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Homelessness, Mental Health, and Substance Use in Northern Ontario, Revisited

By: Holly Parsons

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Our main offices:

Thunder Bay on Robinson-Superior Treaty territory and the land is the traditional territory of the Anishnaabeg and Fort William First Nation.

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Kirkland Lake is on the Robison-Huron Treaty territory and the land is the traditional territory of Cree, Ojibway, and Algonquin Peoples, as well as Beaverhouse First Nation.

Each community is home to many diverse First Nations, Inuit, and Métis Peoples.
We recognize and appreciate the historic connection that Indigenous peoples have to these territories. We support their efforts to sustain and grow their nations. We also recognize the contributions that they have made in shaping and strengthening local communities, the province, and Canada.

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Partners

NOMA

The Northwestern Ontario Municipal Association (NOMA) was organized in 1946, incorporated on September 18th 2001, and is made up of four components: the Kenora District Municipal Association, the Rainy River District Municipal Association, the Thunder Bay District Municipal League and the City of Thunder Bay. Other than the City of Thunder Bay, membership is attained by being a member of the district organization. NOMA currently has 37 member municipalities. The area we represent extends from the City of Kenora in the west to the Town of Hearst in the east.

The objects of the Association are to consider matters of general interest to the municipalities and to procure enactment of such legislation that may be of advantage to the municipalities in Northwestern Ontario and to take united action on all matters where the rights of the municipalities may be affected to advance the standards of municipal government through education and discussion and generally to promote their interests.

FONOM

The Federation of Northern Ontario Municipalities (FONOM) is the unified voice of Northeastern Ontario, representing and advocating on behalf of 110 cities, towns and municipalities. Our mission is to improve the economic and social quality of life for all northerners and to ensure the future of our youth.

FONOM is a membership-based association that draws its members from northeastern Ontario and the districts of Algoma, Cochrane, Manitoulin, Nipissing, Parry Sound, Sudbury and Timiskaming.

NOSDA

The Northern Ontario Service Deliverers Association or NOSDA was formed to develop a co-operative and collaborative approach with municipalities and municipal organizations, to facilitate the consolidated municipal delivery of services in Northern Ontario. NOSDA is intended to create a political forum for reviewing and developing both policies and program delivery issues from a Northern perspective.

Northern Analyst Collective

The Northern Analyst Collective (NAC) is a membership group of organizations, municipalities, charities, chambers, and more. By merging our collective resources, we can ensure that the smallest municipality or local charity can access high-end skills. The expert's salary and benefits are covered in part by NPI/IPN and our sponsors, and in part through the membership fees paid by participating organizations. The end result is that members are able to secure the skills they need when needed.

About the Author

Holly Parsons

Holly Parsons moved to Australia to pursue her undergraduate degree and graduated with a B.A. in Politics & Policy Studies and International Relations from Deakin University in Melbourne. Holly gained experience in research, policy analysis, and advocacy while working at grassroots NGOs in Australia and Indonesia. Once moving back to Canada, Holly was a Policy Analyst at Northern Policy Institute and worked on various research projects related to population growth, northern governance, homelessness, addiction and mental health, and others. Holly is currently pursuing a master's degree in Human Security and Peacebuilding from Royal Roads University. In her spare time, Holly loves to travel, ski, read, cook vegan recipes, and be outdoors.

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Executive Summary

In 2021 and 2022, Northwestern Ontario Municipal Association, Federation of Northern Ontario Municipalities, and Northern Ontario Service Deliverers Association partnered with Northern Policy Institute to establish a baseline around homelessness, mental health, and substance use disorders in Northern Ontario. From there, further analysis was done on the scope of these challenges; then eight policy strategies were recommended for government and community practitioners to address these issues within the Northern Ontario context.

As a follow-up to that initial paper, this second paper aims is to expand on three policy recommendations to provide concrete steps government and community practitioners could take to implement our recommendations (or others like them) in Northern Ontario. The additional five recommendations will be explored in subsequent papers over the next two years.

The three recommendations explored in this second paper are as follows:

1. Support new and existing culturally safe and supportive community housing programs for Indigenous peoples

Support for new and existing culturally safe housing facilities for Indigenous peoples should be enhanced by establishing a baseline for Indigenous homelessness in Northern Ontario; identifying pathways to Indigenous homelessness; defining Indigenous homelessness, and exploring the benefits of both culturally appropriate homes and supportive community housing. Next, to provide insight on how culturally safe and supportive housing initiatives could be implemented in northern communities, three existing evidence-based initiatives for Indigenous peoples are examined: Sioux Lookout Supportive Housing Program, Suswin Centre in North Bay, and the Kenora Supportive Housing Program. Of note, the applicability of these measures goes beyond Indigenous peoples: adoption of a supportive housing framework would benefit a variety of individuals experiencing homelessness, mental health, and substance use disorders. Best practices from these case studies should be highlighted, adapted, and applied widely.

2. Establish a northern "centre of excellence" for mental health and substance abuse disorders

Another barrier to addressing the homelessness, mental health, and substance use crises in the North is the lack not only of a central, coordinating body (or bodies), but also of common key performance indicators and shared infrastructure to disseminate evidence and set service expectations. To address these challenges, support already exists for a "centre of excellence" for mental health and substance use disorders, specifically by, for, and in the North. A new initiative, however, led by five community partners in Algoma District — Algoma University, Northern Ontario School of Medicine, Sault Area Hospital, Sault College, and Shingwaulk Kinoomaage Gamig — promises a timely, cost-effective, and appropriate alternative for the provincial government to support. That is because many similarities exist between the proposed Northern Centre of Excellence for Addiction and Mental Health and the new Mental Health and Addiction Research and Training Institute, as both seek to advocate for the needs of those struggling with mental health and substance use disorders; develop and deliver educational and training programs; establish "best practices" for Northern Ontario through focused research projects; and integrate appropriate, holistic care for Indigenous peoples into the region's mental health and substance use system.

3. Define northern "service hub" communities and reallocate resources based on migration trends and Our Health Counts studies

A number of Northern Ontario communities act as "hubs" for the delivery of core services such as acute care, long-term care for chronic diseases, services for mental health and substance use disorders, and traditional healing services for Indigenous peoples. An additional component that should be considered is the hub's provision of core social services, such as those relating to homeless shelters, counselling, childcare, education, and employment. Properly defining not only the services provided but also the geography and population encompassed within the hub would have implications for service delivery and availability, as well as for funding allotted to these services. The two largest challenges to defining a service hub's catchment area accurately are the in-migration of Northerners from surrounding rural and remote communities to access services not available where they live, and the undercounting of urban Indigenous populations. Both challenges apply additional pressure on already under resourced health and social services in a service hub community. Increasing the accuracy of the population count, standardizing it across communities, and conducting it on a recurring basis would help work towards more adequate and appropriate resource allocation to hub communities.

In conclusion, this report lays out further ways to move the three recommendations forward and increase partnership among Northern Ontario communities to address these issues meaningfully. The additional recommendations include identifying, engaging, and co-designing culturally safe and supportive housing programs for Indigenous peoples; supporting research for mental health and substance use disorders in Northern Ontario via the Mental Health and Addiction Research and Training Institute; and mandating Northern Ontario Health Teams to de ine their catchment populations by conducting migration trend and Our Health Counts studies on a recurring basis.

Introduction

In August 2022, a report titled "More than Just a Number: Addressing the Homelessness, Addiction, and Mental Health Crisis in the North" (Parsons 2022) was published by Northern Policy Institute (NPI) in partnership with the Northern Ontario Municipal Association (NOMA), the Federation of Northern Ontario Municipalities (FONOM), and the Northern Ontario Service Deliverers Association (NOSDA). The paper established the scope of the homelessness, mental health, and substance use crises in Northern Ontario by examining homeless enumeration data, Public Health Ontario data around opioid use, and mental health data from Statistics Canada (see the Appendix). The paper found that four northern districts have larger homeless populations per 1,000 people than do some of Ontario's largest southern municipalities. It also found that opioid-related emergency department visits and opioid-related deaths have increased in most northern public health units consistently over the past five years, and that Northern Ontarians in general experience poorer mental health than do other Ontarians. An engagement process to identify service gaps and barriers was conducted by NPI with mayors, municipal councillors, district social service administration boards, private organizations, and federal and provincial ministries from across Northwestern and Northeastern Ontario during NOMA and FONOM's 2022 conferences. At the same time, the paper's author conducted an encompassing literature review of policy strategies in Northern Ontario, Canada, and globally, and recommended eight strategies to reduce the number of Northerners struggling with homelessness, poor mental health, and substance use disorders.

The aim of this follow-up report is to expand on three of the eight recommended strategies to provide practical insight on how these strategies could be replicated and implemented in communities across Northern Ontario. The three strategies are:

1. support new and existing culturally safe and supportive community housing programs for Indigenous peoples;

2. establish a northern "centre of excellence" for mental health and substance use disorders; and,

3. define northern "service hub" communities and reallocate resources based on migration trends and Our Health Counts studies.

The other five strategies will be explored in forthcoming reports to be published by NPI in partnership with NOMA, FONOM, and NOSDA over the next two years.

