The Health Zone Nurse Practitioner-Led Clinic in London, Ontario: A socio-historical profile*

Prepared by EQUIP Research staff on behalf of Health Zone Nurse Practitioner-Led Clinic

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Downtown London (Platinum Properties Group Corporation, 2014)

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Purpose of this document

This summary contributes to an understanding of key historical events as well as the current status of the Health Zone Nurse Practitioner-Led Clinic and the people it serves. The focus is on the city of London, Ontario, because several of Health Zone's clinic sites, which are distributed across the city, are participating in the EQUIP Research program. This is a 'living' document and will continue to evolve as clinic data and new knowledge needs emerge.

Context of the City of London, Ontario

Overview

The city of London is located at the fork of the Thames River in southwestern Ontario about halfway between Toronto and Detroit, Michigan. Sitting at the junction of highway 401 and 402 (connecting it to Toronto, Windsor and Sarnia), London is a municipality politically separate from Middlesex County, but serves as the county seat. Middlesex County is bordered by Huron and Perth Counties to the north, Oxford County to the east, Elgin County to the south and Chatham-Kent and Lambton Counties to the West.

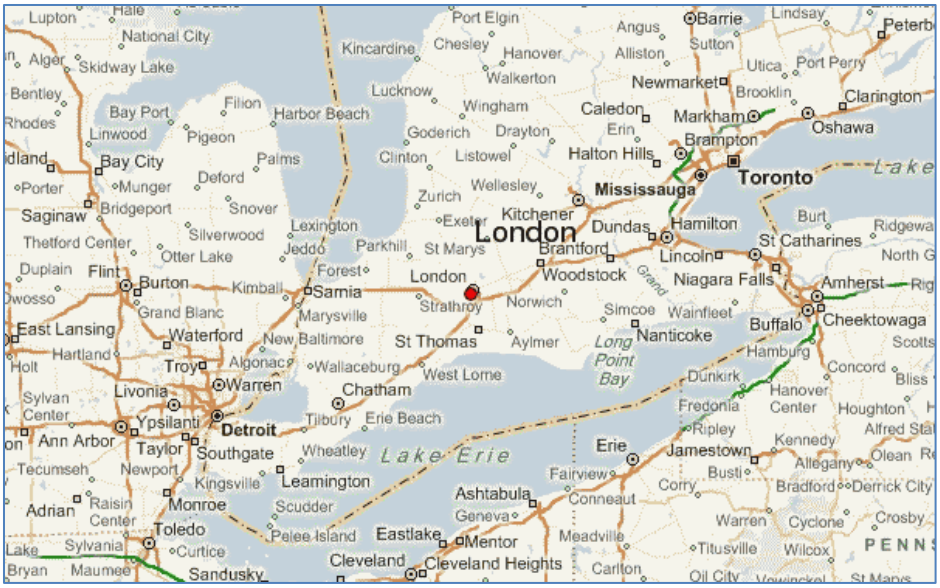

Figure 1: London, Ontario and surrounding area (Weather Forecast, 2015)

According to the 2011 Canadian census (Statistics Canada, 2012c), the City of London has a population of 366,151, making it the sixth largest city in Ontario, and the fifteenth in Canada (City of London, 2014c). The median age of its population is 39.3 years (Statistics Canada, 2012c). In 2006, 13.8% of the London population identified as visible minorities, lower than the provincial average (22.8 %) and national average (16.2%) at that time (Statistics Canada, 2006). Ethno-cultural diversity is reflected in London's immigrant population of 21.7% (Statistics Canada, 2007a) compared to 28.3% in Ontario and 19.8% nationally (Statistics Canada, 2007b). Recent immigrants in London make up 3% of the city's population (City of London, 2014b).

First Nation peoples living close to London on reserves[1] or settlements[2] are Chippewas of the Thames, Munsee-Delaware and Oneida. Less than 2% of the London population identify as

[1] A reserve is "a tract of land set aside under the Indian Act and treaty agreements for the exclusive use of the Indian Band" (First Nations Studies Program at University of British Columbia, 2009).

Aboriginal, with 1% self-identifying as 'Treaty Indians'[3]. The majority of Aboriginal people in London identify as First Nations, and less than a quarter as Métis. Comparatively, 2.5% of Ontarians identify as Aboriginal (City of London, 2014a).

Early History

Aboriginal Peoples

The history of the Aboriginal peoples of Canada and their relationships with early European settlers, the Crown and later the federal government is complex and significant. This history is summarized briefly here to provide context as it relates to health issues and inequities in London.

