010. More than 70% of the gardeners are low-income individuals, and there are a growing number of seniors participating. In addition to feeding themselves, their families and friends, gardeners may also participate in the London Grow-A-Row program providing produce to the London and Area Food Bank (London Community Resource Centre, 2010a). There has been an increased involvement by the Karen Community, the Cambodian Community and the Cross Cultural Learner Centre throughout the first half of the year 2010 (London Community Resource Centre, 2010b). Furthermore, the London Community Resource Centre is interested in working in collaboration with the City of London on the development of additional gardens in the City. No community gardens were identified in Middlesex County.

Healthy Weights

Despite the fact that almost all Middlesex-London residents (98.7%) in 2008/09 were aware that having a healthy body weight can reduce the risk of certain diseases (He et al., 2010a), overweight and obesity is a major public health concern both locally and in Canada overall. There are well-established links between overweight and obesity and health risks, such as heart disease, diabetes, high blood pressure, arthritis, different cancers, and gallbladder disease (Ontario Ministry of Health Promotion, 2010). Factors contributing to unhealthy weights include genetic factors as well as individual behaviours such as physical activity and eating, which are both greatly influenced by the social, cultural, physical and economic environments (Canadian Institute for Health Information (CIHI), 2006). Obesogenic environments, (e.g. communities, workplaces, schools and homes) that actually promote or encourage obesity, may be largely to blame for this obesity epidemic (MOHLTC, 2004; Diez, 2003).

Body Mass Index (BMI) is calculated from weight and height,[49] and is the most practical indicator of weight-related health risk for adult populations. A BMI of 25-29 is considered overweight and a BMI of 30 or more is considered obese (Health Canada, 2003; WHO, 1995).

Unless stated otherwise, BMI-estimates in this section are based on self-reported estimates of weight and height. **When interpreting these results it is important to keep in mind that there is generally a trend of under-reporting for weight and over-reporting for height** (Gorber et al., 2007), **thus yielding under-estimated rates of overweight and obesity. A validation study among Canadian Community Health Survey respondents showed that self-reported measures tended to under-estimate obesity among both males and females** (Shields et al., 2008). This tendency was also seen among adolescents (ages 12 to 17) when comparing self-reported height and weight in 2003 with measured height and weight in 2004 (Shields, 2005). True population

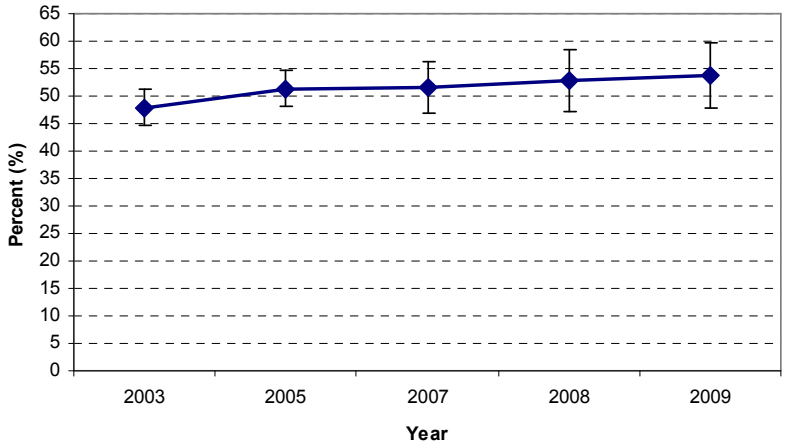
[49] Weight in kilograms divided by height in metres squared

rates of overweight and obesity are thus likely to be higher.

Figure 7.2.2 shows BMI-based estimates of overweight and obesity in Middlesex-London from 2003 to 2009. There was a slight, but not statistically significant, increasing trend from 47.9% in 2003 to 53.7% in 2009. Provincially, the prevalence of overweight or obese individuals increased from 49.5% in 2003 to 51.4% in 2009, which was a statistically significant change.

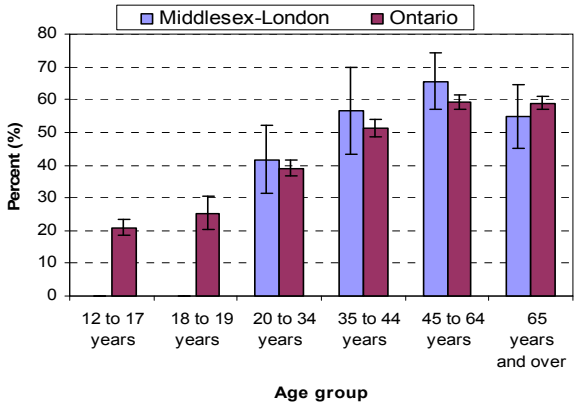
When comparing 2009 Ontario estimates across age groups (Figure 7.2.3.) the rate of overweight or obesity increases by age group from 20.9% among 12 to 17 year olds to approximately 59% among those aged 45 and over. The pattern across age groups was similar for Middlesex-London, although the estimates for the youngest age groups were too unreliable for publication. Being overweight or obese was more common among males than females. Provincially 58.7% of males and 44.1% of females reported being overweight in the CCHS in 2009, and the pattern was the same in Middlesex-London.

Figure 7.2.2. Prevalence of people who were overweight or obese in Middlesex-London 2003-2009 (age 12+)



Source: Canadian Community Health Survey, Statistics Canada

Figure 7.2.3. Overweight or obesity by age group in Middlesex-London and Ontario, 2009



Source: Canadian Community Health Survey, Statistics Canada

Results based on Middlesex-London RRFSS data showed that among adults 20-64 years old, six out of ten were overweight or obese in 2007, which was an increase from 50.2% in 2001 (Middlesex-London Health Unit, 2008). The percentage of overweight adults rose from 36.1% in 2001 to 41.6% in 2007, and the percentage of obese adults increased from 14.2% in 2001 to 18.7% in 2007. Separately the increases in overweight and obesity were not statistically significant, but for the two combined the 20% increase was statistically significant. Males were more likely to be overweight or obese than females, but a greater rate of increase was seen among females, compared to males, between 2001 and 2007. Among 20 to 34 year old women, the percentage of overweight or obese individuals increased from 19.5% in 2001 to 35.1% in 2007. Level of education was found to be related to BMI. Those with a post-secondary degree were less likely to be overweight or obese compared to those without a high school diploma. The difference in rates of overweight/obesity between people with higher and lower education seemed to have widened between 2001 and 2007.

According to combined CCHS data from 2005 and 2007/08, the obesity rate in South West Ontario was lower among immigrants (14.3%) compared to the Canadian-born population (20.4%). However, the rate of overweight was higher among South West immigrants (39.9%), compared to those who were Canadian-born (34.1%) and compared to Ontario immigrants (34.6%) (MOHLTC, 2010).

Compared to non-Aboriginals the off-reserve Aboriginal population in the age group 19-50 (in Ontario and the western provinces) had a higher prevalence of overweight and obesity based on direct measure. In 2004 the obesity rate was 38% among Aboriginals compared to 19% among non-Aboriginals (Garriguet, 2008).

Abdominal fat, and specifically visceral fat, has been suggested to be an independent predictor of disease development (Bigaard et al., 2005; Despres & Lemieux, 2006). In addition to BMI, waist circumference (WC) is considered an adequate surrogate measure of visceral fat (Pare et al., 2001; Ross et a., 1996). RRFSS data on WC were collected in 2008/09 among 12 Ontario health units. Sex-specific WC cut-off points for increased health risk were those used by Health Canada (i.e., male ≥102 cm; female ≥88cm). The results show that 31.2% of the surveyed sample was at increased health risk based on their predicted WC (He et al., 2010b). More females than males were at increased health risk (33.9% vs. 27.7%), and older people were more likely than younger people to be at increased health risk based on their predicted WC (60-69 year olds: 45.0%, 40-59 year olds: 33.2%, and 18-39 year olds: 20.0%). Socio-economic factors (household income and education) seem to have had more impact on predicted WC of females, compared to males, such that mean predicted WC was higher among those with low household income compared to those with higher income, and higher among those with low education compared to those with higher education. The results for Middlesex-London generally followed the same pattern and did not differ statistically from the overall sample.

The 2007 to 2009 Canadian Health Measures Survey also measured physical fitness among Canadians through direct measurement and found that BMI, WC, skinfold measurements and waist-to-hip ratio among adults increased with age (Shields et al., 2010). Compared to estimates from 1981, BMI, WC and skinfold measurements had increased.

Prevalence of overweight and obesity among school-aged children (age 6-13) in a convenience sample of 11 schools in the City of London and Middlesex County was examined in 2001-2003 (He & Beynon, 2006). Weight and height were measured directly. The use of BMI to categorize growing children and youth into groups of overweight and obese is not as standardized as for adults. Depending on what BMI cut-offs were used between 16.6% and 17.5% of the children were categorized as overweight and betwee

7.6% and 11.8% were categorized as obese. The proportion of overweight or obesity was between 24% and 29% among boys and between 26% and 28% among girls.

Among Canadian children and youth (age 6-19), mean BMI, WC and the sum of five skinfolds were higher in 2007-2009 compared to 1981, according to the Canadian Health Measures Survey. Overweight/obesity increased by 79% among girls and more than doubled among boys. The percentage in the elevated/high-risk WC category increased more than three fold among both boys and girls. (Tremblay et al., 2010). Another study exploring changes in overweight and obesity among Canadian children's (age 2-17) over time used direct measures of height and weight from the Canada Health Survey in 1978/79 and the CCHS in 2004. The results showed that the combined overweight and obesity in this age group increased by 73% (from 15% to 26%) in that 25-year period (Shields, 2005). The increase was similar among boys and girls, but differed by age group, with almost no change among 2 to 5 year olds and more than a doubling of overweight/obesity among 12-17 year olds. The Ontario rates for overweight and obesity among 2-17 year olds in 2004 were similar to the national rates.

7.2.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies, Programs, and/or Legislation:

Municipality Related:

Health Canada released a *voluntary program for lower sodium levels* for the food industry in July 2010, by the Sodium Working Group created in 2007 (http://www.hc-sc.gc.ca/fn-an/nutrition/sodium/strateg/index-eng.php). As of February, 2011, the Sodium Working Group has been replaced by the *Food Regulatory Advisory Committee*, with new partner and stakeholder members (http://www.hc-sc.gc.ca/fn-an/consult/frac-ccra/index-eng.php).

Another voluntary program is the *Heart Check* program by the Heart and Stroke Foundation (http://www.healthcheck.org/), affecting Food Manufacturers, Food Service, Retailers, and Health Professionals. The program acts as "a guide for consumers to help them choose healthy foods. The nutrient criteria were developed by the Heart and Stroke Foundation's registered dietitians based on recommendations in Canada's Food Guide" (http://www.healthcheck.org/node/19).

Federally, many elements of legislation relate to food fortification (e.g. mandatory Vitamin D in liquid milk, folic acid in wheat flour/pasta/bread); however, this legislation is beyond the scope of this document.

There is a provincial award program called *Eat Smart!*® that "recognizes Ontario schools, workplaces, and recreation centres that meet exceptional standards in nutrition, safe food handling, and a smoke-free environment" (http://www.eatsmartontario.ca/).

School Board Related:

Nutrition standards for food and beverages sold in elementary school vending machines were provided for school boards by the Ontario Ministry of Education, in 2004. As of September 2011, a new *School Food and Beverage Policy (PPM 150)* established under the *Healthy Foods for Healthy Schools Act,* will replace the aforementioned policy set in 2004 (http://www.edu.gov.on.ca/extra/eng/ppm/ppm150.pdf). Ontario's *School Food and Beverage Policy (PPM 150)* will also replace existing Middlesex-London school board guidelines and policies for food *sold* in schools (not for food *served*) as of September, 2011.

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, Middlesex-London municipal and school board policies related to *Access to Nutritious Food* are largely in review and development with the exception of policies that support the establishment of Farmers Markets.

The following scans of policies depict existing and developing policies that were examined by the Ontario Heart Health Network (OHHN) policy scan (see Methodology for more information). Policies that were scanned for and that do not exist in Middlesex-London could be considered for development and implementation by municipalities and school boards in the future.

Municipal Policies:

Access to Nutritious Food – Key Findings (Table 7.2.1)

- Six of nine Middlesex-London municipalities have policies that support the establishment of Farmers Markets or the revision of existing policies that impede their establishment, and one additional municipality is reviewing their policies related to support of Farmers Markets.
- Three of nine Middlesex-London municipalities have policies that support local sustainable agriculture.
- The City of London and Middlesex Centre:
  - Are developing policies related to sourcing and procuring local foods.
  - Are developing a Food Charter
  - Have a committee that focuses on policies related to access to nutritious food.
- The City of London is reviewing and developing policies that support:
  - The availability of healthy foods in vending machines, snack bars, and cafeterias
  - Community gardens (such as garden water use, use of vacant lots, interim land use)
  - Welfare supplements being used to purchase nutritious foods
  - Promotion and sponsorship of healthy food access maps

Table 7.2.1. - Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Access to Nutritious Food: Municipalities

Access to Nutritious Food									
Policy	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
Policies that restrict advertising of food products to children (e.g. transit ads, no ads for specific foods in recreation centres).									
Policies that support the availability of healthy foods in: vending machines	Plans to review and develop								
Policies that support the availability of healthy foods in: snack bars and cafeterias	Plans to review and develop								

Access to Nutritious Food									
Policy	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
Policies that restrict advertising of food products to children (e.g. transit ads, no ads for specific foods in recreation centres).									
Policies that support the availability of healthy foods in: vending machines	Plans to review and develop								
Policies that support the availability of healthy foods in: snack bars and cafeterias	Plans to review and develop								
Policies that support the availability of healthy foods in: concession stands in public places	Plans to review and develop								
Food and nutrition policies to encourage support for local sustainable agriculture	✓	*		✓	✓				
Policies that support community gardens such as: garden water use policy	Plans to review and develop								
Policies that support community gardens such as: vacant lots policy	*								
Policies that support community gardens such as: interim land use policies	*								
Policies to source and procure local foods	* In Devlt							* In Devlt	
Policies to support the availability of a broader variety of foods available from street vendors									
Policies that support the establishment of Farmers Markets or the revision of existing policies that impede their establishment	* Plans to review and develop	✓		✓	✓	✓	✓	✓	

** Asterisk indicates policy scan validation response differed from initial Ontario Heart Health Network (OHHN) Scan policy scan results.*
"In Dvlt" indicates the policy is "In Development"

Table 7.2.1 continued on next page.

Access to Nutritious Food (continued)									
Policies that support the establishment of Farmers Markets or the revision of existing policies that impede their establishment	* Plans to review and develop	✓		✓	✓	✓	✓	✓	
Policies related to reduction in the use of artificially produced trans fat contained and sold in municipal-operated facilities									
Policies that support breastfeeding									
Policies related to welfare supplements being used to purchase nutritious foods	* In Devlt								
Does the municipality promote or sponsor healthy food access maps	*								
Does the municipality have a Food Charter	* In Devlt								
Committee that focuses on policies related to access to nutritious food	✓*								

** Asterisk indicates policy scan validation response differed from initial Ontario Heart Health Network (OHHN) Scan policy scan results.*

School Board Policies:

Access to Nutritious Food – Key Findings (Table 7.2.2)

Overall, Middlesex-London school boards may update their own policies/procedures to match the standards of *PPM 150* in order to use the same language, criteria, and include food *served* not only *sold* (e.g. at celebrations, at meetings, role modelling, etc.). As an example, Niagara has implemented a policy for their school board that applies both to food *sold* and *served* at schools.

Thames Valley District School Board (TVDSB) has an independent procedure/guideline (not a policy) called *Food in Our Schools*, created in 2001 and amended in 2008 to reflect the document called "*A Call to Action: Creating a Healthy School Nutrition "In Dvlt" indicates the policy is "In Development"*

- *Environment"* (http://www.osnpph.on.ca/pdfs/call_to_action.pdf). TVDSB is currently reviewing *Food in Our Schools.*

- London District Catholic School Board (LDCSB) has a food and beverage policy called *Nutrition,* implemented December 12, 2005, to reflect the document *"A Call to Action for creating a Healthy School Environment"* (http://www.osnpph.on.ca/pdfs/call_to_action.pdf).

- Neither of the Middlesex-London school boards have policies related to the support of school gardens, or policies that support healthy food provided in environments such as meetings.

Table 7.2.2- Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Access to Nutritious Food: School Boards

Access to Nutritious Food		
Policy	Thames Valley District School Board	London District Catholic School Board
Policies that support the availability of healthy foods in: vending machines	**Foods in our Schools** (To be replaced by PPM 150, Sept. 2011)	**Healthy Foods and Beverages in Elementary School Vending Machines** (To be replaced by PPM 150, Sept. 2011)
Policies that support the availability of healthy foods in: snack bars and cafeterias	**Foods in our Schools** (To be replaced by PPM 150, Sept. 2011)	**Healthy Foods and Beverages** (To be replaced by PPM 150, Sept. 2011)
Policies that support the availability of healthy foods in: at meetings	No policy	No policy
Policies that support the availability of healthy foods in: fundraising activities	**Foods in our Schools** (To be replaced by PPM 150, Sept. 2011)	**Healthy Foods and Beverages** (To be replaced by PPM 150, Sept. 2011)
Policies that support the availability of healthy foods: breakfast, lunch or snack programs	**Foods in our Schools** (To be replaced by PPM 150, Sept. 2011)	**Healthy Foods and Beverages** (To be replaced by PPM 150, Sept. 2011)
Policies that support school gardens	No policy	No policy

7.2.3 Assets and Opportunities

On January 11, 2011, from 1:30 to 3:30pm, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority area of Healthy Eating. The purpose of the session was to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: Community Futures Development Corporation (CFDC) of Middlesex County, Child & Youth Network, London Intercommunity Health Centre, Hutton House, London Regional Children's Museum, Middlesex-London Health Unit, SEARCH Mental Health Services, Southwestern Ontario Stroke Network, YMCA of Western Ontario.

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies

- There are 4-5 Farmers markets in London.
- Food mapping has taken place a number of times, which entails mapping of local farmers that have farm gate supplies (that locals or restaurants could use). Food mapping has been beneficial for immigrant populations who are looking for specific produce, or who could be connected with farmers. This initiative is an example of how evaluation is important (to identify how the initiative is being used).
- "Things seem to work well when people collaborate". Awareness about healthy eating as a priority has increased as a result of ministry mandate 10 years ago. For example, a *Middlesex-London Health Unit (MLHU)* dietitian has partnered with preschool staff,

and has noticed a newfound commitment to healthy eating at daycare centers. Daycare centres are an optimal place to introduce new foods as this increases education and experiences of youth for healthy eating and creates an appetite for healthy foods in the future.
- *Healthylivinginfo.ca website* contains recipes and information related to healthy eating, etc.
- Food map for *Farmgate* that shows where fresh produce is sold.
- Middlesex-London has some restaurants that provide local food but not all have this advertised.
- Local farms map are produced and distributed in Middlesex-London area and beyond.

Programs/Activities/Initiatives
- London's *YMCA* childcare has approximately 800 children to whom they are serving food every day. The organization had an MLHU dietitian do workshops for cooks and staff members. *YMCA* evaluated the food they were serving and adjusted accordingly (2 solid snacks and a very healthy lunch) – this has been taken to school age programs as well, to increase nutritional value of snacks and lunches. The afternoon snack may be that child's supper as well.
- Outreach programs at the *London Inter-Community Health Centre* include healthy eating and physical activity education, screening events for pre-diabetes, and prevention programs. There are language interpreters available. Dietitians do a lot of work in researching culture to help make cooking skills/grocery shopping/serving sizes meaningful and relevant.
- *Oneida Nation of the Thames* is targeting healthy eating in schools and providing food skills training with diverse at-risk groups (e.g. teen moms).
- Dieticians at *Middlesex-London Health Unit* have been incorporating skill building (label reading, cooking, canning) with "at-risk" populations in existing small group programs.
- There are healthy food options at *London Regional Children's Museum* day-camp. There was a pilot to have kids as young as 3 years of age making their own healthy snack, such as fruit kabobs. These snacks were colourful, exciting, and kids can take these skills back home.
- The *Growing Chefs! Ontario* program in London is hosted at the *London Community Resource Centre* and shows parents how to make soup, and kids how to make their own salad dressing.
- *Hutton House* teaches people with disabilities how to cook nutritionally, on a budget. There is a cooking program every day that is approximately 4 hours long.
- *Western Ontario Therapeutic Community Hostel (WOTCH)* partnership has 1 dietitian representative go out to meet with clients informally to assist with healthy cooking/eating skills.
- City of London *Spectrum* has some healthy eating programs. For example, there is "Iron Chef" for kids (just like the show) and they are adapting programs to cater to healthy eating.
- *Middlesex-London Health Unit (MLHU)* dietitians are visiting schools for skill building around cooking, using a "train the trainer" model. The program runs for 6 weeks, for staff, parents, etc. to then take back to their organization. The trained trainers take back information and skills to respective schools and teach students. Each session is 45 to 60 minutes
- Middlesex-London has some local food activities occurring, such as a local food conference, with events that feature chefs preparing local foods, and where buyers and producers connect.

- Middlesex-London has some community gardens; one or two have raised beds as well.
- A sodium campaign is planned for Middlesex-London.
- The message to "Eat Local" is leading to healthier, local eating.
- Media has been conveying the importance of healthy eating.
- People are now more aware of the importance of healthy eating and health. Now people want to eat healthier foods (e.g. pesticide free). There are now shows that reveal what is exactly in the processed foods we are eating.
- Great resources being developed, such as menus, recipes. We just need to raise awareness/accessibility to them.

Policy

- *Ontario's Ministry of Education* has *Policy/ Program Memorandum (PPM) 150 – School Food and Beverage Policy*. Will be rolled out as of Sept 2011 and there is training from *Middlesex-London Health Unit (MLHU)* around the policy in schools.

Opportunities

Programs/Activities/Initiatives

- Community Gardens are increasing and there are skill building opportunities around use of food from the gardens. Farmers in some County communities pool their farmed resources. Community gardens could become a part of extra County land that is available.
- Could encourage people who want to support buying local/fresh or the "100 mile diet", to support the local economy or for other known benefits of supporting local food.

Policy

- Schools have to sign off on the *Policy/Program Memorandum (PPM) 150 – School Food and Beverage Policy*; however, there is no monitoring or evaluation plan in place. Further, it would be nice to see the policy extend to not only food sold, but food served at schools. If there is support, could have leverage to monitor and expand the policy.
- The *City of London* has just gone through a 9 month process to develop a *Food Charter* (sustainable governance, food council, increased dialogue between urban and rural, address food deserts). By endorsing the City of London Food Charter, this may give organizations extra clout to follow suit with their programs/services.

Summary of Identified Assets and Opportunities

Organizations, agencies, and establishments are <u>assets</u> for promotion of healthy eating in Middlesex-London. *Local farm maps* are produced and distributed in Middlesex-London area and beyond. There are 4-5 *Farmers Markets* in London, and *Food Mapping* has taken place a number of times to map local farmers with farm gate supplies for local use. Some restaurants use local food, but not all may have this advertised. Community partners and stakeholders indicate "things seem to work well when people collaborate", such as the *Ontario Ministry of Education* mandate for healthy foods in schools 10 years ago that has brought organizations and agencies together for healthy eating. *Daycares* have also displayed a newfound commitment to providing preschool children healthy food, as a result of collaboration with Middlesex-London Health Unit dietitians. For the general population, the *Healthylivinginfo website* contains recipes and information related to healthy eating.

Middlesex-London has many **programs and activities** that are <u>assets</u> for encouraging healthy eating. For example, *YMCA*'s childcare is able to serve hundreds of children a healthy lunch and snacks after receiving workshops from a *Middlesex-London Health Unit* dietitian. Similarly, *London Regional Children's Museum* day camp enables children to develop skills to create healthy snacks. There are elementary and secondary school programs hosted by *Oneida Nation*

of the Thames for "at-risk" groups such as teenage mothers, and *Middlesex-London Health Unit* dietitians use a "train the trainer" model at schools for staff, parents, and other representatives to take back to their own students/organizations. In the community, the *Inter-Community Health Centre* hosts healthy eating and physical activity education, screening events for pre-diabetes, and other prevention programs, with a language interpreter available and a priority. *Middlesex-London Health Unit* has incorporated skill building (label reading, cooking, canning) with "at-risk" populations in a small group format. A *Growing Chefs! Ontario* program exists in London, hosted by the *London Community Resource centre* and is directed toward parents and children. Regarding local and fresh foods, the message "Each Local" is leading to healthier, local eating. There are *community gardens* within Middlesex-London, some of which have raised beds. A *local food conference* holds events that feature chefs preparing local foods and acts as a venue for buyers and producers to connect. In general, media has been conveying the importance of healthy eating which has lead to increased awareness and desire for healthy eating and obtaining healthier foods (e.g. pesticide free). A *dietary sodium reduction campaign* is planned for Middlesex-London. There are excellent resources that have been developed, such as menus and recipes. Awareness and accessibility to such resources would promote optimal use. Opportunities exist for skill building and greater use of foods from community gardens, particularly for *Middlesex County farmers* who sometimes pool farmed resources, and extra land available could be used for community gardens.

A **policy** that will be an asset for local schools is *Ontario's Ministry of Education Policy/Program Memorandum (PPM) 150 – School Food and Beverage Policy*, to be implemented in September 2011. *Middlesex-London Health Unit* has been delivering training in schools regarding implementation of PPM 150. However, no monitoring or evaluation plan is in place and the policy applies only to food sold in schools, rather than also including food served at meetings, etc. It is suggested that with support, there would be an opportunity leverage to monitor and expand the policy. Another opportunity exists with the City of London *Food Charter*, which may give organizations extra clout to follow the Charter's suit with their own programs/services.

7.2.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Healthy Eating within Middlesex-London were identified. There may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Collaboration

- Coordination between agencies could be beneficial.

Resources and Ability to Access Healthy Foods

- Inadequate income - People on disability, low socioeconomic (SES) families, access to grocery stores. Advocate for increase of minimum wage/Ontario Works (OW) monies for healthy food (especially prenatally) in order to enable low SES populations to purchase fresh, healthy food.
- Nutrition supplement gone for Ontario Works (OW).
- Shortage of time: Even if people are living in higher SES areas, people may not have time to prepare/purchase healthy food
- Local food procurement.
- One size fits all meals that are high sodium, high fat (efficiency, lower cost) at hospitals.
- Food in seniors' residences – Educating the cooking staff vs. the seniors who must eat what is available at the residence.
- Profit is valued more than health – this impacts healthy eating (e.g. fundraisers).
- Healthy choice is the more expensive choice at the grocery store or in the school cafeteria.

Knowledge, Skills, and Food Preferences

- Cooking skills – If you are missing ingredients that are imperative to a recipe, this produces more barriers to healthy eating. Solution could be skill building for substituting ingredients, access to healthy ingredients.
- Current labelling is confusing. Need to make consistent. Need to cater to those who are not literate. Numeracy literacy becomes an issue as well.
- Taste is an issue: People eat what tastes good. Training plays a role in this as well (goes to the reference point of what people ate as a child).
- School system does not allow enough time to eat a proper meal – Have longer times to eat. Schools do not allow microwaves in cafeterias anymore. If you have a family who is vegetarian the child cannot eat peanut butter due to school rules which limits what the child can get for lunch that day at school. Parents have limited options for packing a cold lunch. There may be stigmatization of what you bring in your lunch based on cultural background.
- Labelling: Foods that are not actually made in Canada being labelled "Canada"
- Eating as an individual right to select what they eat. Cultural mindset in North America is individualism.

Influence of Media

- Inconsistent messaging, sensationalizing
- Challenge of "diet" mentality
- CBC project (national) – Is this good quality information? This could be a stepping stone to promote healthy eating. A: There needs to be common ground. Differentiate between diet and healthy eating. Our approach needs to be cautious not to promote disordered eating, while being aware that we do have an issue with overweight/overeating.

Summary of Identified Gaps and Needs

The Middlesex-London community has many resources to support healthy eating, however, there is a need to enhance the **collaborative efforts** between organizations and better coordinate existing programs.

Further, **resources and the ability to access healthy foods** is often compromised for various reasons. Those with inadequate incomes and supported by Ontario Works (OW) may lack access to healthy food due to the Nutrition Supplement being removed from social assistance cheques. Those supported by the Ontario Disability Support Program (ODSP), being supported by OW, or living on low working income may not be able to afford the higher cost of healthy foods compared to less healthy foods. There is a need to advocate for increase of minimum wage and OW monies for ability to purchase healthy food, particularly during prenatal development. In general, healthy food is considered more expensive at grocery stores and this can affect the nutritional value of food sold in fundraising activities when profit is valued more than health, or the nutritional value of food purchased by students in their school cafeteria. Hospitals may also purchase "one-size-fits-all" meals, high in unhealthy sodium or fat, for cost-saving and efficiency purposes. Seniors' residences may lack options for healthy eating choices, unless the cooking staff is educated about preparing healthy meals. Shortage of time resources may also affect whether those who are able to afford healthy foods choose to purchase and prepare healthy meals.

Knowledge related to literacy and numeracy, substitution of ingredients, inconsistent product labelling, cultural preferences is challenging and inadequate among various subpopulations. The current labelling system was identified as confusing and there is a need to make food labelling consistent in order to cater to those who lack literacy and numeracy

knowledge. Other labelling issues relate to foods that are not actually made in Canada being labelled as "Canada". **Skills** required to prepare healthy foods can also be lacking among various sub-populations, particularly if ingredients are missing and the individual is unable to develop solutions for substituting ingredients or accessing healthy ingredients. **Food preferences** may be influenced by cultural mindset about individualism such as individual rights to select what food one will eat. Taste was identified as an issue since people may make food choices based on what tastes good. Training plays a role in taste preferences established from a reference point of what people ate as a child.

The ongoing **influences from the media** can lead people to unhealthy food choices as well as lifestyle practices. Inconsistent messaging, sensationalizing, and the challenge of the "diet" mentality were identified as confusing for the public to decipher. A new CBC national project has emerged related to healthy eating, and a question was raised about whether the information presented was quality/evidence-informed. A cautious and consistent approach is needed for delivering healthy eating messages, in order to avoid promotion of disordered eating while addressing the population health issue of overweight/overeating.

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Healthy Eating were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.2.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community stakeholders the following recommended actions emerged:

Increase collaboration

- More collaboration between services so that we are aware of resources, what others are doing, to reduce duplication.
- Partner with primary care providers (e.g. Family Physicians, Nurse Practitioners) – Have family physician champions and utilize that person to disseminate information.
    - There is currently a group of family physicians who are working with a MLHU Public Health Nurse with early years and toddlers – expand this to other age groups.

Enhance Access to Healthy Foods

- A current Middlesex-London Health Unit (MLHU) project is working with group homes to provide healthier meal options for youth. One of the issues coming forward at the table is that employees have limited information/skills for healthy eating. Ensure skills necessary are obtained in order to graduate from these educational institutions to apply in their work setting in group homes, etc.
- Practically: probably make local foods more visible. The idea of the Good Food Box could work well but needs commitment from community partners who have the necessary resources (e.g. space).
- Farm to school programs
- Community gardens subsidy
- More Farmers Markets

Enhance Knowledge Dissemination and Skill Building

- Have more community kitchen programs. Everyone makes 40

meals for the month from communal resources (e.g. farmers).
- Accommodate cooking skills/information to those of low literacy (language, numeracy, etc).
- Re-introduction of home-economics in the secondary system for youth. More train the trainer. Make this course part of life skills in schools that is mandatory to promote basic knowledge of how to use food groups. Ensure home-ec is mandatory in elementary school curriculum as well.
- Have a parental component as well – make a connection between school learning and the home (a bridge between the "artificial setting" and the home).
    - Partner with Loblaws for free classes for children/parents (businesses)
    - Organizations should collaborate/cross sectors and teach/skill build healthy eating
    - Elementary grades an ideal time to promote healthy cooking skills
- Portion sizes, Ingredients, Skills, Time Management, Budget – Awareness, Education, Skill Building.
- Have a hub that disseminates information about current resources for our clients (above and beyond the healthline) that is a place for populations to go to access information.
- Resources given at the family physician's office that directs populations where to access nutritional assistance, information, skill building.
- Food literacy
- Mentoring programs with master gardeners

Advocate for Policies that Support Healthy Eating

- Local policies that change the food environment. Healthy foods more available and affordable will make healthy eating the easy choice. Local food establishments/cafeterias could help make healthy food accessible.
- Look at pricing – you can get a big bottle of pop for $1 but costs $5 for 100% juice – could have a junk food tax.
- Policies to ensure workplaces have healthy food at their meetings (practice what they preach)
- Fundraising policies (ensure healthy food only being sold)
- Sweetened beverages: Dietitians of Canada is launching policy/awareness about strategies to reduce junk food – taxing is one option. Others could support this cause to create leverage – dissemination of this knowledge.
- Energy drinks are another problem that younger and younger children are having access to in schools – policies that do not allow energy drinks to be packed for school/sold at school
- Low nutrition/high-dense/junk food could be taxed across the board and make them more expensive would inhibit purchasing these types of food.
- Hopefully the sodium recommendations would be adopted by the food service industry, but the Federal government has to play a major role here (we can advocate). Do some container gardening workshops for workplaces. Have nutritious environments at workplaces.
- Increase food subsidy for fresh food
- Municipal incentive bylaws

7.2.5 a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Healthy Eating".

I. Advocate for policies at all levels that address healthy eating, always ensuring economic and cultural sensitivity. This could include policies related to healthy/local fresh food access, media & advertising, local foods, food subsidies, healthy food options in cafeterias, foods served during meetings, fundraising, and sodium levels.

- Ensure economic and cultural sensitivity.
- Do not lose track of targeting the unhealthy side of eating.
- Include and strengthen community partnerships in the development/endorsement of London's Food Charter (being developed by London's Child and Youth Network).
- Follow best practice examples such as San Francisco banning toys from McDonald's "Happy Meals" that do not meet minimum nutrition standards.
- Advocate for increased access and subsidy for fresh food.
- Incentive bylaws (e.g. higher taxes on unhealthy food choices).

II. Increase skill building opportunities to augment individual/community capacity for healthy eating. Focus attention on parents and other target groups (e.g. youth and seniors), ensuring cultural/age sensitivity.

- Ensure sensitivity to all audiences.
- Engage physicians.
- Increase awareness of nutrition hubs (where to go to access points).
- Provide healthy eating literacy resources.
- Community kitchens.
- Training for positions in institutions (support workers).
- Farm to School programs.
- School gardens.
- Community gardens subsidy.
- More Farmers' Markets.
- Mentoring programs.

7.3 Injury Prevention

7.3.1 Data

Unintentional injuries (UIs), which are the leading cause of death in Canadians ages 1 to 34 years (PHAC, 2008b). The large majority of UIs are considered preventable (Smartrisk, 2006; Cushman R, 1995). Figure 7.3.1 presents the Injury Pyramid with different outcomes represented by each level. This report deals mainly with the top three levels, but some self-reported indicators of the bottom level will also be presented.

The economic burden [1] of UIs in 2004 in Ontario was $5.5 billion. Falls accounted for 38% of the costs, transport incidents for another 20%, and motor vehicle injuries, specifically, accounted for 10% of the total cost (Smartrisk, 2009).

Key findings from the local Middlesex-London Health Unit report *Leading causes of unintentional injury: a statistical profile of Middlesex-London* (2009c) will be presented on the next few pages. These findings are based on mortality data from 2000-2004 and data on hospitalizations and hospital Emergency Room (ER) visits from 2004-2006.

The eight leading causes and all causes of total UI deaths, hospitalizations and ER visits for Middlesex-London are shown in Table 7.3.1. Overall, the two most common causes of UIs in Middlesex-London were unintentional falls and motor vehicle traffic crashes. There were a total of 598 deaths due to UIs during the 5-year time period 2000-2004. Over half of these were caused by the two leading causes of MV traffic crashes (29.4%) and unintentional falls (25.8%), distantly followed by poisoning and suffocation, including choking. From 2004 to 2006 there were a total of 7035 hospitalizations and 142,207 ER visits due to UIs. Falls was by far the most common reason for hospitalization due to UIs (57.5%), followed by MV traffic crashes (11.9%). Falls (28.3%), sports injury (9.3%), and MV traffic crashes (6.8%) were the three most common causes for ER visit.

Figure 7.3.1. Injury Pyramid

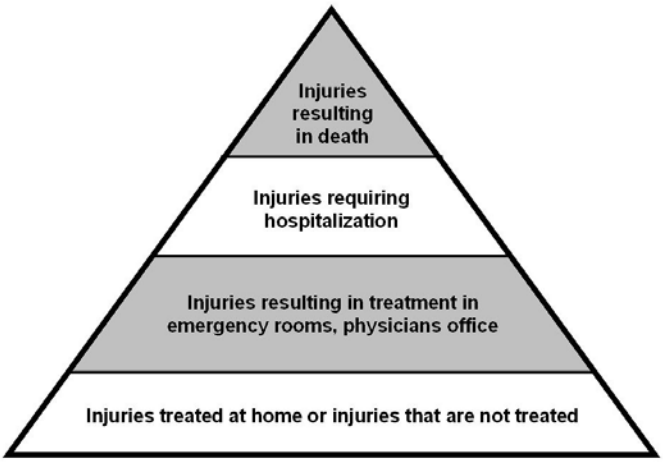


Table 7.3.1. Leading causes of Unintentional Injury Deaths, Hospitalizations and ER Visits in Middlesex-London

Rank	Deaths (2000-2004)	Hospitalizations(2004-2006)	ER Visits (2004-2006)
	Cause Rate (N)	**Cause** Rate (N)	**Cause** Rate CI (N)
1	**MV Traffic Crashes** 8.3 (176)	**Unintentional Falls** 310.0 (4042)	**Unintentional Falls** 3081.3 (40,178)
2	**Unintentional Falls** 7.2 (154)	**MV Traffic Crashes** 64.4 (840)	**Sports Injury** 1015.3 (13,238)
3	**Unintentional Poisoning** 2.4 (51)	**Sports Injury** 27.1 (354)	**MV Traffic Crashes** 739.0 (9636)
4	**Unintentional Suffocation incl. choking** 1.9 (41)	**Unintentional Poisoning** 24.3 (317)	**Pedal Cycle** 263.8 (3440)
5	**Pedestrian, Traffic-related** 1.0, UWC (22)	**Pedal Cycle** 12.7 (166)	**External Causes of Burns** 186.1 (2427)
6	**Unintentional Drowning** 0.8, UWC (16)	**Pedestrian, Traffic-related** 6.4 (84)	**Unintentional Poisoning** 165.0 (2152)
7	**External Causes of Burns** 0.6, UWC (12)	**External Causes of Burns** 5.6 (73)	**Pedestrian, Traffic-related** 38.3 (499)
8	**Pedal Cycle** NR (5)	**Off-road MV Crashes** 5.0 (65)	**Off-road MV Crashes** 37.4 (488)
All UIs	**All Causes** 28.1 (598)	**All Causes** 539.5 (7035)	**All Causes** 10,906.2 (142,207)

Source: Provincial Health Planning Database (PHPDB), Ministry of Health & Long-Term Care, extracted June 2009.

Notes:
Rates = Number of events per 100,000 population
CI = Confidence Interval
(N) = number of events over time period indicated
MV = Motor Vehicle
NR = rate is not reportable due to small numbers
UWC = rate is unstable and should be used with caution

When examining gender difference in injuries it was found that females were 1.5 times more likely than males to be hospitalized due to unintentional falls. Males, compared to females, were:

- 1.5 times more likely to visit the ER
- 1.6 times more likely to die and 1.9 times more likely to be hospitalized due to MV traffic crashes
- 2.5 times more likely to die from unintentional suffocation
- 3.6 times more likely to be hospitalized and 2.8 times more likely to visit the ER due to sports injuries
- 3.3 times more likely to be hospitalized and 2.9 times more likely to visit an ER due to pedal cycle injuries
- 4.3 times more likely to visit an ER due to off-road MV crashes
- 1.5 times more likely to visit an ER due to external causes of burns.

The Middlesex-London Injury report also looked at age differences. From the age groups 45-64 to 65+ UI rates for deaths increased six-fold and UI rates for hospitalizations increased four-fold. Among older residents (65+) in Middlesex-London the aforementioned rates were mostly attributed to falls. The death rate due to falls was 14 times higher among those 65+ compared to those 45-64 years of age. Among people below age 65 the leading cause of UI deaths was MV traffic crashes, and the leading cause of UI hospitalization was falls. The highest rate of ER visits for UIs was seen in the age group 10-19, and falls and sports injuries were the two equally most common causes for ER visits due to UIs in this age group. In all other age groups the most common cause for ER visits due to UIs was falls. Rates of ER visits due to sports injuries, pedal cycle injuries, traffic-related pedestrian injuries, and off-road MV crashes increased and peaked at ages 10-19 and then fell markedly thereafter. ER visits due to motor vehicle crashes were most common in the age groups 10-19 and 20-44. ER visits due to unintentional poisoning decreased with age but hospitalizations increased with age for this cause of UI. ER visits due to external causes of burns were most common among children under one year of age and then declined with increasing age.

In terms of differences between the City and the County it was found that Londoners were more likely to visit the ER due to pedestrian, traffic related causes of UIs than County residents. Residents in Middlesex County, compared to London residents, were:

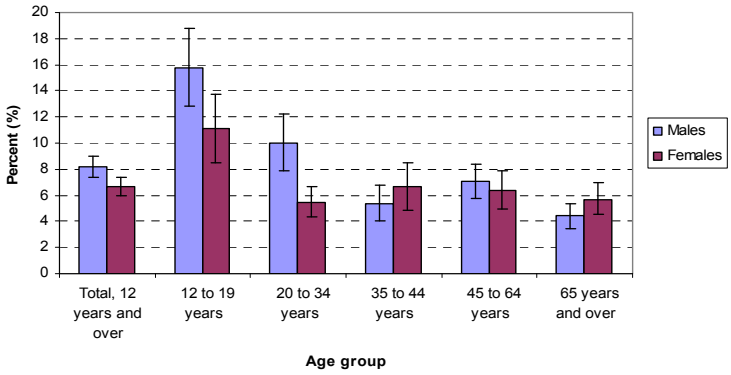
- 1.3 times more likely to die from and visit the ER due to UIs
- 1.2 times more likely to be hospitalized due to UIs
- 2.3 times more likely to die, 1.9 times more likely to be hospitalized and 1.5 times more likely to visit an ER due to MV traffic crashes
- 4.6 times more likely to be hospitalized and 5.4 times more likely to visit an ER due to off-road MV crashes
- 1.4 times more likely to visit an ER due to external causes of burns
- 1.3 times more likely to visit an ER due to sports injuries
- More likely to visit the ER due to agricultural machinery and motor-driven snow vehicle injuries[50]

Self-reported Injuries in Middlesex-London and Ontario

In 2009, 9.7% of Middlesex-London residents (age 12+) reported having had an injury in the past 12 months for which they had sought medical attention, according to the Canadian Community Health Survey (CCHS). This was not statistically different from the provincial rate of 7.4%. In Figure 7.3.2 provincial rates are used to illustrate gender and age differences for this injury indicator for the sake of more reliable rates. The same patterns were seen in Middlesex-London. Ontario males were more likely to report this compared to females (8.2% vs. 6.7%). Most of this difference was made up by gender differences in the age groups 12-19 and 20-34 (Figure 7.3.2).

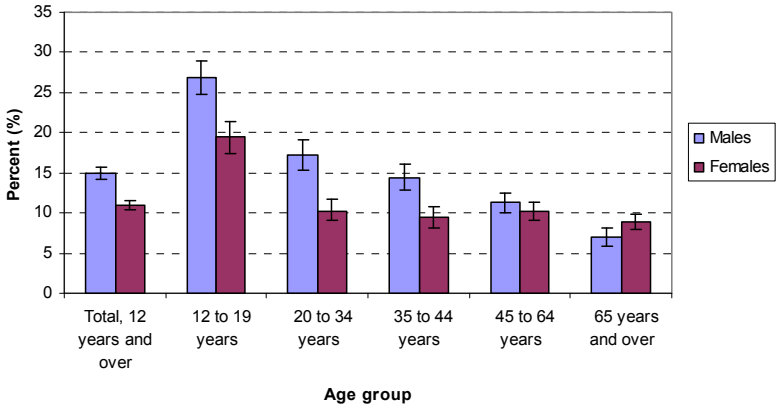
[50] low and less stable rates, use with caution

Figure 7.3.2. Proportion of Ontarians having had an injury in the past 12 months for which they sought medical attention (2009)



Source: Canadian Community Health Survey, Statistics Canada

Figure 7.3.3 Proportion of Ontarians having had an injury in the past 12 months causing limitation of normal activities (2009)



Source: Canadian Community Health Survey, Statistics Canada

Among residents (age 12+) in Middlesex-London in 2009, 16.5% reported having had an injury in the past 12 months causing limitation of normal activities, compared to the provincial rate of 13.8% (not statistically different), according to CCHS data. Males had a higher rate compared to females in Middlesex-London (18.1% vs. 12.1%). Figure 7.3.1 shows that, in Ontario, males were more likely to report injuries that had limited normal activities than females, but this difference was only statistically significant among 12-19 and 20-34 year olds. Those aged 12-19 had the highest reported rates among both males (26.8%) and females (19.4%). Among grade 9-12 students in 2009, 40.5% in the combined LHIN regions of South West and Erie St Clair and 40.6% in Ontario reported having been treated by a doctor or nurse for an injury at least once in the past 12 months (Paglia-Boak et al., 2010). Among grade 7-12 students the rate was 41.7% in West Ontario and 40.5% in Ontario. Males were more likely than females to have been

treated for a physical injury (43.0% vs. 37.6%).

Unintentional Falls

According to data from the Ontario Trauma Register 2008-2009, males represented the largest group (69%) among those injured by unintentional falls (CIHI, 2009). The number of falls increased with advancing age, peaking at age 72 for males and at age 86 for females. Among the specified types of falls the most common was falls from stairs (22%) and falls on the same level from slipping, tripping and stumbling (19%).