After establishing that Indigenous peoples are overrepresented in homeless populations in Northern Ontario, the paper makes a strong case for culturally safe and supportive housing for Indigenous peoples. The paper then examines three supportive housing programs for Indigenous peoples that could serve as a blueprint for Indigenous organizations, community organizations, service providers, and other stakeholders on the implementation of similar grassroots programs in their community. This section is informed by one-on-one interviews with Indigenous organizations such as Nishnawbe-Gamik Friendship Centre, North Bay Indigenous Friendship Centre, and Ontario Aboriginal Housing Services.

The second section of the paper starts by describing the rationale and support in the North for establishing of a northern "centre of excellence" for mental health and substance use disorders, as proposed by the Thunder Bay Drug Strategy. Next, the paper describes the Mental Health and Addictions Centre of Excellence for Ontario that the province is developing as part of its comprehensive strategy to reform the health system for mental health and substance use disorders. The paper, however, proposes a cost-effective, appropriate, and timely alternative led by five community partners in Algoma District: Algoma University, the Northern Ontario School of Medicine, Sault Area Hospital, Sault College, and Shingwaulk Kinoomaage Gamig.

The last section of the paper offers a definition of a northern service hub based on existing definitions of rural and northern "health hubs" that describe core health services required in these communities. The paper expands this definition, however, to include core social services that are also required in northern service hub communities. Beyond core health and social infrastructure, another important characteristic of northern service hub communities should be well-defined catchment areas that consider regional migration trends and that use Our Health Counts studies to overcome census undercounting of Indigenous peoples. Finally, it is recommended that Ontario Health Teams should be responsible for funding and conducting migration trends and Our Health Count studies (Ontario 2022d, 3).

Notably, to align with terminology used by data sources such as Statistics Canada, this paper uses the term "Indigenous peoples" when referring to Canada's First Nations, Métis, and Inuit peoples collectively. The author wishes to acknowledge, however, that First Nation, Métis, and Inuit are culturally distinct groups with unique and varying housing and health needs. The paper further acknowledges that First Nations across Northern Ontario are also culturally, economically, and geographically distinct, with unique and varying housing and health needs.

Methodology

The paper was largely informed by qualitative data collected by the author through a series of one-on-one and group interviews with key decisionmakers who have either implemented one of the three strategies in some capacity or have specific expertise and knowledge on how these strategies could be implemented in northern communities. Interviews were audio-recorded and transcribed verbatim, or notes were taken by the author in real time. Key decisionmakers consulted for this paper represented local Indigenous organizations, health service providers, district social service administration boards (DSSABs), post-secondary institutions, municipalities, provincial ministries, and government organizations. Although the author did not engage directly with people with lived experience, service providers who work directly with individuals struggling with homelessness, poor mental health, and substance use disorders shared valuable insights on daily challenges and opportunities to better serve them. The paper was also informed by a literature review of related topics for necessary background information and to add context to the three recommended strategies. Additionally, quantitative community and regional data from official sources — Statistics Canada, the Ontario Provincial Police, DSSABs, and Our Health Counts — were collected and analyzed to help describe the issues and to demonstrate the evidence-based nature of the proposed strategies.

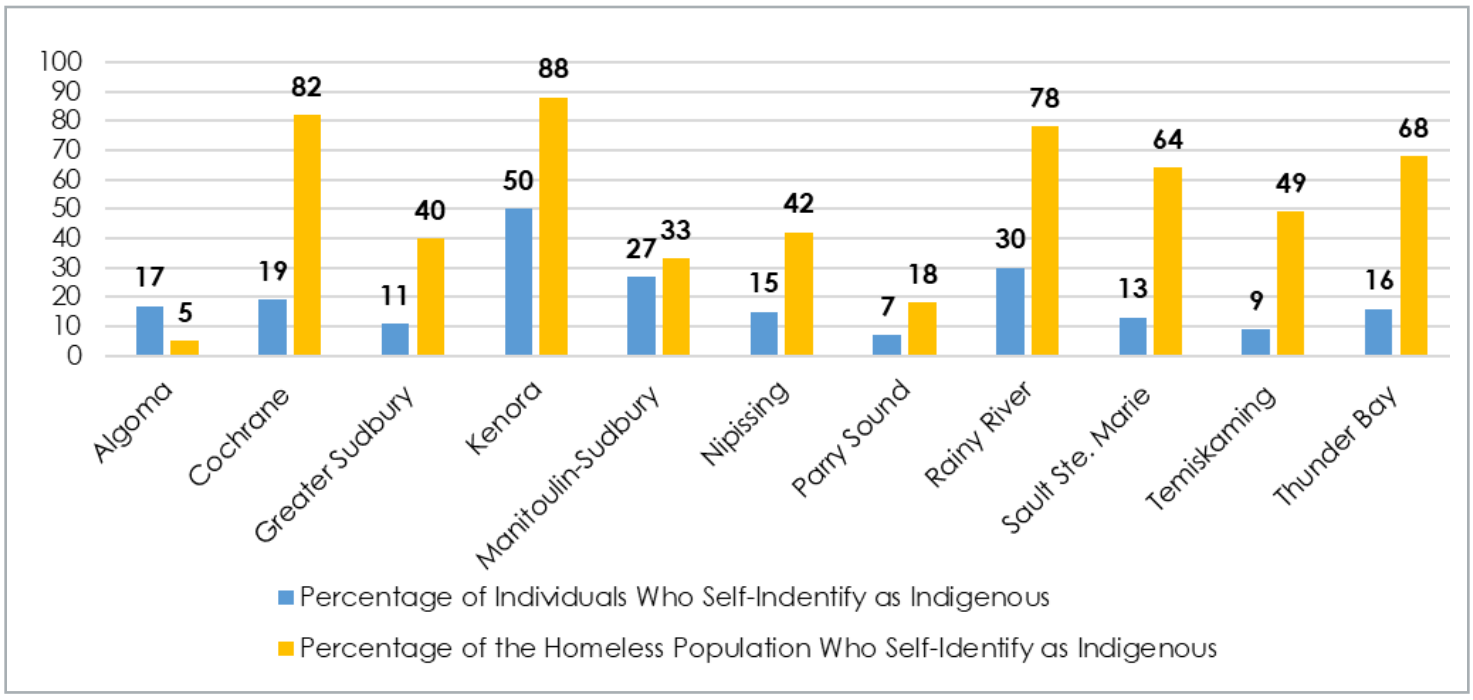
It should also be noted that the three strategies were chosen by the project partners – NOMA, FONOM, and NOSDA – as a starting point towards addressing homelessness, mental health, and substance use disorders in the North, and do not reflect their superiority over the five strategies recommended in the initial report or other, unidentified strategies being implemented in northern communities.

Recommendation #1: Support New and Existing Culturally Safe and Supportive Community Housing Programs for Indigenous Peoples

Establishing a Baseline for Indigenous Homelessness in Northern Ontario

In every northern district, Indigenous peoples are overrepresented among homeless populations. Figure 1 shows the percentage of individuals who self-identify as Indigenous within the general population of each northern district compared with the percentage of individuals who self-identify as Indigenous within the homeless population of each northern district. With the largest discrepancy, Indigenous peoples in the District of Cochrane account for 88 per cent of the homeless population compared with only 19 per cent of the general population. In the District of Thunder Bay, Indigenous peoples account for 68 per cent of the homeless population compared with 16 per cent of the general population. In Sault Ste. Marie, Indigenous peoples account for 64 per cent of the homeless population compared with 30 per cent of the general population. Other northern districts with discrepancies of over 30 per cent include Rainy River, Timiskaming, and Kenora. Moreover, in Canada, urban Indigenous peoples are eight times more likely to experience homelessness than non-Indigenous people (Homeless Hub 2021).

Figure 1: Percentages of Individuals Who Self-Identify as Indigenous and of the Homeless Population Who Self-Identify as Indigenous, by Census District, Northern Ontario, 2021



Source: Author's calculations from 2021 Homeless Point-in-Time counts and Statistics Canada, 2021 Census.

Pathways to Indigenous Homelessness

Typical pathways to homelessness include poverty, poor mental health, substance abuse disorders, lack of social housing, and socio-economic inequities. For Canada's Indigenous peoples, however, these pathways are also paved by "past and present colonial policies that created and sustain systemic racism, cultural oppression, disempowerment and dispossession of Indigenous people's lands" that deny them of their human right to housing (Bingham et al. 2019, 6). Canada's Truth and Reconciliation Commission flagged the era of the Indian Residential School System, which lasted over a century, as "the beginning of intergenerational cycles of trauma" for Indigenous peoples. During this era, thousands of Indigenous children experienced the horrors of being separated forcibly from their families, stripped of their cultural identities, and placed in an environment where psychological, verbal, physical, and sexual abuse was widespread (Macdonald and Hudson 2012, 5). Notably, the impact of residential schools has not ended with the survivors; instead, "their children, their grandchildren, their extended families, and their communities" continue to be affected (Truth and Reconciliation Commission 2015, 136–7).

