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FONOM – The Federation of Northern Ontario Municipalities

NOSDA

Research Report | August 2022

More than Just a Number:

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

NORTHERN POLICY INSTITUTE | INSTITUT DES POLITIQUES DU NORD

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Institu dPolitik di Nor

Aen vawnd nor Lee lway La koonpayeen

By: Holly Parsons

northernpolicy.ca

NPI – Who We Are

Land Acknowledgement

NPI would like to acknowledge the First Peoples on whose traditional territories we live and work. NPI is grateful for the opportunity to have our offices located on these lands and thank all the generations of people who have taken care of this land.

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.
- Sudbury is on the Robinson-Huron Treaty territory and the land is the traditional territory of the Atikameksheng Anishnaabeg as well as Wahnapitae First Nation.
- 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.

This report was made possible through the support of our partner, Northern Ontario Heritage Fund Corporation. Northern Policy Institute expresses great appreciation for their generous support but emphasizes the following: The views expressed in this report are those of the author and do not necessarily reflect the opinions of the Institute, its Board of Directors or its supporters. Quotation with appropriate credit is permissible.

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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. 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

NAC is a shared cost program where NPI partners with organizations in all regions of Northern Ontario to "time-share" professional staff to complete needed projects. The program is not intended to replace consultants. Instead, it is largely focused on baseline analysis or information gathering that will allow any future investment by partners to be focused on higher value-added work by external 3rd parties.

About the Author

Holly Parsons

Originally from Calgary, Alberta, Holly moved to Australia 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. Now, back in Canada, Holly is enjoying her NPI experience in Sudbury as a Policy Analyst. On the weekends, you can find Holly hiking, camping, kayaking, and exploring the majestic Canadian Shield. Holly loves to travel, ski, read books, cook vegan recipes, and be outdoors.

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Executive Summary

Urgent action is required to address Northern Ontario's homelessness, addiction, and mental health crisis. Homeless enumeration data for 2021 show that Sault Ste. Marie and the districts of Kenora, Nipissing, and Cochrane have larger homeless populations than some of Ontario's largest municipalities per 1,000 people. In fact, the homeless populations of Thunder Bay and the District of Cochrane are more than double that of the municipalities of Ottawa, Hamilton, and Waterloo. More astonishing is the growing number of people struggling with opioid addiction in Northern Ontario. Based on extreme spikes in both opioid-related emergency department (ED) visits and deaths reported by most northern public health units over the last five years, it is clear the opioid crisis is becoming increasingly more tragic and deadly for northern communities. The growing number of people struggling with homelessness and addiction in Northern Ontario strongly indicates that there is also a mental health crisis among vulnerable populations. This paper also finds that the mental health crisis is not merely restricted to vulnerable populations in the North. Northern Ontarians in general are experiencing poorer mental health than other Ontarians.

As the homelessness, addiction, and mental health crisis worsens in Northern Ontario, current services and programs are evidently not meeting the needs of northern communities. As the ones 'on the ground' interacting with community members, municipal governments face tremendous pressure from their tax bases to solve homelessness, addiction, and mental health issues in the community, but they are restricted by tight budgets. In the meantime, significant and longstanding barriers, such as the shortage of medical professionals and resources, inadequate funding for housing and health services, lack of action taken by decision-makers, and poor coordination between organizations, are exacerbating the homelessness, addiction, and mental health crisis in the North. These barriers have contributed to breaks in the housing continuum and continuums of care for addiction and mental health that are also exacerbating the crisis. Housing and health service barriers and gaps need to be addressed urgently to reduce the number of Northerners struggling with homelessness, addiction, and mental health issues.

