Executive Summary

Urgent action is required to address the homelessness, addiction, and mental health crisis in Northern Ontario. 2021 homeless enumeration data shows that Sault Ste. Marie, and the Districts of Kenora, Nipissing, and Cochrane have larger homeless populations than the five largest municipalities in Ontario. In fact, Thunder Bay and the District of Cochrane have more than double the homeless populations of Ottawa, Hamilton, and Waterloo, respectively. More astonishing is the growing number of people struggling with opioid addiction in Northern Ontario. Extreme spikes in opioid-related emergency department (ED) visits and deaths in most northern Public Health Units shows 2020 to be the most tragic and deadliest year yet of the opioid crisis. The growing number of people struggling with homelessness and addiction in Northern Ontario strongly indicates that there is also a mental health crisis amongst vulnerable populations. This paper also finds that the mental health crisis is not merely restricted to vulnerable populations in the North, but rather that Northern Ontarians in general are experiencing poorer mental health than Ontarians in the rest of the province.

As the homelessness, addiction and mental health crisis worsens in Northern Ontario, it is clear that current services and programs are not adequately meeting the needs of northern communities. As the ones 'on the ground', municipal governments face tremendous pressure from their tax-bases to solve homelessness, addiction, and mental health issues in their community but are restricted by tight budgets. A collaborative approach ought to be taken by the federal, provincial, and municipal governments in order to solve these issues. In particular, there is opportunity for the provincial government to support existing community-led services and programs which align with commitments already made by the provincial government in the 'Roadmap to wellness'. Provincial support for existing services and programs is an 'easy win' for all levels of government against the homelessness, addiction, and mental health crisis.

This paper identifies eight strategies governments can take to improve the homelessness, addiction, and mental health crisis in Northern Ontario. Those strategies are:

1. Provide long-term funding for capital repairs on community-housing units
2. Amend the *Health Protection and Promotion Act, 1990* to define a 'Northern Service Hub' and provide additional funding to these hubs
3. Establish a joint taskforce to collect data and intelligence on the underlying and systematic retention issues of healthcare professionals in Northern Ontario
4. Support new and existing 'Housing First' programs
5. Support new and existing Indigenous culturally sensitive community-housing facilities
6. Establish a 'Northern Mental Health and Addictions Centre of Excellence' to address the unique challenges of service and program delivery in Northern Ontario
7. Contract a third-party operator for interfacility patient transfers to relieve the workload of paramedics
8. Establish mandated Mobile Crisis Intervention Teams (MCIT) in municipalities throughout Northern Ontario

This paper provides evidence that these strategies are highly effective and economically viable ways to reduce the number of people struggling with homelessness, addiction, and mental health issues in Northern Ontario.

Solving the Homelessness, Addiction and Mental Health Crisis in the North

Introduction

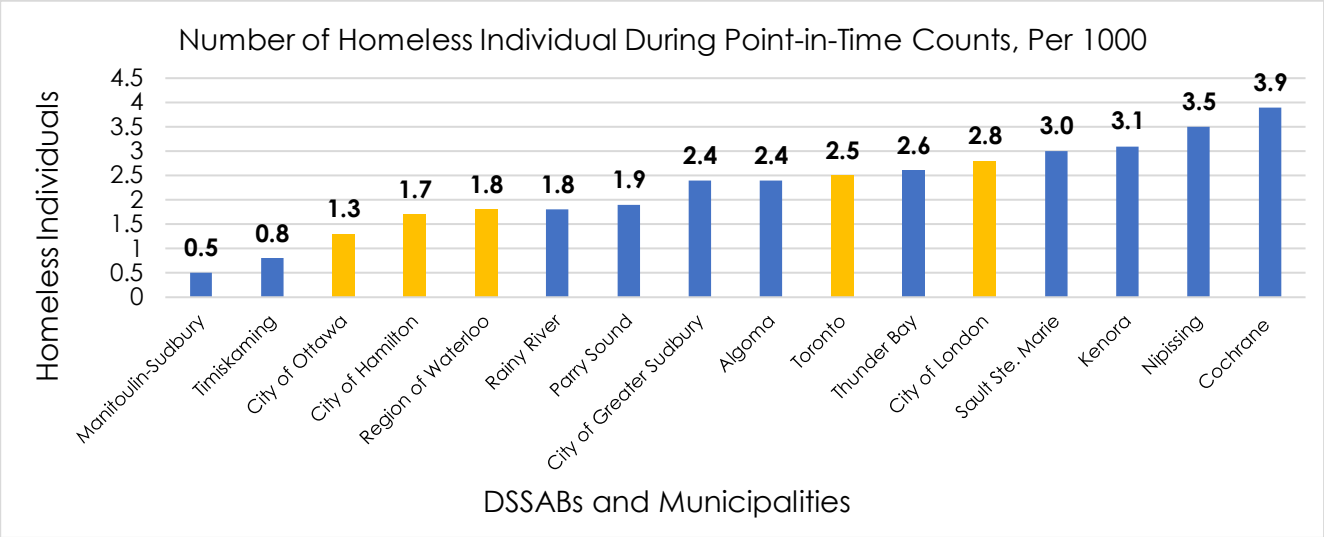
Northern Ontario is experiencing a homelessness, addiction, and mental health crisis. While these issues are not new in the North, significant gaps in health services around homelessness, addiction, and mental health have exacerbated the crisis. The growing number of Northerners suffering from homelessness, addiction, and mental health issues have ignited robust discussions at the provincial and municipal level around strategies to address service gaps. In 2019, the Association of Municipalities Ontario (AMO) published three detailed reports on homelessness, addiction, and mental health in Ontario, outlining recommendations for all levels of government. In March 2020, Ontario's provincial government published the *Roadmap to wellness*, introducing a new plan for the mental health and addiction service system (Government of Ontario, 2021c). Not long after, Ontario's Big City Mayors (OBCM) published a report calling on provincial and municipal governments to act boldly to address service gaps and vocalized their support for the *Roadmap to wellness* (OBCM, 2021). Later in 2021, Northern Ontario Municipal Association (NOMA), the Federation of Northern Ontario Municipalities (FONOM) and Northern Ontario Service Delivery Association (NOSDA) collaborated with municipal governments to draft a multi-ministry delegation package for mental health, addictions, and housing. This flurry of coordinated activity from municipal actors is indicative of the seriousness of the homelessness, addiction, and mental health crisis in the North.