Today, the intergenerational impact of residential schools is evident by the overrepresentation of Indigenous children in Canada's child welfare and foster care system (Alberton et al. 2020, 2), as well as the overrepresentation of Indigenous adults and youth in Canada's prison system (Bingham et al. 2019, 6). According to the 2021 census, Indigenous children and youth accounted for 54 per cent of children in Canada's foster care system, even though Indigenous children and youth were only 7.7 per cent of Canada's overall child population (Canada 2022b). This is because Indigenous parents are more likely to experience "domestic violence, alcohol abuse, lack of social supports, drug or solvent abuse, and a history of living in foster care or groups homes" than are non-Indigenous parents (Truth and Reconciliation Commission 2015, 146). At the same time, Indigenous adults accounted for about one-third of federal and provincial custody populations, despite representing only five per cent of Canada's overall population; Indigenous youth accounted for 50 per cent of custody admissions (Statistics Canada 2022).

There is an overwhelming amount of research literature that links childhood trauma with incarceration, propelling cycles of intergenerational trauma forward (Bingham et al. 2019, 6). The Truth and Reconciliation Commission, for example, noted: "Children who were abused in the schools sometimes went on to abuse others. Many students who spoke to the Commission said they developed substance addictions as a means of coping. Students who were treated and punished like prisoners in the schools often graduated to real prisons. For many, the path from residential school to prison was a short one" (2015, 136). Moreover, the Indian Residential School System, as well as other historical and present colonial state-imposed laws such as the Gradual Civilization Act and the Indian Act, separated thousands of Indigenous peoples from their traditional lands, waterways, and culture so the Crown could profit from land development and resource extraction (Thompson and Suzuki 2022), as well as for the calculated purpose of "ethnic cleansing, linguicide, and domicide of Indigenous peoples" (Thistle 2017, 14). These early colonial practices that excluded Indigenous peoples from appropriate and adequate housing paved the way to Indigenous homelessness as seen today.

Defining Indigenous Homelessness

The ties between historically constructed and ongoing settler colonization and racism have led to a distinct definition of Indigenous homelessness in Canada (Thistle 2017, 6). In contrast to the Canadian European definition of homelessness as "the situation of an individual, family, or community without stable, safe, permanent, and appropriate housing, or the immediate prospect, means and ability of acquiring it" (Gaetz et al. 2012), the definition of Indigenous homelessness is more encompassing of the cultural beliefs around what constitutes a "home." As Thistle explains:

> Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their indigeneity or lost relationships. (2017, 6)

The fundamental difference between the definition of homelessness for Indigenous peoples and for non-Indigenous lies in each group's concept of "home." From a Western perspective, the concept of home is anchored around a physical structure of habitation where social norms for "gender roles, work habits, and domestic ways" were established and cultivated (Thistle 2017, 14). Indigenous peoples, in contrast, conceptualize home as "circles of interconnectedness that together form the heart of healthy Indigenous social and spiritual emplacement" (15). Thus, for Indigenous peoples to feel "at home," they need to feel a sense of "'rootedness' anchored by reciprocal relationships with their community, family, ancestors, stories, and self-determination" (Bowra and Mashford-Pringle 2021, 1), as well as their natural environment.

The Benefits of Culturally Appropriate Homes

Culturally appropriate homes refer to the constructed configuration of residential properties, both artificial and natural, that incorporates cultural constructs of space and time into one or more activity space or room to promote cultural practices such as religious ceremonies, social gatherings, culinary activities, and communal meals, as well as optimize human comfort and quality of lifestyle (Rachelson, Wong, and Han 2019, 9–10). According to Rachelson, Wong, and Han, other benefits of culturally appropriate homes include:

- allowing for comfortable occupation of housing by alternative family structure (i.e., large, intergenerational);
- lower cost by reducing energy burdens, shortening supply chains, and increasing economic security;
- increase sustainability and lower environmental impact of the home, including local sourcing of building materials, energy efficient layout, and technology;
- build resilience and increase adaptive design against context-specific climates, meteorological, or biological factors and patterns; and
- increase wellbeing, health, and sense of belonging (ibid 2019,11; see also Orrantia and Labelle 2022).

In consideration of the typical pathways to homelessness, culturally appropriate homes can have a positive impact on "equity, economic security, wellbeing and health, continuation of cultural traditions, and disaster resilience for ethnocultural minorities and Indigenous communities in Canada" (Rachelson, Wong, and Han 2019, 9). In contrast, Canada's current housing stock of Eurocentric homes suppresses cultural practices that define cultural identities, negatively affecting the physical, mental, and emotional wellbeing of racial minorities. In part, that is because Euro-Canadian homes are largely compartmentalized, prioritizing private over public space with designated rooms for certain activities (ibid).

When it comes to culturally appropriate homes for Indigenous peoples, design features should include "a healing room, a sweat lodge in the backyard, access to land for land-learning with children, a garden, and craft and teaching rooms" (Native Women's Association of Canada 2020, 88). As well, transitional housing facilities focused on serving Indigenous peoples should also be accommodating to families and children (ibid).

The Benefits of Supportive Community Housing

The term "supportive housing" refers to short-term (also known as "transitional") and long-term housing in a clustered setting that is owned, operated, and subsidized by non-profit organizations, government, or service managers (CAMH 2012, 2). Residents are offered a range of on-site clinical and non-clinical supports that focus on recovery, encouraging rehabilitation through independent living and integration into the community (ibid.). Clinical supports can include medical care for physical health, mental health and substance use disorders offered by a multidisciplinary team of health care professionals and social workers (Dohler 2016, 2), while non-clinical supports can include life skills and social skills training, such as financial planning, cooking classes, and resumé building. Importantly, supports are offered to residents based on self-determination, as well as an individual assessment of needs to ensure client-centred care (CAMH 2022, 2). For supportive housing facilities focused on serving Indigenous clients, support services need to be Indigenous-led, and all staff should receive cultural sensitivity training with a special focus on intergenerational trauma (Native Women's Association of Canada 2020, 88).

The benefits of supportive housing are well known. An abundance of research literature shows supportive housing to be advantageous to individuals "who have long histories of hospitalizations, trauma and complex needs" by improving their social supports, independence, self-esteem, health, and overall quality of life (CAMH 2022, 4). From a community perspective, supportive housing significantly alleviates pressure on public health services such as hospitals, emergency services, jails, and shelters, leading to cost savings for all levels of government. To compare, supportive housing has been found to cost between $15 a day for low-support program to $115 a day for high-support program per individual, versus between $330 to $681 a day for a psychiatric hospital bed and between $200 and $800 per emergency room visit (CAMH 2012, 3). Moreover, there is no evidence that links supportive housing facilities to an increase in neighbourhood crime or to a decrease in property values; instead, supportive housing is linked to social cohesion and community pride, in part by reducing the number of visible individual experiences homelessness (CAMH 2022, 4).

Bringing It All Together: Case Studies

It is imperative that all strategies being implemented in the North consider the characteristics of homeless populations in order to meet local needs adequately. Given that Indigenous peoples are overrepresented in homeless populations in Northern Ontario, and in consideration of the established benefits of both culturally appropriate homes and supportive housing, programs to provide culturally safe and supportive housing for Indigenous peoples should be implemented. Such programs, if designed and implemented by Indigenous organizations, would encourage self-determination, a guiding principle of the United Nations Declaration on the Rights of Indigenous People. Such programs would also align with Canada's National Housing Strategy, which affirms "the right of every Canadian to access adequate housing" (Canada 2022a). In an effort to guide Indigenous organizations and other community organizations on the implementation of this strategy in their communities, three case studies are examined below.

Case Study #1: Sioux Lookout Supportive Housing Program, Sioux Lookout[1]

In August 2018, Kenora District Services Board (KDSB) and Ontario Aboriginal Housing Services (OAHS), in partnership with First Step Women's Shelter, Nishnawbe-Gamik Friendship Centre, and Ontario Provincial Police (OPP), opened a 20-unit supportive housing program. The program came to fruition after KDSB conducted an analysis of OPP calls for service[2] in Sioux Lookout that found such calls in the community often involved the same 19 individuals who were experiencing homelessness; this is consistent with the "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). The program was designed to provide housing and 24/7 support for individuals experiencing chronic homelessness – specifically the 19 individuals experiencing homelessness identified by the analysis — and those connected to the justice system. Notably, all 19 individuals experiencing homelessness became the first residents of the facility; five of them are still housed by the program today.

[1] This case study is informed by a series of interviews conducted by the author with Kenora District Services Board and Nishnawbe-Gamik Friendship Centre in the fall of 2022.
[2] Calls for service costs represent costs related to policing that usually require a police officer's attendance (OPP 2019).

To start, KDSB and OAHS developed the proposal for the supportive housing program and brought it to the municipality, which agreed to provide serviceable land for the construction of the facility. OAHS agreed to contribute the nearly $5 million in capital funding, while KDSB and OAHS agreed to split the $1.1 million in annual operation costs. The operational costs fund programs and services offered to residents and delivered by Nishnawbe-Gamik Friendship Centre, First Step Women's Shelter, Meno Ya Win Health Centre, and KDSB. Residents have access to all 20 direct service delivery programs offered by Nishnawbe-Gamik Friendship Centre, from healing and wellness to help navigating the criminal court system from a combined court worker. Notably, KDSB acts as the official tenancy holder on behalf of residents.