Before settlers arrived from Europe in the 1500s, Aboriginal peoples lived in the region that would become Ontario for at least 10,000 years (Citizenship and Immigration Canada, 2012). Many Aboriginal peoples used a clan or totemic system, similar to extended families, to organize, govern, and establish kinship bonds. Responsibilities such as fishing, hunting and medicine were distributed throughout communities. Other roles included warriors and those conducting regulatory functions. Elders played an important role in the health of the community. In general, the introduction of trade with settlers in the USA, Ontario and Quebec brought about difficult change and conflict between settlers and Aboriginal groups, as well as within and among Aboriginal groups. Agreements with settlers were negotiated in ways new for Aboriginal people but familiar to settlers. In the oral tradition, speeches were given and wampum shell belts (white shell beads), considered sacred by some First Nations groups, were used to signify treaty agreements while Europeans often made hasty oral promises – considered binding and acted on by Aboriginal people – but used written contracts to formalize agreements (National Museum of the American Indian, 2012).

In the 1600s, Southern Ontario was inhabited by the Iroquoian Huron, Neutral and Petun peoples who lived in semi-permanent villages and grew corn crops.[4] Also during this time, Ojibwa peoples called lands along the Sydenham and Thames Rivers in Southern Ontario home, and subsisted through hunting, gathering and fishing (Ferris, Kenyon, Prevec, & Murphy, 1985; Musuem of Ontario Archaeology, nd).

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[2] Oneida peoples call the land a settlement while Indian and Northern Affairs designate the land as Oneida reserve 41 (Oneida Language and Cultural Centre, 2014).

[3] "Registered Indian refers to persons who are registered under the Indian Act of Canada. Treaty Indians are persons who belong to a First Nation or Indian band that signed a treaty with the Crown. Registered or Treaty Indians are sometimes also called Status Indians" (Statistics Canada, 2013b).

[4] *Iroquois* was a term used by French settlers to describe Iroquois-speaking peoples of the nations Huron, Cherokee, Neutrals, Tuscarora, Wenro, Erie, and Susquehannock and included political confederates Seneca, Cayuga, Onondaga, Oneida and Mohawk, known as the Five Nations. These peoples are the Haudenosaunee (Haudenosaunee Confederacy, 2015; National Museum of the American Indian, 2012).

By mid-century, the Ojibwa peoples were scattered to other regions due to warfare with the Iroquois nations and disease, leaving the area mostly uninhabited except for a small number of Five Nations Iroquois settlements along the north shore of Lake Ontario. In the late 1700s, Ojibwa peoples from central Northern Ontario moved to Southern Ontario. During this time the Ojibwa lived in large groups until spring-summer when they broke into smaller groups to plant crops and benefit from the resources of the land (Ferris et al., 1985). In 1840, Oneida Iroquois peoples from New York State relinquished their lands at the demand of the New York Governor in order to provide land for men returning from the American Revolutionary war. The Oneida peoples then purchased lands along the Thames River in Middlesex County and established the Oneida Settlement where they still reside today (Musuem of Ontario Archaeology, nd; Oneida Language and Cultural Centre, 2014).

Over the centuries, many treaties were signed between Aboriginal peoples, and European settlers. Treaties made with Aboriginal peoples during the 18th century contributed to the evolution of Canada but remain contentious today with many land claims unsettled (Aboriginal Affairs and Northern Development Canada, 2011). As the European colonialists dominated the colonies of Upper and Lower Canada, they began to impose their way of life on Aboriginal peoples. Through the creation of an Indian Department, the dominant European culture made organized attempts to assimilate Aboriginal peoples to their religious beliefs, agricultural practices, and non-nomadic lifestyle (Aboriginal Affairs and Northern Development Canada, 2011).

Through the signing of the British North America Act – known as Confederation – in 1867, Upper Canada, Lower Canada, Rupert's Land and the Northwestern Territory combined to become the Dominion of Canada. The new provinces became Ontario, Quebec, New Brunswick and Nova Scotia (Parliament of Canada, nd). The Department of Indian Affairs created the Indian Act of 1876, which controlled and influenced many aspects of daily life for Aboriginal peoples in Canada (Aboriginal Affairs and Northern Development Canada, 2011). The policy with perhaps the greatest impact on the present day health and well-being of Canada's, and Southern Ontario's, Aboriginal peoples was the Indian Residential Schools policy, described briefly below (for more detail please refer to the Aboriginal Healing Foundation, 2014).