In Middlesex-London during the period January 2001 to August 2003, one in five older adults (65+) reported having had a fall in the past 12 months, and 7.1% reported having had a fall that affected their daily activities, according to data from the Rapid Risk Factor Surveillance System (RRFSS) (Middlesex-London Health Unit, 2004). Females were somewhat more likely to report more serious falls limiting their daily activities, compared to males (9.1% vs. 4.3%), but this was not a statistically significant difference. No differences in fall rates were found between City of London residents and those residing in Middlesex County, or between income groups.

Motor Vehicle Collisions

Transport Canada estimated the social cost of collisions in Ontario to be as much as $17.9 billion in 2004 (Transport Canada, 2007). Fewer people died on Canada's roads in 2008 compared to 2007, and since 1989, road traffic deaths declined by 42.9% (Transport Canada, 2010a). The number of major and minor injuries decreased by 49% between 1980 and 2007, and over the same period the number of licensed drivers increased by 79% (Ministry of Transportation, 2007). Ontario had a lower fatality and injury rate due to motor vehicle collisions (4.8 and 484.5 per 100,000) in 2008 compared to Canada overall (7.3 and 536.6 per 100,000).

The majority of fatal collisions (66.3%) took place in rural areas, whereas the majority of personal injuries caused by motor vehicle collisions (68.7%) took place in urban areas (Ministry of Transportation, 2007). Of people killed in motor vehicle crashes in 2008, the largest group was drivers (54.4%), followed by passengers (20.4%), pedestrians (12.4%) and motorcyclists (9.0%). The percentages for serious injuries were fairly similar (Transport Canada, 2010a).

In Middlesex-London in 2007 there were 33 deaths from 30 fatal traffic crashes and 2,671 personal injuries involved in 1,841 personal injury crashes, according to statistics reported to the Ministry of Transportation (2007). Of the personal injuries, a total of 2,050 (76%) took place in the City of London, whereas only five (15%) of the deaths occurred in the City. A total of 10 deaths occurred on the provincial highways and the other 18 deaths occurred in the County.

London Police Service reports produced between the years 2000 and 2009 show that the number of fatal crashes, deaths from fatal crashes and injury collisions in the City of London were generally lower in 2007 to 2009 compared to previous years (Table 7.3.2). In Middlesex County the number of fatal crashes, deaths from fatal crashes and injury collisions were generally lower in 2008 and 2009 compared to earlier years presented (Table 7.3.3). However, the number of alcohol involved collisions was higher in those last couple of years. The number of fatal crashes in Strathroy-Caradoc were three or less per year between 2006 and 2009 (Table 7.3.4).

Table 7.3.2 Total number of collisions, fatal crashes and injury collisions in the City of London in 2000 to 2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total collisions	11,792	11,553	12,077	11,039	9,574	9,815	9,592	10,172	10,251	9,635
Number of fatal crashes	12	12	15	13	12	13	18	7	7	9
Deaths from fatal crashes	12	13	16	14	13	14	18	7	7	11
Injury collisions	2,294	2,186	2,179	1,725	1,519	1,737	1,618	1,545	1,515	1,539

Source: London Police Service yearly reports (2000-2009)

Table 7.3.3 Fatal crashes and injury collisions for Middlesex County (Strathroy-Caradoc excluded)

	2005	2006	2007	2008	2009
Total collisions	1,477	1,320	1,590	1,501	1,295
Number of fatal crashes	21	17	24	7	8
Deaths from fatal crashes	24	19	28	7	9
Injury collisions	297	258	291	257	225
Number of alcohol involved collisions	23	41	38	52	49

Source: Traffic Statistics Middlesex County

Table 7.3.4. Collisions in Strathroy-Caradoc

	2006	2007	2008	2009
Total collisions	361	380	353	340
Fatal crashes	0	2	3	2

Source: Strathroy-Caradoc Police

Vulnerable Road Users

Vulnerable road users accounted for 22% of traffic fatalities in Canada in 2004-2006 (pedestrians: 13%; motorcyclists: 7%; and bicyclists: 2%) (Transport Canada, 2010b). Among the pedestrian traffic fatalities 75% occurred on urban roads and 62% happened to people trying to cross the road. Seniors accounted for 34% of the pedestrian fatalities although they represent 13% of the population, whereas those under the age of 16 accounted for 6% of the pedestrian fatalities, while making up 19% of the population.

The majority of pedestrian fatalities in Ontario in 2007 occurred after dark (55%) (Ministry of Transportation, 2007). Visibility was a major contributing factor in these crashes. Positive alcohol levels or drugs were found among 30% of pedestrians who died in traffic crashes. In more than 10% of pedestrian fatalities the pedestrian had been inattentive, e.g., using a cell phone or listening to music on a portable device. The drivers were the major contributor in 30% of the pedestrian fatalities.

Table 7.3.5 shows statistics of London traffic collisions involving pedestrians and cyclists between 2005 and 2009. This material was released by London Police Service under a Freedom of Information mediation agreement. Maps of the locations of these collisions are available online[51].

[51] http://steveh.ca/london-crashes/index.php

Table 7.3.5. Motor vehicle collisions involving pedestrians and cyclists in the City of London

	2005	2006	2007	2008	2009
Total	339	346	366	387	353
Involving pedestrians	206	215	242	233	185
Involving cyclists	138	136	130	158	173
Pedestrians injured	197	199	228	222	176
Cyclists injured	113	129	118	145	149

Off-Road Vehicles

In all of Ontario in 2007 there were two deaths and 20 non-fatal personal injuries[52] involving a motorized snow vehicle (of a total of 765 deaths and 67,175 non-fatal personal injuries), and no deaths and 43 non-fatal personal injuries involving an all terrain vehicle[53] (Ministry of Transportation, 2007).

Speeding

Speeding was involved in about 25% of fatal crashes and in about 20% of serious injuries from vehicle crashes in Canada between 2002 and 2004 (Transport Canada, 2008). At least one in three speeding drivers who were involved in a fatal crash had been drinking. Single-vehicle crashes accounted for more than 50% of speeding deaths and serious injuries.

In 2004, 80% of Canadian drivers reported driving over the speed limit at least occasionally (Traffic Injury Research Foundation, 2004), and 24.3% of Canadians in 2007 indicated that they frequently drive well over the speed limit (Traffic Injury Research Foundation, 2008a). Frequent speeders were more likely to be younger and to drive more kilometres in a typical month, compared to those who did not report frequently driving well over the speed limit.

The number of speeding charges laid in the City of London and Strathroy-Caradoc in 2006 to 2009 is shown Table 7.3.6. There was a drop in speeding charges between 2008 and 2009 in the City of London, and in Strathroy-Caradoc there was a sharp drop between 2007 and 2008 and then an even bigger drop between 2008 and 2009. These numbers, however, only tell us how many people get caught speeding, and may not be a true picture of how many are actually speeding.

Table 7.3.6. Number of speeding charges laid* in the City of London and Strathroy-Caradoc in 2006 to 2009

	2006	2007	2008	2009
City of London	4,844	8,092	8,441	7,122
Strathroy-Caradoc	898	870	472	44

Source: London police service yearly reports (2006-2009) and Strathroy-Caradoc Police
** Per person*

Young Drivers

Road crashes were the leading cause of hospital admissions among Canadian youth (age 15-24) in 2004 and the second leading cause of emergency room visits (Traffic Injury Research Foundation, 2008b). Young drivers account for 25% of the motor vehicle deaths and injuries, which vastly outweighs their representation in the driving population (13%). Looking at motor vehicle injury rates across age groups in Canada in 2006, injury rates decreased with increasing age, and those aged 15-24 had an injury rate that was almost 40% higher than among those 25-34 years of age (1,216 vs. 878 per 100,000 population). Most of the deaths and injuries in the age group 15-24 (80%) occurred when they were drivers or passengers (as opposed to pedestrians and bicyclists). Also, when looking at per-distance death rates[54] teens (16-19) and young adults (20-24) had substantially higher death rates compared to any other age group in 2004. Those aged 15-24 years also had significantly higher per-driver death and injury rates than other age groups in 2005.

[52] Ranging in severity from minimal to major injury
[53] Including two-, three-, and four-wheel off-road vehicles
[54] number of driver deaths per billion vehicle kilometres

Driving over the speed limit at least occasionally was reported by 93% of Canadian teenage drivers (age 16-19), and 90% of those 20-24 years of age, compared to 80% in the general population (Traffic Injury Research Foundation, 2004). In the general population 69% said they, at least occasionally, were speeding up to get through a traffic light before it changed. This behaviour was most common among 20-24 year olds and decreased with increasing age.

Taking a risk while driving, just for the fun of it was reported by 18% of Canadian drivers, but was much more commonly reported by teenage drivers (38%), and 20-24 year olds (33%), than any other age group (Traffic Injury Research Foundation, 2004).

As much as 26% of those 20-24 years of age, and 21% of those 16-19 years of age reported having received a traffic ticket in the past year, compared to 11% in the general population (Traffic Injury Research Foundation, 2004).

Driving and Substance Use Among Adults

In Canada the percentage of drivers tested who died and tests confirmed they had been drinking decreased from about 45% in 1990 to about 33% in 1999, and then increased again to about 39% in 2008 (Transport Canada, 2010a). In Ontario, the number of drinking and driving fatalities dropped by 41% between 1990 and 2007, and the rate per 10,000 licensed drivers declined by 57% (Ministry of Transportation, 2007).

Drinking and driving, being defined as having driven a motor/recreational vehicle within the hour of drinking two or more alcoholic drinks in the past 12 months, was self-reported by 5.8% of Middlesex-London residents during the combined period of the years 2001, 2003, 2005 and 2008 (Middlesex-London Health Unit, 2010c). A significantly higher proportion of males compared to females reported drinking and driving (9.7% vs. 2.2%). Among males only, an increasing trend in the prevalence of drinking and driving could be distinguished (from 8.5% in 2001 to 12.2% in 2008). The prevalence of drinking and driving appeared to fall after age 39 and was notably lower for those aged 50-59 (4.2%) compared to those 19-39 years of age (8-9%). No statistically significant differences were seen in drinking and driving by level of education, marital status, language spoken at home, or area of residence (City vs. County).

In South West in 2007, 13.3% reported having been a passenger in a vehicle with a driver who had been drinking, at least one time during the past 12 months (Ialomiteanu et al., 2009). This was a statistically higher rate compared to the Ontario rate of 9.5%.

Driving within one hour after consuming cannabis in the past year was reported by 1.8% of Ontarians in 2007 (Ialomiteanu et al., 2009). About 7% had been a passenger in a vehicle with a driver who had been using cannabis, at least one time during the past 12 months.

Findings from The British Columbia Roadside Survey 2008 showed that drug use and driving was more common than alcohol use and driving (Beirness & Beasley, 2009). Among night time drivers who provided an oral fluid sample 10.4% tested positive for one or more impairing substances other than alcohol, and 8.1% of drivers who provided a breath sample had a positive BAC[55] (≥ 5mg%). Cannabis and cocaine use were each found among 4.6% of the drivers. A BAC of 50-80 mg% was found among 1.6% of night time drivers and a BAC of over 80 mg% was found among 2.5%. Drivers of pickup trucks and SUVs were more likely to have been drinking (14.7% and 14.2%, respectively), compared to drivers of cars (6.9%), and drivers of SUVs were most likely to have a BAC over 80 mg%. A BAC of 50-80 mg% was found among 4.0% of those driving a car, among 5.3% among those driving a pickup and among 6.1% of those driving an SUV.

[55] Blood Alcohol Level

Driving and Substance Use Among Youth

Among youth (grades 10-12) in the West region of Ontario in 2009, 10.8% reported having driven within an hour after consuming two or more alcoholic drinks at least one time during the past 12 months (Paglia-Boak et al., 2009). Ontario males in this age group were more likely to report drinking and driving compared to females (14.9% vs. 8.3%). No significant grade or regional differences were observed.

Driving within one hour of using cannabis during the past 12 months was reported by 17.8% of Western Ontario students in 2009. Again, Ontario males were more likely to report this behaviour compared to females (20.8% vs. 11.4%, respectively), and an increase was seen with increasing grade.

RIDE Program

The RIDE program (Reduced Impaired Driving Everywhere) serves as an educational "billboard" early in the evening for people who might be heading to a drinking establishment and as an enforcement or deterrent mechanism later in the evening or early morning.

The number of vehicles stopped, breathalyser tests conducted, arrests and licence suspensions in the RIDE program in the City of London is shown in Table 7.3.7. A total of 31,066 vehicles were stopped in 2009 and 24 drivers were arrested for BAC levels over .08. Most of the RIDE program is conducted with Provincial Funding. That funding doubled in 2008, hence the large jump in vehicles stopped[1].

The Highway Traffic Act requires the officer to have "mere suspicion" that a driver has alcohol in their system, but tests are conducted at the discretion of the officer, which may result in individual difference between officers.

In Middlesex County (Strathroy Caradoc excluded) 28,786 vehicles were checked in the RIDE program in 2009. During those RIDE checks a total of 86 road side tests were done, 22 people were issued a 12 hr licence suspension, and 10 people (0.04% of vehicles checked) were charged with impaired offences. Table 7.3.8 shows the RIDE program statistic for Strathroy-Caradoc between 2005-06 to 2009-10.

Table 7.3.7. RIDE Program statistics for the City of London

Year	Vehicles Stopped	Tests	Arrests*	Arrests as % of vehicles stopped	Licence suspensions**	Pass
2005	20,788	485	18	0.09	95	362
2006	16,706	439	21	0.13	75	343
2007	23,331	411	11	0.05	62	338
2008	38,513	558	29	0.08	140	394
2009	31,066	423	24	0.08	86	321

Source: London police service yearly reports (2005-200)

**

* Charges laid due to BAC >.08

Up until May 1, 2009 all "suspensions" listed were for 12hrs. After May 1st suspensions could have been of the 3-day, 7-day or 30-day variety. BAC between .05 and .08.

Table 7.3.8. RIDE Program statistics for Strathroy-Caradoc

Period	Vehicles Stopped	Tests	Arrests	Arrests as % of vehicles stopped	Licence suspensions
2005-06	3,269	8	4	0.12	1
2006-07	1,549	4	2	0.13	2
2007-08	3,501	13	3	0.09	5
2008-09	3,036	28	2	0.07	7
2009-10	2,366	15	0	0	3

Source: Traffic Statistics Middlesex County

Seat Belt Use

The proportion of Ontario driver fatalities where the victims were not using seat belts dropped from 40.2% in 2004 to 34.9% in 2008. The proportion of passenger fatalities where the victims were not using seat belts dropped just slightly from 39.6% in 2004 to 38.3% in 2008 (Ministry of Transportation, 2007). In Middlesex County seatbelts were not used in four of the nine fatal crashes in 2009.[56]

According to results of Transport Canada's rural and urban surveys of seat belt use in Canada 2009-2010, 95.8% of all occupants of light duty vehicles[57] in rural Ontario were using a seat belt, and 96.1% were wearing a seat belt in urban Ontario (Transport Canada, 2011). Females are somewhat more likely to wear seat belts and the use tends to increase with increasing age. Seat belt use was also more common among front seat occupants (95.5%) compared to back seat occupants (89.2%).

Numbers of seatbelt charges in the City of London and Strathroy-Caradoc in 2006 to 2009 are shown in Table 7.3.9. In 2009, there were 1,089 seatbelt charges laid, which is a lower number compared to the two previous years. In Strathroy-Caradoc, 13 seatbelt charges were laid in 2009. These numbers, however, only tell us how many people got caught not wearing a seatbelt, and may not reflect trends in seatbelt use.

Table 7.3.9. Number of seatbelt charges laid* in the City of London and Strathroy-Caradoc in 2006 to 2009

	2006	2007	2008	2009
City of London	1,173	1,452	1,807	1,089
Strathroy-Caradoc	9	28	10	13

Source: London police service yearly reports (2006-2009) and Strathroy-Caradoc Police
** Per person*

Seatbelt charges for the rest of Middlesex County were not readily available. However, a Spring seatbelt campaign was run from April 10th to April 24th, 2010 where a total of 13,325 seatbelts and 504 child seats were checked. Among seatbelts checked, 63 seatbelt charges (0.5%) and one child seat charge were laid (0.2%).[1]

Cell Phone Use

An estimated 3.2% of urban Ontario drivers and 4.3% of rural Ontario drivers were using a cell phone while driving in 2009-2010 (Transport Canada, 2011).

Bike Helmet Use

Helmets may reduce the risk of head injury by up to 88% for all ages of bicyclists (Thompson et al., 2003). In October 1995, provincial legislation came into place requiring every cyclist less than 18 years of age to wear an approved bicycle helmet when riding a bike on roadways.

In Middlesex-London in 2009, 35.9% reported that they always wear a bike

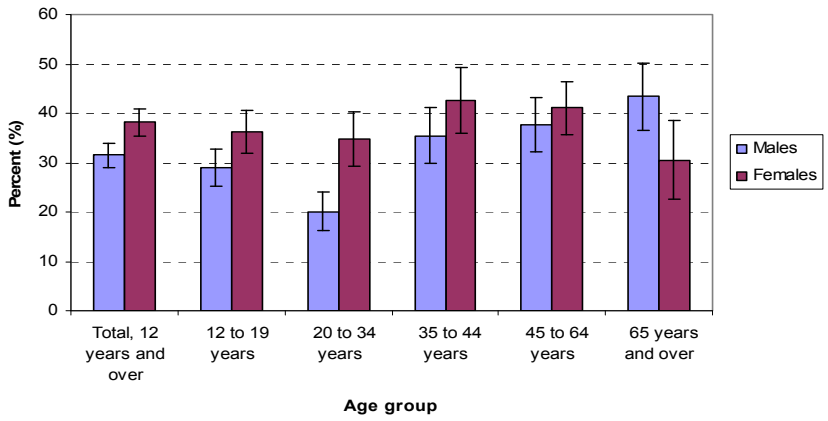
[56] Traffic Statistics from Middlesex County, communicated by Provincial Constable Christina Hunter at the Ontario Provincial Police (OPP)
[57] Cars, light trucks, minivans and SUVs

helmet when riding a bicycle, according to the CCHS. This was very close to the provincial rate of 34.3%. The rate had increased from 26.7% in 2000/01 (Middlesex-London Health Unit, 2003), but this was not a statistically significant increase. In the province females were more likely to report use of a bike helmet compared to males (38.2% vs. 31.5%). However, in Middlesex-London a larger proportion of males than females were always using a bike helmet (42.0% vs. 27.8%). This estimate for females needs to be used with caution though, and the difference is not statistically significant. In Ontario, always wearing a bike helmet when riding a bike was least likely in the age group 20-34 (26.7%), compared to about 39% among those 45 years of age and over, and 32% among youth aged 12-19. The same pattern was seen in Middlesex-London, but the numbers were less reliable. Females tended to be more likely to use a bike helmet in all age groups except for the oldest (65+). The gender difference was only statistically significant among those 20-34, where 29.0% of males and 34.8% of females reported always wearing a bike helmet. Males in this age group were also significantly less likely to wear a bike helmet compared to males in all other age groups (Figure 7.3.3).

Based on RRFSS data 64% of households in Middlesex-London in 2001-2003 reported that their children (aged 5-17) always wore bike helmets when riding a bicycle (Middlesex-London Health Unit, 2003). Occasional use was reported by 22% of the households. Over those three years, the reported rates of bike helmet use remained steady. Whereas as many as 82.6% of younger children (age 5-8) were reported wearing helmets, the rate among those aged 13-17 was only 39.9%. No difference was seen across different levels of income, but respondents with post secondary education were more likely to report that their children wore a bike helmet, compared to those with lower educational attainment. Reported bike helmet use was higher in the City of London compared to Middlesex County (69.2% vs. 48.4%).

Always using a bike helmet was reported by 23.0% of 12-19 year olds in Middlesex-London in 2000/01 according to CCHS data (Middlesex-London Health Unit, 2003). In 2009 the rate had increased to 40.5% in this age group, which was not a statistically significant change.

Figure 7.3.3. Proportion of Ontarions always wearing a bike helmet when using a bicycle (2009)



Source: Canadian Community Health Survey, Statistics Canada

Parental Knowledge of Leading Cause of Death Among Young Children (0-6 years of age)

Data on parental perceptions towards childhood injury among parents with children 11 years and under was collected for the Middlesex-London Health Unit through the Parent Survey of 2004 and 2006 (Middlesex-London Health Unit, 2006). The proportion of parents in Middlesex-London who correctly identified injuries as the leading cause of death in children 0-6 years of age decreased between 2004 (66.8%) and 2006 (58.3%). Knowledge of the leading cause of death in young children was significantly higher among females than males in 2006 (63.6% vs. 50.4%), and lower among parents under the age of 24 years (26.9%) compared to those aged 25-34 (55.2%) and 35-44 (65.4%). Knowledge of injuries being the leading cause of death in young children also varied with household income and education. Parents reporting an annual household income of less than $30,000 were less likely to select injuries as the leading cause of death (38.2%) compared to individuals with incomes between $70,000 and $99,999 (66.9%). Parents with some post secondary education were more likely to be aware of childhood injuries as the leading cause of death compared to those with high school education or less (63.8% vs. 41.7%). No difference was seen between City and County residents.

Despite the fact that up to 90% of childhood injuries are estimated by experts to be both predictable and preventable (SmartRisk, 2006; MacKay et al., 1999) as much as 32.6% of parents believed that injuries were 'not at all preventable' or only 'somewhat preventable'. This rate was higher among parents with household incomes below $30,000 (43.7%) compared to those with incomes $70,000 to $99,999 (26.2%), and higher among parents with only high school education or less (45.2%) compared to those with some post secondary education (28.6%). No statistically significant differences were found for gender, parental age, marital status and place of residence.

7.3.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies, Programs, and/or Legislation:

Municipality Related:

Road Safety

Bill 203, Safer Roads for a Safer Ontario Act (September 30, 2007) prohibits and outlines consequences for Street Racing and Aggressive Driving (Section 172) (http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=1594&isCurrent=false&ParlSessionID=)

Ontario most recently amended *Bill 126, Road Safety Act* in November 2009 (http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2118).

Ontario's *Bill 118, Countering Distracted Driving and Promoting Green Transportation Act* (October 26, 2009) prohibits the use of hand-held devices while driving, including cellular phones, i-pods, blackberries/palms, and navigational devices, etc. (http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2099).

Off-Road Vehicle Safety

Ontario has a *Highway Traffic Act,* along with all-terrain vehicle (ATV) and snowmobile legislation, known as the *Off-Road Vehicles Act* (www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90o04_e.htm) and the *Motorized Snow Vehicles Act* (www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m44_e.htm#BK1).

Children's Injury Prevention

In 2006, the province instated, *Bill 148 Highway Traffic Amendment Act*, related to seat belts.

Legislation regarding child booster seats and child restraints are found in the 2004 *Bill 73, Highway Traffic Statute Law Amendment Act: An Act to Enhance the Safety of Children and Youth on Ontario's Roads*, related to child and youth safety.

School Board Related:
Ontario Building Code standards (http://www.mah.gov.on.ca/Page7393.aspx).

*Ontario's Fire Code (*Ontario Regulation 213/07) made under the *Fire Protection and Prevention Act, 1997* (http://www.e-laws.gov.on.ca/html/source/regs/english/2007/elaws_src_regs_r07213_e.htm).

Ontario Bicycle Helmet Law (http://www.mto.gov.on.ca/english/faq/safety-test.shtml#helmets).

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, policies specifically created by Middlesex-London municipalities and school boards related to *Injury Prevention* are in beginning stages.

There were three priority areas of the Ontario Ministry of Health Promotion and Sport, Healthy Communities Partnership stream that were not scanned for within the Ontario Heart Health Network (OHHN) Policy Scan, including Injury Prevention. Thus, for the priority area of Injury Prevention, Policy Scan questions were created with advice from community partners that possess expertise for the specific priority area (see Methodology for more information).

Policies that were scanned for and that do not exist in Middlesex-London could be considered for development and implementation by municipalities and school boards in the future.

Municipal Policies:

Injury Prevention – Key Findings

- Southwest Middlesex, Thames Centre, and Middlesex Centre identified they have municipal-specific policies related to helmet use, beyond meeting Ontario's established *Bicycle Helmet Law*.

- Policies related to prevention of falls in adults, drowning prevention, and off road safety (e.g. ATVs and snowmobiles), are each addressed by City of London.

- City of London plans to review/develop policies related to cycling safety beyond current provincial by-laws related to streets.

None of the Middlesex-London municipalities reported policies beyond current national and provincial policies and legislation related to Injury Prevention highlighted in the Middlesex-London Health Unit questions of the Policy Scan. Policies scanned for and that provide future policy direction include:

- Policies that promote traffic safety beyond National/Provincial policies, by-laws, and legislation already enforced by Police Services.
- Policies that promote pedestrian safety, beyond National/Provincial policies, by-laws, and legislation already enforced by Police Services.
- Policies related to impaired driving, beyond meeting *Ontario Criminal Code* and *Ontario Highway Traffic Act*.
- Policies related to falls in children (e.g. window guards, balconies, playgrounds), beyond meeting National/Provincial policies such as *Building Code Standards* or *Accessibility for Ontarians with Disabilities Act*.
- Policies related to drowning prevention, beyond current municipal by-law related to private pool fencing.
- Policies related to fire safety, beyond meeting *Ontario Fire Code* and *Ontario Building Codes*.
- Policies related to helmet use, beyond meeting Ontario's established *Bicycle Helmet Law*.

School Board Policies:

Injury Prevention – Key Findings

- Both Middlesex-London school boards (Thames Valley District School Board and London District Catholic School Board) have policies related to falls prevention among children by meeting "*Provincial Guidelines for Playgrounds.*"

- London District Catholic School Board has a policy related to fire safety and another policy related to helmet use for skating programs.

- Thames Valley District School Board has a policy related to cycling safety where no bicycling is allowed on school property.

7.3.3 Assets and Opportunities

On January 12, 2011, from 9:30 to 11:30am, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority areas of Injury Prevention (combined with the Substance Misuse Focused Group Discussion session). The purpose of the session was to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: Addiction Services Thames Valley, Child Safety Middlesex-London, Centre for Addiction & Mental Health, London Intercommunity Health Centre, London Health Sciences Centre, Middlesex-London Health Unit, Ontario Early Years Centre -Child Safety-Buckle Up Baby, School of Nursing-UWO, Southwest Community Care Access Centre – Self Management Program, Southwest Ontario Aboriginal Health Access Centre, Southwestern Ontario Stroke Network, Thames Valley Family Health Team

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies

- *Ontario Early Years Centres (OEYCs)* in Middlesex County and City of London address many aspects of safety and injury prevention, such as home safety.
- *Community Care Access Centres (CCACs)* have falls prevention programs and safety awareness for seniors. *CCAC* also has seniors programs and home care assessments, called 'Safe at Home', 'High Risk Seniors', and 'Wait at Home'.
- *Helmets on Kids* partnership.
- *Child Safety* Middlesex-London
- *Canadian Centre for Activity and Aging* offers exercise programs for individuals who are disabled and seniors, but there is a cost which is often a barrier.
- *IDrive* and crash statistics from *Ontario Provincial Police (OPP)* and *London Health Sciences Centre (LHSC).*
- *London Health Sciences Centre (LHSC) Impact Program.*
- *Immigrant and Francophone Seniors WrapAround initiative* (for those age 55 years and over) through *London InterCommunity Health Centre*, supports individuals who are living in private homes but have few community or social supports. Referred seniors are partnered with *WrapAround* facilitator who works with the senior and his or her family.

Programs/Activities/Initiatives

- *SafeGrad* program.
- Health promotion programs for hard to reach populations.
- *BeCAUSE Campaign* partnership with *London Health Sciences*

Centre Trauma program and *Middlesex-London Health Unit* (three focus areas have been *Distracted Driving, Share the Road,* and *Stepping Out Safely*)..
- *Be Safe Be Seen* awareness-raising by *Southwest Injury Prevention Network*.
- *Farm safety* programs.
- *Risk Watch* training for teachers.
- London designated as *age friendly city.*
- *Stepping out Safely* promotes healthy messages about staying fit and being safe.
- *Buckle Up Baby* program.

Opportunities

Organizations/Agencies
- Collaborations continue to build, and are essential in our community to avoid duplication.
- Planners in Middlesex-London are seeing the link between injury prevention and health issues (e.g. better lighting, bike paths, etc.)

Programs/Activities/Initiatives
- *Stepping out Safely* has been building at the grass root level and has good supporting partners.

Summary of Identified Assets and Opportunities

There are a number of injury prevention **organizations and agencies** that are assets within Middlesex-London. The *Ontario Early Years Centres* in Middlesex County and the City of London address many aspects of safety and injury prevention for children. *Helmets on Kids* and *Child Safety Middlesex-London* also promote injury prevention among children. *Community Care Access Centre*, *Canadian Centre for Activity and Aging*, and the *Immigrant and Francophone Seniors WrapAround initiative of London InterCommunity Health Centre* are organizations/agencies that provide special services for the older adult population. Opportunities exist in the form of collaborations that continue to build, and are essential in the community to avoid duplication. City and County planners are noticing the link between injury prevention and health issues, for example better lighting and bike paths.

Injury prevention **programs and activities** that are assets within Middlesex-London include those targeting the general population such as the *BeCAUSE Campaign (Distracted Driving, Share the Road, Stepping out Safely), Be Safe Be Seen,* and the City of London designated as an *age friendly city.* For youth, the *SafeGrad* program promotes harm reduction for parents and teachers to receive *Risk Watch* training. The *Buckle Up Baby* program aims to prevent infant injuries. There are opportunities for programs that have begun at the grass root level, and have strong supporting partners, such as *Stepping out Safely.*

7.3.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Injury Prevention within Middlesex-London were identified. There may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Access/Equity
- *Canadian Centre for Activity and Aging* assists individuals with disabilities and seniors to be active. However, there is a cost associated with services which may present barriers to access.
- There is a high cost of programs offered to individuals with disabilities who are under 55 years of age.
- Poor snow removal is particularly an issue for seniors.
- Educate communities/neighbourhoods about issues using a holistic approach.

Injury Prevention Culture
- Our social perception of aging may be one of ageism. Need a shift in how we look at older people and the aging process.
- City of London may not be completely pedestrian-friendly.

- There is a culture in the city for jay walking.
- Need to enhance awareness that a "home accessibility evaluation" does not account for whether people are able to afford the recommended devices.

Strength of Partnerships, Collaboration, and Funding Issues

- *Farm safety* is doing a good job but there are not enough schools, and farmers are aging.
- Car seats are difficult to install. An existing volunteer group that checks car seat installations encourages parents to try to install the car seats on their own and then seek help from the group, as there is a lack of funds for the program.
- Organizations may be pitted against each other because of funding issues and funding structure.
- Need to prioritize/collaborate/set common goals/pool resources with limited time and resources.
- There is a culture that injuries are a normal part of life. We all need to help prevent injuries, not just one agency.
- There is an aging volunteer base and it is difficult to recruit new volunteers.

Summary of Identified Gaps and Needs

Some identified gaps and needs for prevention of injury relate to issues of **access and equity**. For example, while Middlesex-London has strong programs for those who are disabled and for older adults, there may be cost barriers for participation. Or, if a home accessibility assessment is conducted, the home-owner may not be able to afford the recommended devices. Poor snow removal creates unsafe surfaces for older adults or those with physical limitations to travel safely. A holistic approach is needed for educating communities and neighbourhoods about injury prevention.

Social perception of injury prevention requires a cultural shift. Focused discussion revealed a perception of ageism toward older adults and injuries, and a culture of unsafe pedestrian activity such as jay walking. Overall, it is perceived that there is a culture where injuries are considered a normal part of life. Injury prevention should be widely promoted, rather than considered the sole responsibility of one agency.

Injury prevention partnerships such as *Farm Safety* and *Buckle up Baby* are identified as providing excellent services. However, it was noted that these partnerships possess an aging volunteer base and it is difficult to recruit new members. Thus, there is a need for renewed membership among these partnerships. As there is **limited time, financial, and human resources**, organizations need to prioritize, collaborate, set common goals, and pool their resources, rather than competing against each other for these funds.

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Injury Prevention were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.3.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community stakeholders the following recommended actions emerged:

Media Campaign and Support to Alter Culture/Norms about Prevention of Injury

- Large media campaign to change culture/norms and perception of Injuries as "part of life".
- Increased government support for injured to take time from work or to care for injured family members.
- Decrease perception that injuries are normal for seniors, and enable seniors to ask for help. By overcoming these barriers it will change thinking to "It's OK to ask for help".
- Advocate for more comprehensive farm safety education (e.g. ATV, age appropriate physical labour) in schools.

Centre of Excellence

- Centre of Excellence to learn life skills following injury to the brain which would facilitate transition back into the community. This would focus on a full spectrum of brain injuries and address clients across the lifespan (e.g. stroke, shaken baby syndrome, fetal alcohol spectrum disorders, sports related) and would include 24 hour care.

Built Environment Policies and Safety

- Advocate for policies regarding physical environment and safety. Highlight connection of injury prevention with built physical environments.
- Ensure adequate snow removal at bus stops, sidewalks, and crosswalks. Advocate for adequate snow removal in public places (e.g. bus stops and sidewalks).
- Advocate for policy changes regarding physical environment and safety.
- Integrate environmental design factors into municipal Master Plan, which improve safety and injury prevention within our communities. Advocate for Master Plans that include/address safety, injury prevention. Policies to promote walkability (when planning building development, mixed land use, sidewalks, locate schools close to housing, paved shoulders in County, etc).
- New building codes with increased safety codes for seniors' residences, and incentives for builders who meet these codes.

Streamline the Ontario Disability Support Program (ODSP) Application Process

- Advocate for streamlining of Ontario Disability Support Program application process.

Injury Prevention and Support across the Lifespan (Age Friendly Communities)

- *Seniors Watch* Program – identify seniors at risk for injuries with the goal of expanding to address life span.
- Remove stigma regarding injury prevention (e.g reduce ageism to enable seniors to ask for help.
- Approach School Boards to better understand and improve how farm safety is delivered to students.
- More government support for employees who care for their parents who are seniors.
- Increased government support for those who are injured or who are caring for an injured family member.
- Increased funding for physical activity programs that help seniors maintain their physical strength, thereby decreasing risk of injury.
- Development of a comprehensive program for health care workers regarding screening, education, and brief interventions related to injury prevention.
- No head sets while driving.
- Extend school speed zones.

7.3.5 a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Injury Prevention".

I. Develop a large media campaign to change culture/norms and perception of injuries as "part of life" and reduce the stigma of asking for assistance related to injury prevention.

- Municipally raise awareness about provincial organizations/agencies that serve as Centres for Excellence for facilitating transition back into the community following brain injuries, through building life skills (e.g. SmartRisk, Safe Kids Canada, etc.)
- Decrease barriers of stigma regarding injury prevention e.g. seniors asking for help.
- Seniors Watch program to identify at risk seniors, with the goal of expanding to address life span.
- Development of a comprehensive program for health care workers regarding screening, education, and brief interventions related to injury prevention.
- Advocate for more comprehensive farm safety education (e.g. ATV, age appropriate physical labour) in schools.
- Awareness about dangers of head sets while driving/walking (distraction), and that they should not be worn while engaging in these activities.

II. Advocate for policies that include the physical environment and safety (snow removal, cross walk signals, speed zones near schools, building codes for seniors' housing), integrated into municipal Master plans.

- Integrate environmental design into municipal Master Plan (safety, injury prevention).
- Advocate for adequate snow removal in public places (e.g. bus stops and sidewalks) – All ages, and those with disabilities.
- Policy to promote walkability and pedestrian access (planning development, mixed land use, sidewalks, schools close to housing, paved shoulders in county, increase the number of "on demand" crosswalks, etc).
- Extend school speed zones.
- New building codes for seniors buildings (and any building) and incentives for builders who meet these codes – Related to safety, injury prevention.
- Senior safety in general.

7.4 Tobacco Use/Exposure

7.4.1 Data

The Burden

Tobacco use is the number one preventable cause of death and disease in Canada (Illing & Kaiserman, 1999) and was estimated to account for 16.6% of all deaths in Canada in 2002; cancer being the leading cause of death, followed by cardiovascular disease and respiratory disease (Rehm et al., 2006a). It is responsible for three times as many deaths as the combined total of alcohol, drugs, suicide, homicide, injuries sustained from car crashes and AIDS (Holowaty et al., 2002). The number of smoking-attributable deaths increased by 11% in Canada between 1992 and 2002 (Patra et al., 2007). Furthermore, second-hand smoke causes disease and death in non-smokers, and is related to childhood respiratory conditions as well as sudden infant death syndrome (U.S. Department of Health and Human Services, 2006). The per capita social cost for tobacco use in Canada in 2002 (including costs for health care, law enforcement, and loss of productivity due to premature death and disability) was an estimated $541 (Rehm et al., 2006a). The direct cost for health care related to tobacco was $1.6 billion in Ontario (Holowaty et al., 2002). When inflation and population growth are considered, this is the equivalent of $1.93 billion in 2009.

Despite efforts in Ontario to significantly reduce tobacco use, the tobacco epidemic has not yet been solved. The tobacco industry – which includes the entities responsible for producing, supplying, marketing, and promoting commercial tobacco to current and potential users – is intelligent, quickly adaptive and has been shown to take advantage of regulatory loopholes to maximize self-interests. In addition, tobacco industry products are highly addictive and furthermore, there are some "at-risk" populations who have not necessarily benefited from the tobacco control gains that have been made. Examples of groups with higher than average tobacco use are those with lower income, Aboriginal peoples, those with mental health concerns, and some occupational groups like those working in manufacturing, trades, construction and agriculture (Ontario Agency for Health Protection and Promotion (OAHPP), 2010). Another risk-population, where smoking seems to have increased lately, is pregnant women. Recent data for the southwest public health region show that maternal smoking rates increased from 13.2% in 2004 to 18.6% in 2008, and also showed a higher rate of maternal smoking compared to the province in 2008 (12.4%) (Better Outcomes Registry & Network (BORN), 2010).

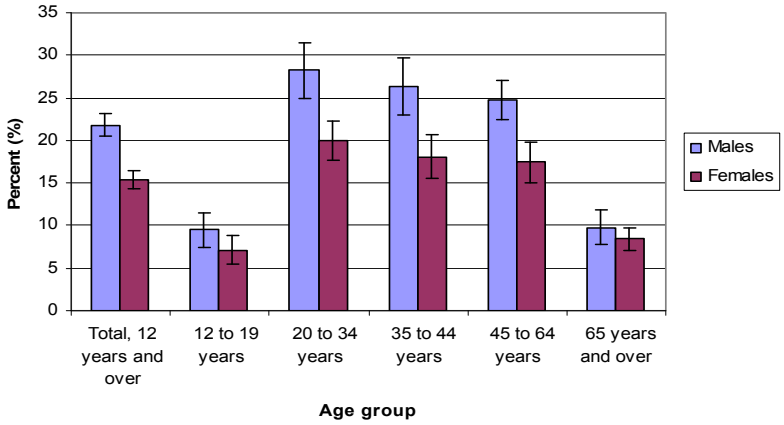
Current Smoking Among Adults

Daily smoking among adults in Middlesex-London decreased from 19.9% in 2001 to 16.1% in 2007 (Middlesex-London Health Unit, 2008). The rate of occasional smoking decreased from 4.6% in 2001 to 3.7% in 2007. Men were generally more likely to be smokers throughout this time period but not always to a statistically significant degree. In 2007, 20.6% of males and 19.1% of females were smokers. A greater decline in smoking rates over time was seen among males (from 27.4% in 2001 to 20.6% in 2007), compared to females. Looking at different age groups, the largest decrease in smoking rates was seen in the age group 18-24 where the rate dropped from 32.0% in 2001 to 17.0% in 2007. No significant decrease was seen in any of the other age groups. Throughout the time period higher smoking rates were consistently observed among those with a lower level of education, compared to those with higher educational attainment. In 2007, 27.8% were smokers among those with less than high school education, compared to only 14.6% of post secondary graduates.

Data from the Canadian Community Health Survey (CCHS) shows a smoking rate of 19.9% among residents in Middlesex-London in 2007, and then a non-significant increase to 22.8% in 2009. However, rates for Canada and Ontario decreased between 2007 and 2009. Male Ontarians were more likely to be smokers compared to females in 2009 (21.8% vs. 15.4%) (Figure 7.4.1). Smoking was highest in the age group 20-34 (24.0%) in 2009, but not statistically different from the smoking rates among those 35-44 and 45-64 (22.2% and 21.0%, respectively).

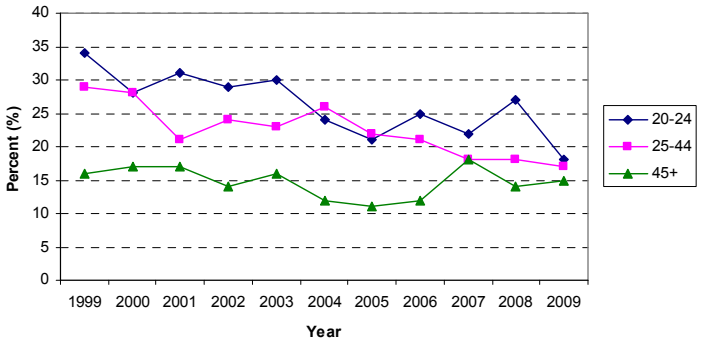
Between 1999 and 2009, rates of current smokers decreased among Ontarians aged 20-24 and 25-44, whereas the rates among those aged 45+ were fairly stable over time (Figure 7.4.2). This resulted in a closing of the gap in smoking rates between those 20-44 and 45+.

Figure 7.4.1. Smoking rates in Ontario by age and gender (2009)



Source: Canadian Community Health Survey, Statistics Canada

Figure 7.4.2. Current smoking rates among Ontario adults (age 20+) between 1999 and 2009



Source: Canadian Tobacco Use Monitoring Survey 1999-2009 (Health Canada, 2010a)

Youth Smoking

Among youth (age 12-19) in Middlesex-London the proportion of current smokers was 14.2% in 2000/01 and 15.9% in 2003, which was not a statistically significant change (Middlesex-London Health Unit, 2008). Rates for 2005 and onwards were too unreliable to report for this age group (based on CCHS data).

According to data from the Ontario Student Drug Use and Health Survey (OSDUHS) 15.9% reported past year cigarette smoking in 2009 and 7.5% reported daily smoking among youth in grades 9-12 in a combined sample of the LHIN regions of South West and Erie St Clair. Among grade 7-12 students in West Ontario (including Southwest) 12.7% reported smoking in the past year. In this sample there was a decrease in smoking rates between 1999 and 2007 (from 31.3% to 11.6%).

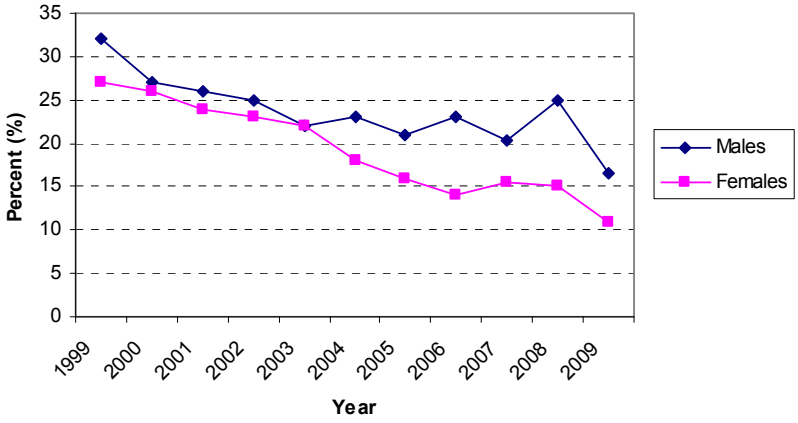
Data from the Youth Smoking Survey (YSS) from 2008-09 show that 14% of Ontario youth (grades 6-9) had ever tried smoking. Among Ontario youth in grades 10-12 there was an increase in current smoking from 10% in 2006-07 to 12% in 2008-09 (Health Canada, 2010b).

Among university undergraduates in Ontario 11.2% were current smokers, according to results from the Canadian Campus Survey in 2004 (Adlaf et al., 2005b).

Youth smoking among 15-24 year olds in Ontario decreased noticeably among both males and females between 1999 and 2009 (Figure 7.4.3). Current smoking declined from 32% to 16.6% among males and from 27% to 10.9% among females. Males were generally more likely to smoke than females throughout this period.

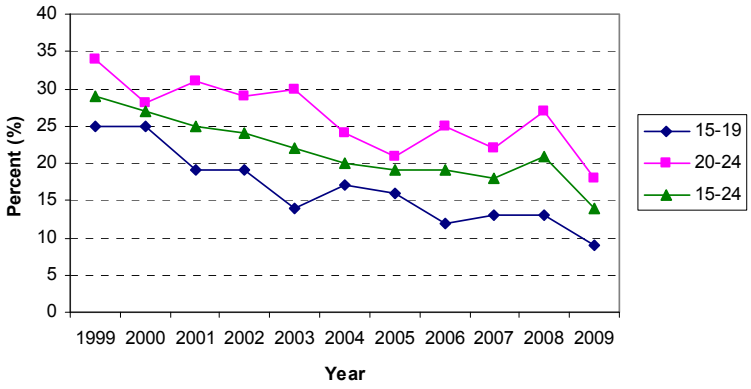
Between 1999 and 2009 smoking rates were consistently higher among those aged 20-24 compared to 15-19 year olds (Figure 7.4.4). Among 15-24 year olds, current smoking rates were cut in half from 29% to 14% over this period of time.

Figure 7.4.3. Current smoking rates among male and female youth (age 15-24) in Ontario between 1999 and 2009



Source: Canadian Tobacco Use Monitoring Survey 1999-2009 (Health Canada, 2010a)

Figure 7.4.4 Current smoking rates among Ontario youth between 1999 and 2009



Source: Canadian Tobacco Use Monitoring Survey 1999-2009 (Health Canada, 2010a)

In absence of recent local data on smoking rates we need to rely on estimates based on samples of larger parts of or the whole province. Most of this evidence points to a substantial decrease in youth smoking rates over the last decade.