Since opening its doors, the Sioux Lookout Supportive Housing Program has been highly successful from both a community and a client perspective. OPP calls for service for the first 20 residents dropped by 56 per cent, from 337 calls to 149 calls, over the two months before and after entering the program. Notably, for four residents, calls dropped by 100 per cent. The reduction in calls means that resources can be reallocated to better serve the community. For example, on-duty officers have more time in their day for community engagement (i.e., relationship building with community members) versus dealing with mental health and substance use disorders in the community for which they are ill-equipped to handle (Parsons 2022). The reduction in calls also translates into cost savings for the community, as municipalities policed by the OPP are billed according to two factors: the number of household, commercial, and industrial properties within municipal borders (the base service fee) and per call for service for crimes such as assaults, break and enter, mischief, and drug offences, as well as calls to enforce provincial statutes such as the Mental Health Act (OPP 2019).

Moreover, a reduction in calls for service also provides the province an opportunity to reallocate resources away from policing mental health and substance use disorders, as data on calls are used to determine the average annual number of officers required for municipal policing. As outlined in Section 5.1 of the Police Service Act, R.S.O. 1990, the OPP Commissioner must conduct an analysis of the workload of OPP officers in the integrated detachment based on the availability of on-duty officers to respond to CFS, the types of CFS received, and the need for multiple officers to respond to certain types of CFS for safety reasons (Canada 2023). If calls are reduced, an OPP detachment might require fewer officers to staff it, meaning resources can be reallocated elsewhere as needed — for example, mobile crisis intervention programs that pair an experienced mental health professional with an on-duty officer (Parsons 2022).

Some of the best practices established by Sioux Lookout's Supportive Housing program include building meaningful relationships between residents and OPP officers through casual interactions at the facility; offering a variety of programs and services to residents based on self-determination; requiring residents to buy into a meal plan with funds from Ontario Works or the Ontario Disability Support Program paid directly to the housing provider; connecting residents directly with service providers and program workers upon entry into the program; incorporating aspects of culturally appropriate homes into the physical design of the building through, for example, large windows and a vegetable garden; and interacting door-to-door with community members to build community understanding, trust, and support for the initiative.

Case Study #2: Kenora Supportive Housing Program, City of Kenora[3]

The success of the Sioux Lookout Supportive Housing Program has paved the way for similar Indigenous supportive housing projects, including in the City of Kenora. In 2018, OAHS presented the success of the Sioux Lookout program to the provincial government and rallied support for a supportive housing facility in Kenora. The province made an initial commitment of $4.5 million to fund capital costs, with additional support dollars becoming available over the next two years. A contribution for capital was made by the Toronto-Dominion Bank, with the balance funded by the Canadian Mental Health Association through a co-ed fund. The provincial government also committed to funding annual operating costs of $1.3 million to provide culturally safe programs and services to residents delivered by Ne-Chee Friendship Centre and KDSB. Programs and services will be based on individuals' needs and can include Western medicine and traditional healers, as well as non-clinical services. To make the project viable, KDSB acquired property from the private sector and subsequently undertook the necessary rezoning work in partnership with the City of Kenora. Kenora further supported the project by realigning municipal water and sewer infrastructure to service the project, which also involved the moving of an entire skating rink. The facility will include shared kitchen and eating space, with three meals per day offered to residents, individualized units with private bathrooms, and programming and medical rooms.

[3] This case study is informed by a series of interviews conducted by the author with Kenora District Services Board in the fall of 2022.

Case Study #3: Suswin (Nest) Village, North Bay[4]

A three-storey, 30-unit culturally safe and supportive housing facility is under construction in downtown North Bay. Construction of Suswin Village (suswin is Ojibwe for nest) began in the fall of 2019 and was completed in early 2023; the first five residents moved in on March 1, 2023. The project is led by the North Bay Indigenous Friendship Centre, with support from OAHS. OAHS is funding capital costs through two forgivable grants: the Indigenous Supportive Housing Program and the First Nations, Inuit, Métis Urban and Rural Assisted Homeownership Program. Operating costs estimated at $700,000 annually will be covered in full by OAHS for the first three years for programs and services provided by North Bay Indigenous Friendship Centre. Long-term funding for annual operating costs has still to be secured.

The design of the facility features many elements of culturally appropriate homes, such as an outdoor area with a firepit for ceremonies, geothermal heating for the environment, and Indigenous artwork throughout. Other features include easily accessible units for people with disabilities, an elevator, an alarm system, a computer room, a large communal kitchen, and private bathrooms in each unit to give residents dignity. To help residents become self-sufficient and to prepare them for the next phase of their lives, employment services and a cook will be available to teach cost-effective cooking. Although the facility is designed for Indigenous peoples, the program will house others if room permits.

Some replicable practices that have been identified during the development phase of this project include hiring a project manager to advocate on behalf of the project partners and complete funding applications, reaching out to communities with existing culturally sensitive supportive housing units to learn about "best practices" and mistakes; hiring Indigenous contractors and employees when possible to increase Indigenous capacity in First Nations; incorporating aspects of culturally appropriate homes into the physical design of the building, such as a healing room, a sweat lodge in the backyard, and access to land for land-learning; a bathroom in each unit to give residents a sense of dignity; and holding Indigenous ceremonies at various stages of the project's lifespan.

[4] This case study is informed by a series of interviews conducted by the author with North Bay Indigenous Friendship Centre in the fall of 2022.

Recommendation #2: Establish a Northern "Centre of Excellence" for Mental Health and Substance Use Disorders

In November 2017, the Thunder Bay Drug Strategy, in partnership with the Centre for Rural and Northern Health Research, began a 15-month-long engagement process in Northwestern Ontario to gauge support for establishing a Northern Centre of Excellence for Addiction and Mental Health to "[s]erve as an advocate for addiction and mental health issues in the north, building local capacity through specialized training and education, connecting service providers, community partners and those with lived experience, researching gaps in service, and developing and sharing educational programming and best practices made in and for the North, with particular attention to cultural sensitivity and the need for respectful and holistic care for Indigenous people" (Thunder Bay Drug Strategy 2018, 2).

The engagement process found that 95 per cent of the 216 participants involved were in favour of a Northern Centre of Excellence. Importantly, participants represented six sectors: social services (119), health care (33), policy (26), peer (25), justice (18), and education (9), as well as 34 Northwestern communities, the majority of which were towns, rural communities, or First Nations (65 per cent) (Thunder Bay Drug Strategy 2018, 7, 19). In the study's corresponding report, participants overall were in favour of a blended model of communication that combines face-to-face interactions (e.g., workshops and conferences) and virtual interactions (e.g., up-to-date information sharing about services and referral pathways). In terms of distribution, some participants preferred a "distributed model" with equal centres in Thunder Bay and small towns throughout the Northwestern region, while others preferred a "hub-and-spoke" model with a head office in Thunder Bay and satellite offices dispersed throughout the region. For those in favour of the distributed model, building and sustaining local capacity, as well as developing relationships with communities and local organizations, were priorities. Those in favour of a "hub and spoke" model placed particular emphasis on equity of resource distribution by providing additional services and supports to satellite offices in the region as needed (Thunder Bay Drug Strategy 2018, 10).

Based on the results of the engagement process, the intended next step was to draft a proposal for a Northern Centre of Excellence with regional partners (Thunder Bay Drug Strategy 2018, 21). This work, however, was paused as the COVID-19 pandemic ravaged Ontario and the world, forcing Thunder Bay to reallocate its resources toward the more immediate threat. Then, in May 2020, the provincial government announced a comprehensive strategy to address the system of care in Ontario for mental health and substance use disorders by establishing a Centre of Excellence for Addiction and Mental Health for the entire province (Ontario 2020). Due to uncertainty around the mandate and oversight model of a Centre of Excellence for Northern Ontario, Thunder Bay Drug Strategy indefinitely tabled the proposal.

A Centre of Excellence for Addiction and Mental Health for Ontario

In March 2020, the provincial government announced a new action plan to address mental health and substance use disorders with the establishment of the Centre of Excellence for Addiction and Mental Health for Ontario. The Centre was conceptualized from recommendations by the 2010 Select Committee on Mental Health and Addictions around creating "a new organization responsible for overseeing the entire mental health and addictions system...so that all Ontario residents have timely and equitable access to an integrated system of excellence" (Legislative Assembly of Ontario 2010, 2). The Select Committee based its recommendations on an engagement process that took place across the province, as well as the evidence-based success of Cancer Care Ontario as "a clinical governance and performance improvement system that produces results" (Duvalko et al. 2009, 9). To avoid mental health and substance use care being siloed from the wider health system as the Ministry of Health and Long-term Care worked to consolidate various stand-alone agencies, the Centre of Excellence was placed within Ontario Health at its conception. In terms of its mandate, set out by the Mental Health and Addictions Centre of Excellence Act, 2019, the Centre of Excellence will:

- Establish a central point of accountability and oversight for mental health and addictions care.
- Create common performance indicators and shared infrastructure to disseminate evidence and set service expectations.
- Standardize and monitor the quality and delivery of evidence-based services and clinical care across the province.
- Provide support and resources to Ontario Health Teams as they connect people to the different types of mental health and addictions care they need (Ontario 2022a).