This commentary seeks to further the coordinated efforts of municipal actors by offering timely data that supports highly effective strategies that governments can take to address this crisis. This commentary will start with an overview of the homelessness, addiction, and mental health crisis, followed by a brief explanation of the role and responsibilities of provincial and municipal governments. Roles and responsibilities of provincial and municipal governments will be discussed to provide context for the recommended strategies provided in the third section of this commentary.

The Homelessness, Mental Health and Addiction Crisis in the North

Section 19.1 of the *Housing Services Act, 2011* requires service managers – or District Social Service Administration Boards (DDSABs) in the North – to conduct detailed enumerations of their homeless populations every two years beginning in 2018. Homeless enumerations offer important insight on the characteristics and needs of homeless populations in specific communities and regions. Figure 1 shows that Sault Ste. Marie and the Districts of Kenora, Nipissing, and Cochrane[1] have higher homeless populations than the five largest municipalities in Ontario. With the largest homeless population in Northern Ontario, the District of Cochrane has more than double the homeless populations in Ottawa, Hamilton and the region of Waterloo.

Figure 1. Homeless Population per 1000 people, 2021[2]



Source: Author's calculations from 2021 enumeration reports from DSSABs and municipalities, and Statistics Canada census district population projections.

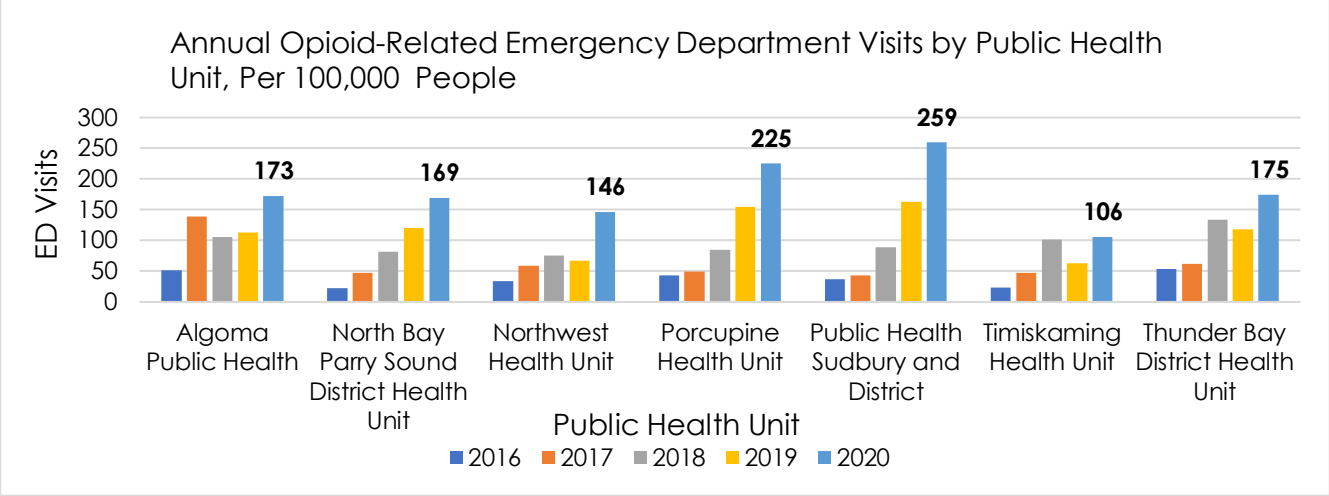
[1]Raw homeless enumeration data was provided by DSSABs and the City of Greater Sudbury. This data did not specify the communities in which homeless enumerations were conducted. Thus, it is assumed that homeless enumeration data represents entire DSSAB service areas. Where DSSAB service boundaries align with Census District boundaries – Cochrane, Kenora, Nipissing, Parry Sound, Rainy River, Thunder Bay and Timiskaming – DSSAB service areas will be referred to as 'the District of'. The service area of Sault Ste. Marie DSSAB will be referred to as simply 'Sault Ste. Marie'. The service area of Sudbury-Manitoulin DSSAB will be referred to as simply 'Sudbury-Manitoulin'. The service area of Algoma DSSAB will be referred to 'the District of Algoma', but notably and unlike the Census District of Algoma, this paper excludes the City of Sault Ste. Marie when referring to 'the District of Algoma'. As Greater Sudbury is a single-tier municipality with a Consolidated Municipal Service Manager, it is referred to as simply 'the City of Greater Sudbury'.

[2] Southern Ontario cities and regions included in Figure 1 were chosen based on available data from 2021 Enumeration Reports at the time of the publication of this paper. 2021 Homeless Enumeration data was unavailable for the district of Thunder Bay.

Moreover, Sault Ste. Marie and Thunder Bay DSSABs – the only two DSSABs that completed a point-in-time (PiT) count in a previous year[3] – reported an astonishing growth of homeless populations within their service area boundaries. Between 2016 and 2018, Sault Ste. Marie reported a 70 per cent increase in the city's homeless population, with a 58 per cent increase between 2018 and 2021 alone. In the District of Thunder Bay, the homeless population increased by 50 per cent between 2016 and 2018.

There is also a growing number of people struggling with addiction in Northern Ontario. As seen in Figures 2 and 3, 2020 was the most tragic and deadly year of the opioid crisis in the last five years. Between 2016 and 2020, opioid-related ED visits increased by an astonishing 695 per cent in the Porcupine Health Unit; 616 per cent in the North Bay Parry Sound District Health Unit; 522 per cent in the Public Health Sudbury and District, and 355 per cent in Thunder Bay District Health Unit (Public Health Ontario, 2021)[4]. At the lower end of the spectrum, all other northern Public Health Units still more than doubled their 2016 amounts in 2020[5].

Figure 2. Opioid-Related ED Visits, 2016-2020



Source: Public Health Ontario Interactive Opioid Tool, 2021.