Tobacco Use and Exposure In Other Sub-Populations

Data from the 2000/01 CCHS show that almost twice as many off-reserve Aboriginals in Canada were daily or occasional smokers (51.4%) compared to the non-Aboriginal population (26.5%) (Tjepkema, 2002). In South Ontario (including Central and Southwest Ontario) smoking and exposure to second-hand smoke was more common among Francophones than non-Francophones (Réseau franco-santé du Sud de l'Ontario, 2006). According to combined data from 2005 and 2007/08 smoking (daily or occasionally) was significantly less common among immigrants in South West Ontario (12.2%) compared to the Canadian-born population (21.1%).[58]

Tobacco-Free Environments

Tobacco-free environments protect people from both the physical and social exposure to tobacco products. Tobacco-free policy interventions help to prevent young people from taking up tobacco use, encourage people to quit, support people in the process of quitting and contribute to the denormalization of tobacco use. Many policy changes have occurred in the last 20 years supporting smoke-free environments (Middlesex-London Health Unit, 2008):

- All municipal buildings, health care facilities, municipal arenas, theatres, movie houses and common areas of apartments were made 100% smoke-free public places in the early 1990's.
- All restaurants in the City of London were made 100% smoke-free in 2002.
- All public places and workplaces smoke-free in 2003.
- *The Smoke-Free Ontario Act*[59] came into effect in 2006 which provided a standard level of protection from second-hand smoke in workplaces and public places across all communities in Ontario.
- Restrictions of smoking in vehicles carrying a child under the age of 16 came into effect in 2009 under the *Smoke-free Ontario Act*.

[58] LHIN specific data provided in separate spreadsheet from the Health Analytics Branch at the Health System Information Management and Investment Division.

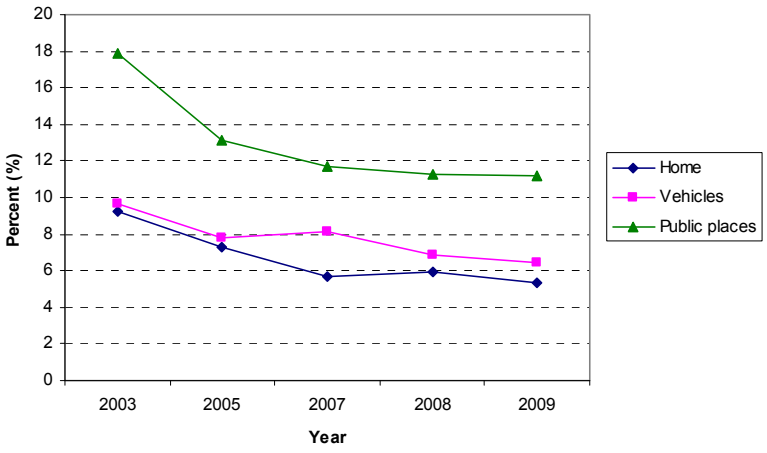
[59] The Act can be accessed online in E-Laws at http://www.mhp.gov.on.ca/en/smoke-free/legislation/default.asp

Environmental Tobacco Smoke (ETS) in Homes, Vehicles and Public Places

The percentage of people in Ontario being exposed to ETS in their homes decreased from 8.8% in 2002 to 4.6% in 2009 (Figure 7.4.5). Exposure to tobacco smoke in private vehicles in the past month fell from 9.7% in 2003 to 6.4% in 2009. Being exposed to tobacco smoke in public places during the past month dropped most notably between 2003 (17.9%) and 2005 (13.1%), and was down to 11.2% in 2009.

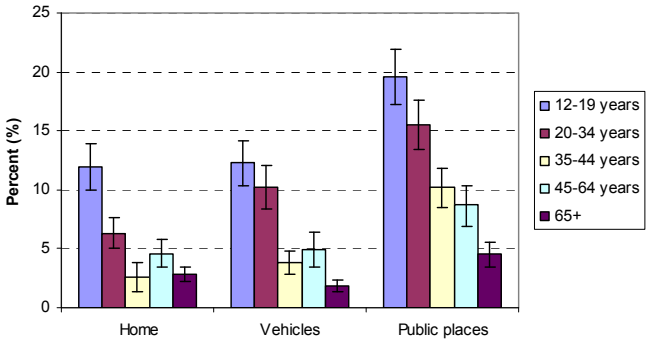
The age group most exposed to ETS in 2009 was that aged 12-19, followed by 20-34 year olds (Figure 7.4.6). ETS exposure at home was 11.6% among 12-19 year olds and 6.3% among 20-34 year olds. Exposure in vehicles had happened to 12.3% of 12-19 year olds and 10.2% of 20-34 year olds in the past month. ETS exposure in public place in the past month was reported by 19.6% of those aged 12-19 and 15.5% among those 20-34 years old.

Figure 7.4.5. Environmental Tobacco Smoke (ETS) exposure rates in Ontario (2003-2009)



Source: Canadian Community Health Survey, Statistics Canada

Figure 7.4.6 Environmental Tobacco Smoke (ETS) exposure rates in Ontario by place and age group (2009)



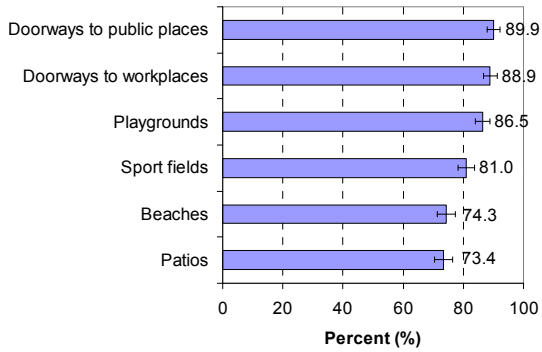
Source: Canadian Community Health Survey, Statistics Canada

Smoke-Free Homes and Vehicles
Among Middlesex-London residents the percentage of people living in smoke-free homes rose from 55.4% in 2001 to 80.1% in 2007 (Middlesex-London Health Unit, 2008). Over the same time period the percentage of individuals never allowing smoking in their vehicles went up from 69.0% to 81.2%. Smoke-free homes and vehicles were consistently more common among those with post-secondary education compared to those with lower education. In 2007, 86.0% of homes and 85.8% of vehicles among post-secondary graduates were smoke-free, compared to 72.6% and 69.8%, respectively, among those with less than high school education. From 2001 to 2007, the percentage of respondents living in smoke-free homes went from 66.2% to 87.7% among non-smokers, and from 21.3% to 48.7% among current smokers. The percentage of Middlesex-London residents who had both smoke-free homes and vehicles rose from 51.1% to 74.1% between 2001 and 2007.

In 2009, restrictions of smoking in vehicles carrying a child under the age of 16 came into effect under the *Smoke-free Ontario Act*, which may have further increased the proportion of smoke-free vehicles.

Public Support For Smoke-Free Environments
In 2009, there was strong support among households in Middlesex-London for bylaws establishing smoke-free public outdoor places (doorways to public places, doorways to workplaces, playgrounds, sport fields, beaches and patios) (Figure 7.4.7). Support was generally high among both smokers and non-smokers, but was highest among non-smokers. No difference in support was found between City of London and Middlesex County residents.

Figure 7.4.7. Support for local bylaws for smoke-free public outdoor places Adults (18+) in Middlesex-London



Source: RRFSS May – Dec 2009.

Support for a smoking-ban in multi-unit dwellings was expressed by 62% of residents in the southwest region of Ontario in 2006, compared to 66% in Ontario (unpublished data from the Centre for Addiction and Mental Health Monitor).

Among Ontario adults in 2009 there was high support for banning smoking in multi-unit dwellings (84%), on patios (80%), in parks and on beaches (59%), and on sidewalks (50%). 80% were of the opinion that parents should not be allowed to smoke at home when children are present (OTRU, 2010).

Exposure to Tobacco Use in Movies and Video Games
Tobacco imagery in movies and in video games is a powerful vehicle for promoting tobacco. Since the November, 1998 *Master Settlement Agreement*, attention has been drawn to the links between Hollywood and the Tobacco Industry, including evidence of payments for tobacco product placement in movies, and files that show the role of movies in tobacco promotion. One letter states: *"Film is better than any commercial that has been run on television or in any magazine, because the audience is totally unaware of any sponsor involvement"* (Polansky, 2010).

Extensive research on the effects of smoking and other tobacco portrayals in films demonstrates a relationship between smoking in the movies and youth tobacco initiation. Research suggests that 44% of the estimated 300,000 Canadian teens who smoke, first lit up because they saw a character smoking in a film (about 130,000 of youth age 15-19) (Polansky, 2010).

Since provincial rating agencies, which in our case is the Ontario Film Review Board seldom apply ratings (18A) to top-grossing films rated "R" in the United States, Ontario children and youth are exposed to an estimated 60% more tobacco imagery than their US counterpoints.

There is strong public support for this kind of policy intervention in Ontario,[60] with 70% of adults aged 18 years of age or older in Southwestern Ontario agreeing that movies with smoking should be rated 18A, compared to 73% in Ontario (unpublished data from the Centre for Addiction and Mental Health Monitor, 2006).

Plans For Cessation (Adults)
In 2007, 15.3% of current smokers in Middlesex-London reported that they were committed to quit smoking in the next 30 days, and an additional 52.5% responded they were considering quitting sometime in the future. These rates were fairly stable across the time period 2001 to 2007. No significant differences were found by sex, age or level of education (Middlesex-London Health Unit, 2008).

Access To Tobacco By Minors
The *Smoke-Free Ontario Act* states that it is illegal to sell or supply tobacco to a person who is under the age of 19. Thus, smokers below this age usually need to rely on alternative sources of tobacco supply. Among students in grades 7-12, who had smoked at least one whole cigarette in the past 12 months, the majority (58%) reporting getting their cigarettes from friends and family members, and the second most common source reported was retail outlets (17%), such as a corner store, grocery store, supermarket, gas station, or bar (Paglia-Boak et al., 2009).

Adults (ages 19+) in Middlesex-London were less likely to have been asked by minors to provide or purchase cigarettes for them in 2007 (6.3% and 4.8%, respectively) compared to 2001 (16.4% and 16.3%, respectively) (Middlesex-London Health Unit, 2008). Current smokers were more likely to have been asked by minors to provide and purchase cigarettes, compared to non-smokers. In 2007 the proportion of adults who had been asked by minors to provide cigarettes was 19.7% among current smokers and 3.3% among non-smokers, and the proportion of adults who had been asked by minors to purchase cigarettes was 9.3% among current smokers vs. 3.6% among non-smokers (the latter difference was not statistically significant).

Contraband Tobacco
Contraband tobacco refers to any tobacco products that are sold without payment of all applicable taxes. The negative public health impact of contraband tobacco is due largely to its low price which makes it affordable and makes some people smoke more cigarettes. Other consequences include decreased government revenue from taxation, increased criminal activity as well as increased ease and unmonitored access by youth.

In 2009, 6.4% of all Ontario students (grades 7-12) and 53.4% of past-year smokers reported smoking contraband cigarettes originating from native reserves in the past year (Paglia-Boak et al., 2009). There were no gender differences or regional differences comparing the North, West and East regions of Ontario.

[60] Comprised of the nine public health unit regions – Windsor-Essex, Chatham-Kent, Lambton, Elgin St.Thomas, Middlesex-London, Perth, Oxford, Huron and Grey-Bruce.

7.4.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies, Programs, and/or Legislation:

Municipality and School Board Related:

Canada's *Tobacco Act*

The purpose of Canada's *Tobacco Act* is to provide a legislative framework to protect the health of Canadians from tobacco use. The *Tobacco Act* intends to protect young people from the impact of tobacco industry product promotion, to limit youth access to tobacco products, and to enhance public awareness of the health hazards of tobacco use.

Tobacco product labelling in Canada is regulated by the Tobacco Products Information Regulations (TPIR) and the federal *Tobacco Act*. These regulations apply to tobacco sold in Canada and mandate the inclusion of:

- graphic health warnings,
- information on toxic emissions; and,
- health information messages.

These information labels are to cover a specific proportion of the package. In December 2010, Health Canada committed to update the graphic warnings on tobacco products and efforts across Canada are underway to ensure that a 1-800 cessation helpline number is included as part of the health warning system. The federal health warnings have not been updated since 2000.

The federal *Tobacco Act* also controls the type of tobacco products that can be sold in Canada. In October 2009, amendments to the *Act* banned fruit flavourings and candy flavoured additives from cigarettes, little cigars and blunt wraps to reduce their appeal to the child and youth population, with the exception of menthol.

Under the Tobacco Reporting Regulations of the Federal *Tobacco Act,* tobacco manufacturers are required to report on their operations to Health Canada, including sales, manufacturing, ingredients, toxic constituents and emissions, research and promotional activities. Unfortunately, there are limitations in the material reported and accessing the information for meaningful purpose is difficult. For example, waterpipe tobacco (hookah or shisha), may not always be labelled properly according to regulation and the distribution, promotion and use of this product is emerging in Ontario's larger cities, including the City of London. Ongoing surveillance is required in order to monitor emerging trends related to waterpipe use and other alternative tobacco products to mitigate the harmful effects of such practices.

Food and Drugs Act and Related Regulations

Nicotine products such as nicotine replacement therapy and electronic cigarettes (e-cigarettes) are regulated under the *Food and Drugs Act and Related Regulations*. These products are required to provide evidence of a product's safety and quality before products can be sold or distributed in Canada. In 2009, Health Canada issued an advisory to potential importers of e-cigarettes that these devices had not yet received approval from Health Canada for importation, marketing, and sale in Canada. Unfortunately, despite their efforts, e-cigarettes are being sold and purchased on the internet and at retail outlets that sell drug-related and tobacco-related products and paraphernalia. Lack of capacity for enforcement and monitoring at the Federal level and creative and substantive marketing is contributing to this growing issue.

The Smoke-Free Ontario Act

The *Smoke-Free Ontario Act* (SFOA), enacted May 31, 2006, prohibits smoking in workplaces, enclosed public spaces,

and also in motor vehicles when children under 16 are present. The law includes a ban on smoking within 9 meters of entrances to health care and residential care facilities, common areas of multi-unit dwellings, and partially enclosed restaurant and bar patios. The City of London's Smoke-Free Bylaw contains further restrictions on smoking on bar and restaurant patios with regards to windows, air intakes, and doorways to reduce the flow of second-hand smoke from the outdoor patio to the indoors.

Under the *Municipal Act,* municipalities in Ontario have the authority to pass bylaws that extend protection from second-hand smoke beyond the areas covered by the *Smoke-Free Ontario Act.* For example, the City of Woodstock's Smoke-Free Outdoor Spaces Bylaw, effective September 1, 2008 restricts or bans smoking in seven different outdoor environments, including downtown sidewalk cafes, city-owned parks and recreational fields, municipal building entrances and entrances to private buildings that elect to be listed, areas around transit stops, and at outdoor special events such as music festivals.

In addition, municipalities have implemented policies which require all buildings and properties, including social housing or municipally-owned and operated residential facilities, to be 100% smoke-free. For example, under a new policy enabled in 2010 by the Region of Waterloo, all new leases signed by Waterloo Region Housing (not for profit housing) require all buildings and properties to be 100% smoke-free (inside) and ban outdoor smoking within 5 meters of windows, entrances, and exits to the unit.

The *SFOA* also includes many provisions to protect youth from tobacco use initiation, prohibiting the sale or supply of tobacco products to anyone under the age of 19 years and requires retailers to request identification from anyone purchasing tobacco products who appear to look younger than 25 years of age. It also bans the public display of tobacco products prior to purchase and prohibits youth-targeted tobacco products such as flavoured cigarillos.

The Film Classification Act

Tobacco imagery in films is pervasive and extensive research on the effect of smoking and other tobacco imagery in movies and the relationship with youth tobacco use initiation suggests that 44 percent of the estimated 300,000 Canadian teens who smoke, first lit up because they saw a character smoking in a film. Since the November, 1998 Master Settlement Agreement in the United States, attention has been drawn to the links between Hollywood and the Tobacco Industry, including evidence of payments for tobacco product placement in movies, and files that show the role of movies in tobacco promotion.

With few exceptions, all films to be distributed or screened in Ontario are classified by the Ontario Film Review Board, by mandate of the *Film Classification Act, 2005.* Changes to the classification system, in particular, rating all movies that depict tobacco use or imagery as 18A would minimize potential harm and enable better-informed viewing choices.

Tobacco Damages and Health Care Costs Recovery Act

Due to the passing of the *Tobacco Damages and Health Care Costs Recovery Act,* the Ontario Government initiated a law suit against tobacco manufacturers in September 2009 to reclaim health-related costs incurred due to smoking since 1955: *Her Majesty v. Rothmans, Benson and Hedges Inc., et al (2009).* The *Act* created a method for quantifying the costs associated with tobacco use and the allocation of liability based on market share. Fourteen companies from Canada, the United States and the United Kingdom are cited.

The Government of Ontario needs to be prepared to leverage the potential opportunity to include public health and tobacco control clauses into any settlement of the current litigation process which could positively impact local and municipal tobacco control efforts moving forward, including the

possible provision of sustained tobacco control funding.

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, Middlesex-London municipal and school board policies to *Tobacco Use and Exposure Prevention* are largely affected by national and provincial legislation (see above). Middlesex-London could move toward examples from nearby regions who have implemented municipal- and school board-specific policies for this priority area.

The following scans of policies depict existing and developing policies that were examined by the Ontario Heart Health Network (OHHN) policy scan (see Methodology for more information).

Policies that were scanned for and that do not exist in Middlesex-London considered for implementation by municipalities and school boards in the future.

Municipal Policies:

Prevention of Tobacco Use and Exposure – Key Findings

- The City of London's Smoke-Free Bylaw contains restrictions on smoking on bar and restaurant patios with regards to windows, air intakes, and doorways to reduce the flow of second-hand smoke from the outdoor patio to the indoors.

None of the Middlesex-London municipalities reported policies beyond current national and provincial policies, and legislation related to prevention of Tobacco Use and Exposure highlighted in the Ontario Heart Health Network (OHHN) policy scan. Policies scanned for and that provide future policy direction include:

- Policies that prohibit tobacco use in municipality-owned outdoor spaces
- Policies that ban tobacco use at public entrances and exits to municipal buildings
- Tobacco-free sport and recreation policies at local sports clubs
- Policies that prohibit tobacco use on outdoor retail property
- Policies for multi-use dwelling property owners, managers and tenants for the availability of smoke-free buildings

School Board Policies:

Prevention of Tobacco Use and Exposure – Key Findings (Table 7.4.8)

- Thames Valley District School Board has a policy related to promotion of tobacco-free sport and recreation activities when off the school site in *Healthy Schools, Code of Conduct*, whereas London District Catholic School Board did not indicate a similar policy.

Table 7.4.8- Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Prevention of Tobacco Use and Exposure: School Boards

Prevention of Tobacco Use and Exposure		
Policy	Thames Valley District School Board	London District Catholic School Board
Policies that promote tobacco-free sport and recreation activities when off the school site	**Healthy Schools, Code of Conduct**	No policy

7.4.3 Assets and Opportunities

On January 12, 2011, from 1:30 to 3:30pm, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority areas of Tobacco Use and Exposure (combined with the Mental Health Focused Group Discussion session). The purpose of the session was

to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: Centre for Addiction & Mental Health, London Intercommunity Health Centre, Middlesex-London Health Unit, Southwest Community Care Access Centre, Southwestern Ontario Stroke Network.

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies

- *Family health teams* have mandatory smoking screening to ask individuals "Do you smoke?"
- At *London InterCommunity Health Centre* Physicians and Nurse Practitioners have *Training Enhancement in Applied Cessation Counselling and Health (TEACH training)* [from *Centre for Addiction and Mental Health (CAMH)*].

Programs/Activities/Initiatives

- The *Smoking Treatment for Ontario Patients (STOP) study* is ongoing, but needs to be provincial and free.

Policy

- The entire *tobacco strategy* was noted by focus discussion group members as successful. Cessation programs have resulted in reduced prevalence of smokers and a decrease in exposure to second-hand smoke. The *Smoke Free Ontario (SFO)* tobacco strategy includes *smoke free vehicles*, *advocacy for non-smoking multi-unit dwellings (MUDs)*, *Training Enhancement in Applied Cessation Counselling and Health (TEACH)*, and the *Canadian Cancer Society (CCS) Smoke Free Line (Smokers' Helpline).*

Opportuntities

Policy

- There are no policies to fund smoking cessation products upon release from jail/hospital/mental health care. There is a network in place beginning to advocate for policy for smoking cessation products for these populations.
- There is a network attempting to move forward a policy to ban smoking in multi-unit dwellings.

Summary of Identified Assets and Opportunities

Organizations and agencies within Middlesex-London provide assets for prevention of tobacco use and exposure. *Family Health teams* follow mandatory screening to ask individuals, "Do you smoke" and provide resources accordingly. At *London InterCommunity Health Centre* Physicians and Nurse Practitioners have *Training Enhancement in Applied Cessation Counselling and Health (TEACH training)* [from *Centre for Addiction and Mental Health (CAMH)*].

Programs and activities which are assets include the *Smoking Treatment for Ontario Patients (STOP) study*; however, could be improved by being a provincial program and free.

In terms of **policy**, the entire *tobacco strategy* was noted by focus discussion group members as successful and assets. Cessation programs have resulted in reduced prevalence of smokers and a decrease in exposure to second-hand smoke. The *Smoke Free Ontario (SFO)* tobacco strategy includes *smoke free vehicles*, *advocacy for non-smoking multi-unit dwellings (MUDs)*, *Training Enhancement in Applied Cessation Counselling and Health (TEACH)*, and the *Canadian Cancer Society (CCS) Smoke Free Line (Smokers' Helpline).* There are opportunities to expand on policy related to tobacco use and exposure. For example, there are no policies to fund smoking cessation products upon release

from jail/hospital/mental health care. There is a network in place beginning to advocate for policy for smoking cessation products for these populations. There is also a network attempting to move forward a policy to ban smoking in multi-unit dwellings.

7.4.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Tobacco Use and Exposure within Middlesex-London were identified. There may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Sustained Support of Existing Initiatives

- Need to support the investment of *Training Enhancement in Applied Cessation Counselling and Health (TEACH) training*.
- Tobacco prevention funding and support from the government has changed (decreased).
- Current work to be done in tobacco is more difficult. With decreased funding it is difficult to build momentum.

Tobacco Industry Influence

- The tobacco industry plays a key role in convincing individuals to use their products.
- Currently, there is more tobacco grown in Ontario in than in the past. Much of the tobacco is exported and then re-imported to Canada from Mexico.

Smoking Cessation Support & Practice Issues

- Some family physicians still do not screen for smoking.
- The definition of ownership/responsibility for smoking can lead to "victim-blaming".

Summary of Identified Gaps and Needs

In order to prevent tobacco use and exposure, there are various gaps and needs related to sustained **support of existing initiatives** that have been working within Middlesex-London. One example is the need to support the investment of *Training Enhancement in Applied Cessation Counselling and Health (TEACH) training*. It was identified that great strides have been made to decrease tobacco use and exposure, but tobacco prevention funding and support from the government has changed, and decreased. Current tobacco prevention work to be done is more difficult and with decreased funding it is difficult to build momentum.

There is also a strong influence opposing tobacco prevention, from the **tobacco industry** that plays a key role in convincing individuals to use their products. Currently, there is more tobacco grown in Ontario than in the past. Much of the tobacco is exported and then re-imported to Canada from Mexico.

Finally, there are **smoking cessation support and practice issues** in that some family physicians still do not screen for smoking and the definition of ownership/responsibility for smoking can lead to "victim-blaming".

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Tobacco Use and Exposure were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.4.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community

stakeholders the following recommended actions emerged:

Expand smoking restrictions (private and public) in outdoor spaces/outside doorways and parks

- Provincial initiative in development
  - Leadership by example at the local level
  - Modelling for children
- Ban smoking in multi-unit complexes
  - Could be folded into the outdoor/public spaces restrictions
- Expand smoking restrictions (private and public) in outdoor spaces/outside doorways and parks. City of London could expand smoking restrictions to doorway smoking, parks – municipal bylaw can't impede highway traffic areas (e.g. sidewalks). Private and public bylaws – private industry could apply for the e.g. 9 metre rule.

Smoking Cessation Support

- Advocate for smoking cessation product funding, as a two-pronged priority:
  1. As a health right
  2. Include the addition of education component "Smoking is bad and when you need help you can come here". Provide the resources and equipment when encouraging people to quit.
- Advocate for all addiction agencies and mental illness agencies to have trained staff to support their smoking clients.
- Survey addiction agencies in Ontario to determine who is providing cessation treatment (1st Step)
- Advocate the provincial government for funding for smoking cessation for low income Ontarians

Contraband Tobacco Industry

- Contraband tobacco industry awareness campaign for the public
- Advocate for municipal annual licensing fee for retailer who wants to sell tobacco products. However, there is no evaluation available and this could increase contraband use.

7.4.5 a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Tobacco Use/Exposure".

I. Expand smoking restrictions (private and public) in outdoor spaces/outside doorways and parks.

- Leadership by example at the local level and modelling for children.
- Provincial initiative starting.
- Ban smoking in multi-unit complexes.

II. Advocate for all addiction treatment agencies and mental health agencies helping clients to quit smoking.

- Endorse advocacy for provision of funding for smoking cessation products.

7.5 Substance and Alcohol Misuse

7.5 Data

Alcohol is the most commonly used legal substance in Ontario with 81.5% of the population being past year drinkers[61] and 5.9% being daily drinkers in 2007 (Ialomiteanu et al., 2009). Alcohol use/misuse can cause a substantial financial burden on society and considerable individual human suffering through acute injury and chronic disease, as well as hardships in employment, family life, relationships, education, housing and social unity (Middlesex-London Health Unit, 2010c). The combined overall social cost[62]of illegal drug and alcohol use in Canada in 2002 was estimated to be $22.8 billion ($14.6 billion for alcohol and $8.2 billion for illegal drugs) or $725 per capita ($463 for alcohol and $262 for illegal drugs) (Rehm et al., 2006a).

Alcohol use has been linked to a number of chronic diseases, including cardiovascular diseases, cancers, cirrhosis and mental disorders, and the net effect is that of substantial loss of life and increased disability among Canadians (Giesbrecht et al., 2005). About 6% of deaths among those below the age of 70 in Canada in 2001 were due to alcohol (Rehm, et al., 2006a). As a percentage of all deaths in 2002 it was estimated that alcohol caused 3.6% and illegal drugs caused 0.8% (Rehm et al., 2006b).

Research has found that the general drinking population is a large contributor to alcohol-related social problems, interpersonal problems and acute health problems (Babor et al., 2010). Thus, because of the vast popularity of alcohol use it is important to focus not only on the smaller population with drinking problems, but also on the general drinking population.

A report by London CAReS (London Community Addiction Resource Strategy) in 2007 shows some statistics from health and social service agencies in London pointing to high rates of substance abuse among their clients:

- 10 to 12% (820 and 984 persons) of the Ontario Works caseload is estimated to be clients with substance abuse problems
- 40 to 60% (350 to 525 people) of shelter residents have substance use or abuse issues.
- About 40% of visits to the London Intercommunity Health Centre are substance related
- My Sister's Place provides services to 50 to 70 women a day with addictions and/or mental health problems
- 730 clients were served by the London Counter Point Needle Exchange Program between January and June 2006, with over 230,000 needles being distributed
- Between 1500 and 1700 clients are served by Addiction Services of Thames Valley each year.
- 900 clients visit 'Clinic 528' (operating a methadone maintenance program) per month

Substance and alcohol addiction contribute to the deteriorating health of the homeless and increase rates of crime and prostitution (London CAReS, 2007).

Daily Alcohol Use

Drinking alcohol daily is an indicator of a regular pattern of drinking, but is not synonymous with a problematic drinking pattern (Ialomiteanu et al., 2009). Between the years 2001 and 2008, daily alcohol use remained fairly stable and the estimated proportion of the Middlesex-London drinkers who were using alcohol every day was 8.1% in 2008 (Middlesex-

[61] Those who reported drinking at least once during the 12 moths before the survey

[62] Including health care, law enforcement, loss of productivity in the workplace or home due to premature death and disability

London Health Unit, 2010c). Males were more than twice as likely as females to report drinking alcohol daily (10.7% vs. 4.6%). Daily drinking also increased significantly by age group, with 15.8% drinking daily among those 65+, compared to 4.8% among 30-39 year olds. No statistically significant differences were seen for education, marital status, language spoken at home or area of residence (City vs. County).

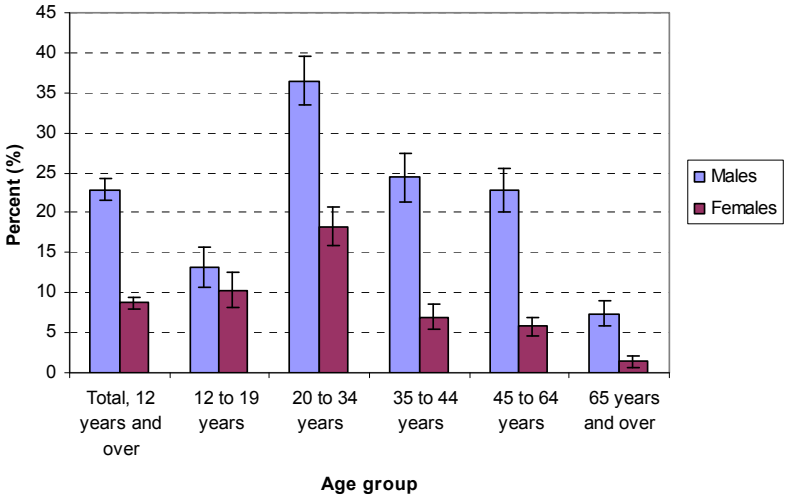
Additional data from the Centre for Addiction and Mental Health (CAMH) Monitor in 2007 show that daily drinking was reported by 7.3% of those who had been drinking alcohol in the past year in Ontario and by 7.7% of drinkers in the South West LHIN (Ialomiteanu et al., 2009). Between 1977 and 2007, there was a considerable decrease in the prevalence of daily drinking among Ontario drinkers, from 13.4% in 1977, down to as low as 4.1% in 1992. The decrease in daily drinking was most pronounced among males, from 19.5% in 1977 to 9.2% in 2007.

Heavy/Binge Drinking

In 2009 the proportion of Middlesex-London residents (ages 12+) who reported having had five or more drinks on one occasion (binge drinking) at least once a month in the past year was 15.0%, compared to 15.6% among Ontario residents. The proportion of binge drinkers was twice as high among males compared to females (20.2% vs. 10.1%). The provincial estimates show an even bigger difference between males and females (22.9% vs. 8.7%) (Figure 7.5.1). Younger adults (ages 20-34) were most likely to report this drinking behaviour (27.6% in Middlesex-London and 27.3% in Ontario). Males were more likely to binge drink than females in all age groups, but the difference was not statistically significant in the age group 12-19 years.

Weekly binge drinking is an indicator of regular heavy intake of alcohol, and was reported by 13.1% of drinkers in the South West LHIN region in 2007 (Ialomiteanu et al., 2009). In Ontario the prevalence was 11.2%. Males were more likely to binge drink weekly compared to females (17.5% vs. 5.3%), and 18-29 year olds were most likely to binge drink weekly (26.1%) compared to older age groups. Those with a university degree were significantly less likely to binge drink on a weekly basis (4.3%) compared to those with lower educational attainment. Weekly binge drinking was most prevalent among people who had never been married (22.5%

Figure 7.5.1. Proportion of adults in Ontario reporting binge drinking (2009)



Source: Canadian Community Health Survey, Statistics Canada)

Among residents in Ontario (age 15+) in 2004, 7.3% were categorized as heavy-frequent drinkers (weekly binge drinkers), 5.0% as heavy-infrequent drinkers (binge drinking less than weekly), 28.3% as light-frequent drinkers (weekly drinking of less than five drinks per occasion), and 37.8% as light-infrequent drinkers (drinking less than weekly and less than five drinks per occasion) in the past year (Adlaf et al., 2005a). Furthermore, 4.6% were daily heavy drinkers and 17.5% of past year drinkers scored 8 or higher on the AUDIT (Alcohol Use Disorders Identification Test) [63], which is a standardized scale of hazardous or harmful alcohol use.

Low-Risk Drinking Guidelines

The Ontario low-risk drinking guidelines (LRDG)[64] recommend no more than two standard drinks on any one day and no more than nine standard drinks per week for women and 14 standard drinks per week for men. These guidelines were developed in 1997 by a team of medical and social researchers from the University of Toronto and the Centre for Addiction and Mental Health.

The average proportion of adults exceeding the LRDG in Middlesex-London during the years 2001, 2002, 2006 and 2008 was 26.7% (Middlesex-London Health Unit, 2010c). Between 2001 and 2008 the rate of adults exceeding the LRDG decreased from 28.3% in 2001 to 24.1% in 2008. Males were more likely to exceed the LRDG than females (33.1% vs. 21.6%). Contrary to daily alcohol use rates, the rates of people exceeding the LRDG decreased with increasing age, ranging from as high as 61.6% among 19-24 year olds to 8.4% among those 65+. The highest proportion of people exceeding the LRDG was found among those with an intermediate level of education, i.e. high school or some post-secondary education (32.5%) compared to those with less than high school (22.4%) and those with a post-secondary degree (23.9%). As with daily drinking English-speaking people were more likely to exceed the LRDG (27.6%), compared to those who mainly spoke another language at home (16.2%). No difference was found comparing rates among those living in the City of London to those residing in the County.

[63] Of a maximum score of 40, score between 8-15 are generally considered to represent a medium level of alcohol problems whereas scores of 16 and above represented a high level of alcohol problems

[64] Available at: http://www.lrdg.net/guidelines.html

Additional data from the CAMH Monitor in 2007 show that 25.8% of adults exceeded the LRDG in the South West LHIN region, and 23.4% exceeded the LRDG in Ontario (Ialomiteanu et al., 2009).

Alcohol Use Among Youth
The legal drinking age in Ontario is 19 years of age (Canadian Centre on Substance Abuse (CCSA) & CAMH, 1999). According to the Ontario Student Drug Use and Health Survey (OSDUHS), alcohol use among students in grades 7-12 in the past year in the West region of Ontario decreased from 69.7% in 1999 to 59.6% in 2009 (Paglia-Boak et al., 2009). In this region the proportion reporting binge drinking in the past month was 26.9%, being drunk at least once in the past month was 24.4%, and hazardous drinking[65] was 21.6%. These rates were higher than in Toronto, but similar to the rates in the North and East regions. No significant gender effects were found, but proportions of all these indicators of alcohol use increased by grade.

In 2009 in Erie St. Clair and South West Ontario 82.3% of the students in grades 9-12 had used alcohol during the past year and 46.5% had been binge drinking compared to a significantly lower rate in the provincial sample (69.4% and 32.9%).

Alcohol Use Among Undergraduate Students
Among undergraduate students in Ontario in 2004, 18.8% were heavy-frequent drinkers in the past year, 33.4% scored 8 or higher on the AUDIT, which was classified as harmful/hazardous drinking (Adlaf et al., 2005b). In the Canadian sample, males were more likely to be heavy-frequent drinkers compared to females (20.6% vs. 12.5%), and those living on campus were more likely to be heavy-frequent drinkers than those living off campus on their own, or with their family (24.1%, 16.8% and 12.0%, respectively).

Alcohol Use Among Older Adults
The National Survey on Drug Use and Health in 2009 found that 39.1% of Canadian adults aged 65+ drink alcohol (Substance Abuse and Mental Health Services Administration (SAMHSA), 2010). Although frequency of drinking may not decrease in this age group, older people tend to drink smaller quantities per occasion, and are less likely to exceed the low risk drinking guidelines compared to younger age groups (Adlaf, Begin & Sawka, 2005). Of special concern in this age group is use of medications in combination with alcohol use. It has been shown that aging Canadians have an increased usage of daily medication (Ramage-Morin, 2009).

Alcohol And Drug Use In Other Demographic Sub-Groups
Significantly higher rates of drug and alcohol misuse are seen in the Aboriginal population, compared to the non-Aboriginal population (Mood Disorders Society of Canada, 2006). Consumption of alcohol is also more common among Francophones than non-Francophones in Southern Ontario (Réseau franco-santé du Sud de l'Ontario, 2006).

Immigrants, on the other hand, are less likely to binge drink monthly, than those who were Canadian-born in South West Ontario (9.5% vs. 20.4%), according to combined CCHS data from the years 2005 and 2007/08 (MOHLTC, 2010).

Fetal Alcohol Spectrum Disorder (FASD)
The Public Health Agency of Canada (PHAC) defines Fetal Alcohol Spectrum Disorder (FASD) as "an umbrella term used to describe the range of disabilities that result from prenatal alcohol exposure. [FASD] is the leading known cause of developmental disability in Canada. The medical diagnoses of FASD include: Fetal Alcohol Syndrome (FAS); Partial FASD (pFAS); and Alcohol Related Neurodevelopmental Disorder (ARND)".

Federal statistics are the primary source used for FASD. Local statistics are scarce. At present, there is limited local diagnostic capacity for FASD. To address

[65] Heavy drinking and alcohol-related problems

lack of local diagnostic capacity, FASD Elgin Middlesex London Oxford (E.L.M.O.) Network and the Child and Parent Resource Institute (CPRI) are in the process of collaborating to develop a Virtual Clinic Pilot Project.

There is a considerable economic impact of FASD. The cost of FASD annually to Canada of those affected from day of birth to 53 years old, is estimated to be $5.3 billion (Stade et al., 2009). Economic impact of FASD coupled with incidence and prevalence of 1% (10 of 1000) of live births is profound.

Data from a Grey Bruce, Ontario 2004-2005 study found 2.5% of babies with significant amounts of fatty acid ethyl esters (FAEE) in meconium, considered to be a stable indicator of in utero alcohol exposure (Gareri et al., 2008). In a 2006-2007 study, among specimens of meconium collected from babies born to women from this same region with high-risk pregnancies, 30% tested positive for FAEEs (Goh et al, 2010).

The Public Health Agency of Canada's (PHAC) Canadian Perinatal Health Report (2008a) reveals the rate of alcohol consumption during pregnancy has fluctuated to 10.5% in 2005, from 12.4% in 2003 and 12.2% in 2000–2001. Certain sub-populations may have higher rates of alcohol consumption during pregnancy, including Canadian Aboriginal women. Data from 2002 to 2006 found 41% of women who participated in the Canadian Prenatal Nutrition Program (CPNP) had used alcohol during pregnancy, over half of whom had consumed more than five drinks in one day (PHAC, 2010a).

FASD affects an estimated 1% of the Canadian population, or 10 per 1000. There are some communities in Canada where studies indicate prevalence rates as high as 190 per 1000 live births (Journal of Obstetrics and Gynaecology Canada, 2010).

Local Rapid Risk Factor Surveillance System (RRFSS) data highlights that FASD questions asked are consistent with provincial data regarding high level of knowledge about the harmful effects of alcohol during pregnancy (85% of those asked between 18-44) but only 77% understood severity or lasting consequence of alcohol use during pregnancy (Sontrop, RRFSS data, 2007).

Illicit Drug Use Among Adults

In 2007 cannabis use in the past 12 months was reported by 14.0% of residents in the South West LHIN region and by 12.5% of Ontarians (Ialomiteanu et al., 2009). Men were more likely than females to have used cannabis in the past year (15.2% vs. 10.1%). Cannabis use was highest among 18-29 year olds (33.6%), followed by 30-39 year-olds (12.5%), and lowest among those aged 50 and older (4.6%). Married people were less likely to use cannabis compared to those who had never been married (7.8% vs. 31.8%). In the South West there was a significant increase in use from 7.6% in 1996 to 14.0% in 2007. Among cannabis users in Ontario 17.4% met the criteria for Hazardous or Harmful Cannabis Use[66].

Use of cocaine in the past year was reported by 2.3% of residents (age 18+) in the South West LHIN region and 1.3%[67] of Ontarians in 2006 (Ialomiteanu et al., 2009). In 2004, 1.2%[68] of Ontarians (age 15+) had used ecstacy in the past year (Adlaf et al., 2005a). Provincial estimates for speed and hallucinogens were not available in 2004, but in Canada overall 0.8% had used speed in the past year and 0.7% had used hallucinogens (Adlaf et al., 2005a).

Misuse of prescription drugs containing narcotics is a serious concern that is being addressed by Ontario's Narcotics Strategy. Residents of Ontario are among the highest users of narcotics in the world, and the number of prescriptions for oxycodone drugs rose by 900 % in Ontario between 1991 and 2009.[69]

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[66] Defined as scoring eight or higher on the Cannabis Use Disorders Identification Test, CUDIT (Adamson & Sellman, 2003)

[67] Estimates are unstable due to high sampling variability and need to be used with caution

[68] Ibid.

[69] Information retrieved from: http://www.health.gov.on.ca/en/public/programs/drugs/ons/

Illicit Drug Use Among Youth

Cannabis was by far the most commonly used illicit drug among students in grades 7-12, with 27.2% having tried cannabis in the past year in Western Ontario in 2009, according to OSDUHS data (Table 7.5.1). More Ontario males had tried cannabis than females (28.8% vs. 22.2%). Furthermore, the rate increased drastically by grade, from 1.1% in Grade 7 to 45.6% in Grade 12. Rates of past year cannabis use have varied over time between 1977 and 2009, but seem to have been decreasing between 2003 and 2009. Among all Ontario students, 14.5% reported using cannabis six times or more during the past year. Daily use was reported by 3.8% of all male students compared to 2.1% of females. About 10.6% of cannabis users had a dependence problem.

After cannabis, the second most commonly used type of drug was hallucinogens other than LSD and PCP (e.g. magic mushrooms) reported by 5.4% of West Ontario students. Ontario males were more likely to use these types of drugs compared to females (28.8% vs. 22.2%). The third most commonly used illicit drug was salvia divinorum[70], reported by 4.7% of West Ontario youth. Also for this drug, males were more likely to report use compared to females (6.2% vs. 2.3%). Ecstasy was the fourth most common drug, used by 3.4% of the West Ontario study participants. Use of ecstasy has decreased significantly between 2001 and 2009. For most of the illicit drugs, reported use increased by increasing grade. Use of any illicit drugs (including cannabis and non-medical use of prescription drugs) in the past year was reported by 42.3% of the students in West Ontario in 2009. About 16% were estimated to have a potential drug use problem.

Illicit Drug Use Among Undergraduate Students

Among undergraduate students in Ontario in 2004, 33.0% had used cannabis in the past year, 17.5% had used cannabis in the past 30 days, 8.2% had used any other illicit drugs in the past year, and 1.8% had used other illicit drugs in the last 30 days (Adlaf et al., 2005b). In the Canadian sample, male students were more likely to have used cannabis than female students in the past year (34.5% vs. 30.1%), and those living on campus were more likely to have used cannabis in the past year compared to those living off campus with family (35.5% vs. 26.9%). Hallucinogens had been used by 5.6% in the past year, and opiates had been used by 5.0% of the students in the past year.

Misuse Of Prescription Drugs and Over-The-Counter Drugs Among Youth

Non-medical use of prescription drugs is a growing concern in Canada and includes use of opioids (e.g. OxyContin), drugs for Attention Deficit Hyperactivity Disorder (e.g. Ritalin), other stimulants, and tranquillizers/sedatives (e.g. Valium) without a prescription or doctor's supervision. Findings from the 2009 OSDUHS survey show that 26.6% of students in grades 9-12 in the Erie St. Clair and South West LHIN region of Ontario had used prescription drugs for non-medical purposes in the past year, compared to 23.3% of the provincial sample (Table 7.5.1). In the West region of Ontario (including students in grades 7-12) 20.1% used a non-medical prescription drug, compared to 20.3% in Ontario. Provincially, females were more likely to report non-medical use of prescription drugs in the past year than males (22.8% vs. 18.1%). The most commonly used prescription drugs among students (grades 7-12) in Ontario were opioid pain relievers (17.8%), over-the-counter cough/cold medicine with dextromethorphan (7.2%), stimulants (4.8%) and sleeping medication (2.6%).

[70] This is a legal plant that causes hallucinations and delusions. Also known by the street names Salvia, Divine Sage and Magic Mint.

Table 7.5.1. Illicit drug use and non-medical use of prescription drugs and over-the-counter drugs in the past year among students in grades 7-12 (2009)

Drug	Ontario region†			
	Grades 7-12		Grades 9-12	
	West %	Ontario %	Erie St. Clair + South West %	Ontario %
Cannabis	27.2	25.6	38.8	34.2
Inhalants			NA	4.5
Glue	2.1	2.1		
Other Solvents	5.7	5.3		
Hallucinogens				
LSD	2.3	1.8		
PCP	0.8	0.8		
LSD or PCP			2.9	2.9
Others	5.4	5.0	9.3*	6.8
Jimson Weed	2.9	2.3	5.4	3.1
Salvia Divinorum	4.7	4.4	7.5	5.9
Methamphetamine (Speed)	1.2	1.4		
Crystal Meth (Ice)	NA	0.5		
Methamphetamine or Crystal Meth.		1.9	NA	2.0
Cocaine	2.7	2.6		
Crack Cocaine	1.0	1.1		
Cocaine or crack	3.7	3.7	4.2	3.5
Heroin	0.7	0.7	4.9	4.3
Ecstasy	3.4	3.2		
GHB	NA	0.5		
Rohypnol	0.9	0.7		
Ketamine	1.8	1.6		
Any non-medical prescription drug	20.1	20.3	26.6	23.2
Any illegal drug use incl. non-medical prescr. drug	42.3	41.7	54.2	48.4
Any substance use	71.0	69.2		
Potential drug use problem	15.7	15.5		

Source: Ontario Student Drug Use and Health Survey, CAMH (Paglia-Boak et al., 2009)

NA= Not available due to unreliable estimate

** Estimate significantly different from Ontario estimate*

†*The highest resolution of data available from this survey is the combined LHIN regions of South West and Erie St. Clair (n=308 across 6 schools in 2009). The second highest resolution available is West Ontario (including Hamilton) with a total survey sample of 2,368 students in 2009.*

7.5.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies, Programs, and/or Legislation:

Municipality Related:

Consequences for convicted drug impaired drivers are the same as for alcohol impaired drivers: Canada's *Bill C-2: An Act to amend the Criminal Code (impaired driving)* (September 25, 2007) expands drug enforcement capabilities by

giving police the authority to demand physical sobriety tests and bodily fluid samples for inspection (http://www2.parl.gc.ca/Sites/LOP/LegislativeSummaries/Bills_ls.asp?lang=E&ls=c32&source=library_prb&Parl=39&Ses=1).