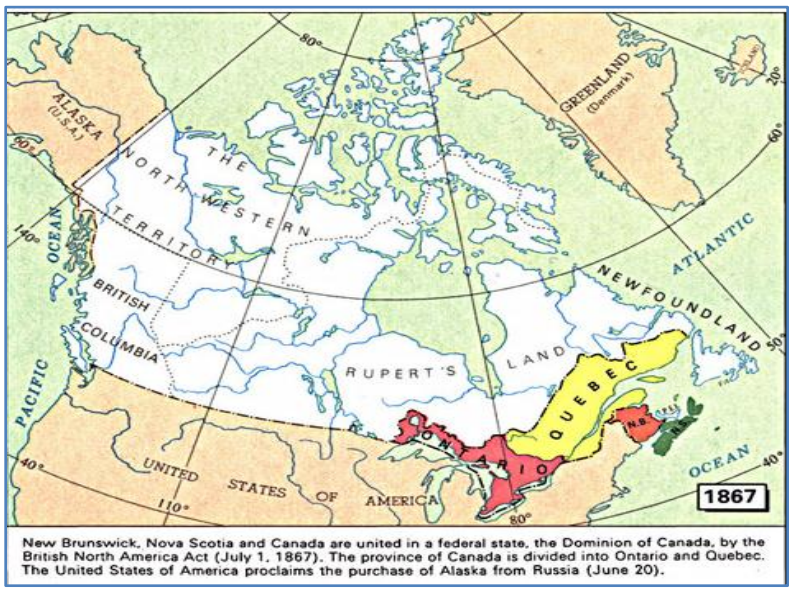

Figure 2: Canada in 1867, retrieved from Library and Archives Canada (2005)

The first residential school opened in the early 1800s. Religious institutions and the Canadian government oversaw the policies that led to the incarceration of more than 150,000 Aboriginal children in such schools. In 1920, it was mandated by the federal government that all Aboriginal children live in an educational setting (Legacy of Hope Foundation, 2014). There were 139 schools across the country, in all provinces except New Brunswick, Newfoundland and Prince Edward Island (Aboriginal Affairs and Northern Development Canada, 2011; Truth and Reconciliation Commission of Canada, 2014). In Ontario, there were 17 residential schools with three located in Southern Ontario. One of the first residential schools in Canada was the Mount Elgin Industrial School, located just west of the present day city of London. Children from Ontario and Quebec were placed in the school (Residential School Archive Project: The Children Remembered, nd). It opened in 1847, and closed in 1946. Like other residential schools, the Mount Elgin School was a place where children suffered neglect and physical, sexual, mental, cultural, and spiritual abuses by administrators and teachers. The impact of residential schools in Canada on First Nations, Inuit and Métis individuals, families, communities and culture is immense, immeasurable and intergenerational. Aboriginal communities experienced "social, economic and political disintegration," the effects of which are still felt today (Aboriginal Healing Foundation, 2009, p. 25).

Figure 3: Residential schools in southern Ontario (Truth and Reconciliation Commission of Canada, 2011)

Founding of London

In the late 1700s, before it was known as London, the area at the fork of the Thames River[5] was Crown land purchased from the Chippewa peoples by John Graves Simcoe, the first Lieutenant Governor of Upper Canada. Details regarding the terms of the purchase are difficult to locate. London was named by Simcoe in 1793, who wished it to become the provincial capital, a designation that instead was given to Toronto (City of London, 2013). Joshua Applegarth is reported by historians to be the first European land holder, arriving around the year 1808 to cultivate hemp. In 1826, London was founded as a town. English, Scottish and Irish settlers established churches, cemeteries, schools, gristmills, saw mills, blacksmith shops and other businesses. During this time, the 4th Battalion Middlesex Militia was founded. In 1854, London was officially incorporated as a city (Musuem of Ontario Archaeology, nd).

Main events that shaped the development of London included: the appointment of the town as an administrative District Seat; its designation as a 'garrison town', with 800 British troops stationed in London in the 1840s; and the arrival of the Great Western Railway from Toronto in the mid-1850s, connecting London to lines from Niagara Falls to Windsor and Michigan (Bonikowsky, 2013; Musuem of Ontario Archaeology, nd).