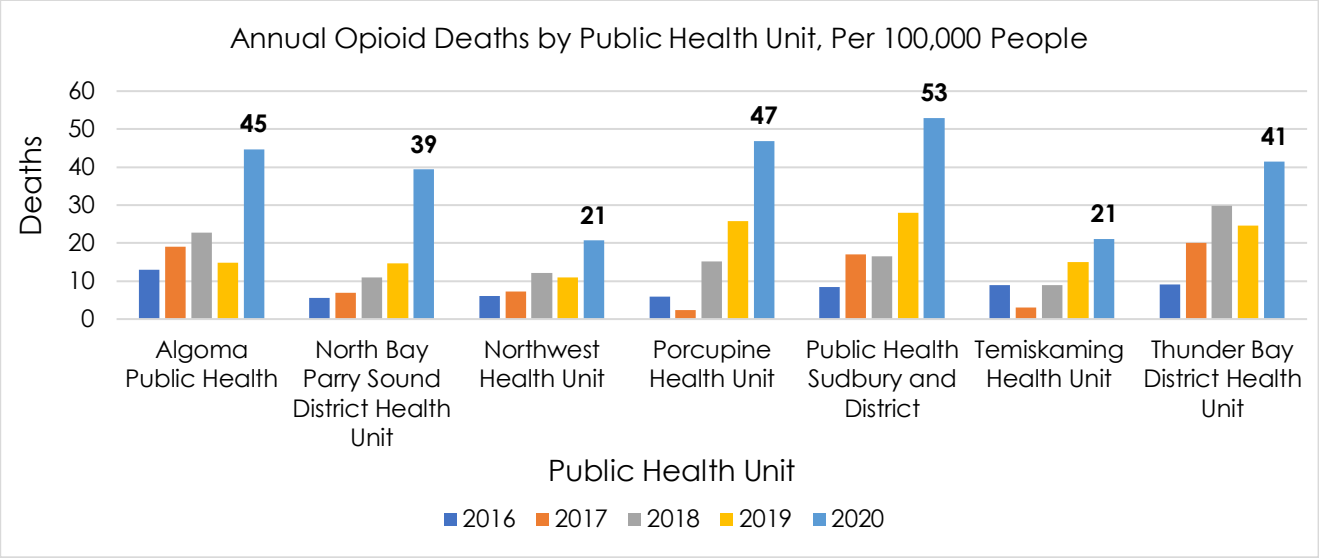
[3] Prior to 2020, municipalities could choose from three methods to conduct their homelessness enumerations: a PiT count, a period prevalence count, or a combination of the two. Due to the logistical challenges of conducting homelessness enumerations in large, sparsely populated districts, most DSSABs opted to conduct period prevalence counts or a combination of the two. According to Employment and Social Development Canada, "results from various communities show that period prevalence counts enumerate between 3 and 10 times as many people as point-in-time counts". Therefore, data collected by period prevalence counts in 2018 is inconsistent with data collected by PiT counts in 2021.

[4] N.B. Public Health Unit have custom service area boundaries that do not align geographically with DSSAB boundaries

[5] While Renfrew County and District Health Unit partially covers territory in Ontario's central, western and northern regions, it has been omitted from this commentary as the majority of the population within this public health unit is situated on territory outside of the political borders of Northern Ontario as defined by the Province of Ontario.

Corresponding with opioid-related ED visits, opioid-related deaths increased significantly in every northern Public Health Unit between 2015 to 2020. Importantly, Figure 3 shows an extreme spike in opioid-related deaths in 2020 compared to 2019. Opioid-related deaths increased by 200 per cent in Algoma Public Health Unit and 168 per cent in North Bay Parry Sound District Health Unit **in a single year.**

Figure 3. Opioid-Related Deaths, 2016-2020

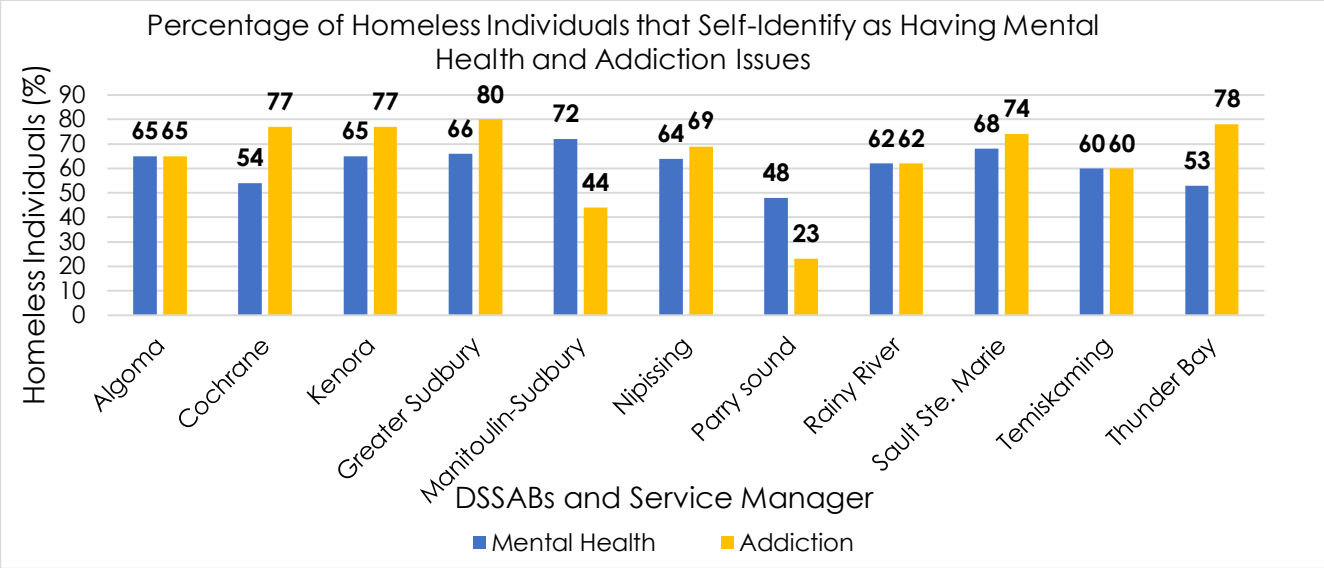


Source: Public Health Ontario Interactive Opioid Tool, 2021.

The growing number of people struggling with homelessness and addiction in Northern Ontario are strong indicators that there is also an ongoing mental health crisis. While mental health issues do not always lead to homelessness or addiction, or vice-versa, an abundance of research literature from organizations such as the Canadian Mental Health Association (CMHA) and the World Health Organization shows homelessness, addiction, and mental health to be interconnected, and part of a larger, multifaceted socio-economic issue. As such, homeless populations are disproportionally affected by mental health and addiction. Figure 4 shows that a staggering 72 per cent of homeless individuals in Manitoulin-Sudbury suffer from mental health issues, followed by 68 per cent in Sault Ste. Marie, and 66 per cent in the City of Greater Sudbury. In the City of Greater Sudbury, 80 per cent of the homeless population suffer from addiction, followed

by 78 per cent in the District of Thunder Bay, and 77 per cent in the Districts of Cochrane and Kenora.