Thus, this paper identifies eight evidence-driven and economically viable strategies decision makers and community practitioners can take to address these barriers and service gaps, both directly and indirectly. They 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 make it available in communities;

3. Establish a joint action taskforce to collect data and intelligence on the underlying and systematic retention issues of health care professionals in Northern Ontario;

4. Support new and existing Housing First programs;

5. Support new and existing culturally sensitive community housing facilities for Indigenous peoples;

6. Establish a Northern Mental Health and Addictions Centre 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; and

8. Establish mandated mobile crisis intervention teams (MCIT) in municipalities throughout Northern Ontario.

Importantly, however, due to the complexity of homelessness, addiction, and mental health issues and uniqueness of each community in Northern Ontario, these strategies should be considered only as a starting point for decision-makers and community practitioners towards solving the homelessness, addiction, and mental health crisis in the North.

Note: While the data in this paper focuses on opioid addiction, the author recognizes that opioids are not the only form of addiction. As such, the literature referenced in this paper refers to addiction more generally.

Introduction

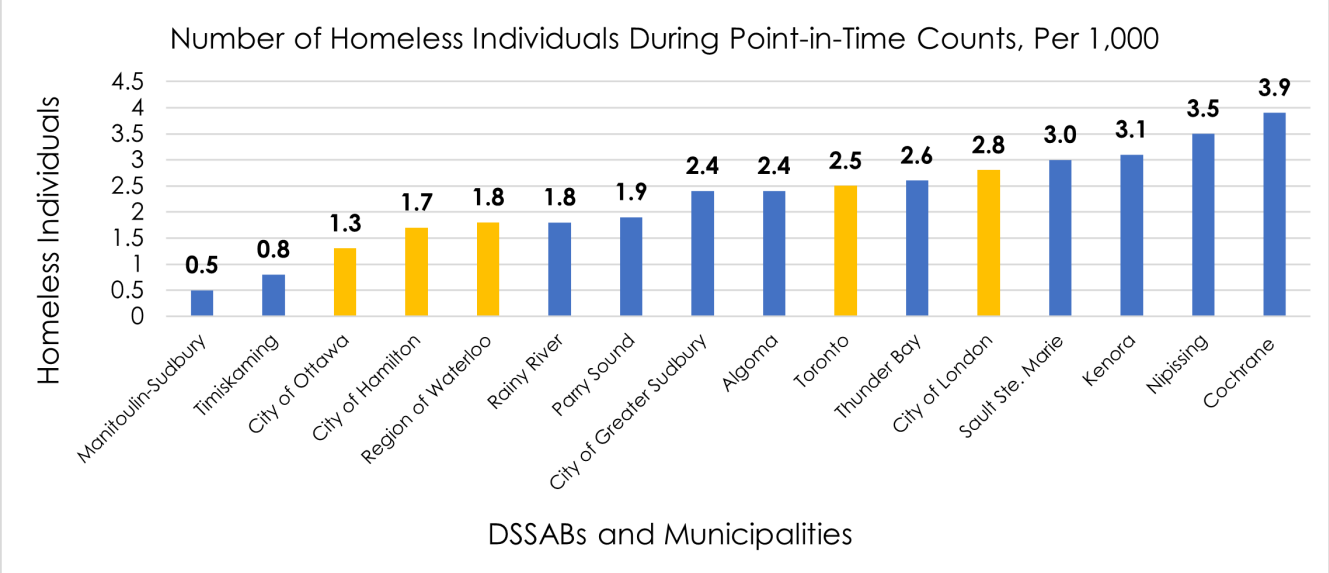
Northern Ontario communities are experiencing a homelessness, addiction and mental health crisis. While these issues are not new in the North, significant gaps and barriers in housing and health services have exacerbated the crisis. The growing number of Northerners suffering from homelessness, addiction, and mental health issues has ignited robust discussions at the provincial and municipal levels about strategies to address service gaps. In 2019, the Association of Municipalities of Ontario (AMO) published three detailed provincial reports on homelessness, addiction, and mental health that outlined recommendations for all levels of government. In March 2020, Ontario's provincial government published the *Roadmap to Wellness*, a new strategy for the mental health and addiction service system (Government of Ontario 2021c). Ontario's Big City Mayors (OBCM) added to the discussion in June 2021 by 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, the Northwestern Ontario Municipal Association (NOMA), the Federation of Northern Ontario Municipalities (FONOM), and the Northern Ontario Service Deliverers 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 provincial and municipal actors is indicative of the seriousness of the homelessness, addiction, and mental health crisis in the North.