Growth and Development

In the 1800s, important regional health-related institutions came into being, such as St. Joseph's Hospital and the London Asylum for the Insane (later named the London Psychiatric Hospital). By the 1930s, there were over 1700 clients at the London Asylum causing serious overcrowding (St. Joseph's Health Care London, 2014). London also became a regional educational centre, with Huron College established in 1863, and the University of Western Ontario in 1878. London was a financial and distribution centre for western Ontario. The London Life Insurance Company

[5] The Thames River was named by Simcoe, however the river was previously known as *Askunessippi* by the Oneida people and *La Tranche* by the French (Musuem of Ontario Archaeology, nd).

was founded in 1874. Other businesses at that time included the head offices of five savings and loans companies, eight banks, 21 insurance companies, and three daily newspapers (London Life Insurance Company, 2014).

Annexation of London's suburbs helped the city grow: London East in 1885, London South in 1890, and London West in 1898, and Pottersburg, Ealing, and Chelsea Green in 1912. In 1914, London had grown to a population of approximately 55,000 people. Another major annexation in 1961 added 60,000 people to the city. By 1976, London had grown close to a quarter of a million people (City of London, 2013).

Immigration

Between 1900 and 1965, Europe (in particular, Britain) was the primary source of immigrants to Canada. By the end of the century, however, Asia represented the largest region of origin for new Canadians. Other areas, including Africa, the Middle East, and South and Central America, have also become important sources of contemporary immigration (Makarenko, 2010).

In 2001, the Immigration and Refugee Protection Act replaced the 1976 Immigration Act. The new act tightened the immigration system with the purported goal of assisting those individuals who needed protection in their home countries while focusing on security and control for Canada (Irvine, 2011).

Legislation introduced in 2005 by the province (Canada-Ontario Immigration Agreement, see Seidle, 2010 for more detail), and in 2010 by the federal government (Bill C-11: The Balanced Refugee Reform Act, for more information see Government of Canada, 2010) was designed to provide more funding to assist in the successful integration of newcomers into Ontario communities (Makarenko, 2010; Public Safety Canada, 2013). However, critics of these pieces of legislation, especially the federal direction in immigration policy, have raised concerns about their potential to perpetuate and exacerbate social injustice, marginalization, and inequities (Adeyanju & Neverson, 2007; Walker, 2008).

Canada uses a rigorous quantitative method of assessing the value of an immigrant applicant's worth as worker, entrepreneur, professional or citizen. In the 1980s, under a conservative government, political and economic decisions encouraged private enterprise rather than public spending, admitting immigrants to Canada who were wealthy or entrepreneurial. Manipulation of the merit point system to ensure acceptance of applications and other forms of fraud, such as human smuggling, have been highlighted recently as the federal government attempts to tighten controls and reduce spending (Canadian Museum of Civilization, 2010; Public Safety Canada, 2013). Many changes to federal, and subsequently provincial, immigration systems have caused confusion and challenge the solid international reputation Canada has held with regard to the treatment of newcomers.

As a primary contributor to Canadian GDP[6], Ontario is key to Canada's economic health. Immigration is critical to Ontario's growth, with immigrants making up approximately 30% of its workforce. Since the federal Conservative government[7] instituted changes to federal immigration policy in 2008, the number of immigrants coming to Ontario has decreased significantly, while the number of refugees has increased (Seidle, 2010). In fact, London currently has the highest per capita population of refugees in Canada (Middlesex-London Health Unit, 2014a). The high proportion of refugees in the region means that many people rely on settlement and integration services.

In June 2012, the federal Conservatives made cuts to the Interim Federal Health Program, instating policy that disproportionally limits health care services being offered to refugees based on a category system. By deeming a country of origin as Designated, the federal government indicates that the country is 'safe' and does not pose a threat to human rights. Refugees from Designated Countries of Origin are not eligible for health care except if a health issue is considered a public health risk. This policy may be viewed as punitive, contributing to further marginalization, and reinforcing social injustice through the denial of basic health coverage, leading to the cascading effects of poor mental and physical health of individuals and communities. Systemically, according to a study by the Wellesley institute, the new program has caused confusion for health care providers, leading to misdiagnosis and misuse of interventions, under-diagnosis, and the under-utilization of treatment and services for refugees (Marwah, 2013).