Ontario's *Vehicle Impoundment Program* includes a minimum 45 day vehicle impoundment for drivers who are caught driving while their licence is suspended for a Criminal Code driving conviction. As of December 1, 2010, "drivers with a blood alcohol concentration of 0.08, or who fail to comply with breath testing, face an immediate seven-day vehicle impoundment at roadside. Also effective December 1, 2010, a seven-day vehicle impoundment applies to drivers who get behind the wheel of a vehicle without an ignition interlock device in violation of such a condition on their licence" (http://www.mto.gov.on.ca/english/safety/impaired/index.shtml). The owner of the vehicle is not able to appeal seven-day convictions and is liable for all towing and impoundment costs.

In Ontario, *Zero Blood Alcohol Concentration (BAC)* for Young Drivers and *Escalating Sanctions for Novice Drivers* were instated August 1, 2010.

The province also decided on early re-instatement for convicted drivers who qualify and install ignition interlock. As of August 3, 2010 the *reduced suspension with ignition interlock conduct review program* allows eligible drivers convicted for a first time alcohol-impaired driving offence, under the Criminal Code, to receive the title of "low-risk" to reduce their license suspension in return for meeting specific requirements such as mandatory installation of an approved ignition interlock device in their vehicle.

As of May 1, 2009, Ontarians who register a "Warn" on the *"Warn Range"* (0.05 – 0.08) on an approved screening device for blood alcohol concentration (BAC), will face escalating administrative sanctions (http://www.mto.gov.on.ca/english/safety/impaired/fact-sheet.shtml#adls).

School Board Related:
Beginning September 1991, the Ontario Ministry of Education required all school boards to have alcohol and drug policies in place (http://www.camh.net/education/Resources_teachers_schools/Drug_Curriculum/Primary/curriculum_drugalcoholpolicies.html).

As of 2000, the *Safe Schools Act, 2000* received Royal Assent, and imparts legal authority to the Ministry of Education to establish rules for student discipline (http://www.ohrc.on.ca/en/resources/discussion_consultation/SafeSchoolsConsultRepENG). The *Ontario Code of Conduct* provides provincial standards of student behaviour and outlines mandatory consequences for student actions that do not adhere to the set standards, including use of drugs or alcohol http://www.ontla.on.ca/bills/bills-files/37_Parliament/Session1/b081ra.pdf

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, policies created by Middlesex-London municipalities and school boards related to prevention of alcohol abuse becoming well-developed in relation to alcohol prevention. Policies regarding *Substance Misuse* prevention are less prominent both at a provincial and municipal level.

The following scans of Alcohol Misuse prevention policies depict existing and developing policies that were examined by the Ontario Heart Health Network (OHHN) policy scan (see Methodology for more information). The priority area of Substance Abuse was not scanned for within the Ontario Heart Health Network (OHHN) Policy Scan. Thus, for the priority area of Substance Misuse policy scan questions were created with advice from community partners that possess expertise for the specific priority area (see Methodology for more information).

Policies that were scanned for and that do not exist in Middlesex-London could be considered for development and

implementation by municipalities and school boards in the future.

Alcohol Misuse: Municipal Policies

Prevention of Alcohol Misuse – Key Findings (Table 7.5.2)

- Eight of nine municipalities have special occasion permits that allow alcohol to be sold.
- In comparison, four of nine municipalities have policies that allow for special occasion permits at civic events not on municipal property, or at other events such as Oktoberfest, Film Festivals, etc., and Lucan-Biddulph is developing a policy.
- Five of nine municipalities have a Municipal Alcohol Policy, and Lucan-Biddulph is developing a policy.
- Five of nine municipalities have policies to reduce or prevent service to minors or to intoxicated patrons, and Lucan-Biddulph is developing a policy.

Table 7.5.2. - Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Prevention of Alcohol Misuse: Municipalities

Prevention of Alcohol Misuse									
Policy	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
Municipal Alcohol Policy	✓		✓	✓	✓	In Devlt*		✓	
Policy that allows for special occasion permits (e.g. Oktoberfest events, Film Festival, Civic events not on municipal property)	✓		✓	✓	✓	In Devlt*			
Policies related to "Dial-a-Bottle" services									
Policies that limits the number of licensed premises (outlet density) within a geographic area									
Policies that support safer bars training (the Centre for Addition and Mental Health – CAMH, program)									
Policies to reduce/prevent service to minors or to intoxicated patrons	✓		✓	✓	✓	In Devlt*		✓	
Are there special occasion permits that allow alcohol to be sold?	✓	✓	✓	✓	✓	✓	✓	✓	
Public documents that provide information regarding licensing premises who have been fined or penalized for over-service									

* In Devlt = In Development

Alcohol Misuse: School Board Policies

Prevention of Alcohol Misuse – Key Findings (Table 7.5.3)

- Both Middlesex-London school boards have policies regarding alcohol prevention programs.

Table 7.5.3 - Ontario Heart Health Network (OHHN) Middlesex-London Policy Scan, Validated: Prevention of Alcohol Misuse: School Boards

Prevention of Alcohol Misuse		
Policy	Thames Valley District School Board	London District Catholic School Board
Policies regarding alcohol prevention programs	**Healthy Schools, Code of Conduct**	**Alcohol and Drugs Policy**

Substance Misuse: Municipal Policies:

Prevention of Substance Misuse – Key Findings

- None of the Middlesex-London municipalities have policies related to prevention of substance misuse.

Substance Misuse: School Board Policies:

Prevention of Substance Misuse – Key Findings

- Neither of Middlesex-London school boards have policies related to substance misuse prevention programs beyond present curriculum requirements.

7.5.3 Assets and Opportunities

On January 12, 2011, from 9:30 to 11:30am, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority area of Substance and Alcohol Misuse (combined with the Injury Prevention Focused Group Discussion session). The purpose of the session was to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: Addiction Services Thames Valley, Child Safety Middlesex-London, Centre for Addiction & Mental Health, London Intercommunity Health Centre, London Health Sciences Centre, Middlesex-London Health Unit, Ontario Early Years Centre -Child Safety-Buckle Up Baby, School of Nursing-UWO, Southwest Community Care Access Centre – Self Management Program, Southwest Ontario Aboriginal Health Access Centre, Southwestern Ontario Stroke Network, Thames Valley Family Health Team.

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies

- *Ontario Public Health Association (OPHA)* and *Centre for Addiction and Mental Health (CAMH)* have initiatives related to alcohol and substance misuse prevention.
- *Heartspace (of Addiction Services of Thames Valley)* provides care and information for women involved with substance use and pregnant or parenting children 0-6 years of age.
- *London CAReS* (9 organizations) provides an action plan for continuity of care and support for individuals living with poverty, homelessness, addiction, and

mental illness. *LondonCARes* is a good example of taking action even while waiting for policies to move forward (follow best evidence and continue to deliver programs).
- The City of London and Middlesex County are great at collaborating.
- *Family Health Clinics* with a multidisciplinary team allow patients to better access services, as many people in the community don't have a family physician. Partnerships allow increased access to services versus solely physician-provided primary health care services.

Programs/Activities/Initiatives
- Needle exchange programs and other harm reduction programs such as *SafeGrad*. Focus group members noted a decrease in the amount of needles found at parks/playgrounds. *SafeGrad* has done well in terms of community based buy-in over a several years, continually being enhanced.

Policy
- *Liquor Control Board of Ontario (LCBO)* controls liquor sales and distribution to both consumers and businesses. LCBO has been advocating for prevention of Fetal Alcohol Spectrum Disorder (FASD) in their magazine articles.
- Advocacy to prevent privatization and deregulation of alcohol sales.
- Lowered "Warn Range" for blood alcohol concentration (BAC) (0.05 – 0.08) in Ontario (2009).

Opportunities

Organizations/Agencies
- Elgin, Middlesex, and Oxford are advocating for a Fetal Alcohol Spectrum Disorder (FASD) diagnostic clinic for those with suspected fetal alcohol spectrum disorder (to address issues such as an over-representation of undiagnosed individuals with FASD in the court system).

Programs/Activities/Initiatives
- Physician screening tools regarding alcohol use, including prenatally, change norms about alcohol use.

Policy
- There is a portfolio with 3 documents for guidance to preventing youth substance abuse called "Canadian Standards for Youth Substance Abuse Prevention".
- Advocates such as *Mothers Against Drunk Driving (MADD)* support randomized breath testing, which could be an opportunity to reduce drinking and driving within Ontario in the future.
- Advocacy for stricter alcohol advertising restrictions.
- Policy works well, a top-down approach. Advocacy is the way to the future to create new norms.

Summary of Identified Assets and Opportunities

There are **organizations and agencies** that are <u>assets</u> for preventing substance and alcohol misuse within Middlesex-London. Provincially, *Ontario Public Health Association (OPHA)* and *Centre for Addiction and Mental Health (CAMH)* have initiatives related to alcohol and substance misuse prevention. There are local organizations and agencies that provide support for vulnerable populations, prenatally, families with children, and throughout the lifespan. For those with poverty, homelessness, addiction, and mental illness *LondonCARes* (9 organizations) provides an action plan for continuity of care and support; this is a good example of taking action even while waiting for policies to move forward, following best evidence to help individuals in need. For women involved with substance use and pregnant or parenting children 0-6 years of age *Heartspace (of Addiction Services of Thames Valley)* provides care and information. *Family Health Clinics* with a multidisciplinary team allow patients to better access services, as 100,000 people

in the community don't have a family physician. Partnerships allow increased access to services versus solely physician-provided primary health care services. Organizations and agencies in Elgin, Middlesex, and Oxford are pursuing an opportunity to advocate for a Fetal Alcohol Spectrum Disorder (FASD) diagnostic clinic for those with suspected fetal alcohol spectrum disorder (to address issues such as an over-representation of undiagnosed individuals with FASD in the court system).

Needle exchange programs and other harm reduction **programs, activities, and initiatives** such as *SafeGrad* are assets in Middlesex-London. There are opportunities for physicians to use screening tools regarding alcohol use, including prenatally (such as at the Sexual Health Clinic), to change norms about alcohol use.

There are provincial **policies** that are assets for controlling sale alcohol for both consumers and businesses (*Liquor Control Board of Ontario, LCBO)* and for penalizing those who drive while under the influence of alcohol or substances. Policy is identified as an effective, top-down approach to creating change related to alcohol and substance misuse. Advocacy is the way to the future to create new norms and present opportunities for new and expanded policies. Such opportunities exist in the form of advocates such as *Mothers Against Drunk Driving (MADD)* who support randomized breath testing, which could be an opportunity to reduce drinking and driving within Ontario in the future. There is also an opportunity to advocate for stricter alcohol advertising restrictions. Currently, there is a portfolio with 3 documents for guidance to preventing youth substance abuse called "Canadian Standards for Youth Substance Abuse Prevention".

7.5.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Substance and Alcohol Misuse within Middlesex-London were identified. There may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Built Environment/Healthy Places

- A healthier built environment would exist if there were reduced density of alcohol outlet locations.
- Alcohol industry attempts to maintain a stronghold on the population's behaviour. A need for altering government standards with respect to limits on alcohol advertising. The alcohol industry has a lot of pull.

Access/Equity

- Need to empower vulnerable populations to take the first step to reach out for assistance and information regarding substance and alcohol misuse prevention.
- Develop policies and education that will eliminate disparities in rates of incidence between low and high income populations driving under the influence of illegal substances or alcohol.
- Need to be innovative and target neighbourhoods including low-income, prostitution, in order to educate about substance and alcohol misuse prevention. Approaching communities and neighbourhoods about issues demonstrates a holistic approach.
- Injection drug use is an epidemic issue in London. *Middlesex-London Health Unit (MLHU)* needs to do much more than needle exchange.

Education/Awareness/Stigma

- Need better education regarding safer drug needle use (blood borne viruses and abscesses). There is no system approach as yet, and it would be great to have such a system approach.
- There are passengers who get in car with someone who have used cannabis (or other substances) then drive (especially youth).
- A gap in info from youth to adults.
- Significant barriers with public perception regarding substance

abuse. Need to decrease stigma and increase public awareness (for example, even with proposals for funding, can't use the term "harm reduction").
- Programs face significant barriers because of public's negative perception of substance abuse. These programs are in danger of losing funding and there is a need for decreased stigma about their mandate, and more public willingness to support these programs.
- There needs to be more curriculum in university/college training regarding Fetal Alcohol Spectrum Disorder (FASD).

Funding/Sustainability/Collaboration & Organization of Services
- There are barriers to what organizations/agencies can do at each level of government, which sets up barriers for action.
- Organizations and agencies need to collaborate and prioritize, to best utilize limited resources.
- Funding structure should be changed to best meet community needs, as sometimes organizations and agencies are pitted against each other because of funding issues.
- When government changes, programs get eliminated. Prevention of substance and alcohol misuse is not a priority with some new governments. The public needs to be aware of these issues when voting, as there can be loss of programs with new governments.
- The next 2 years will require prioritization, collaboration, common goals, and pooling of resources with limited time and resources.
- Sustainability of funding needed.
- Need to partner and work together, which begins with increased public awareness about partnerships (e.g. a public forum).

Summary of Identified Gaps and Needs

There are a number of identified gaps and needs related to substance and alcohol misuse within Middlesex-London. The places we live affect our health, and a healthier **built environment** would exist if there were reduced density of alcohol outlet locations. Further, it was noted that the alcohol industry attempts to maintain a stronghold on the population's behaviour and there is a need for altering government standards with respect to limits on alcohol advertising, as the alcohol industry has a lot of pull.

In terms of **access and equity**, vulnerable populations must be empowered to take the first step to reach out for assistance and to obtain information regarding substance and alcohol misuse prevention. Injection drug use was noted as an epidemic issue in the City of London: *Middlesex-London Health Unit (MLHU)* needs to do much more than solely needle exchange to handle the issue. An innovative, more holistic approach needed is to target neighbourhoods and communities including low-income, prostitution, in order to educate about substance and alcohol misuse prevention. Policies and education are needed to eliminate disparities in rates of incidence between low and high income populations driving under the influence of illegal substances or alcohol. In general, better education is needed regarding safer drug needle use (to prevent blood borne viruses and abscesses). There is no system approach as yet, and it would be great to have such a system approach.

Other **education and awareness** must be given for preventing passengers from getting in cars with someone under the influence of alcohol or drugs, particularly youth. **Stigma** creates significant barriers to prevention of alcohol and substance misuse because of the public's negative perception of these issues. There is a need to decrease stigma and increase public awareness about the importance of alcohol and substance misuse prevention (for example, even with proposals for funding, one cannot use the term "harm reduction" due to stigma). Alcohol and

substance misuse prevention programs are in danger of losing funding and there is a need for decreased stigma about their mandate, and more public willingness to support these programs.

Lack of sustainability of funding, collaboration, and organization of services creates gaps and needs for substance and alcohol misuse prevention. There are barriers to what organizations/agencies can do at each level of government, which sets up barriers for action. When there are government changes, programs may get eliminated. Prevention of substance and alcohol misuse is not a priority with some new governments. The public needs to be aware of these issues when voting, as there can be loss of programs with new governments. The funding structure should be changed to best meet community needs, as sometimes organizations and agencies are pitted against each other because of funding issues. There is a need to partner and work together, which begins with increased public awareness about partnerships (for example, a public forum). Organizations and agencies need to collaborate and prioritize, to best utilize limited resources.

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Substance and Alcohol Misuse were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.5.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community stakeholders the following recommended actions emerged:

Harm Reduction Enhancement

- Supervised injection services with health care providers

Access, Equity, and Sensitivity Training

- Awareness, Education and sensitivity training for Ontario Works, Ontario Disability Support Program workers regarding substance misuse issues in order to increase capacity of these services to understand the needs of some of the clients they are working with.
- Access/equity advocates in Emergency Department for those who are vulnerable (e.g. low SES). Could expand this to whole hospital (Home at Last program) Less paternalistic approach
- Develop a comprehensive strategy for Health Care Providers to address education, screening, and prevention
- Advocacy for seamless access into "the system", providing case management to coordinate care related to alcohol and substance abuse screening, treatment, education, etc
- Family care/work policies/government policies for addressing substance abuse issues
- Reintroduce 'age of majority' card
- Automatic – enter, search, seize for alcohol & drug offences, increased punitive measures

Awareness and Education

- Develop a strategy to address changing the norms relating to Binge Drinking
- Increased awareness and education aimed towards decreasing the stigma regarding substance abuse, with the goal of

decreasing barriers to access help – "it's OK to ask for help"
- Public education – increase awareness/knowledge regarding substance abuse
- Creation of curriculum in schools for guidance counsellors and teachers
- Label alcoholic beverages with low risk drinking guidelines

7.5.5. a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Substance and Alcohol Misuse".

I. Develop a comprehensive strategy related to sensitivity training for Health Care Providers for alcohol and substance misuse education, screening, and prevention.

- Advocates for access/equity for those who are vulnerable (e.g. low SES). Could be in the emergency room or expand to the whole hospital. Counsellor (nurse) at LHSC who works with intervention could be expanded to include this role. This would promote a less paternalistic approach. Expand to include police and other emergency response workers.

II. Implement an education/policy initiative to increase understanding within families, guidance counsellors, and the community in order to decrease stigma for those with substance misuse issues and increase recognition of signs of addiction and heavy drinking.

- Advocacy for seamless access into "the system", providing case management to coordinate care related to alcohol and substance abuse screening, treatment, education, etc
- Increased awareness and education aimed towards decreasing the stigma regarding substance abuse, with the goal of decreasing barriers to access help – "it's OK to ask for help.
- Family care/work policies/government policies for addressing substance abuse issues.
- Public education – increase awareness/knowledge regarding substance abuse.
- Creation of curriculum resources and contacts for referral for guidance counsellors.
- Explore and support OPHA initiative to label alcoholic beverages with low risk drinking guidelines (like a tobacco package warning).

7.6 Mental Health Promotion

7.6.1 Data

Good mental health is pertinent to all aspects of life (social, physical, spiritual, economic and mental). The World Health Organization defines mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community" (WHO, 2010c). Mental health is not only defined by the absence of mental illness, but comprises components such as ability to enjoy life, resilience, balance, self-actualization, and flexibility[1].

The determinants of mental health include multiple social, psychological, and biological factors (e.g. poverty, low levels of education, rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations) (WHO, 2010c).

It has been estimated that one in five Ontarians will have a mental illness or addiction at some time in their lives (CAMH, 2007). Most mental health disorders begin during adolescence and young adulthood (Health Canada, 2002, Kessler et al., 2005, Patel et al., 2007). The prevalence of psychiatric problems among children and youth in Canada ranges between 18% and 22% (Offord, 1995; Romano et al., 2001) and reaches 25% among young adults (Offord et al., 1996).

An overview of selected mental health concerns among youth is presented in Table 7.6.1 and further descriptions of youth mental health will be presented under the respective subheadings.

Perceived Mental Health

Among Middlesex-London residents (age 12+) in 2009 the proportion of people rating their mental health as fair or poor was 5.1%, according to data from the Canadian Community Health Survey (CCHS). The rate was 5.7% in Ontario, which is not statistically different. The rate for Ontario did not change significantly between 2003 and 2009. Similar rates were reported by Ontario males and females (5.6% and 5.8%, respectively). Figure 7.6.1. presents rates of poor mental health in different age groups of students in 2009; the lowest rate being found among those aged 12-19 years (3.7%), and the highest rate being found in the age group of 45-64 years (7.2%).

Results from the 2007 Centre for Addiction and Mental Health (CAMH) Monitor showed that 5.9% of all people aged 12 and older in South West Ontario and 6.2% in Ontario reported their mental health as being fair or poor (Ialomiteanu et al., 2009). Age and education were significantly related to poor mental health. The highest rates were found among those aged 40-49 (8.0%) and among those with less than high school education (12.8%).

Immigrants in South West Ontario were somewhat less likely to report that their mental health was very good or excellent (71.4%) compared to the Canadian-born population in the region (74.9%), according to combined CCHS data from the years 2005 and 2007/08 (MOHLTC, 2010). The difference between immigrants and Canadian-born citizens was not statistically significant in the SW sample, but a similar size difference in the Ontario sample was statistically significant. Similar rates of mental health were reported by both recent and established immigrants in South West Ontario (72.0% and 70.9%, respectively).

Table 7.6.1. Mental health and well-being among youth in 2009

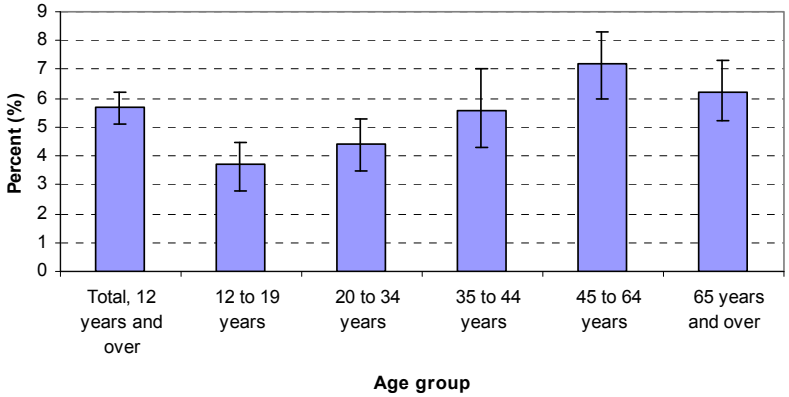
	Region			
	Grades 7-12		Grades 9-12	
	West Ontario	Ontario	South West + Erie St Clair	Ontario
Poor mental health (incl. fair)	12.2	11.7	16.3	13.1
Psychological distress	30.5	31.0	35.0	35.1
Depressive symptoms	5.8	5.4	NA	5.9
Suicide ideation	10.1	9.5	NA	10.3
Suicide attempt	2.4	2.8	NA	3.1
Medical use of				
opioid pain relievers	31.8	38.9	38.6	33.9
ADHD drugs	2.6	2.7		
sedatives/tranqs	2.6	2.7	NA	4.3
anxiety and/or depression drugs	3.3	3.3		
1+ mental health professional visits	23.1	23.8	22.5	23.0
Low self-esteem	8.6	8.3		
Been bullied	30.6	28.9	38.6*	27.9
Bullied others	27.3	25.1	38.3*	25.8
Any gambling activity	43.4	42.6	43.6	46.9
Multi gambling activity	3.0	3.0	NA	3.5
Gambling problem	1.8	2.8	NA	3.3
Video gaming problem	10.5	10.3	13.3	10.5
3 to 4 coexisting problems**	8.5	8.4	9.0	11.1

Source: Ontario Student Drug Use and Health Survey (Paglia-Boak et al., 2010)

NA = estimate not available
** Statistically significant (p<0.01) difference from Ontario estimate*
*** Coexistence of the following problems: psychological distress, hazardous/harmful/ drinking, drug use problem and delinquent behaviour.*

Note: The highest resolution of estimates we can get from this report is the combined LHIN regions of South West and Erie St Clair, however this sample is limited to grades 9-12 and is smaller in size (n=308), thus creating more unstable estimates and limiting the possibilities for sub-group comparisons. The second highest resolution is for West Ontario including grades 7-12. All comparisons between sex, age groups and regions are made on this larger sample (n=2,368). Ontario estimates for both the grade 9-12 and the grade 7-12 samples are provided in the table for comparison.

Figure 7.6.1. Perceived mental health (fair or poor) in Ontario, 2009



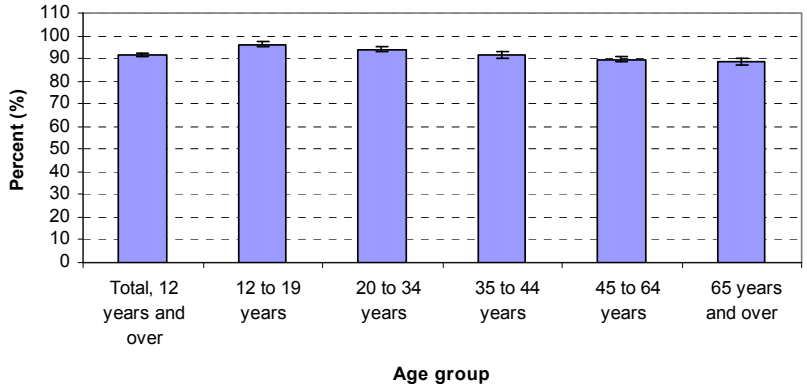
Source: Canadian Community Health Survey, Statistics Canada

Life Satisfaction
About 91% of Middlesex-London residents were satisfied with their life in 2009, compared to a similar rate of 91.5% in Ontario, based on CCHS data. Rates were stable between 2003 and 2009. Males and females reported similar rates of life satisfaction (90.4% and 91.3%, respectively) in Middlesex-London. In the age group 12-19 years, Ontario males reported a higher life-satisfaction compared to females (97.8% vs. 94.2%). Life satisfaction among Ontario residents in 2009 decreased with increasing age, from 96.0% among 12-19 year olds to 88.3% among those aged 65 and over (Figure 7.6.2.).

Sense Of Belonging To Local Community
Results from the CCHS showed that about 70% of Middlesex-London residents had a somewhat strong or very strong sense of belonging to the local community in 2009, compared to the provincial rate of 67.1% (not a statistically significant difference). Males and females reported the same level of belonging to the local community. In Ontario the rate increased slightly from 64.4% in 2003 to 67.1% in 2009. A similar increase was seen in Middlesex-London, but it was not statistically significant. Those in the age groups 12 - 19 and 65+ were most likely to feel a sense of belonging to the local community (67.1% and 73.0%, respectively), whereas this was only reported by 58.5% among 20-34 year olds (Figure 7.6.3.).

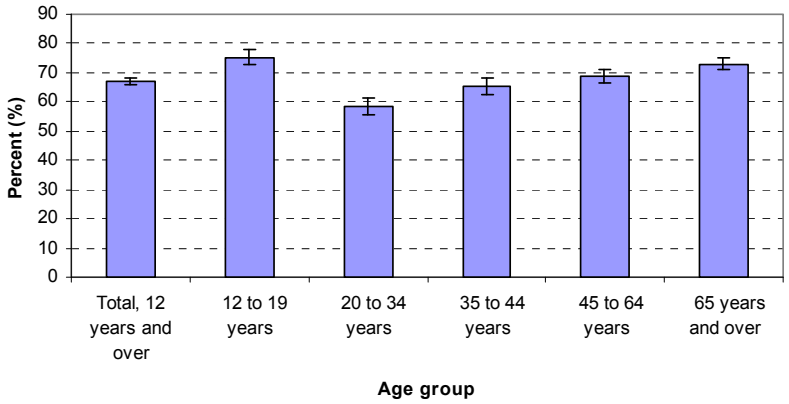
Aboriginal people had a lower sense of community belonging and connectedness than Caucasian people in Canada (Shields, 2008), and Francophones in Southern Ontario were more likely than non-Francohones to report a weak sense of belonging (Réseau franco-santé du Sud de l'Ontario, 2006).

Figure 7.6.2.. Life satisfaction among Ontarians in 2009



Source: Canadian Community Health Survey, Statistics Canada

Figure 7.6.3. Sense of belonging to local community among Ontarians, 2009



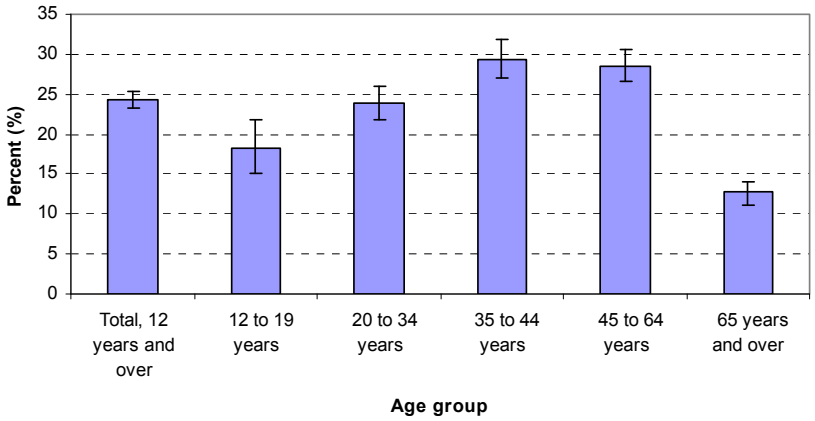
Source: Canadian Community Health Survey, Statistics Canada

Stress

In 2009, 23.7% of Middlesex-London residents 15 years and over experienced quite a lot of life stress, which compares to a similar rate of 24.3% among Ontarians, according to CCHS data. The reported rates were somewhat lower in 2007 compared to 2009 in both Middlesex-London and Ontario. This difference was smaller but statistically significant in Ontario (22.2% vs. 24.3%). In terms of gender, males tended to be more likely to experience life stress, compared to females in Middlesex-London (26.3% vs. 21.1%). However, this difference was not statistically significant. In Ontario, on the other hand, females reported more life stress than males (26.3% vs. 22.2%), a difference that was statistically significant. As shown in Figure 7.6.4., Ontario residents in the youngest and oldest age groups experienced least life stress (18.3% and 12.7%, respectively) and those aged 35-64 years were most likely to perceive quite a lot of life stress (about 29%).

Results from the CAMH Monitor in 2007 show that 10.9% of adults in the South West LHIN region and 12.7% of Ontario adults reported elevated psychological distress during the past few weeks (Ialomiteanu et al., 2009). The three most common symptoms reported by respondents was the feeling of being constantly under stress (16.1%), losing sleep because of worrying (12.9%), and being unable to enjoy daily activities (12.9%). Women were more likely to report psychological distress compared to males (15.3% vs. 10.0%). Distress was highest among 18-29 year olds (16.5%) and lowest among those 65 and older (7.2%). University graduates were least likely to experience psychological distress (9.8%) and those with high school education most likely (16.2%). Frequent mental distress days in the past 30 days were reported by 4.3% of adults in South West Ontario and 6.6% of Ontarians (Ialomiteanu et al., 2009). More females than males reported frequent mental stress days (8.4% vs. 4.7%). Those with less than high school were most likely to report frequent mental stress days (9.5%) and those with a university degree least likely (3.4%). Furthermore, the rate of mental distress days was highest among those with incomes of less than $30,000 (13.5%).

Figure 7.6.4. Perceived life stress (quite a lot) among Ontarians, 2009



Source: Canadian Community Health Survey, Statistics Canada

Among students (grades 7-12) in West Ontario 30.5% had experienced elevated psychological distress in the last few weeks (Table 7.6.1). Females were more likely to report psychological distress compared to males (38.8% vs. 23.4%), and rates increased by increasing grade peaking at about 38% in grades 11-12 (Paglia-Boak et al., 2010). According to results from the Canadian Campus Survey in 2004, 32.8% of undergraduate students in Ontario had experienced elevated psychological distress[71] (Adlaf et al., 2005b).

Work Life Conflict

A survey among employees of Canadian organizations (with 500+ employees) was conducted in 2001, investigating work-life conflict (Duxbury & Higgins. 2003). The following five forms of work-life conflict were examined:

- Role overload (demands on time and energy too high, multiple roles)
- Work to family interference (work situation affects family)
- Family to work interference (family situation affects work)
- Caregiver strain (in relation to assisting a disabled or elderly dependent)
- Work to family spillover (negative, positive or no impact of work on the family)

In 2001, 58% experienced a high role overload, which was an increase compared to 1991 when 47% reported a high role overload. Moderate role overload was experienced by another 30%. Experience of high work to family interference did not change between 1991 and 2001, and was reported by about one in four working Canadians. Moderate interference was experienced by another 40%. High family to work interference was only reported by 10% of the workforce, and moderate interference by about a third. Three times as many Canadians give priority to work at the expense of their family as the reverse. However, the percentage of working Canadians who give priority to family rather than work has doubled between 1991 and 2001. High caregiver strain was experienced by one in four working Canadians. A negative spillover from work to family was experienced by 44%, whereas 47% experienced no spillover from work to family.

A report of the Canadian Index of Wellbeing (CIW) showed that a lower proportion of Canadians worked more than 50 hours per week in 2009 (11.0%) compared to 14.9% in 1996 (CIW, 2010).

[71] Four or more of the symptoms in the General Health Questionnaire

However, more people are working non-standard hours (29% in 2009, compared to 23% in 1992), which has negative consequences for individual and family wellbeing, e.g. less time with family, higher levels of stress, disrupted sleep patterns and difficulty in arranging childcare. The rate of people experiencing high levels of 'time crunch' increased from 16.4% in 1992 to 19.6% in 2005. Time pressure was more common in females than males (22.7% vs. 16.6%). Among working-age adults 19.5% were providing care to seniors in 2006, compared to 17.4% in 1996.

Mood Disorders

Having a mood disorder (such as depression, bipolar disorder, mania, dysthymia diagnosed by health professional), was reported by 8.1% of Middlesex-London residents in 2009, according to CCHS data. The rate among Ontarians was 6.8%. Females were more likely to report having a mood disorder compared to males. This difference was only significant in the Ontario sample (8.6% vs. 5.0%) and not in the Middlesex-London sample (9.3% vs. 6.8%). People in the age group 12-19 and 65+ were least likely to report a mood disorder (2.3% and 6.4%, respectively) and those aged 45 - 64 had the highest rate of mood disorders (8.7%) (Figure 7.6.5.). Depressive symptoms in the past week were reported by 5.8% of West Ontario students and were more commonly reported by females than males (8.1% vs. 2.1%) (Paglia-Boak et al., 2010).

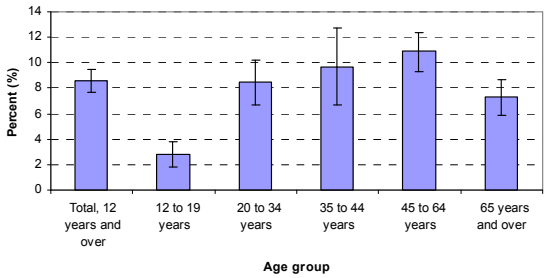
A high rate of depression (18%) is found in the aboriginal population (Mikkonen & Raphael, 2010).

Suicide

Populations at an increased risk of suicide include youth, older people, and people with a mental illness (Weir & Wallington, 2001). Men are about four times more likely to commit suicide than women (Canadian Mental Health Association (CMHA), 2006), and men in Ontario tend to be more likely to die from suicide than from car crashes (CIHI, 2002). Women, however, are three to four times more likely to make suicide *attempts* than men (CAMH, 2002). Suicide is the third most common cause of death among Canadian adolescents (Canadian Institute of Child Health, 2000) and the second most common cause of death among those 10-24 years of age (Canadian Psychiatric Association, 2002).

Overall, 10.1% of the students in West Ontario had ever seriously considered attempting suicide in the past 12 months, but only 2.4% had actually made a suicide attempt in the past year (Table 7.6.1). Suicide ideation was more common among females than among males (11.4% vs. 7.6%), but there was no gender difference in reported suicide attempts in the student population (Paglia-Boak et al., 2010).
Suicide rates are generally higher among First Nations people than among Canadians. Although based on fairly old data (1989-1993), suicide rates among First Nations youth (age 15-24) were seven times higher in males and five times higher in females, compared to Canadian young males and females (Health Canada, 1996).

Figure 7.6.5. Proportion of Ontarians with mood disorders in 2009

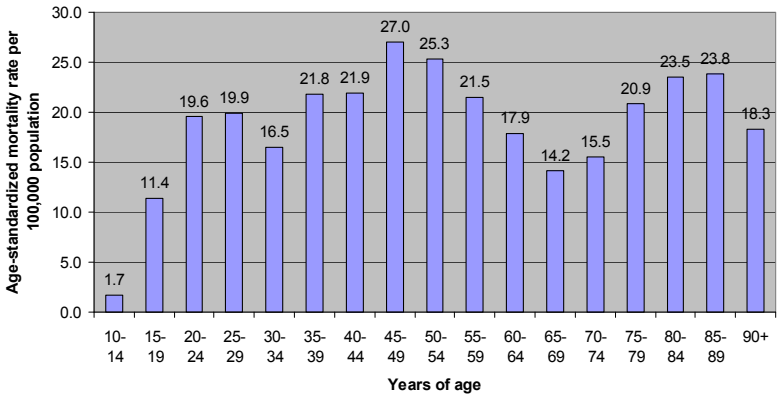


Source: Canadian Community Health Survey, Statistics Canada

Older Adult Suicide

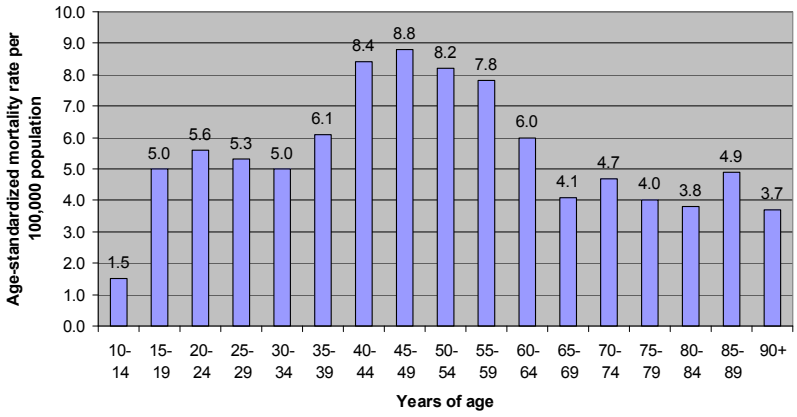
The Centre for Suicide Prevention (1998) identifies that many may be aware of high rates of adolescent suicide, yet may not be aware of high rates of suicide among older adult populations. In 2007, rates of suicide were highest for both Canadian males and females from 45 to 49 years of age, and rates increased again among the older adult population beginning from 65 years of age (as seen in Figure 7.6.6. and Figure 7.6.7.).

Figure 7.6.6. Age-standardized rate of suicide per 100,000 population*, by age group, males, Canada, 2007



Source: Statistics Canada. (2007). Mortality, summary list of causes. Catalogue 84F0209X. Ottawa, ON: Author.
** "Age-standardization removes the effects of differences in the age structure of populations among areas and over time. Age-standardized death rates show the number of deaths per 100,000 population that would have occurred in a given area if the age structure of the population of that area was the same as the age structure of a specified standard population." "The 1991 Canadian Census of Population, is used as the standard population for the calculation of age-standardized death rates" (Statistics Canada, 2007, p. 114).*

Figure 7.6.7. Age-standardized rate of suicide per 100,000 population*, by age group, females, Canada, 2007



Source: Statistics Canada. (2007). Mortality, summary list of causes. Catalogue 84F0209X. Ottawa, ON: Author.
** "Age-standardization removes the effects of differences in the age structure of populations among areas and over time. Age-standardized death rates show the number of deaths per 100,000 population that would have occurred in a given area if the age structure of the population of that area was the same as the age structure of a specified standard population." "The 1991 Canadian Census of Population, is used as the standard population for the calculation of age-standardized death rates" (Statistics Canada, 2007, p. 114).*

Medication and Visits To Mental Health Care Professionals In South West Ontario in 2006, 9.1% of adults had used prescribed medication for anxiety or panic attacks in the past 12 months, which was significantly higher than the provincial rate of 5.7% (Ialomiteanu et al., 2009). Groups with the highest use were women (7.9%), those aged 50-64 (8.4%), and those with incomes of less than $30,000 (13.0%). Use of prescription drugs for depression in the past 12 months was reported among 8.4% of residents in South West Ontario and 6.6% in Ontario (2006). Use was more common among females than males (9.3% vs. 3.6%), and the age group with highest use was 40-49 (9.4%). Those with incomes of less than $30,000 were more likely to use depression medication (14.4%) compared to those in higher income groups.

Among West Ontario students in grades 7-12 medical use of opioid pain relievers in the past year was 31.8%, use of sedatives/tranquillizers was 2.6% and use of ADHD drugs was 2.6% (Table 7.6.1). Medical use of opioid pain relievers was more common among females compared to males (37.3% vs. 26.7%) and ADHD drugs more commonly used among males than females (3.9% vs. 1.4%). Students in grades 9-12 were more likely to use opioid pain relievers than students in grade 7 and 8. Use of tranquillizers or sedatives was most common among grade 10-12 students. Medication for anxiety and/or depression was reported by 3.3% of West Ontario students in grades 7-12. The likelihood of medicating increased with increasing grade (Paglia-Boak et al., 2010).

Having visited a mental health professional[72] in the past 12 months was reported by 23.1% of West Ontario students in grades 7-12, according to Ontario Student Drug use and Health Survey (OSDUHS) data (Table 7.14). Mental health visit was most common among grade 7 students (28.9%) and least common among grade 12 students (19.0%) (Paglia-Boak et al., 2010).

[72] Visit to a doctor, nurse, or counsellor for emotional or mental health reasons.

Youth Mental Health

Poor Self-Esteem

Poor self-esteem was experienced by 8.6% of the students in West Ontario, and was more common among females than males (10.1% Vs. 6.5%) (Table 7.6.1).

Body Image

Hospitalization rates for eating disorders have increased over time among Canadian girls under the age of 15 (Health Canada, 2002). A fixation on body image can in extreme cases lead to eating disorders such as anorexia nervosa or bulimia, especially among females. The majority of Ontario youth in grades 7 – 12 were satisfied with their weight (67.3%) in 2009 (Paglia-Boak et al., 2010). Satisfaction with body weight decreased with increasing grade level. Girls were more likely than males to think they were too fat (28.7% vs. 17.4%), and males were more likely than females to think they were too thin (14.0% vs. 5.4%). In line with this, more females than males were trying to loose weight (38.3% vs. 20.7%), and more males than females were trying to gain weight (19.8% vs. 5.1%).

Bullying

Having been bullied by others in the current school year was reported by 30.6% of all students in West Ontario, and 27.3% had bullied others (Table 7.6.1). Males were more likely to be bullying perpetrators compared to females (28.1% vs. 22.1%), and students in grades 7-10 were more likely to be victims of bullying than students in grades 11 and 12 (Paglia-Boak et al., 2010).

Gambling

Gambling is illegal in Ontario for those under age 19. Problem gambling in youth may increase the likelihood of problems with family, work and school, mental health problems, and delinquent and criminal behaviour (Dickson & Derevensky, 2006). Furthermore, gambling disorders in adulthood are likely to originate from this time in life (Gupta & Derevensky, 1998).
Reported rates for selected indicators of gambling and gaming in the past 12 months among students participating in the OSDUHS survey 2009 are shown in

Table 7.6.1. Among West Ontario students in grades 7-12 43.4% reported any gambling: 43.4%, 3.0% reported multi-gambling, 1.8% reported having a gambling problem, and 10.5% had a video gaming problem (Paglia-Boak et al., 2010). Any gambling for money in the past 12 months was more likely among males compared to females (50.5% vs. 34.3%), and increased with increasing grade from 31.5% among grade 7 students to 56.0% among grade 12 students. Males were also more likely to be involved in multiple gambling activities and to have gambling problems (4.5% and 4.3%, respectively) compared to females (1.5% and 1.2%, respectively). Having a video gaming problem was also much more likely among males than females (16.0% vs. 4.0%). Multi-gambling decreased from 6.1% in 2003 to 3% in 2009.

Among university undergraduates in Ontario 8.3% were at risk gamblers and 4.3% had moderate or severe gambling problems based on the Canadian Problem Gambling Index, according to results from the Canadian Campus Survey in 2004 (Adlaf et al., 2005b).

7.6.2 Policy Initiatives

The following summary provides examples of health-related policies at all levels of government. The summary does not encompass a comprehensive list of all national and/or provincial policies, nor are all municipal or school board policies necessarily captured in the following tables and summaries.

National/Provincial Policies and/or Legislation:

There were no specific national or provincial policies or legislation in place for mental health promotion that affect Middlesex-London municipalities and school boards.

Rather, the World Health Organization (WHO) states that "mental health promotion involves actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles" (http://www.who.int/mediacentre/factsheets/fs220/en/).

Provincially, a document called "Mental Health Promotion in Ontario: A Call to Action" (2008) identifies that, "the three most significant determinants of mental health" are:

- social inclusion,
- freedom from discrimination and violence,
- access to economic resources

This document is a collaborative work between Centre for Addiction and Mental Health (CAMH) and partners Canadian Mental Health Association (CMHA) Ontario, Health Nexus, the University of Toronto Centre for Health Promotion, and the Ontario Public Health Association (http://www.ontario.cmha.ca/admin_ver2/maps/mental_health_promotion_in_ontario_2008.pdf).

The Ontario Chronic Disease Prevention Alliance (OCDPA) also provides direction for promoting mental health with the documents:

Evidence-Informed Messages: Promoting Positive Mental Health (2010) (http://www.ocdpa.on.ca/OCDPA/docs/OCDPA_EM_MentalHealth_Full_Package.pdf)

Direction is provided at both the individual and systems level:

- Individual Level:
- *Message:* Provide individuals with information to help them maintain good mental health, recognize mental health problems and get support.
    - System Level:

Message: Address the socioeconomic conditions which promote mental health: social inclusion, freedom from discrimination/violence and access to economic resources.
Message: Increase availability and access to depression screening and early intervention.
Message: Reduce the stigma associated with mental illness.