This paper seeks to further the coordinated efforts of community actors by offering timely data that support highly effective strategies that decision-makers and others can take to address the homelessness, addiction, and mental health crisis. This paper begins with an overview of the crisis, followed by a brief explanation of the role and responsibilities of provincial and municipal governments. Next, the methodology section will provide context for the recommended strategies featured in the fourth section of this paper.

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

Section 19.1 of the Housing Services Act, 2011 requires service managers—or district social services administration boards (DDSABs) in the North—to conduct detailed enumerations of their homeless populations every two years, a requirement that began in 2018. Homeless enumerations offer important insights 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 some of the largest municipalities in Ontario per 1,000 people[2]. The District of Cochrane, which has the largest homeless population in Northern Ontario, has more than double the homeless population per 1,000 people in the municipalities of Ottawa, Hamilton, and Waterloo.

Figure 1. Homeless Population Per 1,000 People, 2021[3]



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

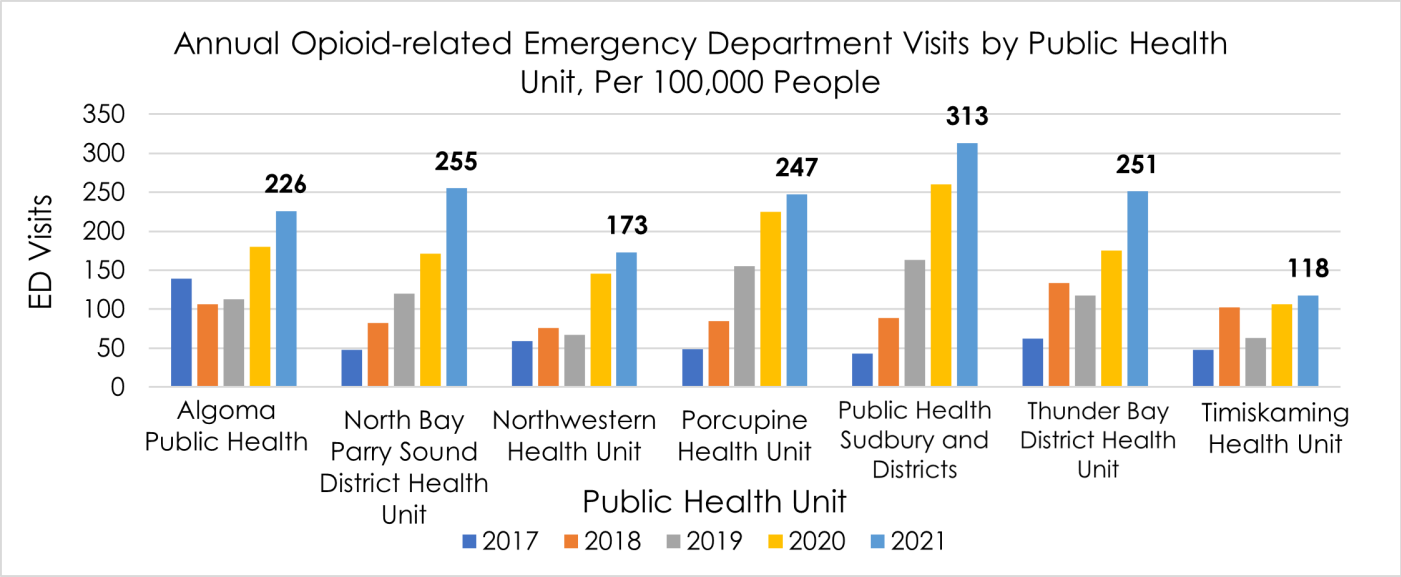
[1] Raw homeless enumeration data were provided by DSSABs and the City of Greater Sudbury. These data did not specify the communities in which homeless enumerations were conducted. Thus, it is assumed that homeless enumeration data represent entire DSSAB service areas. Where DSSAB service boundaries 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 Sault Ste. Marie. The service area of Sudbury-Manitoulin DSSAB will be referred to as Sudbury-Manitoulin. The service area of Algoma DSSAB will be referred to as 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 that district. As Greater Sudbury is a single-tier municipality with a Consolidated Municipal Service Manager, it is referred to as the City of Greater Sudbury.
[2] Southern Ontario municipalities were chosen based on population size and available 2021 homeless enumeration data.
[3] Southern Ontario cities and regions included in Figure 1 were chosen based on available data from 2021 enumeration reports at the time of this paper's publication. The 2021 homeless enumeration data were unavailable for the District of Thunder Bay; Figures 1, 4, and 8 reflect 2018 homeless enumeration data for the District of Thunder Bay.