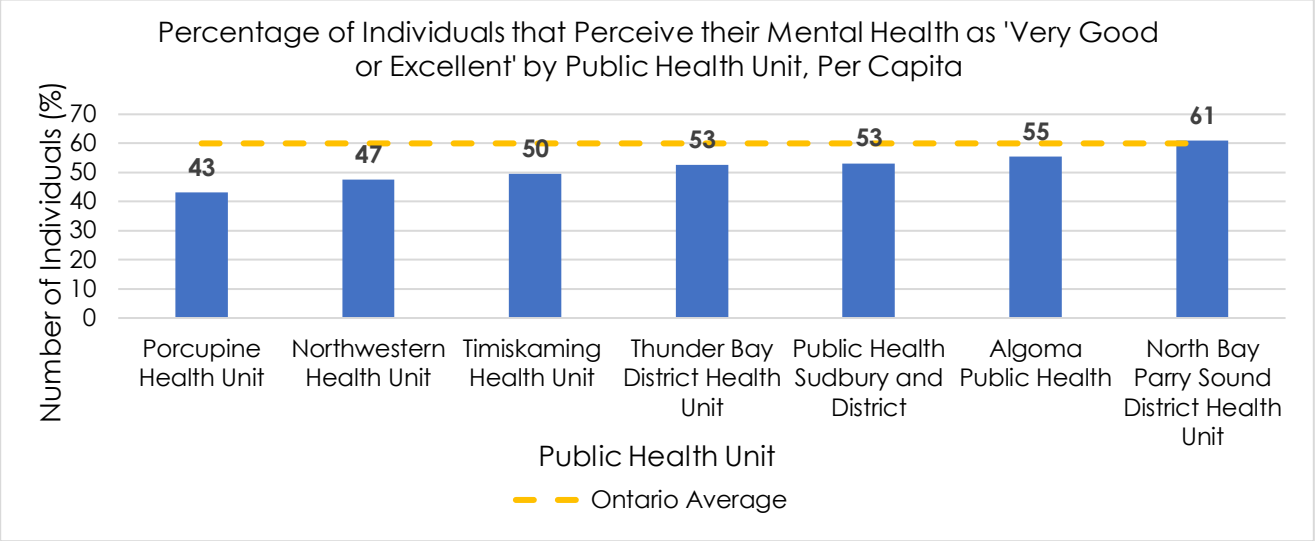
Figure 4. Homeless Individuals Struggling with Mental Health and Addiction Issues, 2021



Source: 2021 enumeration reports from DSSABs and City of Greater Sudbury.

Of course, it must be noted that mental health issues are not merely restricted to homeless individuals, but rather, affect the general population in Northern Ontario. CMHA found that Northern Ontarians self-reported higher rates of depression than the provincial average (CHMA 2009, 2), while Figure 5 shows that the number of Northern Ontarians who perceived their mental health as 'very good or excellent' is below the provincial average, except in North Bay Parry Sound District Health Unit. This data suggests there is a need from many community members in the North for mental health services and programs.

Figure 5. Perceived Mental Health of Individuals, 2017-2018



Source: Author's calculations from Statistics Canada health characteristics, two-year period estimates, and Census Profiles, Public Health Units, 2016 Census.

The Role and Responsibility of Government

The Constitution Act, 1867, as well as federal and provincial legislation and jurisprudence, define the role and responsibilities of all levels of governments regarding homelessness, addiction, and mental health issues. In terms of homelessness, the *Housing Services Act, 2011* states that the role of the provincial government is to provide general oversight and policy direction for "community-based planning and delivery of housing and homelessness services" (Government of Ontario, 2021b). More specifically, the provincial government is required to "assess current and future local housing needs, plan for local housing and homelessness services to address needs, and measure and report on progress" (Government of Ontario, 2021d). Furthermore, Article 92, Section 7 of the *Constitution Act, 1867* assigns the responsibility of public health to provincial governments. As homelessness, addiction and mental health **all** fall within the domain of public health, provincial governments are responsible for "developing and enforcing legislation, regulation, standards, policies and directories" to solve these issues (Public Health Ontario, 2020).

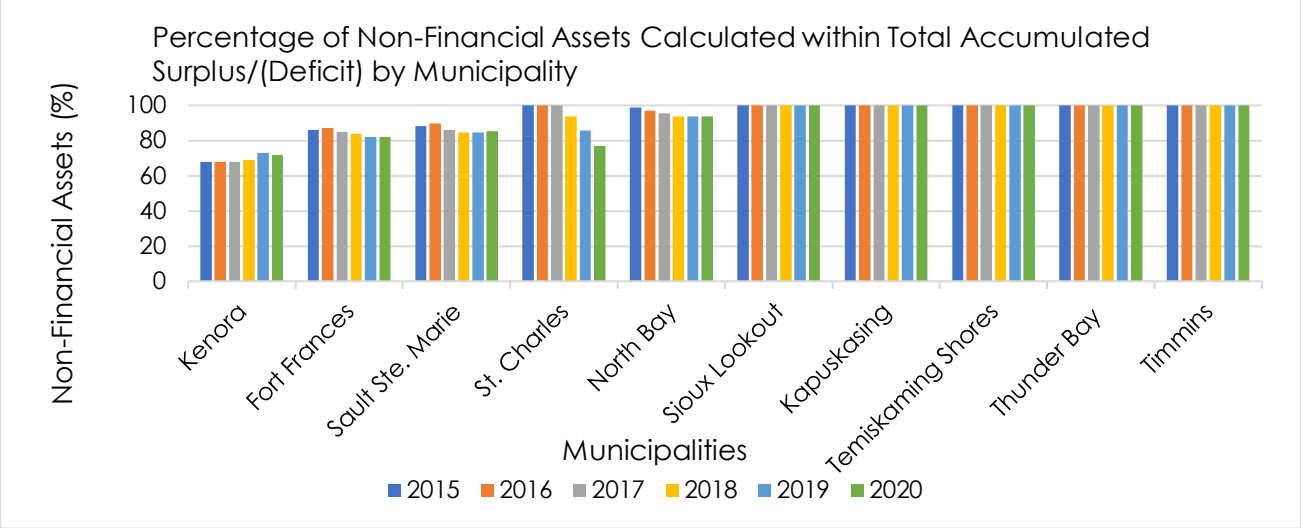
Municipal governments in Ontario play a unique role in community-housing – housing that is owned, operated and subsidized by non-profit organizations, municipal governments or DSSABs for low-income individuals or families (Government of Ontario, 2021a) – compared to the rest of the country. Since community-housing was downloaded from the province in 2001 and 2002, municipal governments act as local planning authorities, administrators of local community housing systems, and funders of housing benefits and rent (Government of Ontario, 2021d). In Northern Ontario, DSSABs – and Consolidated Service Manager in the City of Greater Sudbury – are responsible for the development of housing stock and the delivery of homelessness prevention programs (AMO 2019c, 10). DSSABs must outline their housing strategy in a ten-year housing and homelessness plan, and this plan must include strategies that address the housing needs of communities and that are in-line with provincial priorities (AMO 2019c, 11).