Ideas for Organizations to Promote Positive Mental Health (2010) (http://www.ocdpa.on.ca/OCDPA/docs/rpt_IdeasPositiveMentalHealth.pdf)

In regards to tertiary prevention via early assessment of mental health issues, the Ministry of Health and Long Term Care (MOHLTC) released recommendations for Ontario's Mental Health and Addictions Strategy called "Respect, Recovery, Resilience" which serves as "their [MOHLTC] final report and recommendations for a 10-Year Mental Health and Addictions Strategy for Ontario to Minister Matthews" (http://www.health.gov.on.ca/en/public/publications/ministry_reports/mental_health/mentalhealth.aspx)

Middlesex-London Policies:

Compared across the six Healthy Communities Partnership priority areas, policies created by Middlesex-London municipalities and school boards related to promotion of *Mental Health* are needed.

There were three priority areas of the Ontario Ministry of Health Promotion and Sport, Healthy Communities Partnership stream that were not scanned for within the Ontario Heart Health Network (OHHN) Policy Scan, including Mental Health. Thus, for the priority area of Mental Health, Policy Scan questions were created with advice from community partners that possess expertise for the specific priority area (see Methodology for more information).

Policies that were scanned for and that do not exist in Middlesex-London could be considered for development and implementation by municipalities and school boards in the future.

Municipal Policies:

Mental Health – Key Findings

- None of the Middlesex-London municipalities have policies that specifically promote mental health.

School Board Policies:

Mental Health – Key Findings

- Thames Valley District School Board (TVDSB) has plans to review and develop policy related to mental health promotion, and indicate personnel have been hired at TVDSB for this purpose.

7.6.3 Assets and Opportunities

On January 12, 2011, from 1:30 to 3:30pm, Healthy Communities partners and stakeholders were invited to engage in a Focused Discussion Group regarding service, program, and policy recommendations within the context of the Ministry of Health Promotion and Sport's priority area of Mental Health (combined with the Tobacco Use and Exposure Focused Group Discussion session). The purpose of the session was to hear from as many stakeholders as possible to learn about services, programs, and policies for that priority area. Attendees included representatives from the following organizations: Centre for Addiction & Mental Health, London Intercommunity Health Centre, Middlesex-London Health Unit, Southwest Community Care Access Centre, Southwestern Ontario Stroke Network.

Table 7.6.2 - Middlesex-London Policy Scan: Mental Health: School Boards

Mental Health		
Policy	Thames Valley District School Board	London District Catholic School Board
School board policies that promote mental health	In Development	No Policy

It should be noted that mental health wellness and promotion was a theme that emerged across al Healthy Communities' priority area Focused Discussion Groups conducted in the community.

From the Focused Discussion Group with community partners and stakeholders, assets and opportunities within Middlesex-London were identified. We are aware there are other assets and opportunities that exist but are not listed. Comprehensive lists of these assets and opportunities are too abundant to name, and the following reflects only those items identified by the Focused Discussion Group.

Assets

Organizations/Agencies

- *Mother Reach* offers support for those suffering post partum depression and outreach teaching and awareness to professionals and families
- *Boards of Education* are currently identifying students with mental health issues, but face lack of necessary funding
- *Adolescent Outreach* at St Joseph's Hospital, London, ON
- *Canadian Mental Health Association* promotes workplace mental health wellness and issues in the workplace
- *Child and Parent Resource Institute (CPRI)* & *Madame Vanier Children Services* in London provide assessment
- *School Mental Health Community of Practice* has a partnership with school boards for mental health for kids
- Youth-friendly website called *mindyourmind.ca*
- *WrapAround initiative* networks with children, individuals, and families with complex needs
- Information packages from different agencies for distribution
- *Courses at Fanshawe College* regarding *Settlement Workers* and how to work with newcomers
- *Thames Valley Family Services*
- Faith communities and churches
- *ConnexOntario Health Services Information* formerly *DART*
- *Family health teams*

Opportunities

Programs/Activities/Initiatives

- Mental health mentioned more often than previously was within the community e.g. *United Way*
- Increased acknowledgement of impact of mental health in workplace (e.g. caused by stress)
- *United Way* is currently exploring the development of a city and county wide strategy about mental health

Summary of Identified Assets and Opportunities

Organizations and agencies exist in Middlesex-London and are assets for promoting mental health across the lifespan. Perinatally, *Mother Reach* offers support for those suffering post partum and outreach teaching and awareness to professionals and families. The *Child and Parent Resource Institute (CPRI)* and *Madame Vanier Children Services* in London provide assessment for children's mental health issues. Middlesex-London's *Boards of Education* are currently identifying students with mental health issues, but face lack of necessary funding. The *School Mental Health Community of Practice* has a partnership with school boards to promote children's mental health and has website called *mindyourmind.ca.* This is a youth-friendly website that raises awareness and education about mental health. *Adolescent Outreach* at St Joseph's Hospital in the City of London provides services for youth mental health. The *InterCommunity Health Centre's WrapAround initiative* networks with children, individuals, and families with complex needs. In general, there are information packages from different agencies for distribution such as the *Canadian Mental Health Association.* For immigrant families, there are *courses at Fanshawe College* for *Settlement Workers* and how to work with newcomers. *Family health teams,* faith communities and churches, and other mental health

providers, promote mental health and wellness within the population at large.

Opportunities exist in the form of **programs, activities, and initiatives** from organizations such as *United Way* who are currently exploring the development of a city and county wide strategy about mental health. In general, there is increased acknowledgement of impact of mental health in the workplace caused by stress and mental health is mentioned more often than it previously was within our community.

7.6.4 Identified Gaps and Needs

From the Focused Discussion Group with community partners and stakeholders, gaps and needs related to Mental Health within Middlesex-London were identified. There may be other gaps or needs that exist and the following lists reflect only those identified by the Focused Discussion Group.

Mental Health System Infrastructure (Organization/Human Resources/Funding) and Navigation

- The mental health assessment system is difficult for the user to navigate. The system needs to be overhauled to facilitate access.
- There are lack of supports and resources (e.g. psychiatrists) to support the increasing rate of mental health issues that are in the community.
- Need more funding for Boards of Education to identify and support students' mental health
- There is a need for doctors willing to refer/screen clients. This willingness to refer/screen is influenced by funding and physician payment method.
- The mental health sector experiences funding challenges from government
- There is a need to look at the definition of responsibility and ownership of mental health services. Whose problem is it?

Screening/Awareness and Removal of Stigma

- There is need to recognize the mental health – illness continuum and the importance of early identification
- There is a need for greater focus on mental health promotion and prevention of mental health issues. Currently there is more focus on assessment and treatment than on prevention. When looking at prevention need to look at what are the outside issues and factors – i.e. Determinants of health
- There is a knowledge gap related to culture and mental health and impact on the immigrant population. The introduction of a checklist or training (e.g. certificate course at the community college level) for those working with newcomers to Canada was suggested as a method of bridging the gap and better meet the needs of the immigrant population
- There is a need to examine discrimination of the mental and chronically ill patient, particularly those with low income issues. (E.g. Where is the accommodation for these clients when they cannot find access to a regular physician?)

Built Environment

- Communities need to recognize the impact of the built environment on overall mental health and mental health promotion (e.g. use of green space, creating a sense of community)

Summary of Identified Gaps and Needs

There are gaps and needs related to mental health promotion in Middlesex-London that were identified by community partners and stakeholders. The **mental health sector infrastructure** experiences funding challenges from government. There is a need to look at the definition of responsibility and ownership of mental health services and to designate an organization/agency that directs mental health services. The mental health

assessment system was recognized as difficult for the user to navigate and the system needs to be overhauled to facilitate access. There is a lack of supports and resources (e.g. psychiatrists) to support the increasing rate of mental health issues that are in the community. It was identified that there is a need for doctors willing to refer/screen clients and this willingness to refer/screen is influenced by funding and physician payment method. More funding is also needed for Boards of Education to identify and support students' mental health.

In regards to **screening and awareness** of mental health, discussion revealed there is a need to recognize the mental health and illness continuum and the importance of early identification. There is a need for greater focus on mental health promotion and prevention of mental health issues. Currently, there is more focus on assessment and treatment than on prevention. When looking at prevention, the influence of external issues and factors should be considered (i.e. the determinants of health). There is a need to examine stigmatization and discrimination of the mentally and chronically ill patient, particularly those with low income issues (e.g. where is the accommodation for these clients when they cannot find access to a regular physician)? A knowledge gap exists related to culture and mental health and its impact on the immigrant population. The introduction of a checklist or training (e.g. certificate course at the community college level) for those working with newcomers to Canada was suggested as a method for bridging the gap and better meeting the needs of the immigrant population in regards to mental health.

The impact of the **built environment** and mental health promotion also needs to be recognized by the community (e.g. use of green space, creating a sense of community, etc.).

Francophone Focused Discussion Group

It is important to note that two overarching messages presented consistently in all consultations, which are the need for sustainable funding and access to all resources in both official/other languages. During Focused Discussion with the Middlesex-London Francophone population, assets and opportunities as well as gaps and needs related to Mental Health Promotion were identified. Many of the issues brought forward were similar to those discussed during Focused Discussions for each priority area in English. A detailed account of this Focused Discussion with community partners and stakeholders from the Middlesex-London Francophone population can be found in Appendix 9.8.

7.6.5 Recommendations for Possible Action

During the Focused Discussion Group process taking place with community stakeholders the following recommended actions emerged:

Access and Equity to Care

- Advocate for access and equity to mental health care – looking at both prevention and treatment.
- Advocate for equal access despite income and mental health status
- Advocate for access and equity mental health services prevention and treatment.
- Advocate for equal access to treatment and care – addressing the fact that at times health care workers deny care to mental health clients.
- Advocate for curriculum with nursing and medical schools that addresses equitable access to care.
- Work with emergency department and hospital staff to develop program about how to treat and care for mental health clients.

Coordination/Sustainability of Services

- Set new standards regarding who is hired to be Settlement Workers
- Develop a comprehensive perinatal mental health care program accessible to all clients that is sustainable through consistent funding.

- Ensure language and culture are not barriers to accessing mental health promotion resources
- Every school have a mental wellness promoter to implement strategies

Promotion of Healthy Living/Mental Wellness

- Healthy living choices as part of mandatory curriculum in schools and within other lifespan times (e.g. birth, parents, seniors). Advocate for mandatory education in schools about healthy living for students – ensuring a link with both schools and home.
- Advocate for the development of routine and universal screening for mental wellness when accessing health/medical care
- Advocate for increased access to workplace resources/programs and provision of resources to employers to make mental wellness programming available.
- Increase the use of art, culture and leisure activities to promote mental wellness.
- Develop an anti-bullying program that addresses mental health across the life span (e.g. work, school, family).

Built Environment/Social Cohesion

- Increase the number of peer-to-peer support groups and *WrapAround* programs available in order to increase social support and connection with "community" – all ages, across the lifespan.
- Support the *Strengthening Neighbourhoods initiative* to increase awareness of the importance of community and sense of belonging

7.6.5. a) Top Two Recommended Actions

Two recommended actions were determined among the Healthy Communities Core Group, via a prioritizing exercise using "need", "impact", "capacity and feasibility", "partnership and collaboration", and "readiness" as decision criteria for each potential recommended action.

Based on review of multiple sources of information the top two recommendations for action were identified for "Mental Health".

I. Increase awareness and skill building for anti-bullying/reducing aggression within the community and across the lifespan.

- Capacity building should pay particular attention to populations that do not currently receive training through school or workplace programs and areas in the community that do not currently have bullying policies in place.

II. Advocate for equitable access to mental health services for vulnerable populations.

- Enhanced training, curriculum, and mandatory requirements for graduation among health care workers (e.g. nursing and medical students, and settlement workers) – such as sensitivity training, navigation of the system, etc.
- Routine mental wellness assessments across the lifespan.
- Support programs that help foster "sense of belonging".
- Link existing initiatives.
- Ensure schools have daily coverage by either social worker or public health nurse.
- Comprehensive perinatal mental health program for all families (funded and sustained).
- Workplace mental health resources.

8. Conclusions and Next Steps

As part of the Healthy Communities Partnership initiative from the Ministry of Health Promotion and Sport (MHPS) this Community Picture report is intended to provide a profile of the Middlesex-London community including demographic makeup, health status data, current initiatives and policies that have an impact health and well-being.

The process for engaging the community is detailed within the report. From these activities, insight was gained into community assets, opportunities, gaps, and needs. Explanation is also provided for methodology used when examining local policy, demographic analysis, and health status information. It is noted that limited time frames for submission of the Community Picture did not allow original data analyses and more extensive data collection to be conducted.

Demographic makeup of the Middlesex-London community is presented, along with health status data for each of the six priority areas of the Healthy Communities Partnership Framework (Physical Activity, Sport, and Recreation; Injury Prevention; Healthy Eating; Tobacco Use/Exposure; Substance and Alcohol Misuse; Mental Health Promotion).

Community engagement produced perspectives of community-identified strengths, opportunities, and needs in terms of programs, partnerships, initiatives, and policies within each of the six Healthy Communities key priority areas. A policy scan validation also provides insight into community-identified existing or developing local policies within Middlesex-London municipalities and school boards.

The top two recommended actions for each priority area were determined by community engagement activities. These recommended actions as found in Appendix 9.5 were submitted to the MHPS and are available for community partners and stakeholders to guide future endeavours in these priority areas. To further direct the selection of policy priorities, the recommended actions were subsequently shaped into policy-specific options. On February 28th, 2011 at a community stakeholder meeting, the two top policy priority areas were selected for the Middlesex-London community from all the recommended actions are;

- Mental Health Promotion
- Physical Activity, Sport, and Recreation

Subsequently, the Middlesex-London Healthy Communities Partnership Core Group developed a one-year policy work plan for each priority area to be submitted to MHPS. Once approved, the Core Group along with priority area subcommittees will work on implementation of the work plans and move toward the enactment of the relevant policies.

Communication, consultation and community engagement has been integral in the development of the Community Picture report and the policy work plans. The Community Picture is a live, open ended document and will need to be periodically updated to reflect major health and demographic status changes in our community (e.g. 2011 reports regarding physical activity rates). Furthermore, there will be ongoing policy priority consultations and communication updates regarding the progress of the Middlesex-London Healthy Communities Partnership. To that end, continued communication and partnership development is an integral part of this initiative. In keeping the community informed, the Middlesex-London Healthy Communities website, www.healthylivinginfo.org, will reflect the current status of the Partnership along with educational information on all the six Healthy Communities priority areas.

The authors extend our appreciation to community partners and stakeholders who participated in the creation of the Community Picture, and for steering local policy development in a way that will

benefit the health of all in the
communities of London and Middlesex.

Core Coordinating Committee: Terms of Reference

Goal
To facilitate community engagement and decision making regarding the creation and implementation of the Ministry of Health Promotion & Sport's (MHPS) Healthy Communities Partnership initiative.

Objectives
The focus of this committee will be to finalize the Healthy Community Partnership (HCP) community picture and develop a work plan for Middlesex-London

- To implement the new HC partnership initiative
- To implement a partnership model to mobilize community partners to facilitate healthy public policy.
- To make operational decisions using a shared decision-making process
- To review and identify priority recommended actions and policies using information from the Middlesex-London Community Picture report.

Deliverables

1. Identify and engage key networks and organizations across a variety of sectors.
2. Engage key priority populations to incorporate their perspective into the Community Picture.
3. Identify local community priorities within the six Healthy Communities priority areas (Physical Activity, Sport and Recreation, Injury Prevention, Healthy Eating, Tobacco Use/Exposure, Substance & Alcohol Misuse, & Mental Health Promotion).
4. Finalize the Middlesex-London HC Community Picture Summary within the timelines given by the Ministry of Health Promotion and Sport.
5. Set policy priorities and identify action steps to further these priorities.
6. Develop a HCP work plan for Middlesex-London within the timelines given by the Ministry of Health Promotion and Sport.
7. Provide ongoing oversight and guidance into the implementation of the Middlesex-London HC partnership initiative. (this new point could be for a new Terms of Reference once we know the status of our April submission)

Membership

- Membership consists of representatives who have volunteered to be part of the Core Coordinating committee, who generally represent the 6 key priority areas.
- If a partner is no longer able to be part of the committee they will inform the coordinator, who will advise the group.
- Other partners may be invited to join the committee by group invitation.

Decision making
Members will share responsibility for decision making. Decisions will be made by consensus. Each partner has equal representation. If consensus cannot be reached, the matter must be put to a vote, the matter will carry with a simple majority of votes cast by the coordinating committee members in attendance. All partnering agencies/organizations will have one vote. The representative from the Ministry of Health Promotion and Sport will abstain from all votes.

Accountability
The Middlesex-London Health Unit is the host agency and is accountable to the Ministry of Health Promotion and Sport for the use of initial provincial funds for the Healthy Communities Partnership.

Meetings
Committee will meet during the following months:

Date	Time	Location	Room
February 2, 2011	2 – 4 pm	MLHU, 201 Queens Ave	Board Rm
February 8, 2011	9 – 11 am	Kinsmen Recreation Centre	Rm 3
March 9, 2011	2 – 4 pm	MLHU, 201 Queens Ave	Board Rm
March 22, 2011	2 – 4 pm	MLHU, 50 King St.	Rm LLB
April 20, 2011	2 – 4 pm	MLHU, 50 King St.	Rm LLB

Meeting times will be negotiated within the committee.

Roles and Responsibilities

Facilitator
The position of chair will function as a facilitator for the meetings.

Recorder
The recorder will record meeting highlights and decisions and circulate to members in a timely manner.

Resources
Members can submit travel expenses by using the appropriate documentation forms and following Middlesex-London Health Unit financial policies and procedures.

Terms of Reference
Approved Terms of Reference will be reviewed in April 2011, following the submission of the Middlesex-London Healthy Communities Work Plan.

Healthy Communities Partnership Middlesex London: Network Maps

In November 2010 the Middlesex-London Health Unit distributed the Healthy Communities Network Survey – Middlesex London to 157 organizations. Fifty-three completed surveys were received and sent to Health Nexus for data entry and dataset creation. This response rate (34%) is comparable to those of other partnerships in Ontario completing similar network surveys with Health Nexus. Health Nexus then developed a series of network maps based on the data generated by the survey. The network maps are a snapshot providing insight into where to act and where to further explore partnerships.

Based on completed surveys, an additional 116 organizations were added to the original 108 listed in the survey for a total of 224 organizations being included in the network mapping exercise. This doubling of organizations in the network indicates that as the Healthy Communities Partnership Middlesex-London moves to expand, there is a good pool of connections already in place that can be drawn upon. From these 224 organizations, 2500 links were found to exist between organizations.

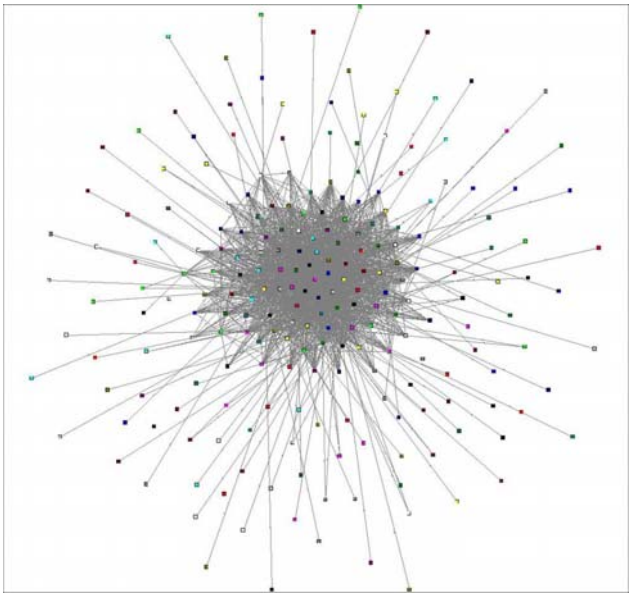


Figure 1 is a picture of all 224 organizations and 2500 links from the Middlesex-London Healthy Communities Network Survey data. This depicts a healthy network with a strong, dense core, a slightly looser layer of inner periphery of those who may be more connected elsewhere than within this network, and an outer periphery of those who are loosely connected, mostly through one person.

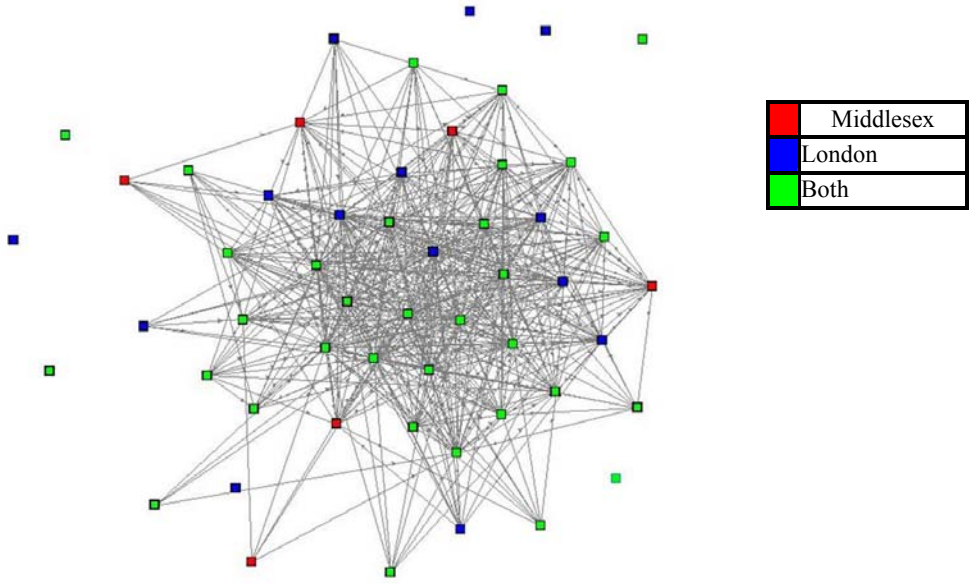


Figure 2 indicates in which geographical area of Middlesex-London the work of an organization is focused. Participants could choose London, Middlesex County, or both London & Middlesex. The map shows that those who work in both areas or in London alone are well-connected and included strongly in the core of this particular network. There appears to be a tendency for those who work only in Middlesex to be more on the periphery of the network and be less well-connected to the core and to each other.

Francophone Network Map

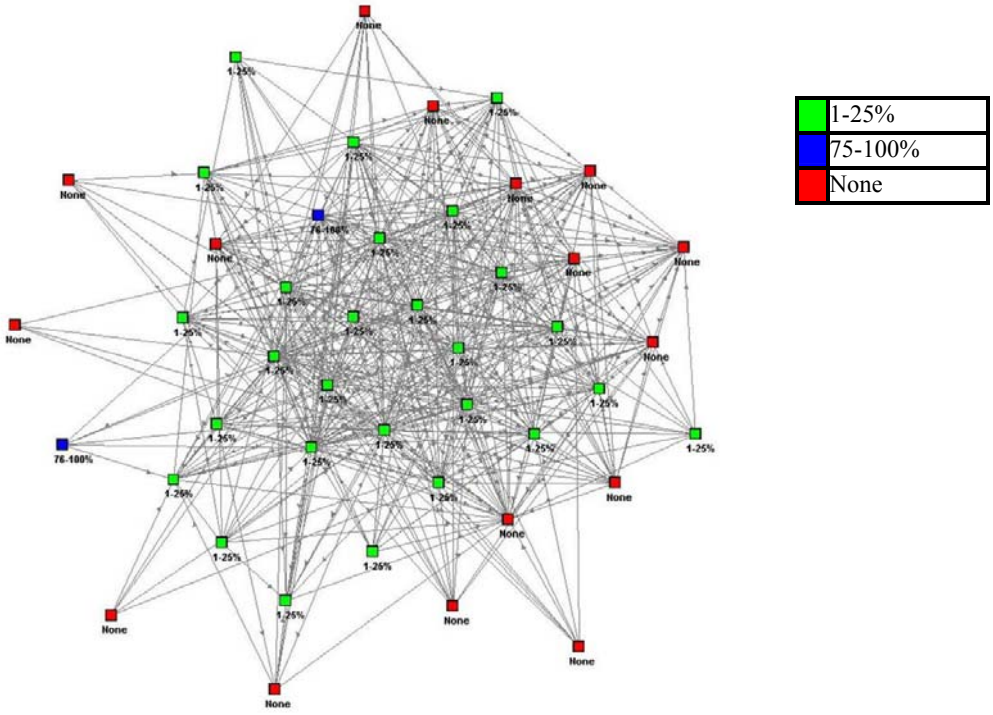


Figure 3 depicts the percentage of work that respondents do with the Francophone community. There are a scattering of 'None' responses, but most respondents indicated that they do have at least some proportion of Francophone clients. As one might expect in an area with less than 10% Francophone population, there are many organizations with less than 25% of their service provided to Francophones. There are a couple of organizations dedicated to that population, with over 75% of their service to Francophones.

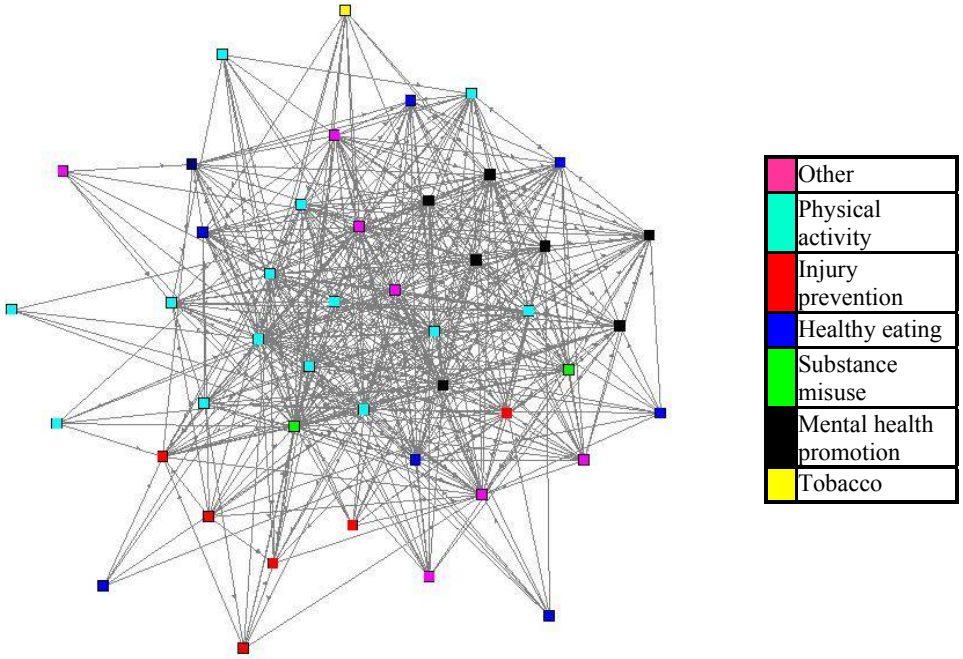


Figure 4 indicates the Healthy Communities topic area that is ranked as a top priority for those completing the survey. Physical activity appears strongly, as does mental health promotion. Healthy eating appears mostly peripherally as a top priority. Tobacco appears only once as a top priority, a pattern across the province. Substance misuse appears only twice, a common pattern across the province, indicating an opportunity to strengthen those connections. Injury prevention is peripheral, but well-represented and connected to the core. All the priority areas are represented and are connected to each other. The partnership is in a good position to act on all six priorities and to expand and strengthen the network to do so.

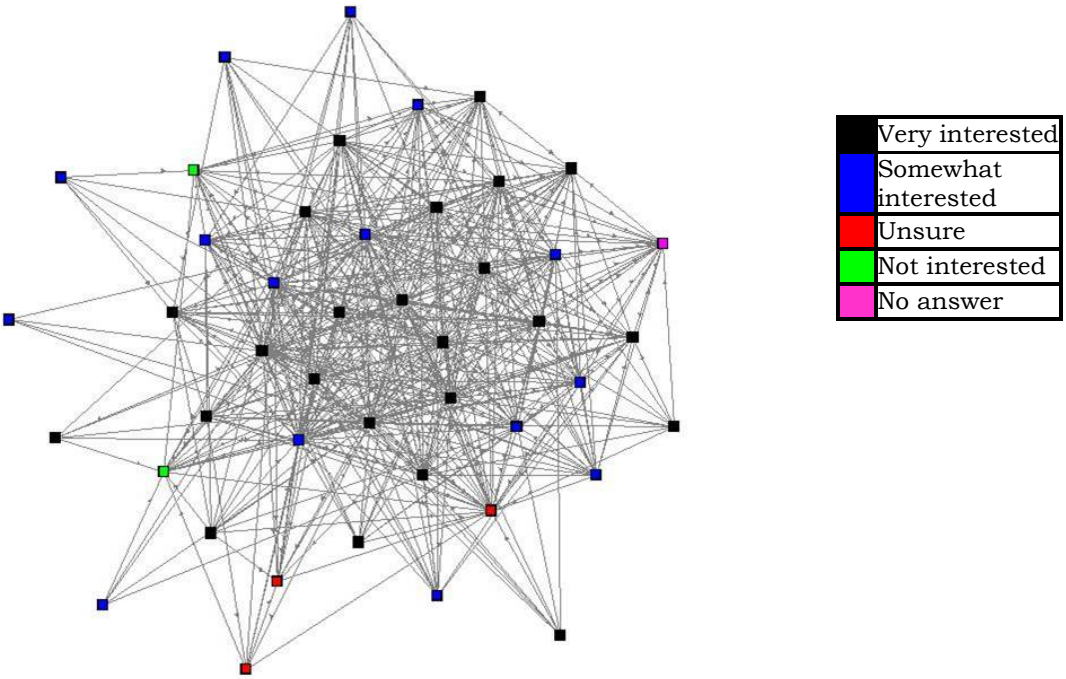


Figure 5 indicates the vast majority of survey respondents were at least somewhat interested in policy work. About half were very interested, including many in the core of the network. This gives the partnership an excellent base from which to move into more policy-oriented work.

Notes on Methodology

The Middlesex-London Health Unit chose to do the survey via paper and pencil rather than an electronic survey. This strategy, while addressed issues of confidentiality did create some degree of error. For example this method of survey completion allowed people to give more than one answer on questions for which only one answer was to be collected. In those cases, in order to be consistent Health Nexus entered the respondents' first choice into the dataset only. This may have created a tendency for the earlier choices within a question to appear more often than they might otherwise.

In addition, Middlesex-London also chose to map organizations versus individual contacts, if more than one person from an organization responded, their relationship data was combined.

Source of Maps and Analysis: Schwenger, Schultz, Kalda, Dieleman, & Carbotte. (February 2011). Health Nexus Mapping [Communication from Health Nexus].

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

HEALTHY COMMUNITIES PARTNERSHIP MIDDLESEX-LONDON
LEVEL OF INVOLVEMENT FORM

Please take a moment to let us know how you would like to be involved with the Healthy Communities Partnership Middlesex-London. Indicate your projected level of involvement and the corresponding geographic area(s) of interest.

	Geographic Region		
Level of Involvement	**Middlesex County**	**City of London**	**Joint London & Middlesex**
CORE Actively involved in the planning process on an ongoing basis			
INVOLVED Engaged in one or more specific aspects of Healthy Communities and available for consultation			
SUPPORTIVE Provide support to the project by participating in a specific function or providing resource(s), e.g., $, space, data, access to clients			
PERIPHERAL Receive information regarding the work and progress of the project through periodic updates; not directly involved			
NO INVOLVEMENT			

Name: _____

Agency: _____

Email: _____ Phone: _____

Healthy Communities Priority Areas of interest to you/the agency that you are representing (check all that apply):

☐ Physical activity, sport & recreation ☐ Injury Prevention ☐ Healthy Eating

☐ Tobacco Use/Exposure ☐ Substance & Alcohol Misuse ☐ Mental Health Promotion

We are considering holding more in-depth topic specific workshops and priority setting sessions in early 2011.

May we contact you by phone or email to participate? Yes □ No □

Please indicate if there is anyone **not** here today that you feel we should invite?

Stakeholders Wheel

Sectors	Government	Health-Related	Non-Health Services	Community / Grass Roots	Private
Core	-City of London – Child & Youth Network *Ministry of Health Promotion & Sport *Middlesex County Planning Dept	*Centre for Addiction & Mental Health *London Health Science Centre (2) *Middlesex London Health Unit (HCIP, CHT, Tobacco) *Heart & Stroke Fdn *Middlesex County Stroke Strategy *Ontario Osteoporosis Society	*Centre communautaire regional de London *London District Catholic School Board *Road Safety Committee *UWO Geography	*London Cross Cultural Learner Centre (2) *Chippewas of the Thames First Nation *Hutton House *United Way of London & Middlesex	
Involved	*City of London Research & Policy / Recreation Neighbourhoods *COL-Community Services (Food Charter, Smart Moves, Parks & Recreation, etc) *COL Community Safety & Crime Prevention Advisory Committee *Ministry of Transportation	*Alzheimer Society of London & Middlesex *Brain Injury Assoc of London & Middlesex *-Cdn Cancer Society *LHSC-Healthy Weight Study *SJHC / Age Friendly *Southwest Ontario Aboriginal Health Access Centre	*Glen Cairn Cmty Res Centre *La Ribambelle *-Local Immigration Partnership – Health & WB SC *OPHEA -Reseau franco-sante du Sud de l'Ontario *Thames Valley District School Board	*Middlesex-London in motion *mind your mind Family Service Thames Valley *Youth Opportunities Unlimited	
Supportive	*London Police Services	-London Intercommunity Health Centre	*OMAFRA *Middlesex Community Living *MC Perth Middlesex Early Years	*Seniors Community Assoc -Boys & Girls Club London -Strengthening Neighbourhoods -Table de concertation francophone de London et des environs	

Sectors	Government	Health-Related	Non-Health Services	Community / Grass Roots	Private
Peripheral	*London Police Services -Middlesex Centre Corporate Support -Middlesex County – Community Futures Development Corporation -Southwest Middlesex Recreation -Thames Valley Family Health Team	-Addiction Services Thames Valley *Cdn Diabetes Assoc -Epilepsy Support Centre -Family Service Thames Valley -London Health Sciences Centre-Healthy Weight Study -Parkwood Hospital-Specialized Geriatrics *SEARCH Cmty Mental Health Services (MC) *Southwest Ontario Aboriginal Health Access Centre (2) -Southwest CCAC *Southwest LHIN -WOTCH Community Mental Health Services	*Brescia University College -Centre communautaire regional de London -Hutton House for Adults with Disabilities -London District Catholic School Board -London Public Library -Middlesex Community Living -Ontario Early Years Centres-Perth-Middlesex -Thames Valley Children's Services -YMCA	-Arthur Labatt Family School of Nursing, Faculty of Health Sciences -Brescia University College *Canadian Centre for Activity & Aging *Child Safety Middlesex-London -Connecting London's Seniors Project -Local Immigration Partnership -London Regional Chidlren's Museum *Middlesex Cty Library -Networking for an Inclusive Community -Seniors Community Assoc -Thames Region Ecological Assoc -Youth Opportunities Unlimited	*Sportsxpress

COL = City of London; MC = Middlesex County

Summary of Recommended Actions by Priority Issue
Healthy Communities Partnership Middlesex-London

Middlesex-London: Who are we?

Total population: 422,333
Middlesex County population: 69,938
City of London population: 352,395

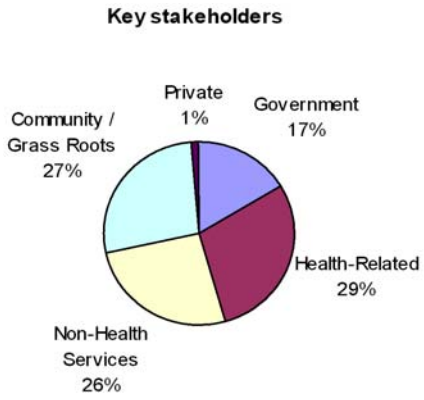
Rural Population: 10.9% Urban Population: 89.1%

- Overall, the Middlesex-London population is aging, similar to trends seen for the rest of the province.
- Middlesex-London has more adults 20-29 years of age compared to the province, with a greater proportion of children and youth in the County compared to the City.
- 1.4% of the population are Aboriginal, living off-reserve.
- 12% of the population are visible minorities, with a higher number in the City compared to the County.
- New immigrants make up 15% of the total immigrant population, with 98% residing in the City.
- About 1 in 5 Middlesex-London residents' mother tongue is a language other than English or French.
- 1.4% report French as their mother tongue and 0.4% report French as the language spoken at home.
- Spanish is the most common non-official language spoken at home in Middlesex-London.
- 13% of individuals age 25-64 years in Middlesex-London, did not graduate from high school.
- 1 in 10 individuals in Middlesex-London are low-income earners, with a higher proportion of low-income earners in the City versus the County.
- 1 in 4 Middlesex-London families with children at home are lone-parent families.

The Ministry of Health Promotion and Sport's, Healthy Communities Fund Partnership Stream supports the work of the Middlesex-London Health Unit (MLHU) to identify local policy needs while engaging with the community. To that end the MLHU developed a strategy to consult with various individuals, groups and agencies to identify recommendations/actions for each of the six priority areas: physical activity, sport and recreation; healthy eating; tobacco use/exposure; injury prevention; substance and alcohol misuse and mental health promotion. The recommendations are not limited to policy but include education/awareness, program and services, capacity building and supportive environment.

This strategy has brought forward members from a wide cross-section of the community, with some aligned to specific priority areas, allowing for rich, knowledgeable exchange. It is important to note that Middlesex-London community members and agencies are passionate about their community as evidenced by the numerous initiatives currently underway.

Community stakeholders completed a Level of Involvement form to identify their level of interest in the Healthy Communities Partnership-Middlesex London (HCP-ML). From the interest expressed, several stakeholders formed the Core Group (CG) to help refine the community-identified recommendations for action. To identify two recommendations for each of the six priority areas, the CG reviewed surveillance data, current evidence and applied a decision-making framework with the following criteria: impact; capacity and feasibility; partnership and collaboration, and readiness. It is important to note that 2 overarching messages presented consistently in all consultations were the need for sustainable funding and access to all resources in both official/other languages.



Physical Activity

- Middlesex-London physical activity levels have decreased significantly since 2003.
- The 2009 *in motion*® Middlesex-London survey (self-reported or parent-reported) reveals only 35% of adults, 30% of youth, and 44% of children were physically active enough for health benefits.
- Direct measures (not self-reported) in Canadian studies indicate that these levels are actually lower, with only 15% of adults (Canadian Health Measures Survey) and 7% of children and youth in Ontario, ages 6-19 (Canadian Health Measures Survey) achieving recommended levels of physical activity.
- Levels for preschool children are unavailable.

Recommendations

Healthy Eating & Healthy Weights

- Rates of fruit and vegetable consumption have decreased between 2003 and 2009; about 1 in 3 people eat 5+ vegetables and fruit per day which is somewhat lower than Ontario.
- Overweight and obesity rates in Middlesex-London rose from 48% to 54% between 2003 and 2009.
- A local study in 2001-2003 of children 6-12 years found 29% of boys and 28% of girls overweight or obese.

Recommendations

3. Advocate for policies at all levels that address healthy eating, always ensuring economic and cultural sensitivity. This could include policies related to healthy/local fresh food access, media & advertising, local foods, food subsidies, healthy food options in cafeterias, foods served during meetings, fundraising, and sodium levels.
4. Increase skill building opportunities to augment individual/community capacity for healthy eating. Focus attention on parents and other target groups (e.g. youth and seniors), ensuring cultural/age sensitivity.

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Tobacco use and exposure

- Smoking rates decreased over the last decade and the current rate is 20% (16% daily, 4% occasionally).
- Highest tobacco use is among males, 20-34 year olds and those with a lower level of education.
- Younger people (12-19 years) are more likely to be exposed to environmental tobacco smoke or second hand smoke.
- In youth 12-19 years, the proportion of smokers was 14% in 2000/01 and 16% in 2003.

Recommendations

3. Expand smoking restrictions (private and public) in outdoor spaces/outside doorways and parks.
4. Advocate for all addiction treatment agencies and mental health agencies helping clients to quit smoking.

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Injury Prevention

- Leading causes of unintentional injuries in Middlesex-London are motor vehicle traffic crashes and falls.
- Falls are the leading cause of hospitalizations in all age groups but are more prevalent among seniors age 65+.
- Numbers of motor vehicle collisions leading to injuries and fatalities have declined considerably since 1989, but are still the main cause of death due to unintentional injuries among those under the age of 65 years.
- Injuries are the leading cause of death in all children and youth.

Recommendations

3. Develop a large media campaign to change culture/norms and perception of injuries as “part of life” and reduce the stigma of asking for assistance related to injury prevention.
4. Advocate for policies that include the physical environment and safety (snow removal, cross walk signals, speed zones near schools, building codes for seniors’ housing), integrated into municipal Master plans.

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Alcohol & Substance Misuse

- 15% of Middlesex-London residents monthly consume 5 or more drinks on one occasion; most common among males, younger age groups, and those with lower education.
- 1 in 4 people in Middlesex-London exceed recommended levels of alcohol intake (low-risk drinking guidelines).

Recommendations

3. Develop a comprehensive strategy related to sensitivity training for Health Care Providers for alcohol and substance misuse education, screening, and prevention.
4. Implement an education/policy initiative to increase understanding within families, guidance counsellors, and the community in order to decrease stigma for those with substance misuse issues and increase recognition of signs of addiction and heavy drinking.

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Mental Health Promotion

- 95% of residents rate their mental health to be good, very good or excellent.
- 70% of residents experience a sense of belonging; however, 1 in 4 report feeling that most days in their life are quite a bit or extremely stressful.

Recommendations

3. Implement awareness and skill building for anti-bullying and to reduce aggression across the life span within the community.
4. Advocate for equitable access to mental health services for vulnerable populations including routine mental wellness assessments; support programs that help foster “sense of belonging”; linking existing initiatives, and ensuring that schools have daily coverage by either social worker and/or public health nurse. As well have enhanced training of health care workers/settlement workers to populations needs.

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Partenariat Communautés en santé de London-Middlesex

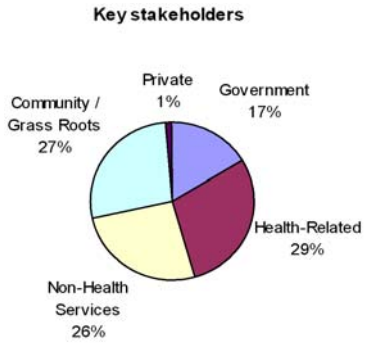
Middlesex-London : Qui sommes-nous?

Population totale: 422 333
Population du comté de Middlesex: 69 938
Population de London: 352 395

Population rurale: 10,9 % Population urbaine: 89,1 %

- Dans l'ensemble, la population de Middlesex-London vieillit, conformément aux tendances observées dans le reste de la province.
- La région de Middlesex-London a plus d'adultes âgés entre 20 et 29 ans par rapport à la province, avec une plus grande proportion d'enfants et de jeunes dans le comté que dans la ville.
- Au total, 1,4 % de la population est d'origine autochtone, vivant hors-réserve.
- En tout, 12 % de la population fait partie des minorités visibles, un plus grand nombre vivant dans la ville que dans le comté.
- Les nouveaux immigrants représentent 15 % de la population immigrée totale, dont 98 % résident dans la ville.
- La langue maternelle d'environ 1 résident de Middlesex-London sur 5 est autre que l'anglais ou le français.
- En tout, 1,4 % des habitants ont déclaré que le français est leur langue maternelle, et 0,4 % ont signalé que c'est la langue parlée à la maison.
- L'espagnol est la langue non officielle la plus couramment parlée à la maison dans la région de Middlesex-London.
- En tout, 13 % des personnes âgées entre 25 et 64 ans dans la région de Middlesex-London n'ont pas obtenu un diplôme d'études secondaires.
- Une personne sur 10 dans la région de Middlesex-London gagne un faible revenu, une proportion plus élevée de personnes à faible revenu résidant dans la ville plutôt que le comté.
- Une famille sur 4 avec enfants à la maison dans la région de Middlesex-London est une famille monoparentale.

Le ministère de la Promotion de la santé et des Sports, Fonds pour les communautés en santé, Volet des partenariats, appuie le travail du Bureau de santé de Middlesex-London (MLHU) visant à cerner les besoins de la région en politiques tout en échangeant avec la communauté. À cette fin, le MLHU a élaboré une stratégie pour consulter différents personnes, groupes et organismes afin de formuler des recommandations et prendre des mesures relativement à chacun des six domaines prioritaires : l'activité physique; le sport et les loisirs; l'alimentation saine; le tabagisme et l'exposition au tabac; la prévention des blessures; l'usage abusif d'alcool et de drogues; et la promotion de la santé mentale. Les recommandations ne sont pas limitées aux politiques, mais comprennent l'éducation/la sensibilisation, les programmes et services, le renforcement des capacités et un milieu de soutien.



Cette stratégie a rassemblé des membres représentant un large échantillon de la communauté, dont certains sont alignés sur des domaines prioritaires particuliers, ce qui a favorisé des échanges éclairés approfondis. Il est important de noter que les membres de la communauté et organismes de Middlesex-London sont passionnés par leur communauté, comme en témoignent les nombreux projets actuellement en cours.

Les intervenants communautaires ont rempli un formulaire de niveau de participation, afin de déterminer leur niveau d'intérêt dans le Partenariat Communautés en santé de London-Middlesex (HCP-ML). D'après les résultats, plusieurs intervenants ont formé le groupe de base (Core Group [CG]) pour aider à peaufiner les recommandations d'action formulées par la communauté.

Dans le but de cerner deux recommandations pour chacun des six domaines prioritaires, le CG a examiné les données de surveillance et les preuves actuelles, et a mis en place un cadre de prise de décision comprenant les critères suivants : incidence; capacité et faisabilité; partenariat et collaboration; et état préparation. Il est important de noter que 2 messages généraux présentés systématiquement dans toutes les consultations ont été le besoin d'un financement durable et l'accès à toutes les ressources dans les deux langues officielles/autres langues.