Moreover, the Sault Ste. Marie and Thunder Bay DSSABs—the only two DSSABs that completed a point-in-time (PiT) count in a previous year[4]—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. Between 2018 and 2021, it reported a 58 per cent increase. 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 opioid addiction in Northern Ontario. As seen in Figure 2, every northern health unit experienced the highest number of opioid-related emergency department (ED) visits within the last five years in 2021. Between 2017 and 2021, opioid-related ED visits increased by an astonishing 628 per cent in Public Health Sudbury and District; 404 per cent in Porcupine Health Unit; 369 per cent in North Bay Parry Sound Health Unit; and 305 per cent in Thunder Bay District Health Unit (Public Health Ontario 2021)[5]. Opioid-related ED visits in Northwestern Health Unit and Algoma Health Unit more than double between 2017 and 2021, while Timiskaming Health Unit experienced the smallest increase in opioid-related ED visits at 69 per cent.

Note: While the data in figures 2 and 3 below are focused on opioid addiction, the author recognizes that opioids are not the only form of addiction. As such, the literature referenced in this paper refers to addiction more generally.

Figure 2. Opioid-related ED Visits, 2017-2021



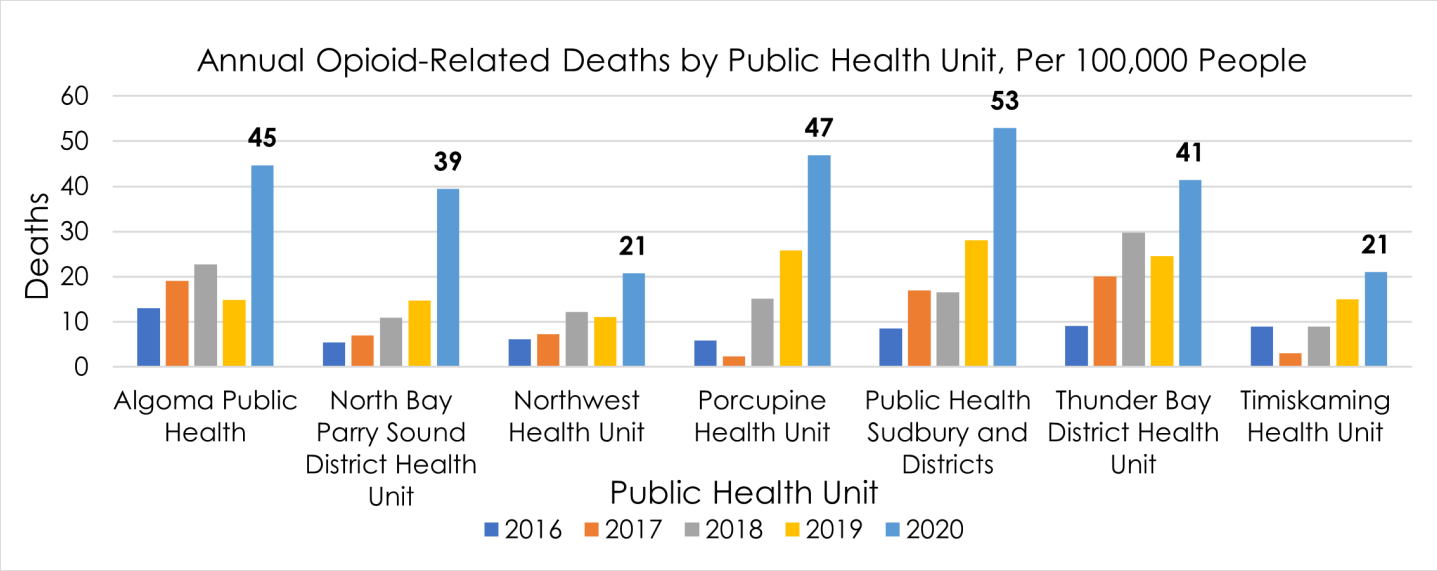
Source: Public Health Ontario Interactive Opioid Tool, 2022.