In other words, while not a service provider or physical structure, the Centre of Excellence will play a critical role in the delivery and quality of services for mental health and substance use disorders by establishing what quality care looks like, setting clear service delivery expectations, monitoring service delivery using comparable and consistent data, and disseminating evidence to stakeholders (Ontario 2022b). Shared and secure digital infrastructure will be built to collect, store, and disseminate performance-based and client-level data "to make it easier to deliver better care, report on performance and track value of investments" (Ontario 2020). Notably, client-level data will be used to understand how clients enter and move within the mental health and addiction system, then shared with frontline providers to overcome system fragmentation (Ontario 2020).

The oversight model for the Centre of Excellence will look similar to health agencies in other areas of care, including cancer (i.e., Cancer Care Ontario), renal, cardiac, and stroke (Ontario 2020). Regional activities and issues will be captured and raised by Regional Mental Health and Addictions Clinical Leads, which represent Ontario's six health regions (Ontario 2022b). Above these Regional Clinical Leads, four Provincial Clinical Leads representing one of the four clinical areas of focus — depression and anxiety-related disorder, schizophrenia and psychosis, substance use disorders, and eating disorders — are responsible for "creating and implementing a strategic vision….and will set, execute, and monitor key priorities" (Ontario 2022b). Additionally, a fifth Indigenous Clinical Lead is responsible for developing and co-designing Indigenous provincial programs for depression and anxiety-related disorders in partnership with Indigenous-led organizations, clinicians, and communities. To further support Indigenous peoples struggling with poor mental health and substance use disorders, a Provincial Advisory Table on Indigenous Depression and Anxiety has been established, and an engagement process is currently under way in the province with Indigenous stakeholders to inform and guide the operational development of the Centre of Excellence (Ontario 2022b). The clinical governing structure will be mirrored by an administrative team responsible for performance management, led by the Provincial Planning and Performance Council.

The Mental Health and Addiction Research and Training Institute

While the province continues to develop and implement its strategy to address Ontarians' mental health and substance use disorders, five community partners in Algoma — Algoma University, the Northern Ontario School of Medicine (NOSM), Sault Area Hospital, Sault College, and Shingwaulk Kinoomaage Gamig — are engaging seriously on the potential for a local strategy to address the urgent health needs of Northerners by establishing and contributing to a new Health and Addiction Research and Training Institute. The Research and Training Institute will focus on "treatment and prevention; developing innovative educational programs to train generations of workers; and comprehensive research to support a social determinants of health-based system of prevention, treatment and healing, with a particular focus on the unique Northern and rural health needs of communities" (MGAC and Corpus Sanchez, forthcoming). It will undertake this work to deliver on its vision of minoeyawin: good spirit, physical health, and emotional and psychological wellbeing for all. In practice, the Institute will offer holistic, cross-cultural educational and training to health care workers; leverage digital innovations to provide additional training to those who need it; launch focused research projects to build local and regional capacity; and work to advance the integration of Indigenous knowledge (including global Indigenous) cross-cultural approaches including Western science in all areas of Algoma's health sector (MGAC and Corpus Sanchez, forthcoming).

Each of the five founding partners will have an opportunity to take on a distinct role within the Research and Training Institute, leveraging their specific expertise and resources to advance training capacity and research innovation, and create a network of teaching, research, and clinical experience across Ontario. Their roles are defined by individual supporting mission statements, developed internally by each founding partner. Algoma University will focus on ensuring programs at both the undergraduate, graduate, and doctorate levels are teaching students about trauma informed care using a cross-cultural approach. They will increase the number course offerings on mental health and substance use disorders and specializations within program. NOSM will enhance physician undergraduate and post-graduate learners with a goal of increasing physician resources in the North. Sault Area Hospital will train future generations of physicians and advance research around mental health and substance use disorders by establishing an academic campus in Sault Ste. Marie. Sault College will advance training and credentialing through continuing education programs to ensure clinicians in the field have mental health and addiction expertise. Finally, Shingwaulk Kinoomaage Gamig will advance traditional land-based teaching expertise to establish wellness, education, and training programs for mental health and substance use disorder service providers (MGAC and Corpus Sanchez, forthcoming).

In terms of the governing structure, the Feasibility study and stakeholder consultation suggested a Research and Training Institute's Partners' Table to address core accountability and corporate risk (MGAC and Corpus Sanchez, forthcoming). It would be comprised of the CEOs of the founding partners and Indigenous leaders. Under the Partner's Table, the Leadership Council is envisioned to advance the Institute's strategic goals by providing oversight, direction, and resource support for key projects undertaken by the Institute. A Director is currently being hired to being moving the recommendations within the report forward. In its implementation, the Council is envisioned to be informed by four councils in particular areas: the Indigenous Research Oversight Council, the Indigenous Communities Council, the People with Lived Experience Advisory Council, and the Community Advisory Council. Finally, at the discretion of the Leadership Council, various working groups will be established in a limited capacity to "advance selected priorities as endorsed by the Partner's Table" (MGAC and Corpus Sanchez, forthcoming). Looking ahead, the Research and Training Institute will adopt a hub-and-spoke distribution model to expand and grow its capacity across Ontario. A physical hub will be established in a central location — likely in Algoma District, as the physical location of the founding partners — with spokes in other areas of Northern Ontario. As of now, the Research and Training Institute will rely on its founding partners and various grants to fund its mandate, but long-term funding from the province would ensure the longevity of this initiative (MGAC and Corpus Sanchez, forthcoming).

Bringing It All Together

Many similarities can be drawn between the proposed Northern Centre of Excellence for Addiction and Mental Health, the Mental Health and Addictions Centre of Excellence, and the Mental Health and Addictions Research and Training Institute. For example, all three prioritize connecting regional actors to overcome system fragmentation, building digital infrastructure to increase regional capacity, and conducting research to improve the quality and equity of service delivery. Further, the two northern initiatives both seek to advocate for the needs of Northerners struggling with poor mental health and substance use disorders; develop and deliver educational and training programs; establish "best practices" for Northern Ontario through focused research projects; and integrate appropriate, holistic care for Indigenous peoples into Northern Ontario's mental health and addiction health system. Additionally, both the Northern Centre of Excellence and the Research and Training Institute suggest the implementation of a hub-and-spoke distribution model, as well as a blended model of communications.

Therefore, although the previous report (Parsons 2022) recommended establishing a Northern Centre for Addiction and Mental Health for Northern Ontario, this report argues that the Research and Training Institute offers a timely and appropriate alternative given that the initiative is already under way and considering that it might be unrealistic to secure infrastructure dollars from the province to fund a Northern Centre of Excellence before an oversight model for the North has been fully developed, implemented, and measured. Importantly, the Centre of Excellence could work closely with the Research and Training Institute by giving its leaders a seat at various regional and provincial tables and councils in recognition of their expertise in mental health and addiction care in the Northern context.

Furthermore, a community-led approach to health care that is inclusive of local Indigenous organizations and governments would ensure that health investments are tailored to meet the specific and unique needs of community members, minimizing misalignment between needs and investment. A community-led approach also would build community capacity and resiliency as organizations work together toward a common goal (Amobi et al. 2019, 292). The governance, operational, and structural model of the Research and Training Institute could also act as a blueprint for similar initiative in other northern communities, leading to greater regional representation. For example, a similar initiative might be beneficial in Northwestern Ontario, perhaps in Thunder Bay, to advocate for regional nuances. Importantly, however, it is recommended that decisionmakers think strategically about location in terms of distance and demand if additional "spokes" are added to these existing organizations.

Recommendation #3: Define Northern "Service Hub" Communities and Reallocate Resources Based on Migration Trends and Our Health Counts Studies

The concept of a health hub is not new — there is a wide range of research literature that defines and characterizes these communities. A health hub can be defined as a community that provides a wide range of core health services to address the encompassing health needs of its catchment population. Core health services within a service hub include emergency and acute care (i.e., 24/7 emergency room and complex continuing care beds), primary care (i.e., chronic disease management and health promotion), home and community long-term living (i.e., long-term care facilities and assisted living programs), and services for mental health and substance use disorders (i.e., withdrawal beds and community support services), as well as traditional healing services for Indigenous peoples (Ontario Hospital Association n.d., 2). This report expands the definition also to include core social services, such as homeless shelters, counselling, childcare, education, and employment.

Another important characteristic of northern service hub communities is well-defined catchment areas that accurately estimate the population within their boundaries. In the North, however, there are two significant challenges to defining a catchment area: in-migration from surrounding rural and remote communities to access health and social services not available in their home communities, and the undercounting of the urban Indigenous population. Both apply additional pressure to already underresourced health and social services in service hub communities. These challenges must be acknowledged and overcome to ensure adequate and appropriate resources are allocated to northern service hub communities.