Activité physique

- Les niveaux d'activité physique de Middlesex-London ont fortement diminué depuis 2003.
- En 2009, le sondage *in motion*® de Middlesex-London (auto-déclaré ou déclaré par les parents) a révélé que seulement 35 % des adultes, 30 % des jeunes et 44 % des enfants étaient assez actifs physiquement pour en tirer des bienfaits pour la santé.
- Les mesures directes (non auto-déclarées) dans les études canadiennes indiquent que ces niveaux sont en fait plus faibles, vu que seulement 15 % des adultes (Enquête canadienne sur les mesures de la santé) et 7 % des enfants et jeunes en Ontario, âgés entre 6 et 19 ans (Enquête canadienne sur les mesures de la santé) répondent aux niveaux recommandés d'activité physique.
- Les niveaux relatifs aux enfants d'âge préscolaire ne sont pas disponibles.

Recommandations

3. Préconiser l'appui par toutes les municipalités d'une charte d'activité physique, veillant à ce que cette dernière soit respectueuse de l'âge et adopte une approche de longévité.
4. Plaider pour un appui et un financement (y compris la dotation en personnel) à tous les niveaux pour parvenir à une infrastructure (environnement bâti et conception) et des programmes qui habilitent/améliorent/accroissent l'activité physique dans la communauté.

Alimentation et poids sains

- Les taux de consommation de fruits et légumes ont diminué entre 2003 et 2009; environ 1 personne sur 3 mange 5 fruits et légumes ou plus par jour, ce qui est légèrement inférieur à celui de l'Ontario.
- Le surpoids et l'obésité dans la région de Middlesex-London est passée de 48 % à 54 % entre 2003 et 2009.
- Une étude locale menée entre 2001 et 2003 sur les enfants âgés entre 6 et 12 ans a révélé que 29 % des garçons et 28 % des filles font du surpoids ou sont obèses.

Recommandations

5. Préconiser des politiques à tous les niveaux qui portent sur l'alimentation saine, tout en ménageant les sensibilités économiques et culturelles. Il peut s'agir de politiques liées à l'accès à des aliments frais sains/ locaux, aux médias et aux annonces publicitaires, aux aliments locaux, aux subventions alimentaires, aux choix alimentaires sains dans les cantines, aux aliments servis lors de réunions, à la collecte de fonds et aux niveaux de sodium.
6. Accroître les possibilités de renforcement des compétences pour augmenter la capacité collective/individuelle pour une alimentation saine. Concerter les efforts sur les parents et d'autres groupes cibles (par exemple, les jeunes et les personnes âgées), tout en ménageant les sensibilités culturelles/liées à l'âge.

Tabagisme et exposition au tabac

- Les taux de tabagisme ont diminué au cours de la dernière décennie, et le taux actuel se monte à 20 % (16 % de personnes fument tous les jours, 4 % occasionnellement).
- Le niveau de tabagisme est plus élevé chez les hommes âgés entre 20 et 34 ans et ceux ayant un faible niveau d'éducation.
- Les personnes plus jeunes (de 12 à 19 ans) sont plus susceptibles d'être exposées à la fumée du tabac ambiante ou à la fumée courante indirecte.
- Chez les jeunes âgés entre 12 et 19 ans, la proportion de fumeurs était de 14 % en 2000-2001 et de 16 % en 2003.

Recommandations

5. Établir des interdictions de fumer (privées et publiques) dans les espaces extérieurs/entrées de portes et les parcs.
6. Plaider en faveur de tous les organismes de traitement des dépendances et de santé mentale, qui aident les clients à cesser de fumer.

Prévention des blessures

- Les principales causes de blessures non intentionnelles dans la région de Middlesex-London sont les accidents de circulation impliquant des véhicules à moteur et les chutes.
- Les chutes sont la principale cause des hospitalisations chez tous les groupes d'âge, mais sont plus fréquentes chez les personnes âgées de 65 ans et plus.

- Les collisions impliquant des véhicules à moteur et causant des blessures et des décès ont diminué considérablement depuis 1989, mais demeurent la principale cause de décès due à des blessures non intentionnelles chez les personnes âgées de moins de 65 ans.
- Les blessures sont la principale cause de décès chez tous les enfants et jeunes.

Recommandations

5. Organiser une importante campagne médiatique pour changer la culture/les normes et la perception des blessures comme «faisant partie de la vie» et réduire le tabou de demander de l'aide liée à la prévention des blessures.
6. Plaider en faveur de politiques relatives à l'environnement physique et à la sécurité (déneigement, signaux pour piétons, zones de vitesse près des écoles, codes du bâtiment pour le logement des personnes âgées), qui soient intégrées aux plans directeurs des municipalités.

Abus d'alcool et de drogues

- Au total, 15 % des résidents de Middlesex-London consomment mensuellement 5 verres ou plus en une occasion; cela est plus courant chez les hommes, dans les groupes d'âges plus jeunes, et les personnes qui sont moins éduquées.
- Une personne sur 4 à Middlesex-London dépasse les niveaux recommandés de consommation d'alcool (directives de consommation à faible risque).

Recommandations

5. Élaborer une stratégie globale en matière de formation aux sensibilités à l'intention des fournisseurs de soins de santé concernant l'éducation, le dépistage et la prévention de l'alcoolisme et de la toxicomanie.
6. Mettre en œuvre une initiative d'éducation/de politique visant à accroître la compréhension au sein des familles, des conseillers d'orientation et de la communauté afin de réduire la stigmatisation des personnes souffrant de problèmes d'abus de substances toxiques et d'accroître la reconnaissance des signes de dépendance et d'usage abusif d'alcool.

Promotion de la santé mentale

- Au total, 95 % des résidents considèrent que leur santé mentale est bonne, très bonne ou excellente.
- En tout, 70 % des résidents ont un sentiment d'appartenance, mais 1 personne sur 4 dit se sentir assez ou extrêmement stressée presque tous les jours.

Recommandations

5. Mettre en œuvre des stratégies de sensibilisation et de renforcement des compétences anti-intimidation, pour réduire l'agressivité tout au long de la vie au sein de la communauté.
6. Plaider en faveur d'un accès équitable aux services de santé mentale pour les populations vulnérables, y compris des évaluations périodiques du bien-être mental; des programmes de soutien qui contribuent à promouvoir «le sentiment d'appartenance»; établir un lien entre les projets en cours; et veiller à ce que les écoles reçoivent quotidiennement la visite d'un travailleur social et/ou d'une infirmière de santé publique. En outre, offrir une meilleure formation aux professionnels de la santé/travailleurs d'établissement, qui répond aux besoins de la population.

MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Health Unit
Policy Scan Validation
of the
Ontario Heart Health Network (OHHN)
Collaborative Policy Scan Project Summary Report
for the Healthy Living Partnership
Middlesex - London

January, 2011

Acknowledgements

We would like to thank the Ontario Heart Health Network (OHHN) Policy Scan working group for the initial scan of healthy policies in municipalities of Ontario. Further thanks extend to Perth County Health Unit for sharing their approach and documents for validating the OHHN Policy Scan. Finally, we are grateful for Middlesex-London municipal representatives who contributed in the completion of this local report by validating the OHHN Policy Scan and providing additional information about local healthy policies.

For More Information about the Ontario Heart Health Network (OHHN) Report

This document was compiled for the Middlesex-London Healthy Communities Partnership, funded by the Ministry of Health Promotion and Sport. For more information or to obtain a full copy of the OHHN report, visit: http://www.hhrc.net/ohhn/policy/index.cfm and click on "Healthy Living Partnership Middlesex" for the local OHHN report.

Policy Scan Validation Methodology

Ontario Heart Health Network (OHHN) Project Overview

"The Ontario Heart Health Network (OHHN) Policy Work Group conducted a scan of policies across the 36 Ontario Heart Health Network-Taking Action for Healthy Living Community Partnerships in five areas:

6. Access to nutritious foods
7. Access to recreation and physical activity
8. Active transportation and the built environment
9. Prevention of alcohol misuse
10. Prevention of tobacco use and exposure.

The purpose of the scan was to create a baseline inventory of the policies that exist at the provincial level based on local data" (OHHN, 2009, p.2).

OHHN Policy Definition

The OHHN policy definition used was:

- A principle, value or course of action that guides present and future decision-making
- Can be implemented in a variety of settings, such as schools, worksites and communities
- Can be formal and informal, but it should specify expectations, regulations and guides to action
- Can provide more equitable access to determinants of health such as income, housing and education, and
- Can have a consequence for non-compliance and some method of enforcement.

(OHHN, 2009, p.2)

OHHN Data Collection

"A protected, web-based data collection system that standardized the data collection of eleven consultants was designed and utilized. Data was collected between October 26, 2009 and December 13, 2009 by scanning publicly available web sites and/or contacting representatives via telephone or email using information provided by OHHN members" (OHHN, 2010, p.10).

Municipal data was collected from 9 Middlesex-London municipalities:
City of London, Strathroy-Caradoc, North Middlesex, Southwest Middlesex, Thames Centre, Lucan-Biddulph, Adelaide-Metcalfe, Middlesex Centre, Village of Newbury

School Board data was collected from:
Thames Valley District School Board and London District Catholic School Board

Additional Priority Area Policy Scan

There were three priority areas of the Ontario Ministry of Health Promotion and Sport, Healthy Communities Partnership stream that were not scanned for within the Ontario Heart Health Network (OHHN) Policy Scan.

Thus, for the priority areas of Injury Prevention, Substance Misuse, and Mental Health, two Public Health Nurses at the Middlesex-London Health Unit created Policy Scan questions with advice from community partners that possess expertise for each priority area.

Middlesex-London Validation Process

Letters explaining the OHHN policy scan and a summary of Middlesex-London findings from the OHHN report were sent electronically to local partners with a request to validate/update their respective information. Through the validation process, partners identified the existence/non-existence of a policy. An opportunity to provide information about local policies related to the priority areas of Injury Prevention, Substance Misuse, and Mental Health policies were presented at the end of the survey.

However, this does not imply the policy is comprehensive, or in the case of municipalities that the policy is an existing by-law. Partners also provided anecdotal comments on policies to be reviewed in the future, as well as practice in place which are not formal policies.

POLICY SCAN VALIDATION – MUNICIPALITIES

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1. Access to Nutritious Foods									
1.1 Policies that restrict advertising of food products to children (transit ads, recreation centres)	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
1.2 Policies that support the availability of healthy foods in: vending machines	**→ PLANS TO REVIEW AND DEVELOP POLICY** **Child & Youth Agenda, Healthy Eating/ Physical Activity working group:** Healthy food access a priority area for 2011. Intend to review practices in community centres and arenas. Introduction of **PPM 150** in schools across the Province (see School Board policy scan) indicates that anywhere school activities take place must sell healthy food options,	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
	including community centres/arenas.								
1.3 Policies that support the availability of healthy foods in: snack bars and cafeterias	**→ PLANS TO REVIEW AND DEVELOP POLICY** **Child & Youth Agenda, Healthy Eating/Healthy Physical Activity working group:** (See 1.2 description)	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
1.4 Policies that support the availability of healthy foods in: concession stands in public places	**→ PLANS TO REVIEW AND DEVELOP POLICY** **Child & Youth Agenda, Healthy Eating/Healthy Physical Activity working group:** (See 1.2 description)	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.5 Food and nutrition policies to encourage support for local sustainable agriculture	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Agriculture, Rural, Settlement and Urban Reserve Land Use"** **POLICY IN DEVELOPMENT** **"The Food Charter"** to be approved by City Council.	****NO POLICY**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Preservation of Prime Agriculture Land"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Official Plan"**	**NO POLICY**	**NO POLICY**	**NO POLICY** Municipality would like to see a policy on this.	**NO POLICY**
1.6 Policies that support community gardens such as: garden water use policy	**→ PLANS TO REVIEW AND DEVELOP POLICY** NEIGHBOUHROODS Funding support for **London Community Resource Centre** to coordinate community gardens. Many gardens are located on City of London property and are maintained by City of London Parks and Operations staff.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
	A review of community gardens practices is currently underway, recommended as part of the **London's Strengthening Neighbourhoods Strategy.**								
1.7 Policies that support community gardens such as: vacant lots policy	****NO POLICY** No vacant lots policy/guidelines available for vacant lot gardening. See 1.6 for Community Gardens support (review of practices underway).	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
1.8 Policies that support community gardens such as: interim land use policies	****NO POLICY** There is no policy for interim land use policies for gardening in apartment complexes.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.9 Policies to source and procure local foods	****→ POLICY IN DEVELOPMENT** GENERAL COMMUNITY **"Food Charter"** to be approved by City Council.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	****→ POLICY IN DEVELOPMENT** A **Food Charter** is under review.	**NO POLICY**
1.10 Policies to support availability of broader variety of foods from street vendors	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
1.11 Policies that support the establishment of Farmers Markets or the revision of existing policies that impede their establishment	****→ PLANS TO REVIEW AND DEVELOP POLICY** **London Strengthening Neighbourhoods Strategy** & **Child & Youth Agenda** speak to community building that may include the establishment of Farmers Markets as a way to provide access to healthy foods in neighbourhoods (e.g. at Western Fair).	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Zoning Bylaw"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Zoning Bylaw"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Zoning Bylaw"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Zoning Bylaw"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Zoning Bylaw"** Currently reviewing planning documents to further support farmers' markets.	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.11 (continued)	**(1.11 cont)** **Neighbourhood action plans** are being developed in Westminster neighbourhood, Kipps Lane neighbourhood (currently holding a Cultural Market), and other neighbourhoods will be considered in the future.	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**	**(1.11 continued)**
1.12 Policies related to reduction in the use of artificially produced trans fat contained and sold in municipal-operated facilities	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.13 Policies that support breastfeeding	**NO POLICY** City of London does provide breastfeeding space in many facilities and partner facilities such as Middlesex-London Health Unit clinics that promote breastfeeding.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
1.14 Policies related to welfare supplements being used to purchase nutritious foods	****→ POLICY IN DEVELOPMENT** GENERAL COMMUNITY See the **Child and Youth Agenda – Ending Poverty** work plan. Some lobbying may also be occurring with the **"Food Charter".**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.15 Does the municipality promote or sponsor healthy food access maps	****NO POLICY** There are several neighbourhoods that have produced **asset maps** (including grocery stores). A **"Get Fresh… Eat Local"** map of locally grown produce is done by the Middlesex Federation of Agriculture, for a cost of $100 for farmers who would like to be included in the map. 3rd Edition is currently underway, to be released in the spring or summer, 2011. All farmers welcome to join the map, regardless of the union to which they belong.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
1.16 Does the municipality have a Food Charter	**→ **POLICY IN DEVELOPMENT** GENERAL COMMUNITY A **Food Charter** was developed by the **Child & Youth Agenda, Ending Poverty** & **Healthy Eating/Healthy Physical Activity** working groups. To be presented to / approved by City Council.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**→ **POLICY IN DEVELOPMENT** A **Food Charter** has been drafted and anticipated to go to Council for adoption in February, 2011.	**NO POLICY**
1.17 Committee that focuses on policies related to access to nutritious food	**✓ **COMMITTEE IN PLACE** FOR CHILDREN AND YOUTH **Child & Youth Agenda** focus on nutritious food access as part of work plan (**Healthy Eating/Healthy Physical Activity)**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**✓ STAFF TEAM IN PLACE** Team is reviewing the importance of local food.	**NO POLICY**
2. Access to Recreation and Physical Activity									
2.1 Policies to ensure people living on low income have access to municipal	**✓ POLICY IMPLEMENTED** INDIVIDUALS IN LOW-INCOME SITUATIONS **Chapter 17:**	**✓ POLICY IMPLEMENTED** INDIVIDUALS IN LOW-INCOME SITUATIONS "Can I Play Too" program	**NO POLICY**	**✓ POLICY IMPLEMENTED** INDIVIDUALS IN LOW-INCOME SITUATIONS "Can I Play Too" program	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
recreation/sport programs	**Financial Assistance for Program Activity Fees**	sponsored by County of Middlesex. Apply through local rec. departments.		sponsored by County of Middlesex. Apply through local rec. departments.					
2.2 Policies related to intramurals and sport programs to ensure inclusive opportunity e.g. 'no cut' intramurals, 'no cut' team sport policies	**NO POLICY** There are many house league sports that use City facilities. No preference is given to ensure opportunity available for everyone.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
2.3 Interim Land Use policies to address the lack of open space for recreation	**NO POLICY** Specific neighbourhoods are part of City's community development. Owners of apartment complexes are in discussions with resident groups to allow access to / creation of community space in these buildings.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **"Official Plan"**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
2.4 Vacant lots policies for public use of private land	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
and city-owned vacant lots					**"Official Plan"**				
2.5 Is there a municipal Parks Master Plan	✓ **POLICY IMPLEMENTED**	**NO POLICY**	**NO POLICY**	**NO POLICY**	✓ **POLICY IMPLEMENTED** **"Community Services Master Plan"**	**NO POLICY**	**NO POLICY**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**
	GENERAL COMMUNITY, CHILDREN, YOUTH, ADULTS, FAMILIES/PARENTS, INDIVIDUALS IN LOW-INCOME SITUATIONS **"Section 16, Parks and Recreation"** outlines the City's Official Plan policies re: parks and recreation. More specific direction is provided in City's **"Parks and Recreation Master Plan"**							Middlesex Centre has budget monies for a new **Recreation Master Plan** to **include parks**.	

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
2.6 Is there a municipal Recreation Master Plan	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY, CHILDREN, YOUTH, ADULTS, FAMILIES/PARENTS, INDIVIDUALS IN LOW-INCOME SITUATIONS **"Parks and Recreation Master Plan" 2009 update**	**NO POLICY**	**NO POLICY**	**NO POLICY**	✓ **POLICY IMPLEMENTED**	**NO POLICY**	**NO POLICY**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
3. Active Transportation and the Built Environment									
3.1 Is there a municipal public transportation system	✓ **YES**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**
3.2 Is there a municipal Official Plan	✓ **POLICY IMPLEMENTED** ** **"Official Plan for the City of London"** **Review** scheduled for **2011.**	✓ **POLICY IMPLEMENTED** **"Township of Strathroy-Caradoc Official Plan" (2005)**	✓ **POLICY IMPLEMENTED** **"Municipality of North Middlesex Official Plan" (2004)**	✓ **POLICY IMPLEMENTED** **"Southwest Middlesex Official Plan" (2010)**	✓ **POLICY IMPLEMENTED** **"Thames Centre Official Plan" (Consolidated 2009)**	✓ **POLICY IMPLEMENTED** **"Township of Lucan Biddulph Official Plan" (2003)**	✓ **POLICY IMPLEMENTED** **"Consolidated Official Plan - Township of Adelaide Metcalfe" (2005)**	✓ **POLICY IMPLEMENTED** **"Municipality of Middlesex Centre Official Plan" (2003)**	✓ **POLICY IMPLEMENTED** **"Village of Newbury Official Plan (1985) - Updated as needed"**
3.3 Does the Official Plan incorporate active transportation policies	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY Found throughout the **"Official Plan for the City of London"**. **Section 2.11** outlines the **Transportation Planning Goal, Principles, and Strategies. Section 18-Transportation** contains policies related to the City's transportation system.	✓ **POLICY IMPLEMENTED**	✓ **POLICY IMPLEMENTED**	✓ **POLICY IMPLEMENTED**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
3.4 Are there risk management policies to support and encourage physical activity in municipal Official Plans?	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **Section 16, Parks and Recreation** outlines **Official Plan** policies regarding parks and recreation. These policies are land-use based, and describe the nature of parks and open space systems. Policies speak to the role of the parks system as a means of meeting the recreational needs of public. More specific direction provided in the **"Parks and Recreation Master Plan".** Risk management policies focus accessible and safe Active Transportation infrastructure.	**NO POLICY**	✓ **POLICY IMPLEMENTED**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
3.5 Does Official Plan have mixed/ priority land use policies for active transport?	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY Found in **"Official Plan"**	**✓ POLICY IMPLEMENTED**	****✓ POLICY IMPLEMENTED** Found in **"Official Plan"**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
	Section 2.11 outlines the **Transportation Planning Goal, Principles, and Strategies.** Also policies regarding **Transit Nodes and Corridors** that promote compact, transit-oriented, pedestrian friendly activity centres.	**)**							
3.6 Does Official Plan "Identify plans for infrastructure (e.g. sidewalks; bike lanes; shared-use paths) that support active transportation?"	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **See. 3.3 and 3.5**	**✓ POLICY IMPLEMENTED**	**✓ POLICY IMPLEMENTED**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
3.7 Is there a "sector" Transportation Demand Management Plan that incorporates active transportation	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY **City is currently updating its Transportation Master Plan (SmartMoves).**	****✓ POLICY IMPLEMENTED** **"Transportation Master Plan"**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
	Transportation Master Plan (SmartMoves) focuses on the transportation system, and will provide direction for the future development of the City's transportation system, recognizing the roles of cars, pedestrians, transit, the movement of goods, and the connection between land use and transportation. **Transportation Demand Management (TDM) policies** support active transportation infrastructure								

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
	and use								
4. Prevention of Alcohol Misuse									
4.1 Municipal Alcohol Policy	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Alcohol Risk Management Policy"**	**NO POLICY**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipality of Southwest Middlesex Alcohol Policy"**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	→ **POLICY IN DEVELOPMENT** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	**NO POLICY**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipal Alcohol Policy"** Planning to review an **Alcohol Monitoring Program**	**NO POLICY**
4.2 Policy that allows for special occasion permits (e.g. Oktoberfest events, Film Festival, Civic events not on municipal property)	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY, LICENSED OUTLETS, SERVING STAFF **"Alcohol Risk Management Policy"**	**NO POLICY**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipality of Southwest Middlesex Alcohol Policy"**	✓ **POLICY IMPLEMENTED** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	→ **POLICY IN DEVELOPMENT** GENERAL COMMUNITY **"Municipal Alcohol Policy"**	**NO POLICY**	**NO POLICY**	**NO POLICY**
4.3 Policies related to "Dial-a-Bottle" services	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
4.4 Policies that limit the number of licensed premises (outlet density) within a geographic area	**NO POLICY**	**NO POLICY** No restrictions in zoning bylaw.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
4.5 Policies that support safer bars training (the Centre for Addition and Mental Health – CAMH, program)	**NO POLICY** City of London does require Smart Serve training.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
4.6 Policies to reduce/ prevent services to minors or to intoxicated patrons	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, LICENSED OUTLETS, SERVING STAFF **"Alcohol Risk Management Policy"**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING STAFF **"Municipal Alcohol Policy"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING STAFF **"Municipality of Southwest Middlesex Alcohol Policy"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING STAFF **"Municipal Alcohol Policy"**	**→ POLICY IN DEVELOPMENT** GENERAL COMMUNITY, SERVING STAFF **"Municipal Alcohol Policy"**	**NO POLICY**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING STAFF **"Municipal Alcohol Policy"**	**NO POLICY**
4.7 Are there special occasion permits that allow	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, LICENSED	**✓ POLICY IMPLEMENTED** ▼ SOPs are	**✓ POLICY IMPLEMENTED** **"Municipal Alcohol Policy"**	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY, SERVING	**✓ POLICY IMPLEMENTED** **"Municipal Alcohol Policy"**	**✓ POLICY IMPLEMENTED** ▼	**✓ POLICY IMPLEMENTED** GENERAL COMMUNITY	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
alcohol to be sold? ▼ = Not able to determine if there are limits on who receives permits e.g. based on the # requested in past, past experience with requestor, past breaches	OUTLETS, SERVING STAFF **"Alcohol Risk Management Policy"** ▼	responsibility of LCBO only in Strathroy-Caradoc.	▼	STAFF **"Municipality of Southwest Middlesex Alcohol Policy"** ▼	STAFF **"Municipal Alcohol Policy"** ▼	▼		**"Municipal Alcohol Policy"** ▼	
4.8 Public documents that provide information regarding licensing premises fined or penalized for over-service	**NO POLICY**	**NO POLICY** No business licensing program.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
5. Prevention of Tobacco Use and Exposure									
5.1 Policies to prohibit tobacco use in municipally-owned outdoor spaces	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
5.2 Policies that ban tobacco	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
use at public entrances & exits to municipal buildings									
5.3 Tobacco free sport & recreation policies at local sports clubs	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
5.4 Policies to prohibit tobacco use on outdoor retail property	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
5.5 Policies for multiuse dwelling property owners, managers & tenants for the availability of smoke-free buildings	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
◊ 6. Mental Health									
6.1 Policies that promote mental health	NO POLICY Mental health is considered in City of London programming. Procedures in place for City	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
	staff to consider.								
◊ 7. Prevention of Substance Misuse									
7.1 Policies to prevent substance misuse	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
◊ 8. Injury Prevention									
8.1 Policies to promote traffic safety beyond national/ provincial policy, by-laws, and legislation already enforced by Police Services	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
8.2 Policies to promote pedestrian safety, beyond national/provincial policies, by-laws, and legislation already enforced by Police Services	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY
8.3 Policies	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO POLICY	NO

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
related to impaired driving, beyond meeting the provincial *Ontario Criminal Code* and the *Ontario Highway Traffic Act*									**POLICY**
8.4 Policies related to falls in children (e.g. window guards, balconies, playgrounds), beyond meeting provincial *Building Code Standards, Accessibility for Ontarians with Disabilities Act*	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
8.5 Policies related to falls in adults	✓ **POLICY IMPLEMENTED** Policies around the prevention of falls through **sidewalk maintenance** and **building access**.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
8.6 Policies related to drowning prevention, beyond meeting current municipal by-law related to private pool fencing	**NO POLICY** City offers **Learn to Swim** programs which target at-risk populations.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
8.7 Policies related to fire safety, beyond meeting the current provincial *Ontario Fire Code* and *Ontario Building Codes*	**NO POLICY** Adherence to codes Administered by the **London Fire Service** and **City of London's Building Control Division**.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY** Annual education program exists for children up to 12 years of age.	**NO POLICY**
8.8 Policies related to cycling safety, beyond meeting current national/provincial by-laws related to streets.	**→ PLANS TO REVIEW AND DEVELOP POLICY** GENERAL COMMUNITY **Sidewalk cycling in the Streets By-law** is currently under review.	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**
8.9 Policies related to	**NO POLICY**	**NO POLICY**	**✓ POLICY IMPLEMENTED**	**✓ POLICY IMPLEMENTED**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**✓ POLICY IMPLEMENTED**	**NO POLICY**

POLICY	City of London	Strathroy-Caradoc	North Middlesex	Southwest Middlesex	Thames Centre	Lucan-Biddulph	Adelaide-Metcalfe	Middlesex Centre	Village of Newbury
helmet use beyond meeting the current provincial *Ontario Bicycle Helmet Law*			Staff must wear helmets when working on an ice surface.	Helmets for ice pads at arenas.				Helmets during public skating.	
8.10 Policies related to off road safety (e.g. ATVs and snowmobiles)	✓ **POLICY IMPLEMENTED** Parks on private property have policies related to off road safety. Policies related to **City multi-use pathway use.**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**	**NO POLICY**

POLICY SCAN VALIDATION – BOARDS OF EDUCATION

1. Access to Nutritious Food		
	Thames Valley District School Board (TVDSB)	**London District Catholic School Board (LDCSB)**
Background	Thames Valley District School Board (TVDSB) has an independent procedure/guideline *Food in Our Schools* in place, created in 2001 and amended in 2008 to reflect a document called *A Call to Action: Creating a Healthy School Nutrition Environment* (http://www.osnpph.on.ca/pdfs/call_to_action.pdf). This is not a policy, rather a procedure/guideline of TVDSB. As of Sept. 2011, the Ministry of Education will roll out the *School Food and Beverage Policy (PPM 150)*. However, PPM 150 applies to food *sold* only. School Boards could update their own policies to match the standards of PPM 150 in order to use the same language, criteria, and include food *served* (e.g. at celebrations, at meetings, etc.). This could be done by following the *Food in Our Schools* guideline that also includes food served, role modelling, etc. As an example, Niagara has implemented a policy for their school board that applies both to food *sold* and *served* at schools. TVDSB is currently reviewing their *Food in Our Schools* independent procedure.	The *Healthy Foods and Beverages in Elementary School Vending Machines* policy refers to *Healthy Foods and Beverages in Elementary School Vending Machines.* In September 2011, as part of the overall strategy to promote a healthier lifestyle to young people, the new *School Food and Beverage Policy (PPM 150)* (http://www.edu.gov.on.ca/extra/eng/ppm/ppm150.pdf) established under the *Healthy Foods for Healthy Schools Act*, will replace the policy for *Healthy Foods and Beverages in Elementary School Vending Machines*" (http://www.edu.gov.on.ca/eng/healthyschools/healthyfoods.html). The name of the existing food and beverage policy on file for London District Catholic School Board (LDCSB) is *Nutrition.* This policy was implemented December 12, 2005, according to *A Call to Action for creating a Healthy School Environment*. If this policy is still in effect it could be updated to contain language and criteria consistent with *PPM 150* and needs to include both foods sold and served (e.g. at celebrations, at meetings, etc.). As an example, Niagara has implemented a policy for their school board that applies both to food *sold* and *served* at schools.
POLICY	**Thames Valley District School Board (TVDSB)**	**London District Catholic School Board (LDCSB)**
1.1 Policies that support the availability of healthy foods in: vending machines	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current Independent procedure/guideline is called **"Foods in our Schools"** for elementary school students. http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current policy is called **"Healthy Foods and Beverages in Elementary School Vending Machines"**
1.2 Policies that support the availability of healthy foods in: snack bars and cafeterias	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current Independent procedure/guideline is called **"Foods in our Schools"** for elementary school students. http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current LDCSB policy is called **"Nutrition"** policy and **"Healthy Foods and Beverages"**

POLICY	Thames Valley District School Board (TVDSB)	London District Catholic School Board (LDCSB)
1.3 Policies that support the availability of healthy foods in: at meetings	**NO POLICY** PPM 150 standards do not apply to food and beverages that are sold in staff rooms	**NO POLICY** The PPM 150 standards do not apply to food and beverages that are sold in staff rooms
1.4 Policies that support the availability of healthy foods in: fundraising activities	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** PPM 150 standards do not apply to food and beverages that are sold for fundraising activities that occur off school premises. Current Independent procedure/guideline is called **"Foods in our Schools"** for elementary school students. http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** PPM 150 standards do not apply to food and beverages that are sold for fundraising activities that occur off school premises. Current LDCSB policy is called **"Nutrition"** policy and **"Healthy Foods and Beverages"**
1.5 Policies that support the availability of healthy foods: breakfast, lunch, or snack programs	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current Independent procedure/guideline is called **"Foods in our Schools"** for elementary school students. http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	✓ **POLICY TO BE IMPLEMENTED**, SEPT 2011 **"School Food and Beverage Policy (PPM 150)"** Current LDCSB policy is called **"Nutrition"** policy and **"Healthy Foods and Beverages"**
1.6 Policies that support school gardens	**NO POLICY** Eco Schools in place – Under "Programs" in the Thames Valley Environmental Newsletter. School decision.	**NO POLICY**
2. Access to Recreation and Physical Activity		
2.1 Policies for mixed use of school grounds	✓ **POLICY IMPLEMENTED** FOR ELEMENTARY SCHOOL STUDENTS **"Community Use of Schools" (Ontario Ministry of Education)** for elementary school students. http://www.edu.gov.on.ca/eng/general/elemsec/community/	✓ **POLICY IMPLEMENTED** FOR ELEMENTARY SCHOOL STUDENTS **"Community Use of Schools" (Ontario Ministry of Education)** for elementary school students. http://www.edu.gov.on.ca/eng/general/elemsec/community/

POLICY	Thames Valley District School Board (TVDSB)	London District Catholic School Board (LDCSB)
2.2 Policies that reduce sedentary screen time while on school property	**NO POLICY**	**NO POLICY**
3. Active Transportation and the Built Environment		
3.1 Does the school board have active transportation policies for students to attend school	****NO POLICY** An example would be, "Walking Wednesdays" which is a Healthy Schools activity at some elementary schools.	**NO POLICY**
4. Prevention of Alcohol Misuse		
4.1 Policies regarding alcohol prevention programs	✓ **POLICY IMPLEMENTED** FOR ELEMENTARY SCHOOL STUDENTS **"Healthy Schools, Code of Conduct"** http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	✓ **POLICY IMPLEMENTED** FOR ALL STUDENTS, STAFF, AND THE LDCSB COMMUNITY **"Alcohol & Drugs"** http://www.ldcsb.on.ca/schools/cfe/elearning/gifted/pdf/codeofconduct.pdf
5. Prevention of Tobacco Use and Exposure		
5.1 Policies that promote tobacco-free sport and recreation activities when off the school site	✓ **POLICY IMPLEMENTED** FOR ELEMENTARY SCHOOL STUDENTS **"Healthy Schools, Code of Conduct"** http://www.tvdsb.on.ca/policies/policydocs/HealthySchools.pdf	**NO POLICY**
◊ 6. Mental Health		
6.1 School board policies that promote mental health	→ **PLANS TO REVIEW AND DEVELOP POLICY** In Development – Someone has been newly hired at TVDSB for this purpose.	**NO POLICY**
◊ 7. Prevention of Substance Misuse		
7.1 School board policies for substance **misuse prevention programs** (beyond curriculum requirements)?	**NO POLICY**	**NO POLICY**

POLICY	Thames Valley District School Board (TVDSB)	London District Catholic School Board (LDCSB)
◊ 8. Injury Prevention		
8.1 Policies that promote traffic safety	NO POLICY	NO POLICY
8.2 Policies that promote pedestrian safety	NO POLICY	NO POLICY
8.3 Policies related to impaired driving	NO POLICY	NO POLICY
8.4 Policies related to falls in children (e.g. window guards, balconies, playgrounds)	✓ POLICY IMPLEMENTED FOR ELEMENTARY SCHOOL STUDENTS For Playgrounds: Provincial Guidelines	✓ POLICY IMPLEMENTED FOR ELEMENTARY SCHOOL STUDENTS For Playgrounds: Provincial Guidelines
8.5 Policies related to falls in adults	NO POLICY	NO POLICY
8.6 Policies related to drowning prevention	NO POLICY "Swim to Survive" program in place	NO POLICY
8.7 Policies related to fire safety	NO POLICY	✓ POLICY IMPLEMENTED
8.8 Policies related to cycling safety	✓ POLICY IMPLEMENTED Rule not to ride bike on school property	NO POLICY
8.9 Policies related to helmet use	NO POLICY	✓ POLICY IMPLEMENTED For skating programs
8.10 Policies related to provision of shade and trees (e.g. for school playgrounds)	NO POLICY	NO POLICY

Legend:
**** Policies with two asterisks** indicate the validated answer to the Ontario Heart Health Network (OHHN) policy scan was opposite to the information the OHHN report had indicated. For example, ****NO POLICY** denotes the OHHN report found a policy does exist, when in fact the individual(s) validating the policy indicated the policy does not exist (or vice versa).

◊ **Diamond shape** denotes a Healthy Communities Partnership priority area that was not assessed in the Ontario Heart Health Network (OHHN) report. Questions regarding these priority areas were created by Middlesex-London Health Unit Public Health Nurses, and collected v

Appendix 9.7A

Nutrition Facts

The Weekly Cost of the Nutritious Food Basket in London and Middlesex County

(May, 2010)

This information outlines the approximate price of eating well in London and Middlesex County. Weekly costs are based on a May 2010 survey of 67 food items (the *Nutritious Food Basket*) from 12 main chain and independent grocery stores in London and Middlesex County. The foods surveyed are determined by food buying patterns of average Canadians and data provided by Statistics Canada. The *Nutritious Food Basket* is calculated to meet the nutrient needs of most people in each age and gender group.

	Age	Approximate Cost Per Week ($)
Boy	2-3	21.16
	4-8	27.32
	9-13	36.33
	14-18	51.48
Girl	2-3	20.74
	4-8	26.50
	9-13	31.07
	14-18	37.20

	Age	Approximate Cost Per Week ($)
Man	19-30	49.68
	31-50	44.86
	51-70	43.40
	70+	43.00
Woman	19-30	38.43
	31-50	38.00
	51-70	33.65
	70+	33.06
Pregnant Woman	Younger than 18 years of age	41.52
Pregnant Woman	19-30	41.88
Pregnant Woman	31-50	40.89
Breastfeeding Woman	Younger than 18 years of age	43.21
Breastfeeding Woman	19-30	44.49
Breastfeeding Woman	31-50	43.49

London Office
50 King St., London, ON N6A 5L7
(519) 663 - 5317 fax: (519) 663 - 9581
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MIDDLESEX-LONDON HEALTH UNIT
An Accredited Teaching Health Unit

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy, ON N7G 1Y5
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Appendix 9.7b

Monthly Cost of Basic Needs in Middlesex-London Area in 2010

Case Scenario 1: Income vs. Basic Expenses for Family of Four (Male: 42 yrs, Female: 38 yrs, Boy: 14 yrs, Girl: 8 yrs) as Ontario Works Recipients

Expenses	Urban	Rural	Income	Urban & Rural
Rent[1] (includes utilities)	$1075.00	$768.00	Shelter Allowance	$674.00
Food[2]	$699.65	$699.65	Basic Need	$438.00
Transportation			Canada Child Tax	$552.74
2 Adult Bus Passes[3] (Citipass)	$162.00	$0.00	Benefit and National Child Benefit Supplement (July 2010)	
1 car[4] for rural areas	$0.00	$379.39	Ontario Child Benefit[7]	$183.33
Personal Care Items[5]	$167.35	$167.35	Ontario Sales Tax Credit	$86.67
Clothing[6]	$180.09	$180.09	Harmonized Sales Tax Credit	$63.50
			Property Tax Credit (basic amount only)	$20.83
Total	**$2284.09**	**$2194.48**	**Total**	**$2019.07**

[1] Based on average rental cost of 3-bedroom apartment in London and in Strathroy-Caradoc to represent average rental costs for the County as per the Canadian Mortgage and Housing Corporation (CMHC), Rental Market Report, Fall 2009.
[2] Based on local pricing of the Nutritious Food Basket (May 2010)
[3] Based on London Transit rates in 2010. Individuals may be eligible to obtain a bus pass through OW.
[4] Estimated based on the total adjusted cost of operating a vehicle in rural area in Ontario as per *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts adjusted from Canadian Statistics and the cost of purchasing the vehicle as per *A Living Wage for Toronto* by Canadian Centre for Policy Alternatives, November 2008.
[5] Based on adjusted average spending expenditure on personal care items in Ontario as per *Spending Patterns in Canada* publication by Statistics Canada, 2008.
[6] Based on adjusted cost from *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts from 2006 Canadian Statistics.
[7] Effective July 2009 this amount increased from $50 to $92 per child

Appendix 9.7b continued

Monthly Cost of Basic Needs in Middlesex-London Area in 2010

Case Scenario 2: Income vs. Basic Expenses for a Single Male: 26 yrs as Ontario Works Recipient

Expenses	Urban	Rural	Income	Urban & Rural
Rent[1] (includes utilities)	$714.00	$645.00	Shelter Allowance	$364.00
Food[2]	$216.11	$216.11	Basic Need	$221.00
Transportation			Ontario Sales Tax Credit	$21.67
1 Adult Bus Pass[3] (Citipass)	$81.00	$0.00		
1 car4 for rural areas	$0.00	$379.39	Harmonized Sales Tax	$20.83
Personal Care Items[5]	$41.84	$41.84	Credit (excludes single supplement)	
Clothing[6]	$45.02	$45.02	Property Tax Credit (basic amount only)	$20.83
Total	**$1097.97**	**$1327.36**	**Total**	**$648.33**

[1] Based on average rental cost of a 1-bedroom apartment in London and in Strathroy-Caradoc to represent average rental costs for the County as per the Canadian Mortgage and Housing Corporation's 2009 Rental Market Report

[2] Based on local pricing of the Nutritious Food Basket (May 2010)

[3] Based on London Transit rates in 2010. Individuals may be eligible to obtain a bus pass through OW.

[4] Based on the total adjusted cost of operating a vehicle in rural area in Ontario as per *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts adjusted from Canadian Statistics and the cost of purchasing the vehicle as per *A Living Wage for Toronto* by Canadian Centre for Policy Alternatives, November 2008.

[5] Based on adjusted average spending expenditure on personal care items in Ontario as per *Spending Patterns in Canada* publication by Statistics Canada, 2008.

[6] Based on adjusted cost from *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts from 2006 Canadian Statistics.

Appendix 9.7b continued

Monthly Cost of Basic Needs in Middlesex-London Area in 2010

Case Scenario 3: Income vs. Basic Expenses for a Single Parent (Female 35 yrs) and Child (Boy 11 yrs) as Ontario Works Recipients

Expenses	Urban	Rural	Income	Urban & Rural
Rent[1] (includes utilities)	$910.00	$893.00	Shelter Allowance	$572.00
Food[2]	$323.34	$323.34	Basic Need	$341.00
Transportation			Canada Child Tax	$286.33
Adult bus pass[3] (Citipass)	$81.00	$0.00	Benefit and National	
1 car[4] for rural areas	$0.00	$379.39	Child Benefit Supplement (July 2009)	
Personal Care Items[5]	$83.68	$83.68	Ontario Child Benefit[7]	$91.67
Clothing[6]	$90.04	$90.04	Ontario Sales Tax Credit	$43.33
			Harmonized Sales Tax Credit	$31.75
			Property Tax Credit (basic amount only)	$20.83
Total	**$1488.06**	**$1769.45**	**Total**	**$1368.91**

[1] Based on average rental cost of 2-bedroom apartment in London and in Strathroy-Caradoc to represent average rental costs for the County as per the Canadian Mortgage and Housing Corporation's 2009 Rental Market Report

[2] Based on local pricing of the Nutritious Food Basket (May 2010)

[3] Based on London Transit rates in 2010. Individuals may be eligible to obtain a bus pass through OW.

[4] Based on the total adjusted cost of operating a vehicle in rural area in Ontario as per *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts adjusted from Canadian Statistics and the cost of purchasing the vehicle as per *A Living Wage for Toronto* by Canadian Centre for Policy Alternatives, November 2008.

[5] Based on adjusted average spending expenditure on personal care items in Ontario as per *Spending Patterns in Canada* publication by Statistics Canada, 2008.

[6] Based on adjusted cost from *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts from 2006 Canadian Statistics.

[7] Effective July 2009 this amount increased from $50 to $92 per child

Appendix 9.7b continued

Monthly Cost of Basic Needs in Middlesex-London Area in 2010

Case Scenario 4: Income vs. Basic Expenses for a Single Person (Male 50 yrs) as Ontario Disability Support Program Recipient

Expenses	Urban	Rural	Income	Urban & Rural
Rent[1] (includes utilities)	$714.00	$645.00	Shelter Allowance	$464.00
Food[2]	$195.14	$195.14	Basic Need	$578.00
Transportation			Ontario Sales Tax Credit	$21.67
Adult bus pass[3] (Citipass)	$81.00	$0.00		
1 car[4] for rural areas	$0.00	$379.39		
Personal Care Items[5]	$41.84	$41.84	Harmonized Sales Tax Credit (excludes single supplement)	20.83
Clothing[6]	$45.02	$45.02	Property Tax Credit (basic amount only)	20.83
Total	**$1077.00**	**$1306.39**	**Total**	**$1115.16**

[1] Based on average rental cost of a 1-bedroom apartment in London and in Strathroy-Caradoc to represent average rental costs for the County as per the Canadian Mortgage and Housing Corporation's 2009 Rental Market Report

[2] Based on local pricing of the Nutritious Food Basket (May 2010)

[3] Based on London Transit rates in 2010. Individuals may be eligible to obtain a bus pass through OW.

[4] Based on the total adjusted cost of operating a vehicle in rural area in Ontario as per *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts adjusted from Canadian Statistics and the cost of purchasing the vehicle as per *A Living Wage for Toronto* by Canadian Centre for Policy Alternatives, November 2008.

[5] Based on adjusted average spending expenditure on personal care items in Ontario as per *Spending Patterns in Canada* publication by Statistics Canada, 2008.

[6] Based on adjusted cost from *Low Income in Canada: 2000-2006 Using the Market Basket Measure,* October 2009 with amounts from 2006 Canadian Statistics.

Appendix 9.7c

Weekly Cost of a Nutritious Food Basket, 2010
Reference Family of Four[1] by Health Unit

Sorted Alphabetically by Health Unit	Cost - 2010	Cost - 2009
ALGOMA	$173.64	*$168.27*
BRANT	$164.52	*$162.71*
CHATHAM-KENT	$158.63	*$157.74*
DURHAM	$162.07	*$162.32*
EASTERN ONTARIO	$173.19	*$171.02*
ELGIN-ST. THOMAS	$170.09	*$170.60*
GREY-BRUCE	$166.64	*$162.14*
HALDIMAND-NORFOLK	$167.53	*$163.80*
HALIBURTON (HKPR)	$167.73	*$174.60*
HALTON	$167.99	*$161.80*
HAMILTON	$159.49	*$162.10*
HASTINGS	$164.42	*$165.07*
HURON	$172.12	*$175.27*
KINGSTON (KFL&A)	$173.96	*$165.91*
LAMBTON	$163.74	*$170.89*
LEEDS	$163.06	*$166.51*
LONDON	$160.85	*$162.22*
NIAGARA	$168.70	*$167.74*
NORTHBAY – PARRY SOUND	$168.34	*$169.38*
NORTHWESTERN	$211.67	*$190.55*
OTTAWA	$167.16	*$170.04*
OXFORD	$168.86	*$169.72*
PEEL	$159.75	*$156.15*
PERTH	$169.55	*$164.78*
PETERBOROUGH	$171.27	*$166.73*
PORCUPINE	$183.35	*$189.94*
RENFREW	$168.68	*$166.12*
SIMCOE-MUSKOKA	$160.39	*$165.64*
SUDBURY	$170.96	*$187.79*
THUNDER BAY	$182.44	*$179.13*
TIMISKAMING	$174.99	*$174.47*
TORONTO	$165.19	*$164.18*
WATERLOO	$168.45	*$169.41*
WELLINGTON G-D	$170.73	*$167.02*
WINDSOR	$160.66	*$158.14*
YORK	$169.39	*$165.92*
ONTARIO AVERAGE	**$169.17**	***$168.50***

Notes:

The mix of stores and the approach to store selection may be quite different between health units, making between health unit comparisons inappropriate.