For health care and public health services, the role of municipal governments is as the employer for health services and funding partners to the provincial government (AMO 2019b, 15). Under the *Health Protection and Promotion Act, RSO, 1990*, provincial and municipal governments are required to cost-share the financial burden of health services, with the provincial government covering 75 per cent of service fees and municipal governments covering the remaining 25 per cent (AMO 2019b, 15). Municipal governments also support Public Health Units by providing a local lens to view policies and services (AMO 2019b, 15).

Despite well-defined roles of governments in Canada, as the ones 'on the ground', municipal governments face extraordinary pressure from their tax-bases to solve homelessness, addiction, and mental health issues in their community. Some municipalities have contributed additional funds to address homelessness, addiction, and mental health, but many more municipalities in Northern Ontario do not have the fiscal capacity to do so. Tight budgets leave little – or nothing – left-over for municipalities to spend on additional services and programs.

Figure 6 shows the percentage of non-financial assets accounted for within municipal budget surpluses. Where the percentage of non-financial or physical assets such as hospitals, schools, and community-housing are equal to 100, the municipality is experiencing a major cash deficit as 100 per cent of their surplus represents their physical assets rather than available cash funds. Importantly, Figure 6 shows that many municipalities in Northern Ontario do not have the available cash – despite budget surpluses on paper – to spend appropriately on homelessness, addiction, and mental health.

Figure 6. Percentage of Non-Financial Assets[6], 2015-2020



Source: Author's calculations of Net Financial Assets, end of year, total non-financial assets, and total accumulated surplus/(deficit) from municipal Financial Information Returns.

Budget shortfall is part of a complex economic issue for many municipalities in Northern Ontario. Rural and remote municipalities do not have the fiscal capacity to generate large amounts of municipal revenue due to small tax bases, nor do they benefit from the efficiency of scale. Furthermore, important factors such as population totals, population density, diminishing subsidies for rural areas and the number of service providers impact the cost-of-service delivery (Rizzuto 2020, 18).

[6] Municipalities represented in Figure 6 were chosen as a representative sample size to describe the general fiscal capacity of municipalities in Northern Ontario

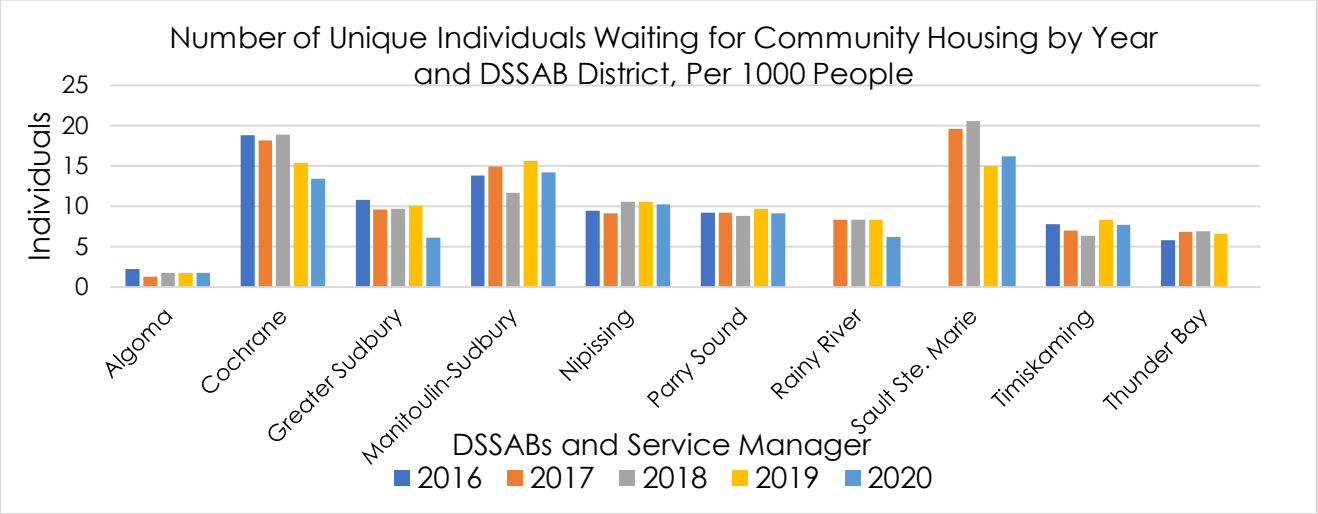
Service Gaps and Policy Strategies

The current – and worsening – homelessness, addiction, and mental health crisis in Northern Ontario indicates that existing policies, services, and programs do **not** meet the needs of northern communities. The following section identifies eight evidence-driven strategies that governments can take to improve the homelessness, addiction, and mental health crisis in Northern Ontario.

1. Community-Housing Waitlists

A shortage of community-housing has contributed to the growth of the homeless population in Northern Ontario (AMO 2019c, 5). Figure 7 shows long and stagnated waitlists for community-housing in the North.

Figure 7. Community-Housing Waitlist[7], 2016-2020



Source: Author's calculations from direct outreach to DSSABs and the City of Greater Sudbury, and Statistics Canada Census Division Population Projections for the corresponding years.

Much of the community-housing shortage can be attributed to the depletion of existing stock that is between 40 and 60 years old, and overdue for routine maintenance and repair (AMO 2019c, 23). As DSSABs struggle financially to keep up with the growing

[7] Community-housing waitlist data not available for the District of Kenora.

backlog of capital repairs, much needed community-housing units are left vacant despite the growing demand (AMO 2019c, 24).