Northern Migration Trends

To track migration trends of Northerners seeking access to health and social services, community-level data need to be collected by health and social service providers, with support from municipalities. For example, in an effort to understand why migrants are overrepresented in Thunder Bay's homeless population, Lakehead University, in partnership with the District of Thunder Bay Social Services Administration Board, conducted a study to answer seven key research questions (Gokani et al. 2022, 7):

- From which home communities are people migrating?
- Why do people leave their home communities in the first place?
- Why do people choose to come to Thunder Bay?
- Why do people choose to remain in Thunder Bay?
- What factors predict if someone stays or leaves Thunder Bay?
- How long is someone likely to stay?
- What factors predict how long someone stays?

To answer these questions, researchers used four different data types: the 2021 Point-in-Time count; a survey researchers administrated in homeless shelters; the Homeless Individuals and Families Information System; and one-on-one interviews with people experiencing homelessness who migrated to Thunder Bay. Using machine learning models to analyze both the qualitative and quantitative data collected, a comprehensive view of migration and homelessness in Thunder Bay District, as well as some important insights around migration and homelessness in Northwestern Ontario, were captured and presented in the corresponding report (Gokani et al. 2022, 7). According to the report, "service factors, such as health care, housing, and social service like addiction and mental health support might be driving migration" (Gokani et al. 2022, 3). To give another example, the report found that "being from or passing through Kenora, Cochrane, and Rainy River is a predictor of migration to Thunder Bay and stay in a shelter, including, though to a lesser extent, longer stay in shelter" (Gokani et al. 2022, 4). With a comprehensive view of migration and homelessness, the District of Thunder Bay Social Services Administration Board can make evidenced-based policy and programming decisions (ibid).

Importantly, while this study on migration was restricted to individuals experiencing homelessness in Thunder Bay, similar studies should be conducted by every Northern Ontario Health Team to gain a comprehensive view

of migration trends in their catchment area. Research questions could include:

- From which community are people coming from to access services?
- What specific services are people accessing?
- Why did people choose to come to this community?
- What other communities have people travelled from to access services?
- How often are people required to travel to access services?

Undercount of Indigenous Populations

The census is a widely cited and used source for demographic information in Canada (ibid). The data, however, are far from perfect as it routinely undercounts "hard-to-reach" populations and populations made marginal, such as Indigenous peoples and individuals experiencing homelessness, due to a lack of engagement and participation (Rotondi 2017, 1).

In an effort to quantify census undercounts and fill critical health information gaps of urban Indigenous populations, a handful of Ontario communities — Hamilton, Kenora, London, Ottawa, Thunder Bay, and Toronto — completed an Our Health Counts enumeration and health assessment study, led by Indigenous health researchers (Smylie et al. 2011, 1). The study found that only 15 per cent of Indigenous adults in Thunder Bay reported participating in the 2016 census, while only 14 per cent of Indigenous adults in London completed the 2011 census. Unbiased population estimates, in contrast, are generated using Respondent Driven Sampling formulas and methods that "adjust for different probabilities of being sampled and by use of a structured recruitment frame" (McConkey et al. 2020, 1). The structured recruitment frame is "built on Indigenous values, skills, knowledge, beliefs and practices" by leveraging existing social networks and kin systems within Indigenous communities to recruit participants and to establish a chain referral system (2). Furthermore, by being Indigenous led, Our Health Counts studies promote First Nation research principals of ownership, control, access, and possession, as well as self-determination and Indigenous capacity building (FNIGC 2022). As seen in Table 1, the Our Health Counts model shows that urban Indigenous populations are undercounted by factors of two to five.

Table 1: Our Health Counts Population Estimates, Selected Ontario Cities, 2008-2017

City	Canadian Census Estimate	Ontario Health Count Estimate	Undercount Factor
Kenora	3,155	8,448–12,892	2.6–4
London	8,410	17,108–22,155	3–4
Ottawa	1,145	3,361	X
Thunder Bay	13,490	42,359	3.1
Toronto	19,270	45,000–73,000	2–5

Sources: Our Health Count reports for the cities of Ottawa (2008), Hamilton (2008), Toronto (2013), London (2014), Kenora (2016), and Thunder Bay (2017). Note: The OHC study in the City of Ottawa was restricted to Inuit only; data not available for Hamilton.

Northern Ontario has significant on- and off-reserve First Nations populations that suffer from poorer overall health than do non-Indigenous peoples due to socio-economic inequities tied to food insecurity, loss of traditional lands, discrimination in health services, underfunded Indigenous health services, and lack of cultural safety in service provisions (Kim 2019, 378). Accordingly, Indigenous-led health services are required across the province to meet the health needs of all Indigenous peoples adequately, in terms of both treatment and prevention. Yet, without high-quality, comprehensive, and inclusive population and health data for Indigenous populations, decisionmakers are ill-equipped to make evidence-based policy and programming decisions.

Ontario Health Teams

In April 2019, new legislation was passed to fix Ontario's fragmented public health care system. The government's plan, as reflected in The People's Health Care Act, is largely centred around the establishment of Ontario Health Teams (OHTs), which will adopt an integrated model of care and funding that connects health care providers, social service providers, and educators in the community with patients and families, with the goal of achieving full provincial coverage (Ontario 2022c, 2). More specifically, each OHT will:

1. Provide a full and coordinated continuum of care for a defined population within a geographic region;
2. Offer patients 24/7 access to coordination of care and system navigation services and work to ensure patients experience seamless transitions throughout their care journey;
3. Improve performance across a range of outcomes linked to the "Quadruple Aim": better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value;
4. Be measured and reported against a standardized performance framework aligned to the Quadruple Aim;
5. Operate within a single, clear accountability framework;
6. Be funded through an integrated funding envelope;
7. Reinvest into front line care; and
8. Take a digital first approach, in alignment with provincial digital health policies and standards, including the provision of digital choices for patients to access care and health information and the use of digital tools to communicate and share information among providers" (Ontario 2022c, 2–3).

To date, three OHTs have been established in the Northeastern Region: Algoma OHT, serving Algoma District; Nipissing Wellness, serving Nipissing District and East Parry Sound; and Maamwesying OHT, serving Indigenous communities in Northeastern Ontario, including the urban Indigenous population in Sault Ste. Marie (Ontario 2022c). In the Northwestern Region, four OHTs have been established: All Nations Health Partners OHT, serving Kenora and Sioux-Narrow-Nestor Falls; City and District of Thunder Bay OHT; Kiiwetinoong Healing Waters OHT, serving Dryden, Red Lake, and Sioux Lookout; and Rainy River District OHT (Ontario 2022d). Additionally, in October 2022, the Ministry of Health invited four new potential teams in the North to complete full applications to become approved OHTs: Équipe Ontario Cochrane District Team; Équipe Sudbury Espanola Manitoulin Elliot Lake Team; Équipe des régions du Temiskaming Area Team; and West Parry Sound Team (Ontario 2022d). With the addition of these four OHTs, the goal of full provincial coverage will be realized (ibid).

Bringing It All Together

Considering that OHTs act as an umbrella network for core health and social services within a specified geographical area, and "are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographical population," northern OHTs should conduct a study on migration trends in relation to access to services (Ontario 2022). The study should quantify the number of migrants accessing health and social services to determine which communities are accommodating an influx of migrants from surrounding areas. Northern OHTs should also be responsible for conducting studies to generate unbiased population estimates within their catchment areas. It is further recommended that these studies be standardized across Northern Ontario, and that they be conducted on a reoccurring basis.

Conclusion

Based on the findings of this paper, several targeted recommendations are proposed that all levels of government, as well as other decisionmakers and community practitioners, can take to address the issues identified.

Recommendations for Culturally Safe and Supportive Housing

Municipalities and District Social Service Administration Boards

1. Identify community demand and the current stock of supportive housing services in the community and nearby. If stock already exists, identify if it is sufficient in terms of both quality and quantity.

2. If existing stock is present, identify if more is required or an upgrade is needed — or both.

3. Identify strategic partners and local champions in the community and nearby. Partners could include municipalities, targeted provincial and federal government ministries and agencies,[5] health and social service deliverers, and nearby communities experiencing similar demand. Partners must include local First Nations and local and regional Indigenous organizations.

4. Engage with Indigenous partners early on and continuously to co-create a supportive housing plan that includes a planning phase, implementation phase, and a monitoring phase.

5. Identify available funding opportunities — locally, regionally, provincially, and nationally — as well as who will be leading these efforts.

6. Ensure a transparent engagement process with the community and those with lived experience. This can include open engagement sessions, online feedback forms, and so on. Additionally, education about supportive housing can help to build community buy-in as well as tackle negative attitudes toward supportive housing.

7. Work with strategic partners, as well as individuals with lived experience, to identify community needs.

8. DSSABs should be the tenant holder on behalf of residents, connecting residents with social services such as Ontario Works and providing additional funding as necessary.

9. Partners should seek and implement "best practices" from existing supportive housing programs in their region, the province, Canada, and comparable geographies internationally, if applicable.

The Provinical Government

1. Support new and existing supportive housing initiatives (i.e., the Suswin Centre) in Northern Ontario with long-term funding from a dedicated funding envelope.