Equally notable, Figure 3 shows opioid-related deaths increased significantly in every northern public health unit between 2016 and 2020, with extreme spikes in opioid-related deaths between 2019 and 2020 in most northern public health units. Between 2019 and 2020, opioid-related deaths increased by 200 per cent in Algoma Public Health; 168 per cent in North Bay Parry Sound District Health Unit; 89 per cent in Public Health Sudbury and District; and 88 per cent in Northwestern Health Unit in a single year.

[4] 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 are inconsistent with data collected by PiT counts in 2021.

[5] NB: public health units have custom service area boundaries that do not align geographically with DSSAB boundaries

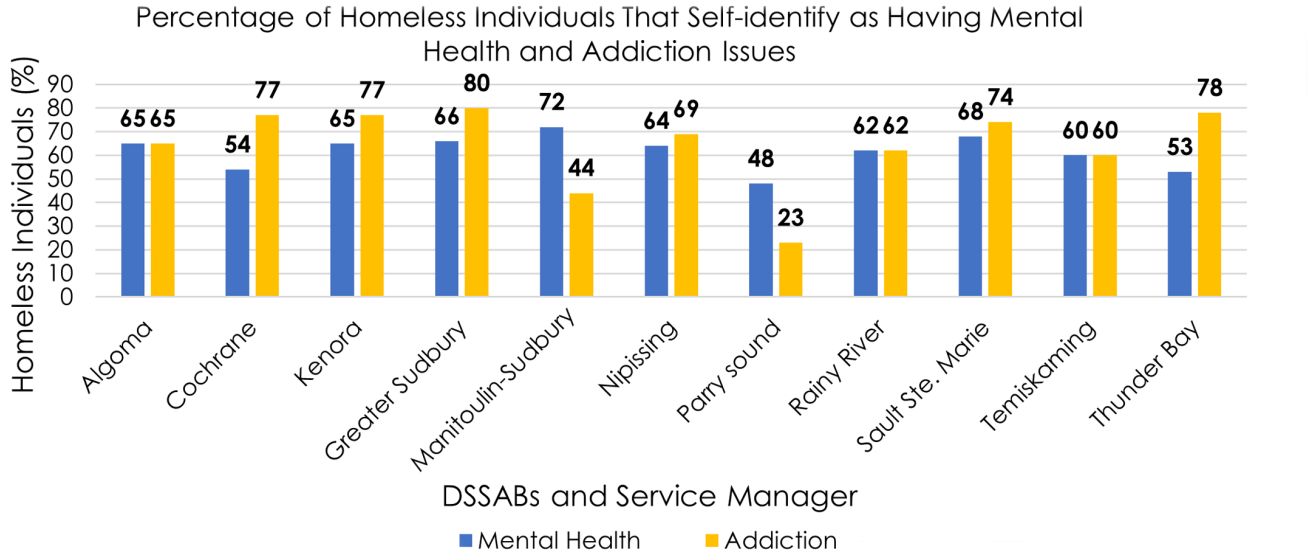
Figure 3. Opioid-related Deaths, 2016-2020



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

Although mental health issues do not always lead to homelessness or addiction more generally, 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 socioeconomic issue. Moreover, homeless populations are disproportionately 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.