Current Socioeconomic Indicators

According to the 2011 National Household Survey, the unemployment rate in London is 9% (City of London, 2014d; Statistics Canada, 2014). This compares to 7.8% unemployment in the province of Ontario in 2012 (Employment and Social Development Canada, 2014). London's top three industries are retail trade, manufacturing, and health care and social assistance (City of London, 2014d). There are approximately 45,000 full time post-secondary students enrolled annually at the University of Western Ontario and Fanshawe College. The average starter house price in London is significantly lower than comparable regions in Ontario and outside the province, with the average price of a standard two-story home at $262,600 (London Economic Development Corporation, 2014). According to the 2006 census, over half (51%) of the London population (15 years and older) has some sort of postsecondary certificate, diploma, or degree (Statistics Canada, 2007a), which is the same as the provincial and national rates (Statistics Canada, 2007b).

[6] Ontario generates 39% of the national Gross Domestic Product, produces 43% of the merchandise exports and employs 50% of all employees in high tech, financial services and other knowledge-intensive industries (Alboim & Cohl, 2012).

[7] The 2008 Budget Bill and 2012 Budget Implementation Act amended the Immigration and Refugee Protection Act (IRPA). The budget bills enable the Minister of Citizenship, Immigration and Multiculturalism to make decisions about immigrant applications, processing quotas of immigrants, and impose conditions on employees without consultation with the public, provinces or Parliament (Alboim & Cohl, 2012).

London (CMA)[8] has an overall police-reported crime rate almost identical to the national average (74.49 and 75.0, respectively; Statistics Canada, 2012a), and a lower police-reported violent crime rate (64.09) than the national average (81.4; Statistics Canada, 2012b).

Health and Well-Being – Current Challenges

A 2012 'Vital Signs' report by the London Community Foundation highlighted several challenges the city is facing related to health and the social determinants of health. The following are drawn from this report, unless otherwise noted:

Social determinants of health

- In London, 17% of families live below the Low Income Cut-off, and 46% of single parents and 20% of children live in poverty; 51% of immigrants also live below the low-income cut-off.
- In 2010, the poverty rate of 12.3% was higher than the provincial and national average (8.8% and 9.0%, respectively). Similarly, the incidence of child poverty in the London census area of 12.1% was higher than the provincial and national average (8.0% and 8.2% respectively).
- The average wait time for affordable housing for London families is 1.5 years, compared to the Ontario average of 2.3 years (Ontario Non-Profit Housing Association, 2012).
- An average of 3,000 people visited the London Food Bank every month in 2011, or just under 1% of the population. This is slightly below the provincial average of ~3%, and the national average of ~2.5%.[9]
- Over one year, as of March 31, 2011, Children's Aid Services provided 865 children with in-care resources and provided prevention services to an additional 2,042 families in the community, representing service to more than 4,000 children and youth. In Ontario overall, as of March 2011, 16,953 children were in the care of Ontario's CASs (Ontario Association of Children's Aid Societies, 2010).
- Approximately 6.6% of London's household and total population receive Ontario Works[10]. Of those receiving benefits in July 2011, 64% were adults and 36% were children under the age of 18. By comparison, in April 2011, there were 465,005

[8] CMA refers to a census metropolitan area. The London CMA includes "the municipalities of London, St. Thomas, as well as Thames Centre, Middlesex Centre, Strathroy-Caradoc, Adelaide Metcalfe, Central Elgin and Southwold" (Middlesex-London Health Unit, 2014b). The population of London CMA is 474,786 (Statistics Canada, 2012c).

[9] In March 2011, 400,360 individuals accessed Ontario food banks and 861,775 individuals accessed food banks across Canada (Food Banks Canada, 2011).

[10] In Ontario, social assistance consists of two programs: Ontario Works and the Ontario Disability Support Program.

individual Ontario Works beneficiaries in Ontario, representing approximately 3.6% of its population (Ministry of Community and Social Services, 2013).

- London Police response to calls involving individuals identified as having "definite or probable serious mental illness" increased by 12%, from 1,411 in 2005 to 1,574 in 2009.
- An estimated 40% of homeless shelter users in London present with mental health and addiction issues.
- In 2011, London's 360 emergency shelter beds operated at 87% capacity.

Table 1 provides comparative information about other key health indicators at the city, provincial and federal levels.