2. Work with strategic partners to understand local needs and challenges.

Recommendations for a Mental Health and Addictions Centre

Municipalities and Regional Organizations

1. Municipalities should identify community demand and the current stock of services that focus on mental health and addictions. For existing stock, identify who is accessing these services locally and from where.

2. Municipalities should identify strategic partners in the community and nearby to discuss local mental health and addictions issues. Partners could include municipalities, targeted provincial and federal government ministries and agencies,[6] health service deliverers, nearby communities experiencing similar demand, local First Nations, and local and regional Indigenous organizations.

[5] These should include the Ontario Ministry of Children, Community and Social Services, Ontario Ministry of Indigenous Affairs, Ontario Ministry of Municipal Affairs and Housing, Ontario Ministry of Northern Development (Northern Ontario Heritage Fund Corporation), FedNor, and the Canada Mortgage and Housing Corporation.
[6] These should include the Ontario Ministry of Health, Ontario Ministry of Indigenous Affairs, Ontario Ministry of Municipal Affairs and Housing, Ontario Ministry of Northern Development (Northern Ontario Heritage Fund Corporation), FedNor, and Health Canada.

3. To avoid duplication and enhance greater connections in health infrastructure, additional "spokes" of the Mental Health and Addictions Research and Training Institute, as well as the Centre of Excellence for Addiction and Mental Health, should be supported. The Northern Ontario Municipal Association, the Federation of Northern Ontario Municipalities, the Northern Ontario Service Deliverers Association, the Northern Ontario School of Medicine, and other industry champions could kickstart these discussions.

4. Support mental health and addictions research in Northern Ontario via the Research and Training Institute, in partnership with the Northern Ontario School of Medicine and other health-focused programs at post-secondary and Indigenous institutions in Northern Ontario.

The Provincial Government

1. Engage with post-secondary institutions in Northern Ontario to learn about homelessness, addiction, and mental health initiatives being undertaken and to understand local needs.

2. Partner with the Mental Health and Addictions Research and Training Institute to advance its mandate and mission.

3. The Mental Health and Addictions Centre of Excellence and Mental Health and Addictions Research and Training Institute should work closely with each other to share knowledge, resources, and expertise.

Recommendations for a Northern Service Hub

1. Ontario Health Teams should be mandated to define their catchment populations by conducting migration trend studies and Our Health Count studies on a recurring basis.

2. Based on these studies, funding should be allocated based on catchment population size.

3. The Ministry of Health should fund data-collection initiatives that focus on sociodemographic issues in relation to all health services.

4. The federal government should allocate resources to understanding discrepancies between OHC and census population estimates and explore adopting these sampling methods during the national census in partnership with Indigenous organizations.

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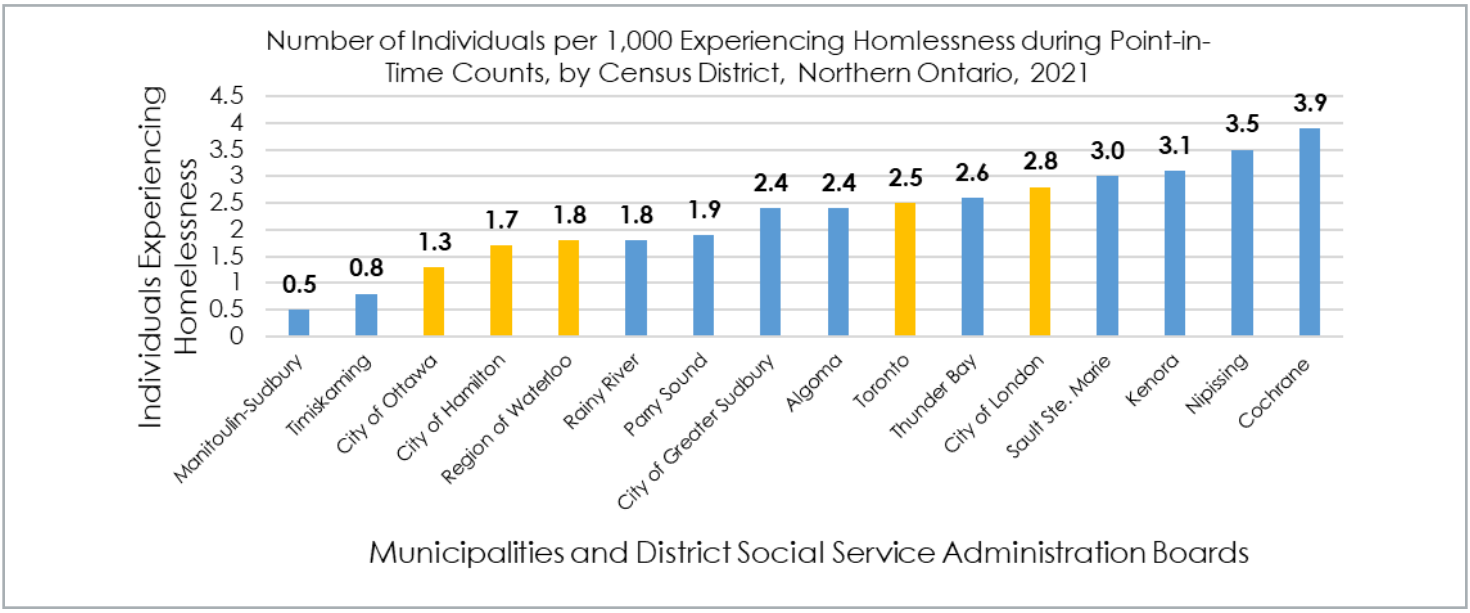
Appendix

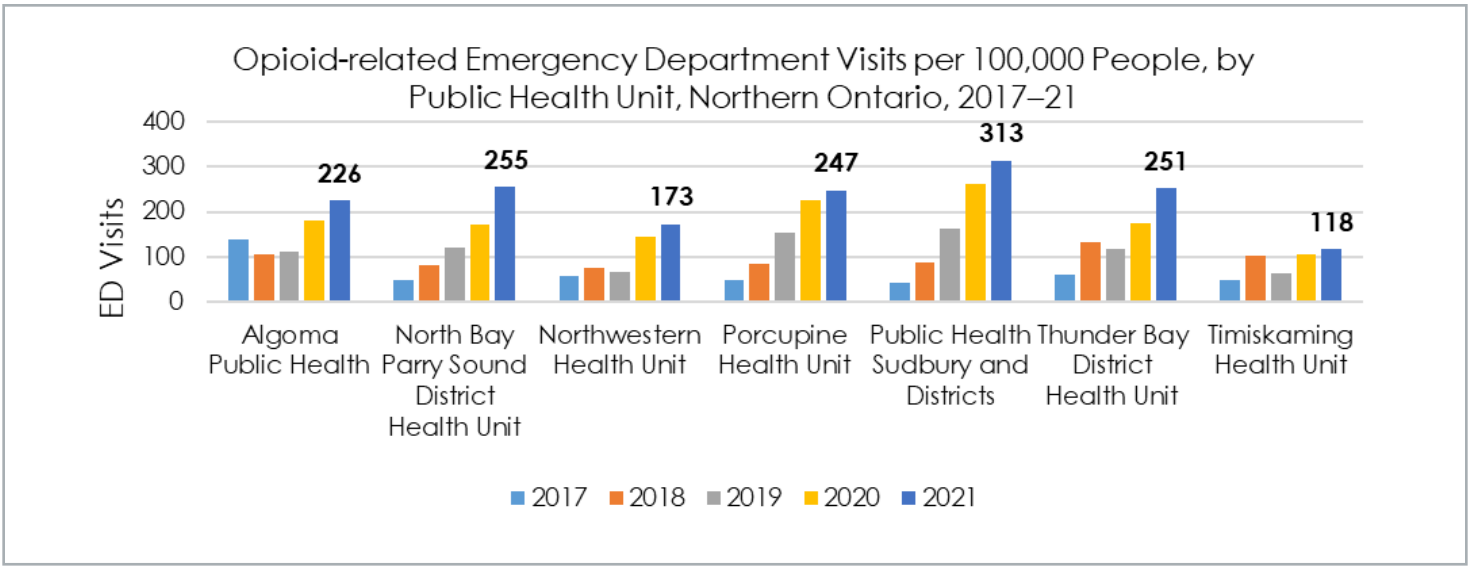
Figures A-1 through A-5 have been copied from the report, "More than Just a Number: Addressing the homelessness, addiction, and mental health crisis in Northern Ontario" (Parsons, 2022). The data in the figures establish a baseline for homelessness, addiction, and mental health issues in Northern Ontario.

Figure A-1: Homeless population per 1,000 people, 2021.