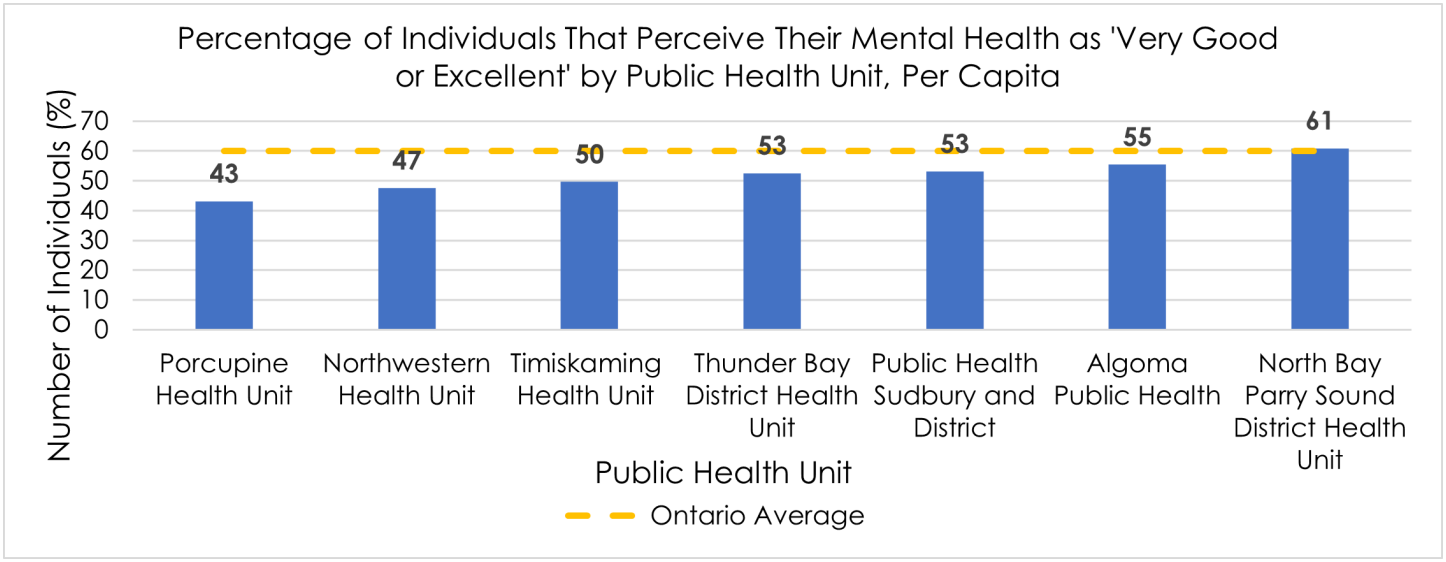
Figure 4. Homeless Individuals Struggling with Mental Health and Addiction Issues, 2021