The most time-effective and financially responsible way to address the shortage of community-housing in Northern Ontario is by maintaining and repairing the existing housing stock (AMO 2019c, 23). When the province downloaded community-housing to municipalities, however, the transfer was completed without a corresponding transfer of adequate reserve funds for current and projected future capital repairs (AMO 2019c, 24). While DSSABs do not have the fiscal capacity to properly address the backlog of capital repairs, federal and provincial governments do *and should*. Long-term funding for capital repair should be delivered from the federal and provincial governments to DSSABs to address this long-standing problem. Ideally, funding should span over a 10-year period so DSSABs can incorporate their strategy in their 10-year housing and homelessness plans, and provide an update on progress in their 5-year review report (AMO 2019c, 24).

2. Migration to Service Hubs

Service hubs in Northern Ontario face unique challenges in terms of their homeless population: the in-migration of people from surrounding rural and remote communities to access employment, education, and social and health services that do not exist in their community. Removed from their familiar environments and support systems, migrants often find themselves without the financial means to support themselves or return to their communities and, thus, become dependent on emergency shelters and other social services. This in-migration of vulnerable people applies pressure to "the housing stock, the homeless shelters, and the social services as a whole" in service hub communities (KDSB 2014, 8). The Districts of Kenora and Cochrane are particularly impacted by this migration trend as the District of Kenora includes 40 First Nations and a large unincorporated area, while the District of Cochrane includes seven First Nations, three unincorporated areas, and the only railway connection to the James Bay coast. In 2018, Thunder Bay DSSAB reported that 62 per cent of their homeless population within their service boundaries were migrants from surrounding areas (TBDSSAB 2018, 5).

Case Study: Sioux Lookout

Sioux Lookout, also known as "the Hub of the North", is a major service hub in the District of Kenora. Sioux Lookout Meno Ya Win Health Centre, a regional hospital and extended care facility, services the towns of Sioux Lookout, Pickle Lake, Savant Lake and 28 First Nations (Meno Ya Win Health Centre, 2021a). Collectively, Meno Ya Win provides health services for a population of 30,000, dispersed over 385,000 square kilometers (Meno Ya Win Health Centre, 2021b). Meno Ya Win and Sioux Lookout's Out of the Cold Emergency Shelter, both which services roughly the same area and communities, are significantly under-resourced for the population size they serve (Municipality of Sioux Lookout 2021, 20). Currently, the William "Bill" George Extended Care Unit operates with 20 beds, amounting to one bed per 1,500 people. In 2019, 768 unique individuals slept at the Out of the Cold Emergency Shelter – amounting to 15 per cent of Sioux Lookout's population – for a total of 5,000-person night stays annually (Municipality of Sioux Lookout 2021, 20). If this ratio was true for Toronto, it would mean 439,500 unique individuals stayed at an emergency shelter in one year, compared to the *actual* amount of 3,876 unique individuals (City of Toronto 2018, 7). Of course, it's not accurate to say 15 per cent of Sioux Lookout's population stayed at the emergency shelter, but rather it was mix of migrants from within the District of Kenora and residents of the town.

To ensure service hubs in Northern Ontario have adequate resources for their service area, an amendment could be made by the provincial government to the *Health Protection and Promotion Act, 1990*. This amendment should define a 'Northern Service Hub' and mandate the provincial government to provide additional support to these communities through reserve funds or the like.

3. Medical Professionals

According to a report from CMHA, titled 'Rural and Northern Community Issues in Mental Health', Northern Ontarians are disadvantage by "limited availability and access to primary health care, specialists, hospitals and community services and supports" (CMHA 2009, 3). In 2010, the publication date of this report, CMHA identified 34 northern

communities considered by the Ministry of Health and Long-Term Care (MOHLTC) to be 'an area of high physician need'. As of December 2021, this list has grown to **163** northern communities, encompassing the **entirety** of Northern Ontario (MOHLTC, 2021). The MOHLTC bases this list on a variety of compelling factors including "long-standing challenges in recruiting and retaining physicians, low health care provider-to-population ratios, travel time to reach service providers, and local demand for services" (CHMA 2009, 3). The scarcity of general physicians in the North acts as a major barrier to the establishment of necessary addiction and mental health services, such as medical detox centres and treatment facilities (Turner, 2021). Northerners struggling with addiction are often sent to treatment facilities in Thunder Bay, Winnipeg or Southern Ontario, separating them from their support systems and setting them up to fail (Turner, 2021).

The European Union faces many similar challenges to Northern Ontario and Canada when it comes to the shortage of health care workers. All member-states expressed serious concern around the sustainability and robustness of their health sectors due to demographic shifts, increased demand for services, an aging workforce, and recruitment and retention of health care workers (JAHWF 2016, 2). To enable strategic planning and informed decision making, the EU established the 'Joint Action Health Workforce Planning and Forecasting' (JAHWF). JAHWF is a three-year project mandated to collect intelligence and data of health sectors in the EU by "monitoring timely data, identifying mobility trends, estimating future skills and competencies that health workers will need, encouraging cooperation to find possible solution on expected shortages, and health workforce planning and forecasting on policy decision making" (Nordic Council of Ministries 2014, 36). By conducting research on the most advanced planning methodologies, JAHWF has enabled two pilot-programs in Italy and Portugal, and a feasibility study in Germany (Health Workforce EU, 2021). The Canadian Federation of Nurses Union have called on the federal government to lead a similar taskforce in Canada to investigate "new staffing models and other pilot projects", and address underlying and systematic retention issues (Yun, 2021).

Additionally, there is opportunity for government and others to support the work of the Northern Ontario School and their work around physician recruitment in Northern Ontario. The Physician Workforce Strategy has the goal of "linking human health resources to Northern Ontario's needs" (NOSM, n.d.). According to data collected in June 2021, 325 physicians are in demand across Northern Ontario – particularly for family physicians and rural generalists (NOSM, n.d.).