[1] A reference family of four includes: a man and a woman each aged 31-50 years; a boy aged 14-18 years; and a girl aged 4-8 years.

Appendix 9.7c continued

Weekly Cost of a Nutritious Food Basket, Ontario 2010
Total Weekly Cost by Age and Sex

Total Weekly Cost by Age and Sex (in years)	Ontario Average Year 2010	*Ontario Average Year 2009*[1]
BOY		
2-3	$22.46	*$22.27*
4-8	$28.95	*$28.77*
GIRL		
2-3	$22.03	*$21.87*
4-8	$28.09	*$27.96*
MALE		
9-13	$38.36	*$38.14*
14-18	$54.00	*$53.78*
19-30	$52.13	*$51.98*
31-50	$47.14	*$46.93*
51-70	$45.57	*$45.27*
Over 70	$45.11	*$44.81*
FEMALE		
9-13	$32.88	*$32.66*
14-18	$39.26	*$39.07*
19-30	$40.40	*$40.28*
31-50	$39.95	*$39.82*
51-70	$35.46	*$35.26*
Over 70	$34.83	*$34.52*
PREGNANCY		
18 and younger	$43.74	*$43.50*
19-30	$44.13	*$43.95*
31-50	$43.05	*$42.83*
LACTATION		
18 and younger	$45.55	*$45.36*
19-30	$46.76	*$46.56*
31-50	$45.68	*$45.45*
FAMILY OF FOUR[2]	**$169.17**[3]	***$168.50***

Notes:

[1] Data from all 36 Health Units were submitted and used to calculate the average cost of the Nutritious Food Basket (NFB) for Ontario.

[2] A reference family of four includes: a man and a woman each aged 31-50 years; a boy aged 14-18 years; and a girl aged 4-8 years.

[3] This average should not be compared with that of 2008 or the preceding years, because the 2009 NFB is newly defined in terms of: (i) the food items included in the NFB and their corresponding weights, and (ii) the age of members included in a family of four.

Appendix 9.7c continued

Weekly Cost of a Nutritious Food Basket Ontario, 2010
Northern and Southern Health Unit Comparison

	Avg Weekly Cost for a Family of Four - 2010	*Avg Weekly Cost for a Family of Four - 2009*	**Northern / Southern**
ALGOMA	$173.64	*$168.27*	Northern
NORTHBAY – PARRY SOUND	$168.34	*$169.38*	Northern
NORTH WESTERN	$211.67	*$190.55*	Northern
PORCUPINE	$183.55	*$189.94*	Northern
SUDBURY	$170.96	*$187.79*	Northern
THUNDER BAY	$182.44	*$179.13*	Northern
TIMISKAMING	$174.99	*$174.47*	Northern
Average of 7 Northern Health Units	**$180.80**	***$179.93***	
BRANT	$164.52	$162.71	Southern
CHATHAM-KENT	$158.63	$157.74	Southern
DURHAM	$162.07	$162.32	Southern
EASTERN ONTARIO	$173.19	$171.02	Southern
ELGIN-ST. THOMAS	$170.09	$170.60	Southern
GREY-BRUCE	$166.64	$162.14	Southern
HALDIMAND-NORFOLK	$167.53	$163.80	Southern
HALIBURTON (HKPR)	$167.73	$174.60	Southern
HALTON	$167.99	$161.80	Southern
HAMILTON	$159.49	$162.10	Southern
HASTINGS	$164.42	$165.07	Southern
HURON	$172.12	$175.27	Southern
KINGSTON (KFL&A)	$173.96	$165.91	Southern
LAMBTON	$163.74	$170.89	Southern
LEEDS-GRENVILLE & LANARK	$163.06	$166.51	Southern
MIDDLESEX-LONDON	$160.85	$162.22	Southern
NIAGARA	$168.70	$167.74	Southern
OTTAWA	$167.16	$170.04	Southern
OXFORD	$168.86	$169.72	Southern
PEEL	$159.75	$156.15	Southern
PERTH	$169.55	$164.78	Southern
PETERBOROUGH	$171.27	$166.73	Southern
RENFREW	$168.68	$166.12	Southern
SIMCOE-MUSKOKA	$160.39	$165.64	Southern
TORONTO	$165.19	$164.18	Southern
WATERLOO	$168.45	$169.41	Southern
WELLINGTON DUFFERIN-GUELPH	$170.73	$167.02	Southern
WINDSOR	$160.66	$158.14	Southern
YORK	$169.39	$165.92	Southern
Average of 29 Southern Health Units	**$166.37**	**$165.73**	
Ontario Average (of 36 Health Units)	**$169.17**	**$168.50**	

Notes:

1. Geographic and environmental conditions throughout the Northern region may vary markedly from the Southern region. These differences in geographic and environmental conditions between Northern and Southern regions may be reflected in the retail prices of food items.
2. The Northern region is defined as: Algoma, North Bay-Parry Sound, Northwestern, Porcupine, Sudbury, Thunder Bay, and Timiskaming health units. The remaining 29 health units make up the South region.

MEAL PROGRAMS

All Saints Church
249 Hamilton Rd

Ark Aid Street Mission Inc
696 Dundas St at Lyle St

Beth Emmanuel Church
430 Grey St between Colborne / Maitland St

Bishop Cronyn Memorial Church
442 William St at Queens Ave

Calvary United Church
290 Ridout St S at Garfield Ave

Centre of Hope (Salvation Army Hostel)
281 Wellington St at Horton St

Christ Anglican Church
138 Wellington St at Hill St

Dundas Street Centre United Church
482 Dundas St at Maitland St

East London Anglican Ministries
2060 Dundas St E

Elmwood Presbyterian Church
111 Elmwood Ave E at Cathcart St (5th Saturday)

First Baptist Church
568 Richmond Street

First St Andrew's United Church
350 Queens Ave at Waterloo St

Grace United Church
818 Hamilton Road at Glenwood Ave

Metropolitan United Church
468 Wellington St at Dufferin Ave

My Sister's Place
566 Dundas St.

New Life Centre
220 Adelaide St N at Hamilton Rd

New St. James Presbyterian
280 Oxford St. E

Rowntree Memorial United Church
156 Elliot St at Cheapside St

St. George' Anglican Church
227 Wharncliffe Rd. N. ***Not* Wheelchair Accessible***

St James Westminster Church
115 Askin St at Wortley Rd

St Joseph's Hospitality Centre
707 Dundas St at Lyle St

St. John
280 St. James Street

St. Luke's Anglican
1204 Richmond St. N.

St Martin of Tours Church
46 Cathcart St at Elmwood Ave E

Salvation Army Hillcrest (Church)
310 Vesta Rd., corner of Huron & Highbury

Salvation Army London Citadel
555 Springbank Dr

Salvation Army Westminster Park Corps (Church)
1190 Southdale Rd.

Street Connection
258 Horton St at Wellington

Trinity United Church
76 Doulton at Hale one block south of Dundas

Wesley Knox United Church
91 Askin St at Teresa St

Youth Action Centre

FOOD BANKS

Food Banks usually provide a one to three day supply of food, once a month to once every three months, per individual or family. Proof of home address or identification for each family member may be required.

Centre of Hope, Community Services
281 Wellington St at Horton St 8:00 am – 3:30pm - Mon-Fri
No appointment required – call (519) 661-0343 ext 227
***Note-Clients may not visit both Centre of Hope and Salvation Army Foodbanks**

Salvation Army Westminster Park
1190 Southdale Rd.

Chalmers Presbyterian Church
342 Pond Mills Rd at Commissioners Rd E., 1 -2 pm Tuesday and Thursdays
Residents of the area only, appointment required, call (519) 681-7242

(Continued)

Crouch Neighbourhood Resource Centre
Baby food/formula/diapers and food items available on an emergency basis only, 550 Hamilton Rd. Tuesday, Wednesday 9 am – 12 noon, Thursday, Friday 9 am – 4 pm.
For residents of the Hamilton Road area only

Daily Bread Program
Daily Bread Program, St. Paul's Cathedral, 472 Richmond St. at Queens Avenue
9:30 am - 12 pm, Monday to Friday - Baby Food is available.

Families First CAPC White Oaks (South London Community Centre)
1119 Jalna Blvd. 9:30am – 4:30 pm Monday – Friday

Families First CAPC Westminster
1043 Southdale Rd. E. 9:30am – 4:30pm Monday - Friday
Baby food bank for Westminster area residents, call first, (519) 649-1248

Fanshawe College, **Student Sharing Shop**
1460 Oxford St E, Room B1050 at First Ave / 9-4 Mon-Fri College students only. *Note: if The Student Sharing Shop is closed please go to the Student Success Centre at Room F2010 for assistance*

Gethsemane United Church
1461 Huron St. and Sandford St., Wednesday, Friday 9:30 am – 12:00 noon
Appointment required. (519) 451-0600 Area Residents only

Glen Cairn Community Resource Centre
150 King Edward Ave at Thompson Rd Monday, Tuesday, Thursday & Friday 9:00 – 4:00, Closed Wednesday.
Emergency & Baby Food Bank available to residents of Glen Cairn & Pond Mills Community. Please call ahead for availability of items (519) 668-2745.

London and Area Food Bank –
****Note - Permitted postal code areas only for each depot**

926 Leathorne at Adelaide – (519) 659-4045 9-4 Mon-Fri – All London & Area

Satellite Locations: (Note: You **may not** visit both the Main and Satellite locations)

Argyle Food Depot, (Richards Memorial United Church – Clarke Road Entrance – across from Argyle Mall), 10-3:30 (2nd Thursday) **N5V, N5W**

St. Lawrence Church, 910 Huron St, 11-3:30 (3rd Wednesday) **N5V, N5Y**

Impact Church, 220 Adelaide St N, 1-5 (3rd Thursday) **N6B, N5W, N5Z,**

Kinsmen Food Depot, Kinsmen Recreation Centre, 11 – 3 (3rd Friday)
N6A, N6C, N6H, N6J
NW Food Bank Depot at Northwest London Resource Centre 1225 Wonderland Rd N.
c/o Sherwood Forest Library, 10 am – 3:30 pm. (3rd Tuesday) **N6G, N6H**

Northwest London Resource Centre
Emergency Cupboard for northwest residents only N6G N6H at Resource Ctr.
Tuesday – Thursday, Appointment Required. Call first (519) 471-8444.

St Vincent de Paul Society Vouchers
Contact the secretary or priest of any Catholic Church to arrange a home visit from a volunteer to discuss your needs. A food voucher may be issued.

St. Paul's Cathedral
Daily Bread Program – 472 Richmond St (at Queens Ave)
9:30 am – 12:00 pm, Monday to Friday – Baby Food is available

Southdale Chaplaincy Centre
983 Southdale Rd. E.
Baby food bank for Westminster area residents (519) 685-2771

The University of Western Ontario, USC Food Bank – UWO Students only
24-hour anonymous food hamper system; e-mail usc.foodbank@uwo.ca to request a hamper. Locker number and combination provided to pick up the food hamper; Baby food and food vouchers available

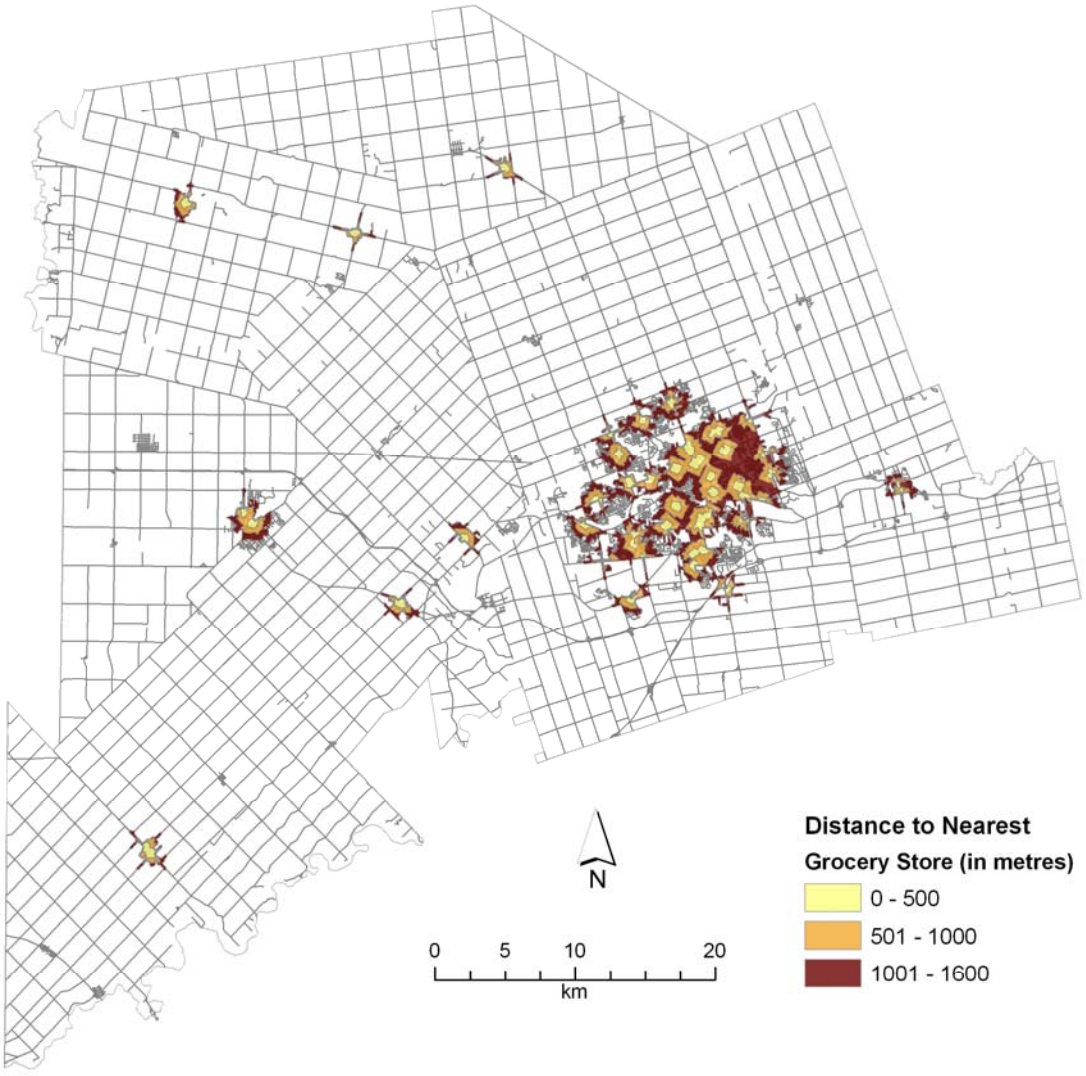
Meal Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
MEALS FOR INDIVIDUALS AND FAMILIES IN NEED **Addresses and food banks listed on reverse**		1 9–11 am - **Bishop Cronyn Memorial Church** 5:30–7 pm - **Rowntree**	2 11–12:30 pm - **Salvation Army Westminster Park** 11–1 pm - **Salvation Army Hillcrest** 5:15 pm - **Centre of Hope** 5:30 pm - **Dundas Centre United**	3 5:30- 6:30 pm – **New St. James Presbyterian**	4 5:30 pm - **Metropolitan nited**	5 9-11 am - **St. James Westminster** 5-6 pm - **St John**
6 9-9:30 am - **Salvation Army Westminster Park** 5:15 pm - **Centre of Hope** 5:30 – 6:30 pm - **Trinity United**	7 5:30 pm - **First St Andrew's**	8 9–11 am - **Bishop Cronyn Memorial Church** 5:30–7 pm - **Rowntree**	9 11–12:30 pm - **Salvation Army Westminster Park** 11–1 pm - **Salvation Army Hillcrest** 5:15 pm - **Centre of Hope** 5:30 pm - **Dundas Centre United**	10 5:30- 6:30 pm – **New St.James Presbyterian** 5:30–6:30 pm – **First Baptist Church**	11 5-6 pm – **St. George's Anglican** 5:30 pm - **Metropolitan United**	12 9-11 am – **Wesley Knox** 9–11 am - **St. Luke's** 5-6 pm - **St John**
13 9-9:30 am - **Salvation Army Westminster Park** 5:15 pm - **Centre of Hope** 5:30-7 pm – **Grace United**	14 5:30 pm - **First St Andrew's**	15 7:30–10:30 am - **East London Anglican Ministries** 9-11 am - **Bishop Cronyn Memorial Church** 5:30–7 pm - **Rowntree**	16 11–12:30 pm - **Salvation Army Westminster Park** 11–1 pm - **Salvation Army Hillcrest** 5:15 pm - **Centre of Hope** 5:30 pm - **Dundas Centre United**	17 5:30- 6:30 pm – **New St. James Presbyterian** 6-7 pm – **Impact Church**	18 5:30 pm - **Metropolitan United**	19 9–10:30 am - **Rowntree** 9–11 am - **Calvary United** 9-11 am – **All Saints Church** 5-6 pm - **St John**
20 9-9:30 am - **Salvation Army Westminster Park** 5:15 pm - **Centre of Hope** 5-6 pm - **St. Martin of Tours Church** 5-7 pm – **Beth Emmanuel**	21 **Family Day**	22 9-11 am - **Bishop Cronyn Memorial Church** 5:30–7 pm - **Rowntree**	23 1–12:30 pm - **Salvation Army Westminster Park** 11–1 pm - **Salvation Army Hillcrest** 5:15 pm - **Centre of Hope** 5:30 pm - **Dundas Centre United**	24 5:30- 6:30 pm – **New St. James Presbyterian**	25 5:30 pm - **Metropolitan United**	26 9-11 am – **Christ Anglican** 9-11 am - **St. Martin of Tours Church** 5-6 pm - **St John**
27 9-9:30 am - **Salvation Army Westminster Park** 5:15 pm - **Centre of Hope** 5:30-6:30 pm **- Wesley Knox**	28 5:30 pm - **First St Andrew's**					
Operation Mobilizing Hope **The Salvation Army Emergency Services Vehicle** Thursdays 7:30 pm – 8:15 pm Dundas and William - @ the Coffeehouse Thursdays 8:30 pm – 9:15 pm Just east of Dundas and Lyle St		5-6:30 pm Sun & Mon 8-9:30 pm Fri & Sat *(light meal)* **Street Connection *(16-24 yrs)*** 7 pm Mon-Sat; Sunday – times as posted **Ark Aid Street Mission**	**DAILY MEALS** 7-10 am and 5 pm Monday – Friday **Youth Action Centre** *(16-23 yrs)* 12-1 pm Monday to Friday **My Sister's Place** (women only 16 years and older)	7-9 pm Tuesday & Thursday **Streetlight Bus** First Baptist Church 568 Richmond Street **Youth 16 – 25 yrs.**	**St Joseph's Hospitality Centre** 9:30-11am & 12noon-2pm Mon-Fri, **ID required** Daily fee: .50 breakfast; $1.00 lunch Monthly: $10 breakfast; $15 lunch; $25 both ****Closed Monday, February 21, 2011 – Family Day****	

Accessibility to Healthy Food: Distance to Grocery Stores, City of London, Ontario, 2011

Source: Human Environments Analysis Laboratory, University of Western Ontario

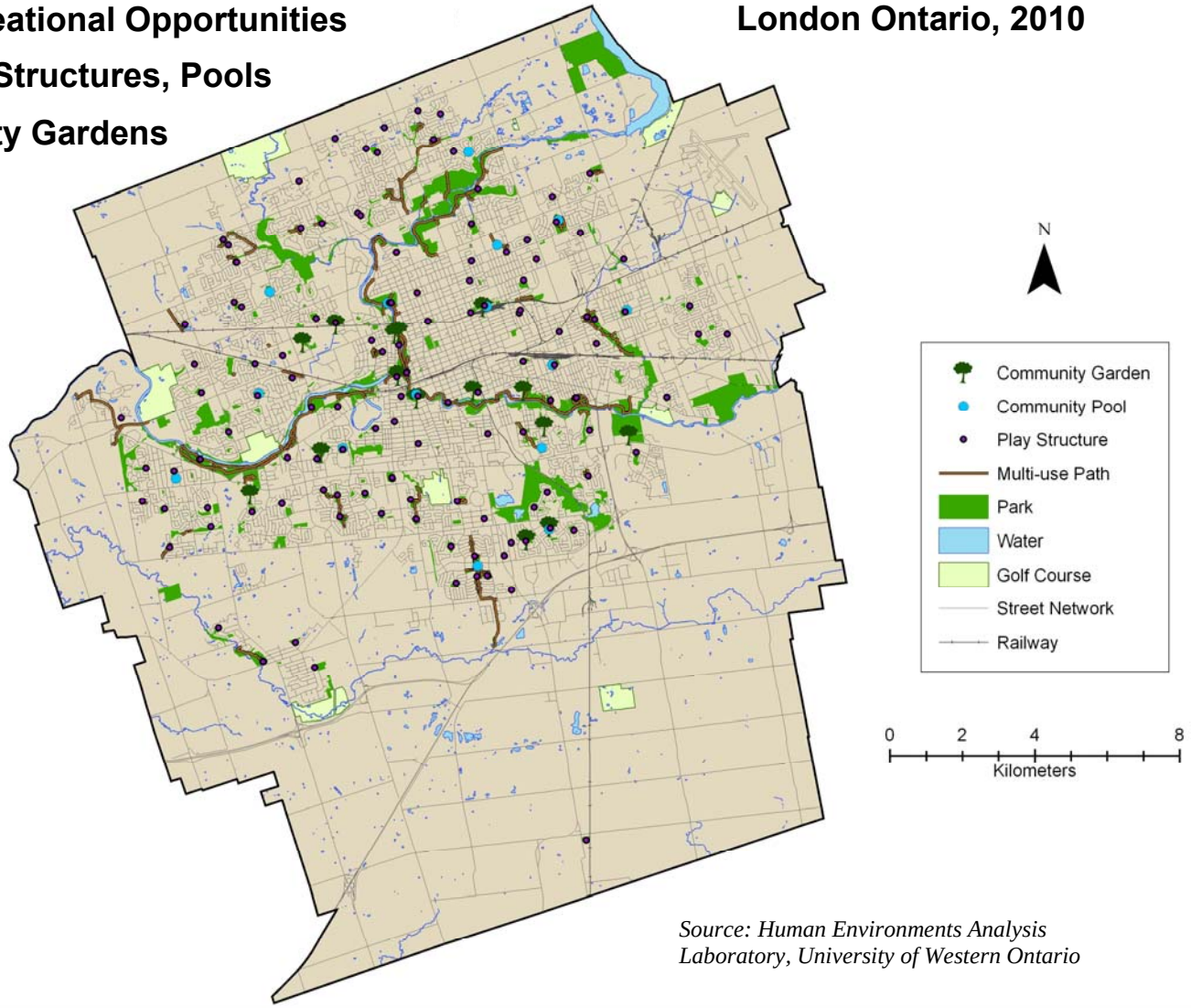
Accessibility to Healthy Food: Distance to Grocery Stores, Middlesex County, Ontario, 2011



Source: Human Environments Analysis Laboratory, University of Western Ontario

Public Recreational Opportunities
Parks, Play Structures, Pools & Community Gardens

London Ontario, 2010

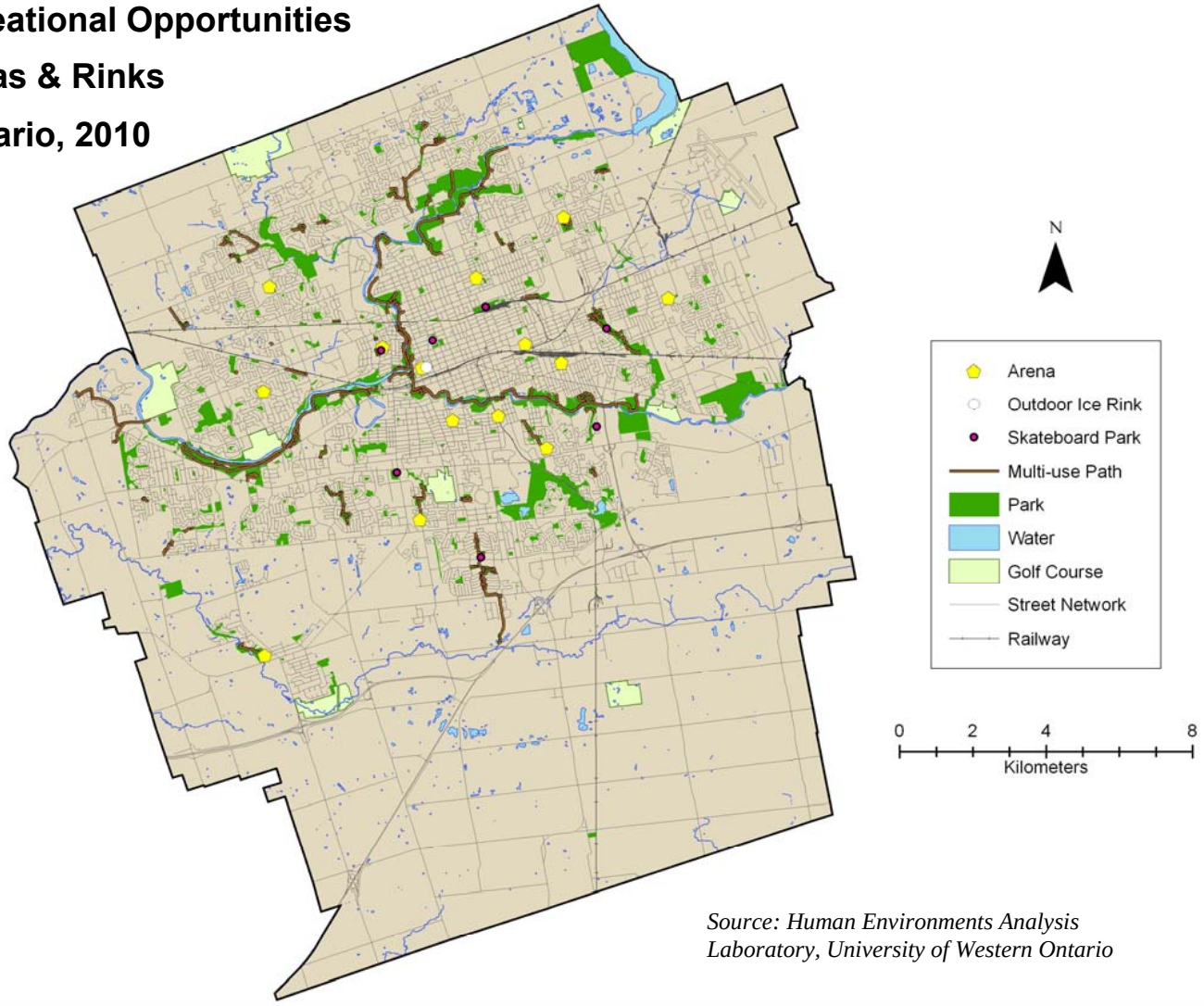


Source: Human Environments Analysis Laboratory, University of Western Ontario

Public Recreational Opportunities

Parks, Arenas & Rinks

London Ontario, 2010

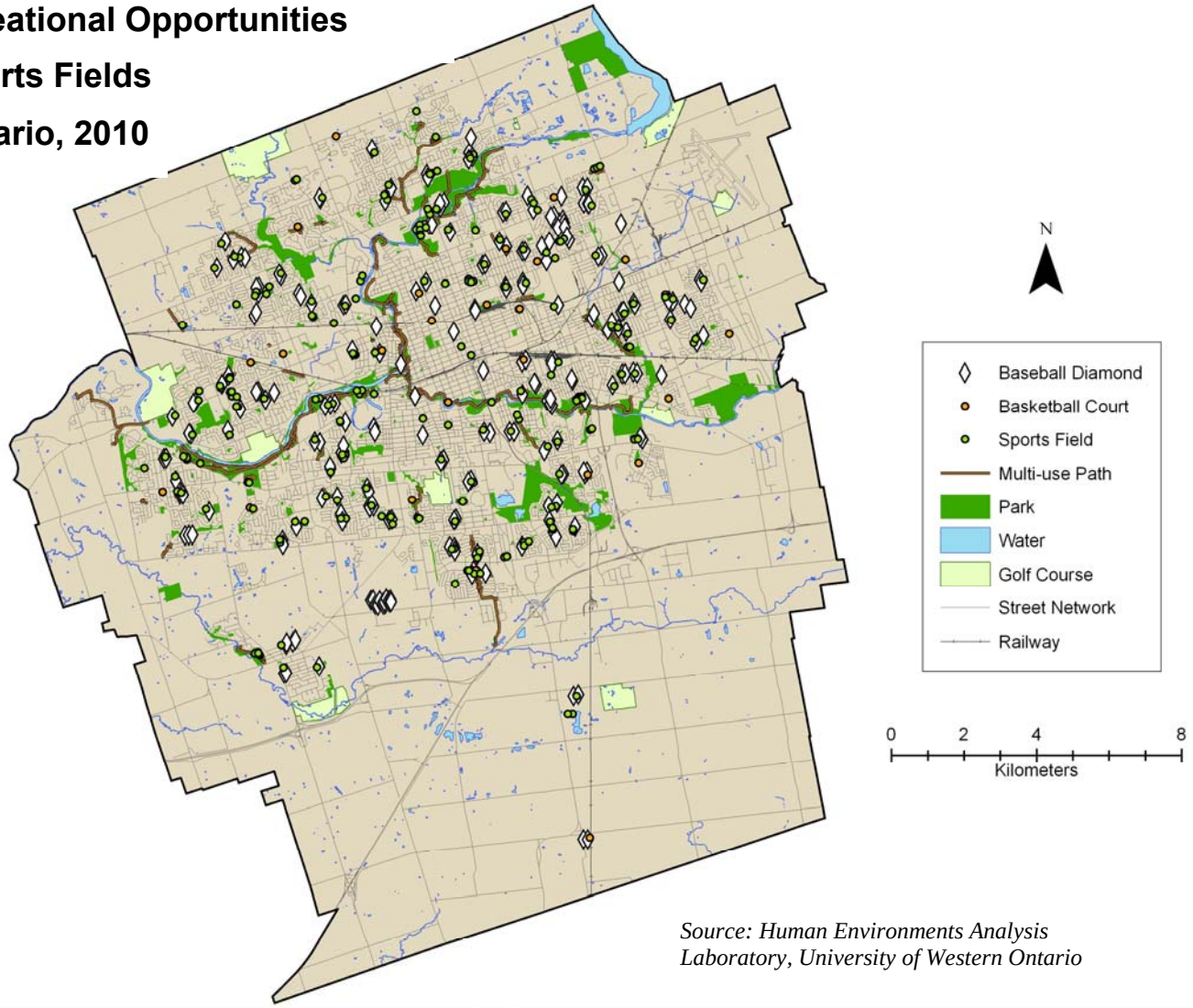


Source: Human Environments Analysis Laboratory, University of Western Ontario

Public Recreational Opportunities

Parks & Sports Fields

London Ontario, 2010



Source: Human Environments Analysis Laboratory, University of Western Ontario

Table de concertation francophone de London et des environs

Recontre du 20 janvier 2011
12h30 – 14h00
Vanier Children's Services/Centre d'enfance Vanier
871, rue Trafalgar, London

Translation services provided by Robert Gervais through Across Languages

Representation from:

la ribambelle
Ontario Trillium Foundation (OTF-FTO)
Heart and Stroke Foundation of Ontario (HSFO)
Ontario *Ministry of Training, Colleges, and Universities* (**MTCU)**
Ministry of Community and Social Services and the Ministry of Children and Youth Services (MCSS-MCYS)
Cercle Des Copains (London, ON)
*Conseil scolaire de district des écoles catholiques du Sud***-Ouest**
Communicat*é* **Ste Marguerite D'Youville**
Collège *Boréal*
Centre d'acquisition des comp*é***tences et des talents des immigrants francophones de l'ontario (CACTIFO)**
Conseil scolaire (CS) Viamonde
Le Réseau de développement économique et d'employabilité (*RDÉE) Ontario*
Réseau de soutien à l'immige franco

Initial Questions/discussion during introduction of Healthy Communities Program (following presentation by Ghislaine Brodeur)

Ghislaine Brodeur (Ghislaine.Brodeur@ontario.ca)
Ministère des Affaires civiques et de l'Immigration de l'Ontario,
Ministère du Tourisme et de la Culture,
Ministère de la Promotion de la santé et du Sport

- Distribution of French presentation regarding Healthy Communities Partnership
- No questions

Question 1/
"If money was no object and there were no constraints or barriers, what would you like to see in terms of this priority area?"

- Implementation – in the francophone community there is a small community room for two high schools. Don't have infrastructure available with a large area for physical activity (e.g. gymnasium), need a kitchen (e.g. for cooking demonstrations for seniors), etc.**Expand the community center and provide the necessary infrastructure.**
- **Canteens in high schools and elementary schools where they can serve healthy lunches** (menu planning like this has been done in Scandinavian countries for years). We are the only G8 country that doesn't provide a lunch program

- Some preschool providers ensure that what is served is based on good menu but there are many agencies that do not serve good food – need **provision of menus, options, legislation to ensure healthy food is served in child care centers, as a broad standard vs standalone.**
- **Strong education and communication campaign** – building on **Centre Réseau** program – good solid information, easy to use, fun, inexpensive. Easy food, recipes, easy activities. More of what was done [e.g. Family Physical Activity and Healthy Eating Toolkit]. Every family should have a toolkit for these Healthy Activities.
- Besides information going to schools, information should simultaneously go to parents as well – **families should receive information at same time as schools.** Ensure whatever children are getting at school that parents are getting at home – because if children only get information at school the follow-through will not happen at home. Help parents understand their role in healthy living. **Invite parents to school for information sessions**
- **Concertation tables (Community Round Tables with community partners)**- need for more of these type of meetings to ensure the work happens and to increase inter-partner-discussion.
- **Communication simultaneously in French and English** so that French are not receiving information 2 weeks later (eg. H1N1). **Need better communication system.**
- Challenge for Francophone representatives to be at every table for every launch - **need more strategic way to streamline initiatives** because schools cannot be all places at all times. Eg. Need to say "you don't have a choice" will change behaviour change (**i.e. policy**). **Implement "across-board policies".** Programs/Initiatives do not match what is happening in the larger community (e.g. there are many programs, but to or from the programs people are still able to stop for fast food restaurants).
- Francophone community needs to communicate efficiently and effectively and with authority. As a francophone community seems to be isolated and often asked to intervene too late.
- **Need more people "on the ground"** – key to engaging community. **Francophone community needs more robust human infrastructure.**
- **French language services shouldn't be a second thought**. When something comes out needs to be available right away for francophone population because at equal risk, and are considered a priority population. **French community often doesn't *know* what is available**.
- According to the **Official Languages Act** –English and French resources must be delivered simultaneously. Not good customer service from various ministries. Need to do this better. Please tell Ministry of Health Promotion this message.
- Healthy eating and participation in activities is difficult on a budget. When looking at policies we **need to look at how to make these things affordable and accessible for Francophone com.**
- **Increase communication** to a larger degree. French people don't know what is available to them.
- Difficult to find **French presenters**. Presenters that are available have had limited opportunity for practice because have had limited requests.
- Government needs to know that French presentations may be requested if people knew it is available. "Built it and they will come". **Offer the service and they will use it** – may not have a group of 25 the first time but word of mouth will mean that they will use it more and more. Need to promote that French services are available.
- Sometimes the services are available but it is the responsibility of tables such as this to enhance the services/**promote the services.**
- **Tripartite initiative related to Mental Health - 3 clusters (eg. Windsor, London, St. Clair)** - the school boards have to cover all the clusters and create a link between school boards and mental health for kids. London is district #28. **Challenges result because of breadth of size of geographic area** – funding is same as for more concentrated/smaller Anglophone geographic areas so have same number of people on the ground but covering much larger area. This also **emphasizes a greater need for human infrastructure among Francophone community.**
- Do Anglophone community respond appropriately? – Absolutely-- always willing to work with us in French. (some disagreement around table related to speed of response etc.)

<u>Question 2</u>/
"Identify what is currently happening in our community."
"Identify what is working well in our community."

- Lots of activities happen in our schools seem to work well, but they are all spread out and they are **delivered drop by drop without coordination (lack of coordination).** Request for services

leads to doubling/duplication of efforts. Therefore, **some services are lost in the long run because too much is going on.**

- A report identifies the needs of the Francophone community (we know them)—all 6 Priority Areas are in the report. Have the information in the report and participants have reported what they want "**6 domains included in the report**" – deals with both immigrants and French Canadians. Report currently in French [Mary Lou Albanese to follow-up and get copy of report following meeting]
- **Richness of services are available, but there is lack of coordination, concentration, depth, and sustainability** – need more coordination with community and school boards. It feels like programs/initiatives only skim the surface but cannot get to the root of the problem
- Different organizations have healthy eating/healthy living but **don't always know what else is going on. Need a view of the whole picture** of what is occurring in the community.
- **Little bits of things available but very little depth to the services** being offered because there is no time available to do it in depth so that there is depth and sustainability
- **la ribambelle** - **Weekend seminars re. healthy eating, well attended.** If funding was available, there were be 3 times as many who would show up.
- There is **very little information available for French people new to Canada**, where there is plenty of info for permanent residents of Canada. There is also **lack of continuity of services for newcomers to Canada who are French**. Lots of these people come from countries where healthy eating is not a priority so it is hard to convince them of the necessity of having all of these 6 domains. **French newcomers may not have observed issues of "Healthy Eating" prior to coming to Canada – they ate to survive. Need to explain these 6 priority areas, but there is a lack of opportunity to do so.**
- Important for government to understand the **need for the francophone community to gather** and build momentum/to unify. Government should understand that Francophone community could join forces to create change.
- **Community centres** offer a lot of good supports and activities, but mostly for the old people (seniors).
- **Violence against women (La Femme) – centre** (mental health and adding a sprinkling of physical activity) Abuse centre deals with Mental Health and most recently Physical Activity (e.g. yoga).
- ***In motion***
- Little groupings of French Canadians will often offer services that aren't being provided by the government – results in **lack of continuity and working on little or no budget.** Always the **same people working at the table** and lose motivation/burn out.
- Disappearance of organizations is often a result of **people burnout** and **lack of sustained funding** then means we lose the people that have been engaged. **Need a sense of teamwork from the government to work effectively.**
- One of the best practices – hospitals provide in French either through the interpreter or the medical staff – Note: not a sense of agreement amongst the group. Sometimes **people don't know they can ask for the service in French** and sometimes they don't ask because they know that they **might need to wait**. Some organizations make an effort to **provide an interpreter, but it doesn't last.**
- If there was **funding and strategies available we would get more people out to these workshops,** and people would respect that French services are available.
- **Child Youth Network and Healthy Eating Healthy Physical Activity**
- **Healthy eating program/Nutrition Guide originating from la ribambelle –** now being translated into English and being distributed city wide (and outside of the province as well). Initially was made for 200 people, and now being given to all of the City, Manitoba, New Brunswick (part of CYN). School Boards would like to provide kits for the vast population like this, but lack funding.

Question 3/

"Identify the challenges in our community."

- Services **aren't necessarily available as much as they should be**, **not integrated**, **not deep enough**, **not enough communication and coordination** – **French and English programs and alerts are not offered simultaneously when launching programs** (e.g. H1N1).
- **Basic community of French needs to ask for the services in French** or it won't be offered **–** we don't put services into place unless they are asked for. As soon as the service is identified and sufficient demand then the service will be provided. Therefore, **those who are perfectly bilingual need to ask for French** – starts in the family. French Canadian families speak English at the table and watch tv in English so how do we expect services in French?
- Sometimes translation is offered word for word but that is not the same thing. **The service should be offered in quality and not simply translated.**

<u>Question 4/</u>
Practical brainstorming
"Going back to your dream/vision, think practically identifying what you would like to see happen in our community with respect to this priority area – including awareness raising, programs and services, and policy"
"What can we do?"

- See **animated shows offered to kids in the school** to talk about healthy food and really capture the kids. A lot more **animated** road shows for kids that will **capture** them, versus ambassadors who may not be engaging or to whom they cannot relate.
- **People should ask for more services in French** – increase the number of users.
- **Talk about these 6 topic areas in the schools** they will begin to ask for them more as they grow up in the community. **Need to educate the school boards and the parents at the same time.** Not just the children but families as a whole.
- **Support organizations that work with parents outside the schools** - provide them funding. Not just the kids find out but the parents. Provide funding for those programs so both students and parents receive the information.
- **Have more opportunities for these activities (physical activities that are involved with both children and parents.)**
- Sometimes you have a good young group that works well the community but because they don't have years of experience they don't the funding that more established groups get, and people end up having to pay out of pocket – need government funding support.
- Grocery stores – more French resources. **Integration centre where grocery stores can access resources and bring back to their own store.**
- As a parent I know what is going on in English and there isn't as much going on in French. **Organizations don't have the funding or the capacity to provide the services** and the English organizations tend to have more activities available.
- When addressing an issue, **a multi-level approach is required** (e.g. programs, food outlets, etc.). Talk about improving healthy eating – the whole area needs to be included including the stores.
- **Offer more sports available in French**
- **Lack of integration between Francophone efforts. Collaboration needed** – similar to **Child Youth Network, Best Start,** where Francophone community is involved. How can we make a network that serve the Francophone – need to integrate efforts of francophone organizations. Francophone is involved in some of the larger networks – how do we better incorporate them. Health Unit has been at the forefront of providing French services (French resources are provided on website and French services are offered).
- Needs to be openness and willingness. Need to go further – **not just education, awareness – it needs to become part of who we are.** We sleep, eat and exercise. It becomes automatic. It

starts with our kids – we need to help our families. Whether you are francophone Anglophone etc.

- **Criteria for grants need to be customized for Francophone needs** (eg. Numbers reaching are smaller because francophone population is smaller so when competing with Anglophone the criteria of "reach" is not on a level playing field). This comment is for the **Ministry of Health Promotion and Sport,** where the Francophone community is a priority population in the grant.
- **School boards can offer facilities to support activities of those who apply for MHP&S grants, even though they cannot apply themselves. School boards are willing to support with their facilities, etc.**
- Hard to coordinate application. Show **strength of partnership when applying for funding** in francophone stream, which will increase probability of receiving (even if a new organization).
- Need to look at **sustainability** – therefore need to look for **partnerships.**
- Takes one good idea to work – sometimes start small and then expand project
- **Look at other provinces and utilize the already existing resources.**
- For awareness activities such as *in motion*- put the bus ads in French as well

Additional comments and suggestions

- Awareness – provide French resources and we will awaken the Francophones and engage them
- Windsor working on policies around **no smoking at the soccer fields, affordable access for children**
- Internal **policies for places (eg. Workplaces) that translation must take place**
- One of the barriers is that we don't know the policies
- Barrier to translation is cost and inadequate resources.
- Barriers: We often don't know the barriers (don't know policies exist/do not exist).
- **Smoke free areas** at malls, entry ways between building, parks – all outdoor spaces (Provincial goal: All outdoor spaces smoke-free).
- Translation is costly**. Translation could be provided by connecting with this particular table of partners** – the service exists
- Secretary of state (federal level) has funds for translation.

Table de concertation francophone de London et des environs

Rencontre du 20 janvier 2011
12 h 30 – 14 h
Vanier Children's Services/Centre d'enfance Vanier
871, rue Trafalgar, London

Services de traduction fournis par Robert Gervais par l'intermédiaire d'Across Languages

Représentants de :

La Ribambelle
Fondation Trillium de l'Ontario (OTF-FTO)
Fondation des maladies du cœur de l'Ontario (HSFO-FMCO)
Ministère de la Formation et des Collèges et universités de l'Ontario (**MFCUO)**
Ministère des Services sociaux et communautaires et ministère des Services à l'enfance et à la jeunesse (MSSC-MSEJ)
Cercle des copains (London, ON)
*Conseil scolaire de district des écoles catholiques du Sud***-Ouest**
Communauté Ste Marguerite D'Youville
Collège *Boréal*
Centre d'acquisition des compétences et des talents des immigrants francophones de l'Ontario (CACTIFO)
Conseil scolaire (CS) Viamonde
Réseau de développement économique et d'employabilité (*RDÉE) Ontario*
Réseau de soutien à l'immigration francophone

Questions initiales/discussion durant l'introduction du programme Communautés en santé (suivant la présentation par Ghislaine Brodeur)

Ghislaine Brodeur (Ghislaine.Brodeur@ontario.ca)
Ministère des Affaires civiques et de l'Immigration de l'Ontario
Ministère du Tourisme et de la Culture
Ministère de la Promotion de la santé et du Sport

- Distribution de la présentation en français sur le Partenariat Communautés en santé
- Pas de questions

Question 1
«Si l'argent n'était pas une préoccupation et qu'il n'y avait pas de contraintes ni d'obstacles, que désireriez-vous accomplir dans ce domaine prioritaire?»

- Mise en œuvre – dans la communauté francophone, il y a un petit espace pour deux écoles secondaires. L'infrastructure n'offre pas un grand espace pour les activités physiques (un gymnase, par exemple). Besoin d'une cuisine (par exemple, pour des démonstrations culinaires pour personnes âgées), etc. **Élargir le centre communautaire et fournir l'infrastructure nécessaire**.
- **Besoin de cantines dans les écoles secondaires et élémentaires pouvant servir des repas sains** (une telle planification des menus se fait dans les pays scandinaves depuis des années). Nous sommes le seul pays parmi les G8 qui ne prévoit pas un programme de repas.