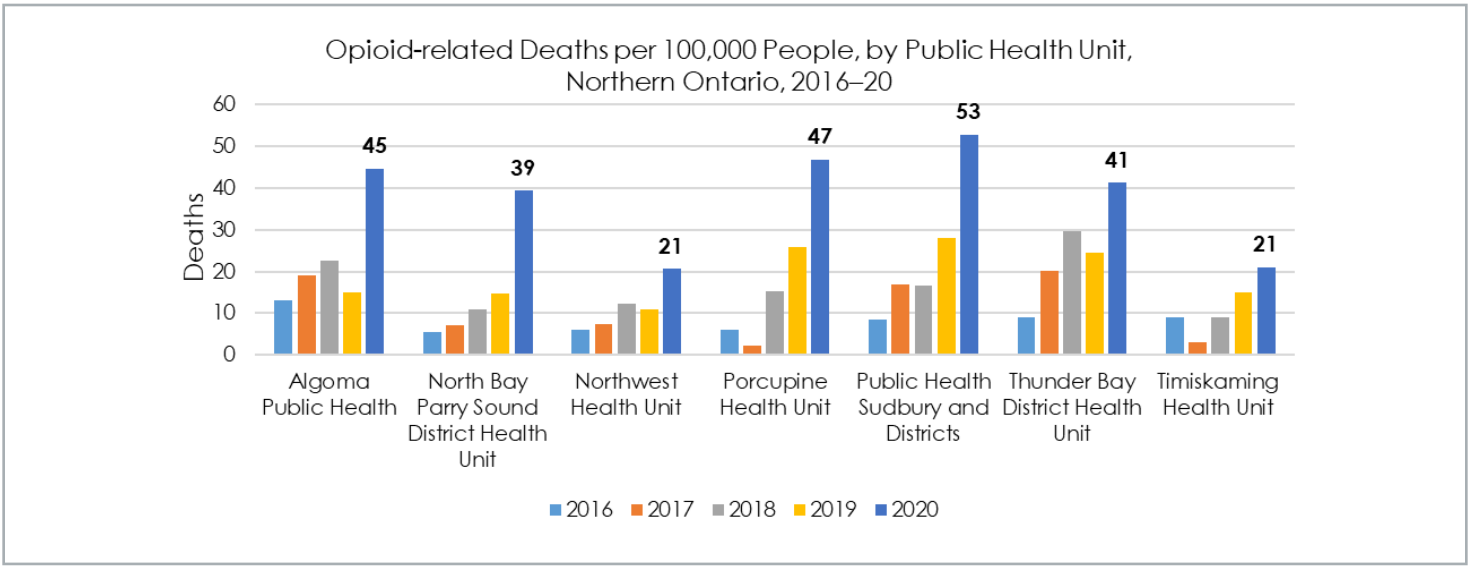
Source: Author's calculations from 2021 enumeration reports from municipalities and District Social Service Administration Boards, and Statistics Canada census district population projections. Note: Thunder Bay figure is based on 2018 data.

Figure A-2: Opioid-related ED visits, 2017-2021.



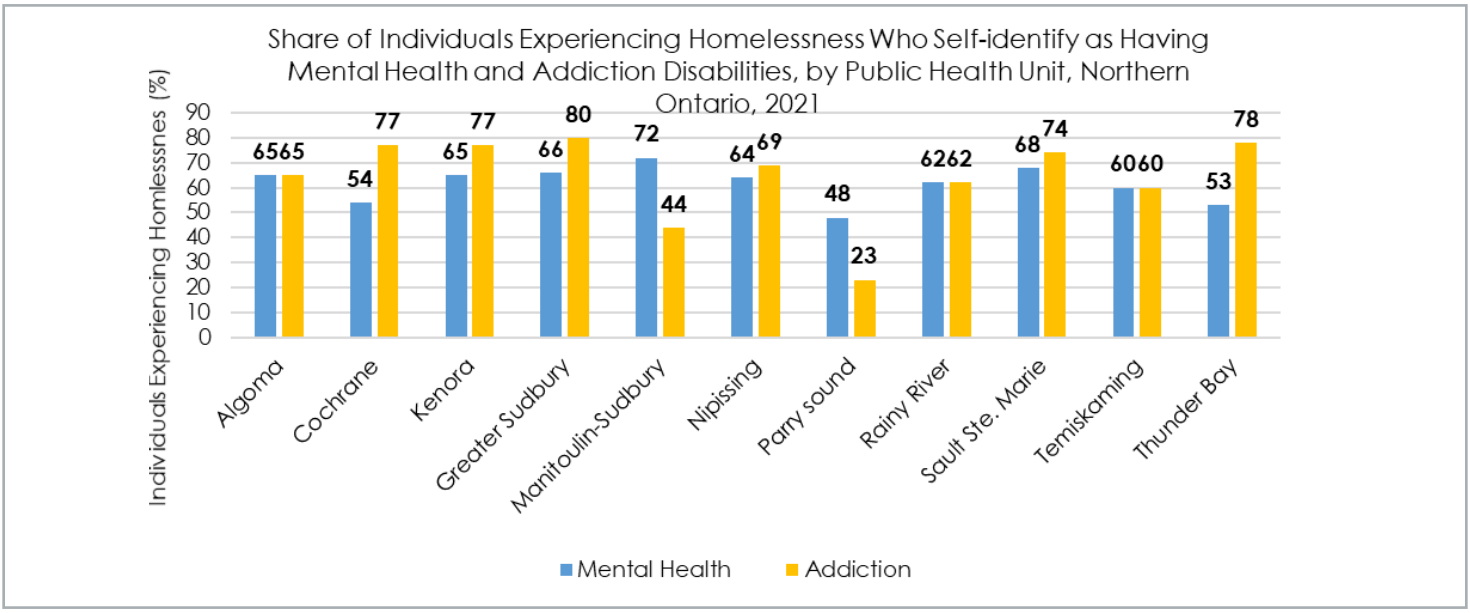
Source: Public Health Ontario Interactive Opioid Tool, 2022.

Figure A-3: Opioid-related Deaths, 2016-2020.



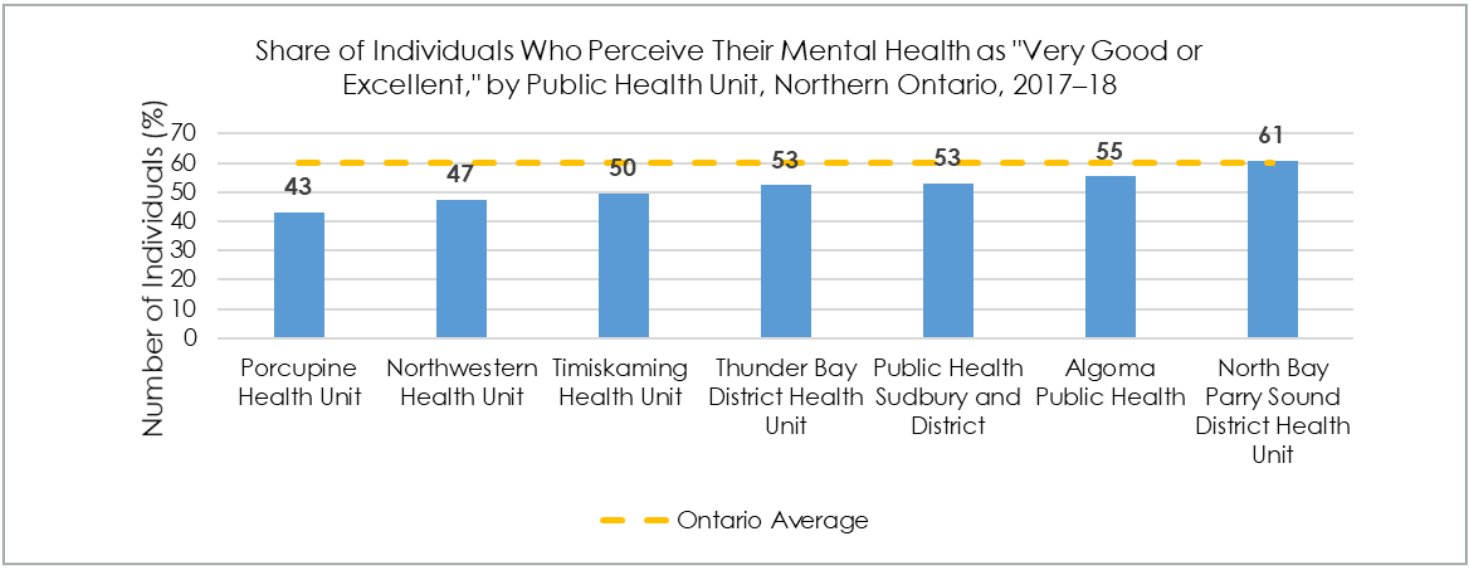
Source: Public Health Ontario Interactive Opioid Tool, 2021. Note: 2021 data not available of the time of publication of this paper.

Figure A-4: Homeless Individuals Struggling with Mental Health and Substance Disorders, 2021.



Note: Thunder Bay figure is based on 2018 data.
Sources: 2021 enumeration reports from District Social Service Administration Boards and City of Greater Sudbury.

Figure A-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.

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Northern Policy Institute is Northern Ontario's independent, evidence-driven think tank. We perform research, analyze data, and disseminate ideas. Our mission is to enhance Northern Ontario's capacity to take the lead position on socio-economic policy that impacts our communities, our province, our country, and our world.

We believe in partnership, collaboration, communication, and cooperation. Our team seeks to do inclusive research that involves broad engagement and delivers recommendations for specific, measurable action. Our success depends on our partnerships with other entities based in or passionate about Northern Ontario.

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Holly Parsons

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