4. Housing-First Programs

'Housing First' is a multidisciplinary homelessness strategy that prioritizes the rapid placement of the most vulnerable individuals and families into housing with no preconditions (Gaetz, Scott and Gulliver 2013, 18). Since gaining popularity in the 1990s, Housing First is now described as a 'best practice' for ending homelessness in Canada, the United States and around the world (Homelessness Hub, 2021). In 2008, the federal government committed $110 million to conduct a four-year, five-city research project on Housing First – the world's most extensive study on Housing First programs at that time (Mental Health Commission of Canada 2014, 6). Each of the five cities – Vancouver, Winnipeg, Toronto, Montreal, and Moncton – focused on specific sub-populations such as individuals struggling with substance abuse in Vancouver and the urban Indigenous population in Winnipeg. Shockingly, the study found that 80 per cent of the 1,000 randomized participants remained housed after one year (Homelessness Hub, 2021). Moreover, a study published by Canadian Homelessness Research Network, the Homeless Hub, and the Government of Canada in 2013 that examined eight Housing First programs in Vancouver, Hamilton, Lethbridge, Victoria, Fredericton, Edmonton, and two in Calgary reported similar findings. The case study in Vancouver found no participants of the program were discharged to the streets within a four-year period (Gaetz, Scott and Gulliver 2013, 67), while the case study in Hamilton found 74 per cent of participants remained housed after six months and 90 per cent of this group remained housed after 12 months (Gaetz, Scott and Gulliver 2013, 80). The case study in Lethbridge revealed 90 per cent of participants remained housed within a 12-month period (Gaetz, Scott and Gulliver 2013, 95), while the case study in Victoria found 73 per cent of participants

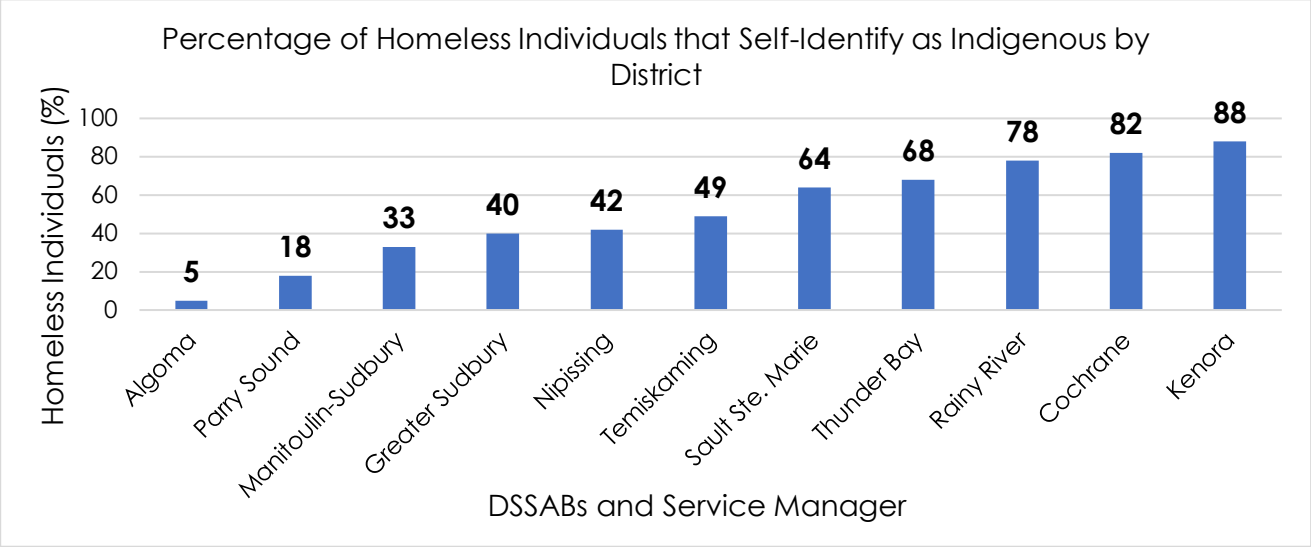
remained housed within a two-year period (Gaetz, Scott and Gulliver 2013,106). In Fredericton, 93.5 per cent of participants remained housed after 6 months, while 86 per cent of participants remained housed within a 3-year period (Gaetz, Scott and Gulliver 2013, 132). In Calgary, one case study found 92 per cent of participants within a 5-year period remained housed, while the other found 80 per cent of participants remained housed for at least 12 months (Gaetz, Scott and Gulliver 2013, 52).

In October 2020, the federal government launched the Rapid Housing Initiative (RHI) through Canada Housing and Mortgage Corporation (CMHC) to support Housing First programs. The federal government committed $1 billion in 2020 for 3,000 affordable housing units, with a second round of funding in the 2021-22 federal budget of $1.5 billion for a minimum of 4,500 affordable housing units. Seven First Nations in Northern Ontario have received $21 million collectively in funding from the RHI to build 85 new homes, but more communities can be supported. Moreover, RHI funding should support existing Housing First programs in the North, such as Housing Now, a new program established in 2020 by Cochrane DSSAB, in partnership with the Canadian Mental Health Association.

5. Culturally Sensitive Community-Housing

A significant proportion of the homeless population in Northern Ontario self-identify as Indigenous. Figure 8 shows Indigenous people account for over 60 per cent of the homeless population in four Northern Districts and in Sault Ste. Marie. In the District of Kenora, 88 per cent of the homeless population self-identify as Indigenous, followed by 82 per cent in the District of Cochrane, 78 per cent in the District of Rainy River, 68 per cent in the District of Thunder Bay, and 64 per cent in Sault Ste. Marie. Despite Indigenous people accounting for an overwhelming proportion of the homeless population in the North, there is limited culturally-sensitive services and programs to address their specific needs.

Figure 8. Homeless Individuals that Self-Identify as Indigenous, 2021



Source: 2021 Enumeration Reports from DSSABs and City of Greater Sudbury.

To tackle this problem, Kenora District Service Board (KDSB), Ontario Aboriginal Housing Services, North West Local Health Integration Network, Meno Ya Win Health Centre and Nishnawbe-Gamik Friendship Centre collaborated to lead a project that opened a 20-unit community-housing facility in Sioux Lookout. The facility offers culturally sensitive and easily accessible programs and services for Indigenous people (KDSB 2018, 21). This facility has reduced 911 calls to Ontario Provincial Police (OPP) in Sioux Lookout by 90 per cent (Helwig, 2021). A similar project is underway for a new 30-unit facility in the City of Kenora, while discussion between the District of Sault Ste. Marie Social Services Administration Board and OAHS have recently begun for another 30-unit facility in Sault Ste. Marie (Helwig, 2021).

These facilities align with the commitments made by the provincial government in the *Roadmap to wellness* to continue to work with Indigenous people and communities to co-developed services and programs that "enable Indigenous clients to access high-quality, culturally appropriate mental health, addictions and well-being services" (Government of Ontario, 2020c). They *also* align with the goals of the RHI. As such, supporting the existing facilities and the expansion of similar facilities across Northern

Ontario is an 'easy win' for the provincial and federal government in supporting Indigenous people struggling with homelessness, addiction, and mental health issues.