Table 1: Comparison of Key Health Indicators, Across Levels

Health Indicator	Prevalence (%)		
	London (CMA)	Ontario	Canada
Diabetes	5.6	6.8	6.2
Chronic Obstructive Pulmonary Disease	4.2*	4.2	4.3
High blood pressure	17.3	17.4	17
Arthritis	18.7	17.3	15.8
Asthma	6.7	8.3	8.3
Obesity	20.2	18	18
Pain/discomfort preventing activities	14.6	13.5	12.5
Mood disorder	8.1	6.8	6.4
Daily smoker	17	14.5	15.6
Heavy drinking (5+ drinks at least once a month for past year)	16.8	15.9	17.3

Note: Percentages drawn from Statistics Canada (2013a).

* Use with caution

London's Health Zone Nurse Practitioner Led Clinic

The Health Zone Clinic at Merrymount Children's Centre in London started more than 10 years ago as one of The University of Western Ontario's Service Learning projects through the School of Nursing. With funding from the T.R Meighen Family Foundation, the clinic was led by Dr. Marilyn Ford-Gilboe, Professor at the School of Nursing. Dr. Carole Orchard, also a Western Nursing professor and coordinator of Interprofessional Education Initiatives, became involved to extend the Health Zone model to other areas of the city. In 2009, partnerships with community organizations, such as the London Middlesex Housing Corporation, led to the opening of two clinics in two London Housing Communities, funded by a short-term grant from Workforce Ontario. Due to the lack of ongoing funding, Health Zone was forced to close the clinics in April 2010. In April 2010, Ford-Gilboe and Orchard completed a new proposal for a Nurse Practitioner-Led Clinic at Merrymount, and at Southdale and Allen Rush housing complexes,[11] and were successful in obtaining funding from the Ontario Ministry of Health and Long-term Care (MOHLTC).

Figure 4: Health Zone Nurse Practitioner Led-Clinic

The Health Zone clinic serves London residents who do not have a family doctor and who are socially marginalized or in transition. Specifically, the target client population are those who experience barriers to accessing traditional health care, such as those who: live in poverty, lack transportation, mistrust service providers, have language barriers, and/or live with multiple complex health and social problems (e.g., trauma histories). The goals of Health Zone are "to enhance early detection and treatment of new health problems, improve secondary prevention of existing problems and prevent the emergence of new problems" through identification, ongoing assessment and management of acute and chronic health problems, counseling, education and health promotion, and support in navigating complex systems. Through the MOHLTC, Ontario provides $1.3 million in annual funding to the Health Zone Nurse Practitioner-Led (NP-Led)

[11] The Merrymount site is located in the Merrymount Family Resource Centre in northeast London. The Allan Rush and Southdale Health Zone clinic sites are in rent-geared-to-income housing complexes in southeast London.

Clinic.[12] Health Zone is one of 24 such Clinics currently accepting patients across the province. As of 2013, Health Zone had approximately 1,020 registered clients and could serve 3,200 people when running at full capacity (Ontario Ministry of Health and Long-Term Care, 2013).

Health Zone is a registered non-profit organization governed by a Board of Directors with representatives from its founding partners. It has an Administrative Lead at the Allen Rush site and a Clinical Lead at Merrymount. Each of the three clinic sites is led by a Nurse Practitioner (NP) with the support of two registered nurses, a dedicated receptionist, a registered dietician and a social worker who provide service across the sites. The clinic also promotes inter-professional education. Students from various health disciplines provide clinical services with the goal of gaining work experience with, and improving health care for, marginalized populations (Ford-Gilboe & Orchard, 2010).

Health Zone staff work creatively and collaboratively with clients. For example, for those living with multiple chronic health issues, staff skillfully navigate the many local and provincial systems and supports that are available to clients. All Health Zone team members contribute diverse knowledge about client care. The clinic excels at building and maintaining strong community relationships with organizations that focus on the social determinants of health (e.g., WOTCH Community Mental Health Services, LifeSpin Low Income Family Empowerment / Sole-support Parent Information Network, Middlesex-London Health Unit).

Figures 5 and 6: Health Zone

[12] NP-Led clinics offer comprehensive health care, illness prevention and health promotion. In this model, NPs collaborate with a team of health care providers including registered nurses, registered practical nurses, collaborating family physicians, registered dietitians, pharmacists and social workers. A client does not need a referral to access a NP-Led clinic. NP-Led clinics are one of many primary health care options within Ontario. Others include: Family Health Teams, Urgent Care, Walk-in and After Hours clinics, Community Health Care Centres, Public Health Units, Family Health Care Provider, Breast Screening Centres, Diabetes Education Programs and Emergency Rooms (Ontario Ministry of Health and Long-Term Care, 2014).

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