- Certains fournisseurs de repas pour enfants d'âge préscolaire font en sorte que ce qui est servi soit fondé sur un bon menu, mais de nombreux organismes ne servent pas une bonne nourriture – **il faut prévoir des menus, des options et des lois pour garantir qu'une alimentation saine est servie dans les garderies, et ce, en tant que norme généralisée plutôt que de laisser la décision entre les mains des particuliers**.
- **Campagne d'éducation et de communication puissante** – s'appuyant sur le programme **Centre Réseau** – bonne information solide, facile à utiliser, amusante, peu coûteuse. Nourriture facile, recettes, activités simples. Plus de ce qui a été fait [par exemple, trousse d'outils sur les activités physiques et l'alimentation saine pour familles]. Chaque famille devrait avoir une trousse d'outils pour ces activités saines.
- Outre l'information transmise aux écoles, l'information doit être communiquée simultanément aux parents – **les familles devraient recevoir l'information en même temps que les écoles**. Il faut s'assurer que tout ce que les enfants reçoivent à l'école est envoyé aux parents à la maison – parce que si seuls les enfants reçoivent l'information à l'école, il n'y aura pas de suivi à la maison. Aidez les parents à comprendre leur rôle dans la vie saine. **Invitez les parents à l'école pour des séances d'information**.
- **Tables de concertation** (**tables rondes avec les partenaires communautaires**) – Besoin de tenir un plus grand nombre de ces réunions pour s'assurer que les travaux se font et accroître les discussions entre les partenaires.
- **Communication simultanée en français et en anglais** afin que les francophones ne reçoivent pas l'information 2 semaines plus tard (par exemple, H1N1). **Besoin d'un meilleur système de communication**.
- Les représentants francophones ne peuvent pas faire partie de chaque discussion concernant chaque lancement – **Besoin d'une méthode plus stratégique de rationaliser les projets**, car les écoles ne peuvent pas être partout à la fois. Par exemple, besoin de dire «vous n'avez pas le choix» pour effectuer un changement dans le comportement (**c.-à-d., politique**). **Il faut mettre en place «des politiques généralisées**». Les programmes et projets ne correspondent pas à ce qui se passe dans la communauté (par exemple, il existe de nombreux programmes, mais en allant aux programmes ou en y revenant, les gens sont encore en mesure de s'arrêter manger dans des restaurants-minute).
- La communauté francophone doit communiquer efficacement et avec autorité. Elle semble être isolée et on lui demande souvent d'intervenir trop tard.
- **Besoin de plus de personnes «sur le terrain»** – un élément clé à la mobilisation de la communauté toute entière. **La communauté francophone a besoin d'une infrastructure humaine plus robuste**.
- **Les services de langue française ne doivent pas être offerts a posteriori**. Quand une information devient disponible, elle doit être communiquée immédiatement à la population francophone, car elle subit le même risque et est considérée comme une population prioritaire. **La communauté francophone ne *sait* souvent pas ce qui est disponible**.
- Conformément à la ***Loi sur les langues officielles*** – les ressources en anglais et en français doivent être livrées simultanément. Il ne s'agit pas d'un bon service à la clientèle par les différents ministères. Besoin de faire mieux. Communiquer ce message au ministère de la Promotion de la santé.
- Une alimentation saine et la participation à des activités est difficile quand le budget est limité. En examinant les politiques, **il faut analyser comment rendre ces choses abordables et accessibles pour la communauté francophone**.
- **Améliorer considérablement la communication**. Les francophones ne savent pas ce qui est à leur disposition.
- Difficile de trouver des **présentateurs francophones**. Les présentateurs disponibles ont eu peu d'occasions de pratiquer parce qu'ils reçoivent un nombre limité de demandes.
- Le gouvernement doit savoir que des présentations en français peuvent être demandées si les gens savaient qu'elles sont disponibles. «Construisez-le, et ils viendront». **Offrez le service et ils l'utiliseront** – Il se peut qu'il n'y ait pas un groupe de 25 personnes la première fois, mais grâce au bouche-à-oreille, de plus en plus de personnes l'utiliseront. Besoin de communiquer que des services en français sont disponibles.
- Parfois, les services sont disponibles, mais il incombe aux tables, comme celle-là, d'améliorer/de **promouvoir les services**.
- **Le projet tripartite lié à la santé mentale – 3 groupes (Windsor, London, St. Clair)** – les conseils scolaires doivent couvrir tous les groupes et créer un lien entre les conseils scolaires et

la santé mentale des enfants. London est le district n° 28. **Les défis résultent de la grandeur de la zone géographique** – Le financement est le même que pour les plus régions anglophones plus denses/petites. Il s'agit du même nombre de personnes, mais dans une superficie beaucoup plus grande. **Cela souligne également le besoin accru d'une infrastructure humaine au sein de la communauté francophone**.

- La communauté anglophone répond-elle de façon appropriée? – Absolument – toujours prête à collaborer avec nous en français. (Un certain désaccord autour d'une table concernant la vitesse de réponse, etc.).

Question 2
«Identifier ce qui se passe actuellement dans notre communauté.»
«Identifier ce qui fonctionne bien dans notre communauté.»

- Beaucoup d'activités qui ont lieu dans nos écoles semblent bien fonctionner, mais elles sont dispersées et **livrées goutte à goutte sans coordination (manque de coordination)**. La demande de services conduit au dédoublement des efforts. Par conséquent, **certains services sont perdus en fin de compte parce que beaucoup de choses se passent en même temps**.
- Un rapport cerne les besoins de la communauté francophone (nous les connaissons) – Les 6 domaines prioritaires se trouvent dans le rapport. L'information se trouve dans le rapport et les participants ont signalé ce qu'ils veulent «**6 domaines inclus dans le rapport**» – traite à la fois des immigrants et des Canadiens français. Le rapport est actuellement en français [Mary Lou Albanese fera un suivi et obtiendra un exemplaire du rapport après la réunion]
- **Il y a une richesse de services, mais un manque de coordination, de concentration, de profondeur et de durabilité** – besoin d'une plus grande coordination avec les communautés et les conseils scolaires. Il semble que les programmes/projets ne font qu'effleurer la surface sans parvenir à la racine du problème.
- Différents organismes offrent des programmes d'alimentation saine/mode de vie sain, mais **ne sont pas toujours au courant de ce qui se passe ailleurs**. Besoin d'une vue d'ensemble de ce qui se passe dans la communauté.
- **De petites activités ça et là sont disponibles, mais les services offerts sont peu détaillés**, car il n'y a pas de temps pour le faire en profondeur. En conséquence, il n'y a pas de profondeur ni de durabilité.
- **La Ribambelle – Bonne participation aux séminaires de week-end sur l'alimentation saine**. Si le financement était disponible, il y aurait 3 fois plus de participants.
- **Il y a très peu d'information disponible pour les nouveaux arrivants francophones**, alors qu'il y a beaucoup d'information à l'intention des résidents permanents du Canada. Il y a aussi un **manque de continuité dans les services offerts aux nouveaux arrivants au Canada qui sont francophones**. Beaucoup de ces personnes viennent de pays où l'alimentation saine n'est pas une priorité de sorte qu'il soit difficile de les convaincre de la nécessité d'avoir l'ensemble de ces 6 domaines. **Les nouveaux arrivants francophones peuvent ne pas avoir observé des problèmes «d'alimentation saine» avant de venir au Canada – ils ont mangé pour survivre. Besoin d'expliquer ces 6 domaines prioritaires, mais il y a un manque d'occasion de le faire**.
- Il est important que le gouvernement comprenne **l'importance que la communauté francophone se rassemble et se donne une impulsion/s'unit**. Le gouvernement devrait comprendre que la communauté francophone pourrait unir ses forces pour créer un changement.
- Les **centres communautaires** offrent beaucoup de bons soutiens et activités, mais surtout pour les personnes âgées.
- La **violence contre les femmes (La Femme) – Centre** (santé mentale et une pincée d'activités physiques) – centre contre les mauvais traitements se concentre sur la santé mentale et, plus récemment, l'activité physique (par exemple, le yoga).
- ***In motion***
- De petits groupes de Canadiens français offrent souvent des services qui ne sont pas fournis par le gouvernement – ce qui résulte en un manque **de continuité et des services avec peu ou pas de budget**. Ce sont toujours **les mêmes personnes qui travaillent**, mais perdent leur motivation ou souffrent d'un épuisement professionnel.
- La disparition des organismes est souvent le résultat de l'**épuisement professionnel** des personnes et le **manque de financement durable**, ce qui mène à la perte des personnes qui

étaient engagées. **Besoin d'un esprit d'équipe du gouvernement pour travailler efficacement**.

- L'une des meilleures pratiques – les hôpitaux offrent des services en français, soit par l'intermédiaire d'un interprète ou du personnel soignant – Remarque : pas un sens d'accord parmi le groupe. Parfois, **les gens ne savent pas qu'ils peuvent demander d'être servis en français** et parfois n'en font pas la demande pas parce qu'ils savent qu'**ils devraient attendre**. Certaines organisations font un effort pour **fournir un interprète, mais cela ne dure pas**.
- S'il y avait **un financement et des stratégies, nous pourrions inciter plus de personnes à assister à ces ateliers**, et les gens respecteraient que des services en français sont disponibles.
- **Réseau de l'enfance et de la jeunesse et Alimentation saine/Activité physique saine**
- **Programme d'alimentation saine/Guide de la nutrition provenant de La Ribambelle** – actuellement en cours de traduction en anglais et sera distribué dans toute la ville (et à l'extérieur de la province ainsi). Au départ, il a été fait pour 200 personnes, mais maintenant est remis à la ville entière, au Manitoba, au Nouveau-Brunswick (partie du REJ). Les conseils scolaires aimeraient remettre des trousses comme celle-là à la population, mais il y a un manque de financement.

Question 3

«Identifier les défis dans notre communauté.»

- Les services **ne sont pas nécessairement disponibles autant qu'ils devraient l'être, ne sont pas intégrés, ne sont pas assez détaillés, et il n'y a pas assez de communication et de coordination** – **Les programmes et alertes en français et en anglais ne sont pas proposés simultanément lors du lancement des programmes** (par exemple, H1N1).
- **La communauté de base de francophones doit demander des services en français**; autrement, ils ne seront pas offerts – nous ne mettons pas des services en place à moins qu'il n'y ait une demande. Dès que le service est cerné et la demande est suffisante, le service sera fourni. Par conséquent, **les personnes qui sont parfaitement bilingues doivent demander d'être servies en français** – commencez dans la famille. Les familles francophones parlent l'anglais à table et regardent la télé et en anglais; alors comment peut-on s'attendre à des services en français?
- Parfois, la traduction est offerte mot pour mot, mais ce n'est pas la même chose. **Le service devrait être de qualité et non une simple traduction**.

<u>Question 4</u>
Exercice de remue-méninges
«Pour revenir à votre rêve/vision, pensez pratiquement pour cerner ce que vous aimeriez voir dans notre communauté à l'égard de ce domaine prioritaire – notamment, la sensibilisation, les programmes et services, et la politique.»
«Quoi faire?»

- **Spectacles animés offerts aux enfants à l'école** pour parler de l'alimentation saine et susciter l'intérêt des enfants. Des tournées beaucoup plus animées pour enfants qui attirent leur **attention** plutôt que des ambassadeurs qui ne sont peut-être pas captivants ou avec lesquels ils ne peuvent pas établir un rapport.
- **Les gens devraient demander plus de services en français** – augmenter le nombre d'utilisateurs.
- **Parler de ces 6 sujets dans les écoles**; les élèves commenceront à en faire la demande davantage, à mesure qu'ils grandissent dans la communauté. **Besoin de sensibiliser les conseils scolaires et les parents en même temps**. Non seulement les enfants, mais les familles entières.
- **Organismes de soutien qui collaborent avec les parents en dehors des écoles** – leur fournir le financement nécessaire. Ne pas communiquer seulement avec les enfants, mais aussi les parents. Fournir des fonds à ces programmes pour que les élèves et les parents reçoivent l'information.
- **Avoir plus de possibilités pour ces activités (activités physiques qui font participer les enfants et les parents).**

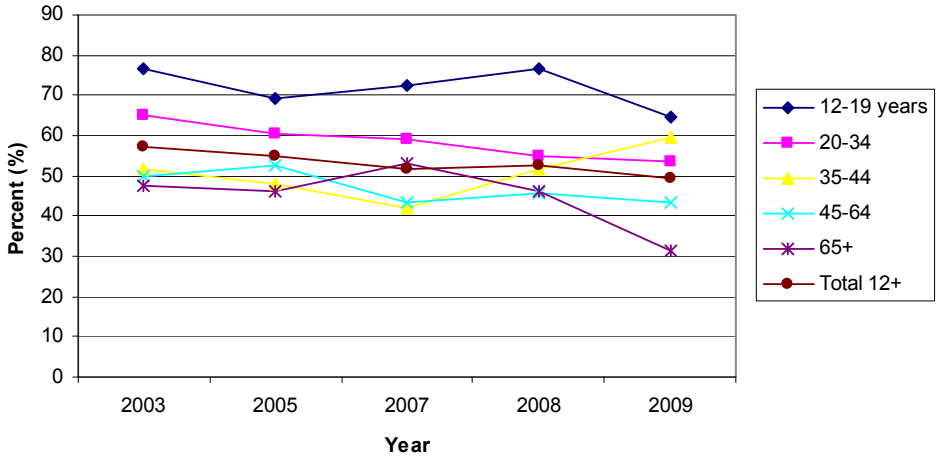
- Parfois, vous avez un bon groupe de jeunes qui travaillent bien dans la communauté, mais parce qu'ils n'ont pas l'expérience nécessaire, ils ne reçoivent pas le financement que les groupes plus établis reçoivent, et les gens finissent par avoir à défrayer personnellement le coût – besoin d'un soutien financier du gouvernement.
- Épiceries – plus de ressources en français. **Centre d'intégration où les épiceries peuvent accéder aux ressources et les offrir dans le magasin**.
- En tant que parent, je sais ce qui se passe en anglais, et il n'y a pas grand-chose qui se passe en français. **Les organisations n'ont pas le financement ni la capacité d'offrir les services**, et les organisations anglophones ont tendance à offrir plus d'activités.
- Quand on aborde un problème, **une approche multi-niveaux est nécessaire** (par exemple, programmes, magasins d'alimentation, etc.). Parlez de l'amélioration de l'alimentation saine – toute la région doit être incluse, y compris les magasins.
- **Offrez plus d'activités sportives en français.**
- **Il y a un manque d'intégration entre les efforts francophones. La collaboration est nécessaire** – tout comme le **Réseau de l'enfance et de la jeunesse**, **Meilleur départ**, où la communauté francophone participe. Comment pouvons-nous mettre en place un réseau qui dessert les francophones – besoin d'intégrer les efforts des organismes francophones. Ces organismes font partie de quelques-uns des grands réseaux – comment pouvons-nous mieux les intégrer? Le bureau de santé a été à la pointe de la prestation de services en français (des ressources en français sont fournies sur le site Web et des services en français sont offerts).
- Besoin d'honnêteté et de volonté. Besoin d'aller plus loin – **non seulement l'éducation, mais aussi la sensibilisation – elle doit faire partie de nous**. Nous dormons, mangeons et nous nous exerçons. L'activité physique devient automatique. Elle commence avec nos enfants – nous devons aider nos familles. Que vous soyez francophone, anglophone, etc.
- **Les critères d'octroi des subventions doivent être adaptés aux besoins francophones** (p. ex, la portée est plus petite, car la population francophone est plus petite; donc, en comparaison avec les critères anglophones, la «portée» n'est pas sur un pied d'égalité). Ce commentaire concerne le **ministère de la Promotion de la santé et des sports**, où la communauté francophone est une population prioritaire dans la subvention.
- **Les conseils scolaires peuvent offrir des installations pour soutenir les activités de ceux qui demandent des subventions du ministère de la Promotion de la santé et des Sports, même s'ils ne peuvent pas faire la demande eux-mêmes. Les conseils scolaires sont prêts à offrir leurs installations, etc.**
- Difficile à coordonner la demande. Montrer **la force du partenariat pour demander une subvention** dans le volet francophone, ce qui augmentera la probabilité du succès (même s'il s'agit d'une une nouvelle organisation).
- Besoin d'examiner la **durabilité** – il faut donc rechercher des **partenariats**.
- Il suffit qu'une idée fonctionne – parfois, il faut commencer graduellement, puis élargir les projets.
- **Examiner ce que les autres provinces ont fait et utiliser les ressources déjà existantes.**
- Pour les activités de sensibilisation, comme *in motion* – mettre aussi les annonces sur les bus en français

Autres commentaires et suggestions

- Sensibilisation – fournissez des ressources en français, et nous réveillerons les francophones et les mobiliserons.
- Windsor œuvre à élaborer une **politique d'interdiction de fumer sur les terrains de soccer et un accès abordable pour les enfants**
- **Politiques internes pour les lieux (par exemple, lieux de travail) imposant la traduction**
- Un des obstacles est que nous ne connaissons pas les politiques
- Un des obstacles à la traduction est le coût et l'insuffisance des ressources.
- Obstacles : Nous ne connaissons souvent pas les obstacles (ne savons pas si les politiques existent/n'existent pas).
- **Aires sans fumée** dans les centres commerciaux, les vestibules des bâtiments, les parcs – tous les espaces extérieurs (objectif provincial : Tous les espaces extérieurs sans fumée).
- La traduction est coûteuse. **La traduction pourrait être fournie en se connectant à ce tableau particulier de partenaires** – le service existe.
- Secrétaire d'État (niveau fédéral) dispose de fonds pour la traduction.

Physical activity, sport and recreation

Proportion of Middlesex-London population (age 12+) being moderately active or active during leisure time, 2003-2009 *(Source: Canadian Community Health Survey, Statistics Canada)*



- Overall decrease from 57% in 2003 to 49% in 2009
- Decrease with increasing age
- Males more physically active than females
- 8% walk or bike to work
- Active transportation to work most common in the City of London (8%) and Strathroy-Caradoc (6%) and least common in Newbury (0%), Adelaide Metcalfe (3%), Lucan Biddulph (3.5%) and Thames Centre (4%)

Children and youth

- Health-enhancing physical activity reported by 30% of youth (13-19) and for 44% of children (5-12)
- Daily physical activity (≥60 minutes) reported by 21% of grade 7-12 students (OSDUHS)
- Girls age 5-12 more physically active than boys
- Young males age 13-19 more physically active than young females their age
- Direct measures show only 7% of Canadian children and youth achieve recommended levels
- 88% reported walking and 58% reported biking to school, to work, or on errands in past 7 days
- Active travel to school among 11-13 year olds more likely among boys, in areas with lower incomes and where residential densities are lower
- Most common recreational activities for children: swimming, walking/hiking, biking, organized team sport
- Most common recreational activities for youth: walking/hiking, swimming, jogging/running, organized sports

- Screen time of more than ≥7 hrs per day in the past week was reported by 8%
- Sedentary behaviour more common among male youth than females, and increases with grade
- Access to recreational opportunities positively associated with physical activity among grade 7-8 students
- Some 'recreational deserts' exist in London urban core and the rural-suburban fringes, but no correlation between public recreation spaces and socioeconomic status

Adults

- Health-enhancing physical activity reported by 36% in 2009
- Direct measures show only 15% of adult Canadians achieve recommended levels (150 minutes/week)
- Lowest level of health-enhancing physical activity among those with household incomes between $20,000 to $40,000
- 54% intended to increase their daily physical activity over the next year
- Most common physical activities reported: walking for exercise, bicycling, jogging or running, and yard work/gardening

Older adults (65+)

- Regular physical exercise (not quantified) reported by 72%
- No differences across gender, age group, income level, retirement status or single household
- City of London residents less likely to exercise than those living in the County

Knowledge of recommended physical activity level

- Almost 100% awareness of health benefits of daily physical activity
- Only 33% could correctly identify the amount of daily physical activity recommended by Canada's Physical Activity Guide (previous guidelines)
- Females more knowledgeable than males
- Positively related to income and level of education
- Older adults (60-69 years) less likely to know the recommendations than younger individuals

Trails and walkways

- Knowledge of recreational trails increased from 81% in 2001 to 88% in 2008
- 63% reported using them in 2008 (unchanged over time)
- Knowledge and use was most common among people aged 25-44
- Use was less common among those without high school education compared to those with higher education

Healthy Weights

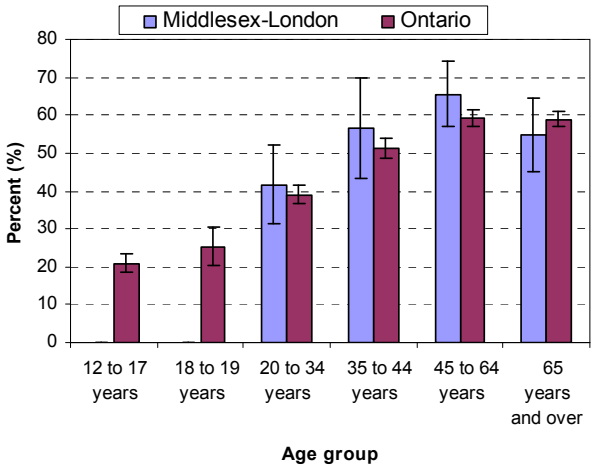
Overweight/obesity based on Body Mass Index (BMI)

NOTE: When based on self-reported measures overweight and obesity tend to be underestimated

- Almost 100% awareness that a healthy body weight reduces the risk of certain diseases
- Proportion of overweight/obese people (age 18+) in Middlesex-London increased between 2003 and 2009 (48% to 54%, not statistically significant). Provincially, the increase from 49% to 51% was statistically significant
- Higher rate among males compared to females
- Greater rate of increase among females than males, between 2001 and 2007
- Increase by age group: from 21% among 12-17 year olds to 59% among those 45 and over

Overweight/obesity by age group in Middlesex-London and Ontario, 2009

Source: Canadian Community Health Survey, Statistics Canada



- Highest proportion of overweight/obese individuals among those without a high school diploma

- Direct measures of Canadians show higher proportion of overweight/obese:
    - Female rates: from 25% among 15-19 year olds to 70% among 60-69 year olds
    - Males rates: from 31% among 15-19 year olds to 73% among 60-69 year olds
- Among school-aged children (age 6-13) in 2001-2003 about 17% were overweight and between 8-12% were obese based on direct measures (depending on which BMI cut-offs were used)
- Similar rates among boys and girls

Waist Circumference (WC)

- 31% at increased health risk based on WC
- More females than males are at increased health risk (34% vs. 28%)
- Health risk increases with increasing age (age 18-39: 20%; age 40-59: 33%; age 60-69: 45%)
- Clearer socio-economic gradient among females: higher risk among those with lower education and income
- Direct measures among Canadians show higher proportions of people with an unhealthy WC; among females the rates go from 28% in 15-19 year olds up to 82% in 60-69 year olds, and among males the rates go from 15% in 15-19 year olds up to 75% in 60-69 year olds

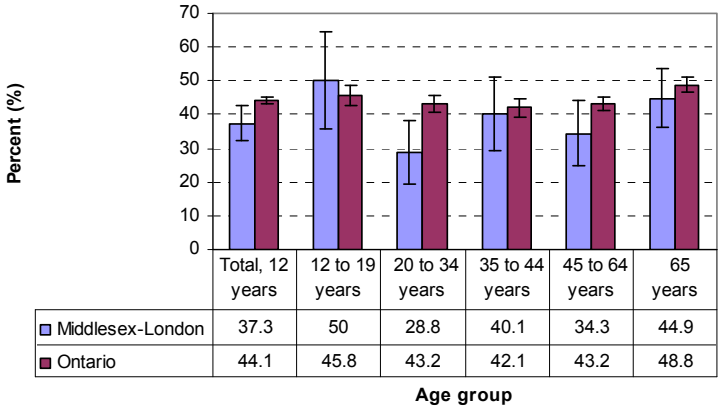
- Significant increase in BMI, WC, and skinfold measurements among both Canadian adults, children and youth between 1981 and 2007-2009 (direct measures)

Healthy Eating

Fruit and vegetable (FV) consumption

- Consumption of ≥5 FV servings daily lower in Middlesex-London than in Ontario (37% vs. 44%)
- Highest consumption among older Ontarians (65+)

Percentage of Middlesex-London and Ontario population eating ≥ 5 FV servings per day, by age group (2009). *Data Source: Canadian Community Health Survey, Statistics Canada.*



	Total, 12 years	12 to 19 years	20 to 34 years	35 to 44 years	45 to 64 years	65 years
Middlesex-London	37.3	50	28.8	40.1	34.3	44.9
Ontario	44.1	45.8	43.2	42.1	43.2	48.8

Age group

- Higher consumption among females than males
- Higher consumption among those with higher education and those with higher income

- Only 28% could identify the minimum number of daily FV intake recommended in the previous or current Canada's Food Guide
- Females more knowledgeable than males
- Knowledge increased with increasing education and household income.
- Almost 100% awareness of the overall health benefits of daily FV intake
- 84% agreed that FV consumption reduces rates of diabetes, cancer and cardiovascular disease
- Belief in health benefits increased with increasing education and income

Consumption of sweetened beverages

- About 72% of adults in London drink ≥1 sweetened beverages per day
- Highest consumption found among 18-39 year olds (>80%)
- Education and income related to consumption: lower consumption among those with university education and those earning >$80,000

Sodium intake

In 2004 the average daily sodium intake among Ontarians was 2,871mg (about twice the recommended maximum intake)

Food/nutrition literacy

- 76% of London residents read nutrition labels before purchasing food products
- More females than males read nutrition labels (85% vs. 68%)
- Rates positively related with education and income
- Almost 3/4 had good or excellent understanding of nutrition labels
- Lowest rate of understanding among older people (65+)
- No gender difference was seen for understanding

- Lower rate of understanding nutrition labels among those with lower education
- Nutrition labels affected food purchasing decisions least among 18-29 year olds
- Nutrition items affecting food purchasing most: carbohydrates (59%), fat (59%) and sodium (48%)
- Those 50 years and over were most concerned by sodium content (about 63%)

Community gardens

- 21 community gardening sites in the City of London (about 600 garden plots), but none in Middlesex County
- More than 70% of gardeners are low-income individuals
- Growing number of participating seniors
- Increased involvement by ethnic minority groups (e.g. the Karen Community, the Cambodian Community and the Cross Cultural Learner Centre)

Food deserts

'Food deserts' identified in the inner-city neighborhoods of Central and East London. After introduction of a Farmer's market in East London, this area is no longer a food desert.

Injury Prevention

- Focus on **Unintentional Injuries** (UIs)
- Leading cause of death among Canadians ages 1-34 years
- Top causes in Middlesex-London are falls and motor vehicle (MV) traffic crashes
- Annual average number of deaths is 120: majority are MV traffic crashes (29%) and falls (26%)
  - Between the age groups 45-64 and 65+ there is a 6-fold increase in death rates due to UIs (mostly attributed to falls)
  - County residents more likely to die from UIs
- Annual average of 2,345 hospitalizations: majority due to falls (58%) & MV traffic crashes (12%)
  - Between the age groups 45-64 and 65+ there is a 4-fold increase in hospitalizations rates due to UIs (mostly attributed to falls)
  - County residents more likely to be hospitalized due to UIs
- Annual average of 47,402 ER visits: falls (28%), sports injuries (9%) & MV traffic crashes (7%)
  - Males more likely to visit the ER due to UIs than females
  - Highest rates of ER visits among 10-19 year olds (mainly due to sports injuries and falls)
  - County residents more likely to visit an ER in general, and due to sports injuries specifically

4 leading causes of UI Deaths, Hospitalizations and ER Visits in Middlesex-London

Rank	Deaths (2000-2004)	Hospitalizations (2004-2006)	ER Visits (2004-2006)
	Cause Rate ± 95% CI (N)	**Cause** Rate ± 95% CI (N)	**Cause** Rate ± 95% CI (N)
1	**MV Traffic Crashes** 8.3 ± 1.2 (176)	**Unintentional Falls** 310.0 ± 9.5 (4042)	**Unintentional Falls** 3081.3 ± 29.7 (40,178)
2	**Unintentional Falls** 7.2 ± 1.1 (154)	**MV Traffic Crashes** 64.4 ± 4.4 (840)	**Sports Injury** 1015.3 ± 17.2 (13,238)
3	**Unintentional Poisoning** 2.4 ± 0.7 (51)	**Sports Injury** 27.1 ± 2.8 (354)	**MV Traffic Crashes** 739.0 ± 14.7 (9636)
4	**Unintentional Suffocation incl. choking** 1.9 ± 0.6 (41)	**Unintentional Poisoning** 24.3 ± 2.7 (317)	**Pedal Cycle** 263.8 ± 8.8 (3440)
All UIs	**All Causes** 28.1 ± 2.3 (598)	**All Causes** 539.5 ± 12.6 (7035)	**All Causes** 10,906.2 ± 53.5 (142,207)

Data Source: Provincial Health Planning Database (PHPDB), Ministry of Health & Long-Term Care, extracted June 2009.

Falls

- Falls is the leading cause of death among females, among those 65+, and in the City of London
- Death rate due to falls is 14 times higher among those 65+ (compared to those 45-64 years)
- Females more likely than males to be hospitalized due to falls
- Falls is the leading cause of ER visits in all age groups except 10-19 year olds
- About 20% of older adults (65+) reported having had a fall in the past year and 7% had a fall that affected their daily activities (2001-2003)
  - Females twice as likely to report a more serious falls compared to males
  - No differences between City and County, or between income groups

Motor vehicle crashes

- Males more likely to die from and be hospitalized due to MV traffic crashes
- ER visits due to MV crashes are most common in the age groups 10-19 and 20-44
- Visits to the ER due to pedestrian accidents much more common in the City than the County
- County residents about twice as likely to die from, or be hospitalized due to MV traffic crashes
- In Canada most fatal collisions occur in rural areas and most personal injuries occur in urban areas
- 43% decrease in road traffic deaths in Canada between 1989 and 2007
- 49% decrease in major and minor injuries due to MV collisions in Canada between 1989 and 2007
- Pedestrian fatalities in Canada are more prevalent among seniors than children under age 16

Driving and substance use

- 6% of Middlesex-London residents reported drinking and driving (2001-2008)
- More males drink and drive
- Highest rates among those aged 19-39
- 2% of Ontarians reported having been driving after using cannabis in the past year (2007)
- 11% of youth (grades 10-12) reported drinking and driving and 18% reported driving after using cannabis in the past year (2009)
- Males more likely to drive after consuming alcohol or cannabis compared to females

Self-reported measures of injuries (Middlesex-London, 2009)

- 10% reported having sought medical attention for an injury in the past year
- 17% reported having had an injury causing limitation of normal activities in the past year
- Highest rates among males and those aged 12-19 years old

Self-reported treatment for injury among youth

- 41% of grade 9-12 students treated for an injury in the past 12 months (2009)
- More common among males than among females

Bike helmet use

- In 2009 36% reported always wearing a bike helmet when riding a bicycle (age 12+)
- Increase from 27% in 2000/01
- Males 20-34 years old were least likely to wear a bike helmet
- 64% of households with children (aged 5-17) reported that their children always used bike helmets (2001-2003); occasional use among 22%
- Use was only 40% among 13-17 year olds, compared to 83% among younger children
- Household income was not related to use among children
- Higher use among children reported by respondents with post secondary education compared to those with lower education
- Higher use in the City than the County (69% vs. 48%)

Parental knowledge of leading cause of death among young children (0-6), 2006

- 58% of parents of children ≤11 years knew that injuries are the leading cause of death in young children
- Higher awareness among mothers than among fathers
- Lowest awareness among parents under the age of 24 (27%)
- Lowest knowledge among low income parents (<$30,000) and those with only high school
- 33% of the parents believed that injuries were not at all or only somewhat preventable

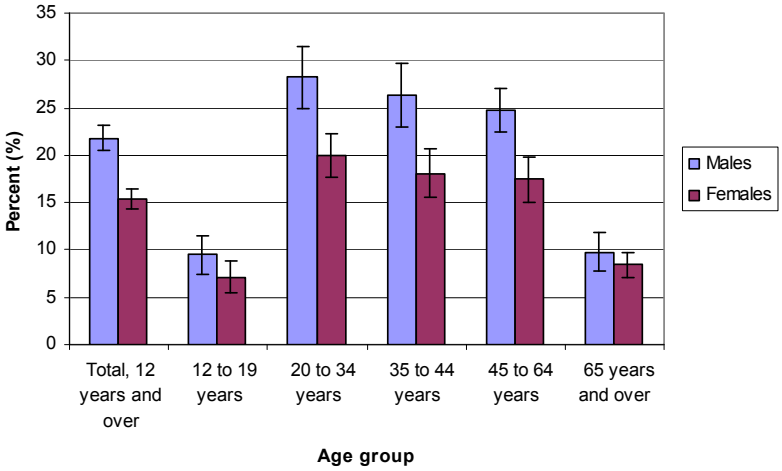
Tobacco Use and Exposure

Current smoking among adults

- The smoking rate in Middlesex-London was 20% in 2007: 16% daily and 4% occasional smoking
- Between 2001 and 2007 daily smoking decreased from 20% to 16%
- Males more likely to smoke compared to females
- Greater decline in smoking rates over time among males compared to females
- Largest decrease in smoking rates among 18-24 year olds (from 32% in 2001 to 17% in 2007)
- Smoking was highest in the age group 20-34 (24.0%) in 2009
- Higher smoking rates among those with less than high school education (28%) in 2007, compared to post secondary graduates (15%)

Smoking rates (daily or occasional smoking) in Ontario (2009)

Source: Canadian Community Health Survey, Statistics Canada



- About 15% of current smokers in Middlesex-London were committed to quit smoking in the next 30 days, and 53% considered quitting sometime in the future

Youth smoking

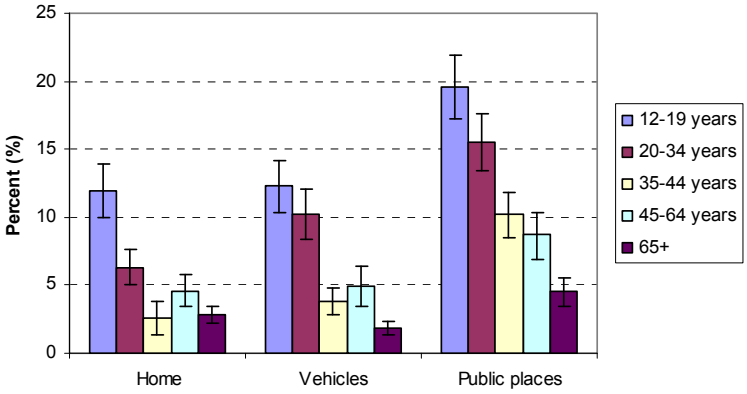
- In grades 9-12 16% reported ever smoking in the past year and 8% reported daily smoking (2009)
- Increase in current smoking among Ontario youth in grades 10-12 from 11% in 2006/07 to 13% in 2008/09
- Among 15-24 year old Ontarians current smoking declined from 29% in 1999 to 14% in 2009
- Males more likely to smoke than females among 15-24 year olds

Contraband cigarette smoking among youth

53% of past-year smokers had smoked cigarettes from native reserves in the past year (2009)

Environmental Tobacco Smoke (ETS)

- Between 2002 and 2009 exposure to ETS in past month decreased in homes (9% → 5%); private vehicles (10% → 6%); and public places (18% → 11%) in Ontario
- Youth aged 12-19 are most exposed to ETS, followed by 20-34-year olds



Source: Canadian Community Health Survey, Statistics Canada

Smoke-free homes and vehicles, Middlesex-London

- Percentage of smoke-free homes rose from 55% in 2001 to 80% in 2007
- Among smokers the proportion of smoke-free homes increased from 21% to 49%
- Proportion of people with smoke-free vehicles rose from 21% to 81%
- Smoke-free homes and vehicles were more common among post-secondary graduates (86%) compared to those with lower education (about 70% among those with less than high school)
- The proportion of people with both smoke-free homes and vehicles increased from 51% to 74%

Support for smoke-free public outdoor places (2009)

- Strong support for smoke-free public places in Middlesex-London: doorways to public places (90%), doorways to workplaces (89%), playgrounds (87%), sport fields (81%), beaches (74%) and patios (73%)
- Generally high support among both smokers and non-smokers, but highest among non-smokers
- No difference in support between City and County residents

Substance & Alcohol Misuse

- About 6% of deaths among those below the age of 70 in Canada in 2001 were due to alcohol
- Higher rates of drug and alcohol misuse are seen in the Aboriginal population

Daily alcohol use among adults

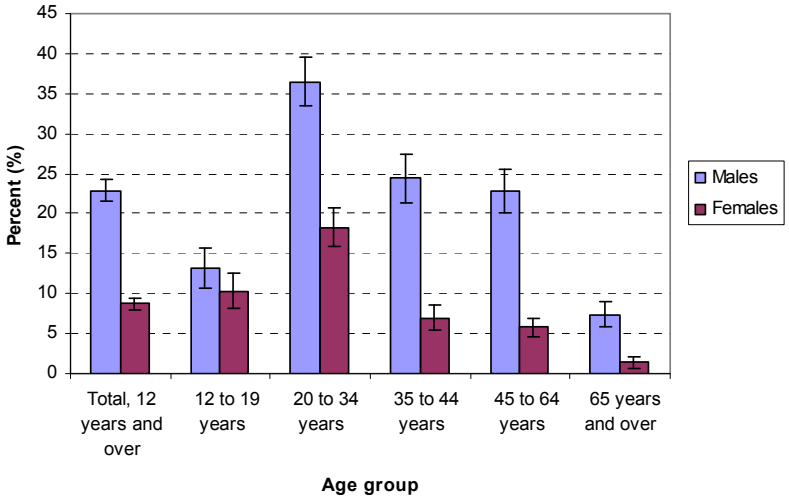
- In Middlesex-London about 8% of those using alcohol were drinking daily (about 6% in Ontario)
- Stable rates between 2001 and 2008
- In Ontario daily drinking has decreased from about 13% in 1977
- Males were more than twice as likely as females to report daily drinking
- Daily drinking increase with age (eg. 16% among those 65+ vs. 5% among 30-39 year olds)
- No differences found across education levels or between the City and the County

Heavy/binge drinking

- 15% of Middlesex-London residents (ages 12+) reported drinking ≥5 drinks on one occasion at least once a month in the past year (2009)
- Males twice as likely to binge drink as females (20% vs. 10%)
- Younger adults (ages 20-34) most likely to binge-drink (27%)
- Lower rates of weekly binge-drinking among university educated (4.3%)

Ontario rates of binge-drinking (2009)

Source: Canadian Community Health Survey, Statistics Canada



Exceeding the Low-risk drinking guidelines (LRDG)

- Decrease in Middlesex-London from 28% in 2001 to 24% in 2008
- Males were more likely to exceed the LRDG than females (33% vs. 22%)
- Decrease with increasing age, from 62% among 19-24 year olds to 8% among those 65+
- No difference between those living in the City vs. the County

Alcohol use among youth and university students

- Alcohol use among students in grades 7-12 in the past year in the West region of Ontario decreased from 70% in 1999 to 60% in 2009
- Binge-drinking in past month: 27% in grades 7-12 and 47% in grades 9-12 (higher than Ontario)
- 24% had been drunk at least once in the past months, and 22% reported hazardous drinking
- No difference between males and females, increasing rates with increasing grade
- Among Ontario undergraduate students in 2004 19% were heavy frequent drinkers and 33% reported hazardous/harmful drinking

Illicit drug use among adults

- In 2007 14% reported cannabis use in the past year in South West Ontario (12.5% in Ontario)
- Increasing cannabis use from 8% in 1996 to 14% in 2007
- Cannabis use more common among males than females (15% vs. 10%)
- Highest use of cannabis among 18-29 year olds (34%)
- Hazardous or harmful cannabis use among 17% of cannabis users in Ontario
- About 2% had used cocaine in South West Ontario in 2006 (1% in Ontario)

Illicit drug use among youth

- Use of any illicit drugs (including cannabis and non-medical use of prescription drugs) in the past year was reported by 42% of the students (grade 7-12) in West Ontario (2009)
- About 16% were estimated to have a potential drug use problem
- Most common illicit drugs used in past year:
    1. Cannabis (27%) (33% among Ontario university undergraduate students in 2004)
    2. Hallucinogens other than LSD and PCP (e.g. magic mushrooms) (5%)
    3. Salvia Divinorum (5%)
    4. Ecstasy (3.4%)
- Use more common among males than females, except for ecstasy
- Use of illicit drugs generally increase with increasing grade
- 15% of Ontario students reported using cannabis $\geq$6 times in the past year
- About 11% of cannabis users may have a dependence problem

Non-Medical Use of Prescription Drugs and Over-the-Counter Drugs

- 27% of students in grades 9-12 in the Erie St. Claire and South West LHIN region had used prescription drugs (Ontario: 23%)
- More common among females, compared to males in Ontario (23% vs. 18%)
- Most commonly used prescription drugs (grade 7-12) in Ontario:
    1. Opioid pain relievers (18%)
    2. Over-the-counter cough/cold medicine with dextromethorphan (7%)
    3. Stimulants (5%)
    4. Sleeping medication (3%)
- Ontario residents are among the highest users of narcotics in the world
- Number of prescriptions for oxycodone drugs increased by 900% between 1991 and 2009
- Misuse of narcotic drugs is a serious concern

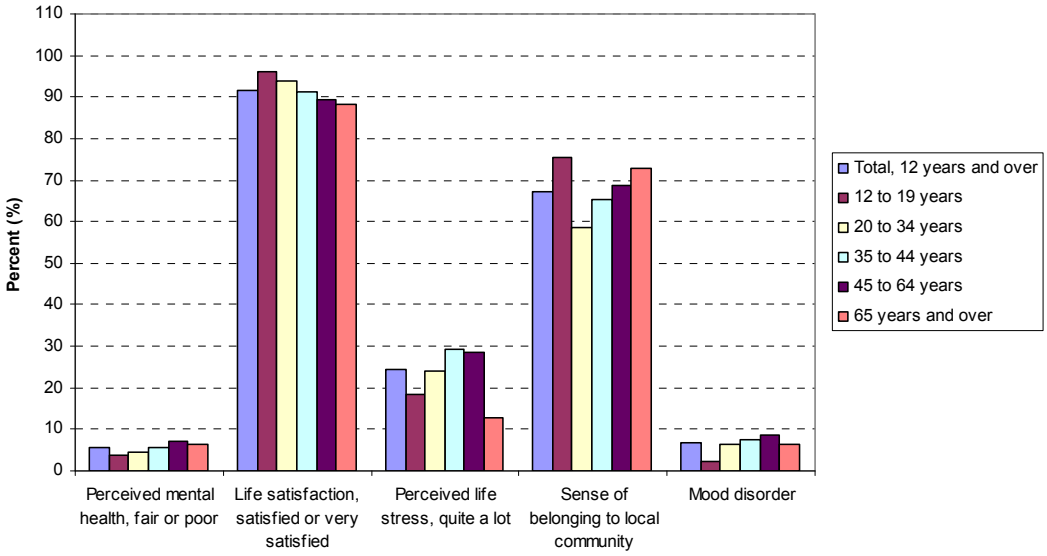
Mental Health Promotion

- 1 in 5 Ontarians will have a mental illness or addiction at some point in their lives

Among Middlesex-London residents (age 12+) in 2009:
- 95% rated their mental health as good, very good or excellent
- 91% were satisfied with their life
- 70% had a strong sense of belonging to the local community (slight increase 2003-2009)
- 24% of those aged 15+ felt that most days in their life were quite a bit or extremely stressful (slight increase between 2007 and 2009 and more common among Ontario females)
- 8% reported having a mood disorder (more common among females)

Indicators of mental health among Ontarians age 12+ (2009) **Appendix 9.9f**

Source: Canadian Community Health Survey, Statistics Canada



Adult mental health (2006)
- Overall, 11% of residents in the South West LHIN region reported elevated psychological distress during the past few weeks (≥3 symptoms)
- Most common symptoms: constantly under stress (16%), losing sleep because of worrying (13%), and being unable to enjoy daily activities (13%)
- Psychological distress was more common among females than males (15% vs. 10%)
- Distress highest among 18-29 year olds (17%) and lowest among those 65+ (7%)
- Most common among those with only high school education (16%)

Among South West Ontario residents:
- 9% used prescribed medication for anxiety or panic attacks, compared to 6% in Ontario in 2006 (highest use among women, those aged 50-64, and those earning <$30,000)
- 8% used prescription drugs for depression in the past 12 months (highest use among females, those aged 40-49, and those earning <$30,000)
- 6% reported poor mental health (including fair mental health) in 2007 (highest rates were found among those aged 40-49 and among those with less than high school education)

- 4% reported Frequent mental distress days in the past 30 days, compared to 7% of Ontarians (more common among females, those with less than high school, and those earning <$30,000)

- Men are about 4 times more likely to commit suicide than women
- Men in Ontario tend to be more likely to die from suicide than from car crashes (1990-2000)
- Women are 3-4 times more likely to make suicide attempts than men

Mental health among youth

- Prevalence of psychiatric problems among children and youth in Canada is about 20% and reaches 25% among young adults
- Suicide is the third most common cause of death among Canadian adolescents and the second most common cause of death among those 10-24 years of age

Among grade 7-12 students in West Ontario (including South West) in past year (2009):

- 23% had visited a mental health professional (most common in grade 7, and among females)
- 32% reported medical use of opioid pain relievers (more common in grades 9-12)
- 3% had used sedatives/tranquillizers, and 3% had used ADHD drugs (more common in males)
- 3% had used medication for anxiety and/or depression (increased with increasing grade)
- 12% had experienced poor mental health (increased with increasing grade, more common in females)

- 9% experienced poor self-esteem (more common among females)
- 6% had depressive symptoms in the past week (more common among females)
- 31% had experienced elevated psychological distress in the last few weeks (most common in females, increased with increasing grade)
- 10% had seriously considered attempting suicide in the past 12 months (more common among females), but only 2% had made a suicide attempt in the past year (no gender difference)
- 31% had been bullied by others in the current school year (most common in grades 7-10), and 27% had bullied others (more common among males)

Gambling and gaming in the past year among West Ontario students in grades 7-12 (2009):

- any gambling: 43% (increased with increasing grade)
- gambling problem: 2%
- video gaming problem: 11%
- All of these were more common among males than females

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