6. 'Northern' Mental Health and Addictions Centre of Excellence

In March 2020, the provincial government announced a new action plan to address mental health and addiction in Ontario with a more coordinated approach. The plan, outlined in the *Roadmap to wellness*, introduces the establishment of the 'Mental Health and Addictions Centre of Excellence'. As the "central point of accountability and oversight for mental health and addictions care" in Ontario, the Mental Health and Addiction Centre of Excellence will strive to **standardize** and monitor service delivery, report on performance, and provide support to health professionals (Government of Ontario, 2021c).

Northern Ontario, however, faces unique challenges compared to the rest of the province which must be considered by the provincial government before the establishment of a new standardized and centralized system of care for the province. While the *Roadmap to wellness* addresses many addiction and mental health issues in Northern Ontario, the implementation and delivery of these services must look different in the North for them to be effective. In recognition of the challenges of service delivery due to sparse populations within a large geographical region, there is robust support in Northern Ontario for the establishment of a '*Northern* Centre of Excellence for Mental Health and Addiction'. An engagement process conducted by the Centre for Rural and Northern Health Research and the Thunder Bay Drug Strategy, found that 95 per cent of the 216 participants from within six engagement areas – social services, education, peer, health care, policy and justice – and 65 Indigenous organizations, support the establishment of a 'Northern Centre of Excellence' (Lakehead University 2018, 4). As the *Roadmap to wellness* remains in the development phase, there is an opportunity for the provincial government now to consult with Northern decision makers and reassess the benefits to establishing a 'Northern Centre of Excellence'.

7. Inter-Facility Transportation

The opioid crisis is putting severe strain on municipal paramedic services. In the third quarter of 2021, Superior North EMS answered 187 opioid overdose calls – the highest amount ever recorded in the District of Thunder Bay (Public Health Ontario, 2021a). Similarly, the District of Cochrane is projected to surpass last year's total of 269 emergency medical services calls, with a total of 259 call recorded by the end of October 2021 (Porcupine Health Unit, 2021). To add to their workload, paramedics in Northern Ontario are uniquely required to assist in "non-urgent transfers of low-acuity patients between health facilities", often delaying their response time for emergency calls as resources are extremely limited (AMO 2019a, 6). Inter-facility transfers are a costly expense for municipal governments, and are avoided in other areas of the province through private contracts with private and non-profit operators that are funded by the province (AMO 2019a, 6)

To alleviate the workload of paramedics and solve a long-standing issue in the North, this commentary supports the recommendation made by AMO in their report, 'A Compendium of Municipal Health Activities and Recommendations', to include the provision of a third-party operator for inter-facility patient transfers in Northern Ontario provided and funded by the provincial government. Importantly, this commentary seconds the additional recommendation that only in situations where there is no alternative, should municipal paramedic services be used, and when this occurs, the cost should be reimbursed from the provincial government to municipalities from LHINs (AMO 2019a, 6).

8. Mobile Crisis Intervention Teams (MCIT)

Police officers are ill-equipped to handle an increasing number of service calls involving individuals experiencing mental health crises, resulting in a 'revolving door' phenomenon "where police have frequent contact with the same individuals who are often unable to access long-term, appropriate care" (Semple et al 2021, 3). These calls drain police resources due to their frequency and time-consuming nature as police

officers are typically required to remain in ED with individuals apprehended under the *Mental Health Act* until they have been seen by a physician (Semple et al 2021, 4).

The MCIT model, which pairs an experienced mental health professional with a police officer, has been implemented with tremendous evidence-based success in many cities across Ontario and Canada. MCIT models have proven to relieve pressure on police officers and provide better support to people in crisis. A study conducted on the Crisis Outreach and Support Team (COAST) by South Simcoe Police Service (SSPS) in partnership with CMHA and York Support Services Network found the implementation of COAST contributed to fewer apprehensions and significantly more resources provided to people in crisis (Semple et al 2021, 4). Moreover, the study found COAST provided significant economic benefits for SSPS. Reduced call times of patrol officers responding to mental health calls saved $47.43 **per call** and SSPS also saved on calls where COAST responded compared to patrol officers (Semple 2021, 14). A similar study conducted on the Joint Mobile Crisis Response Team Pilot Project (JMCRT) by Thunder Bay Police Services, Thunder Bay Regional Health Sciences Centre and CMHA also found a reduction in the number of apprehensions and less time spent by officers in ED. Since 2018, JMCRT has been successful in diverting 661 people from ED and 131 from police custody (Human Services & Justice Coordinating Committee, 2021).

As part of the $18.3 million commitment made by the provincial government in 2019 to support Ontario's first responders in the *Roadmap to wellness*, a pilot project for four new mobile mental health and addictions clinics were announced, with one set to open in Northern Ontario on Manitoulin Island. In June 2021, OBCM called on the federal government to establish "a consistent program to be mandated province-wide with the necessary funding" as a viable solution for solving the mental health crisis that has been "tried and tested" with success – a position supported by this paper (OBCM, 2021). Federal, provincial and municipal governments should work collaborative to introduce MCIT in communities across Northern Ontario.

Conclusion

It is clear that current efforts made by governments are not enough to address the worsening homelessness, addiction, and mental health crisis in Northern Ontario. Thus, all levels of government musts commit to new strategies for Northern Ontario. The strategies identified in this paper have been proven to be successful in reducing homeless populations and those struggling with addiction and mental health issues with evidence-based data. This data also shows the economic benefits of the suggested strategies. Importantly, the eight strategies align with commitments already made by the federal and provincial government, and therefore, should be supported whole-heartedly and without reservation.

Appendix A

Association of Municipalities of Ontario (AMO)

Canadian Mental Health Association (CHMA)

Canadian Mortgage and Housing Corporation (CMHC)

Crisis Outreach and Support Teams (COAST)

District Social Service Administration Board (DSSAB)

Emergency Department (ED)

Federation of Northern Ontario Municipal Association (FONOM)

Joint Action Health Workforce Planning and Forecasting (JAHWF)

Joint Mobile Crisis Response Team Pilot Project (JMCRT)

Kenora District Services Board (KDSB)

Ministry of Health and Long-Term Care (MOHLTC)

Mobile Crisis Intervention Teams (MCIT)

Northern Ontario Municipal Association (NOMA)

Northern Ontario School of Medicine (NOSM)

Northern Ontario Service Delivery Association (NOSDA)

Ontario's Big City Mayors (OBCM)

Ontario Provincial Police (OPP)

Point-in-Time (PiT) Counts

Rapid Housing Initiative (RHI)

South Simcoe Police Service (SSPS)

Thunder Bay District Social Service Administration Board (TBDSSAB)

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