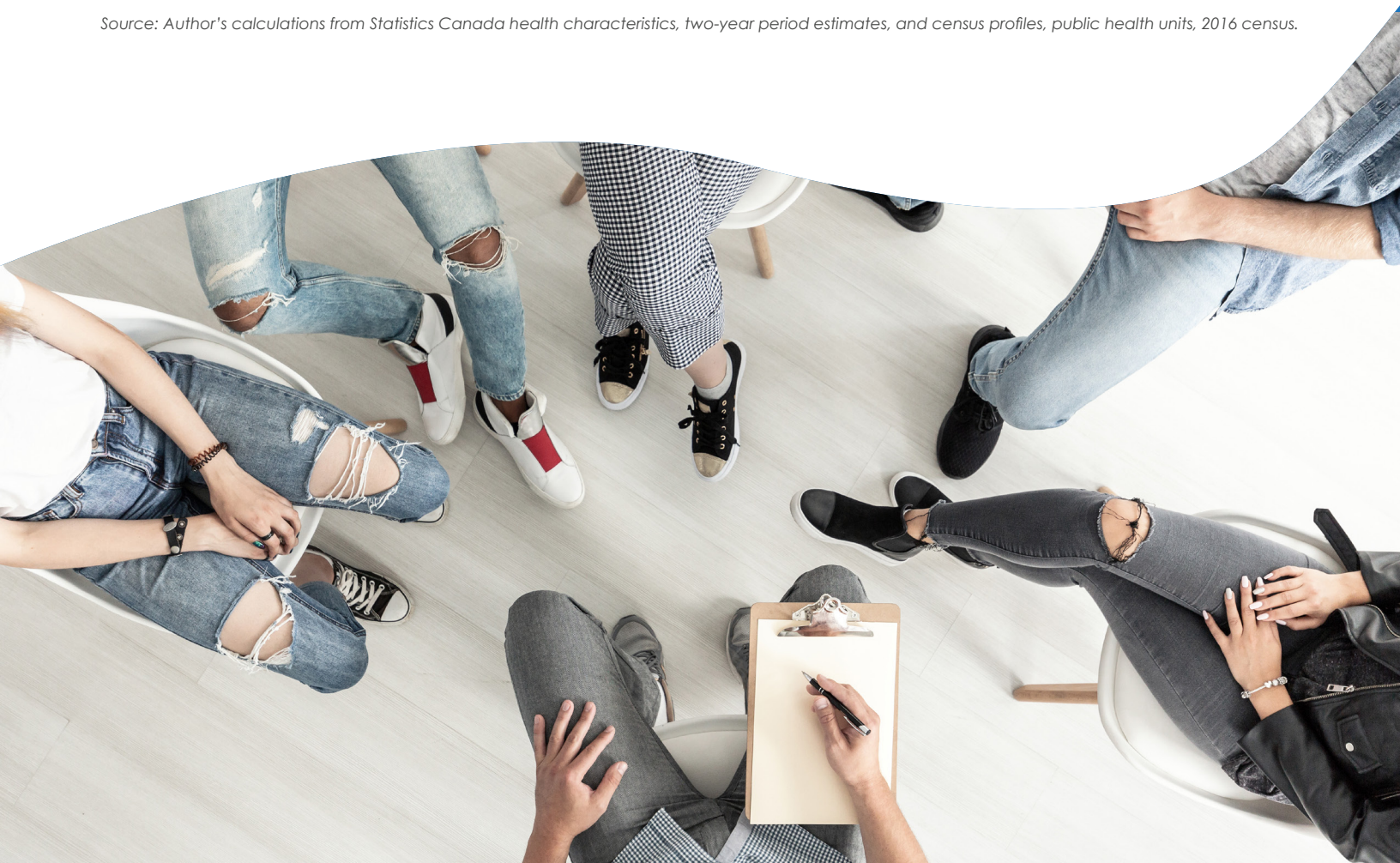
Source: 2021 enumeration reports from DSSABs and City of Greater Sudbury.
Note: Thunder Bay is based on 2018 data.

It must be noted that mental health issues are not merely restricted to homeless individuals; they can 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), and Figure 5 shows that, excluding North Bay Parry Sound District Health Unit, the number of Northern Ontarians who perceived their mental health as 'very good or excellent' is below the provincial average. These data suggest there is a need for mental health services and programs among many community members in the North.

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* and federal and provincial legislation and jurisprudence define the roles 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).

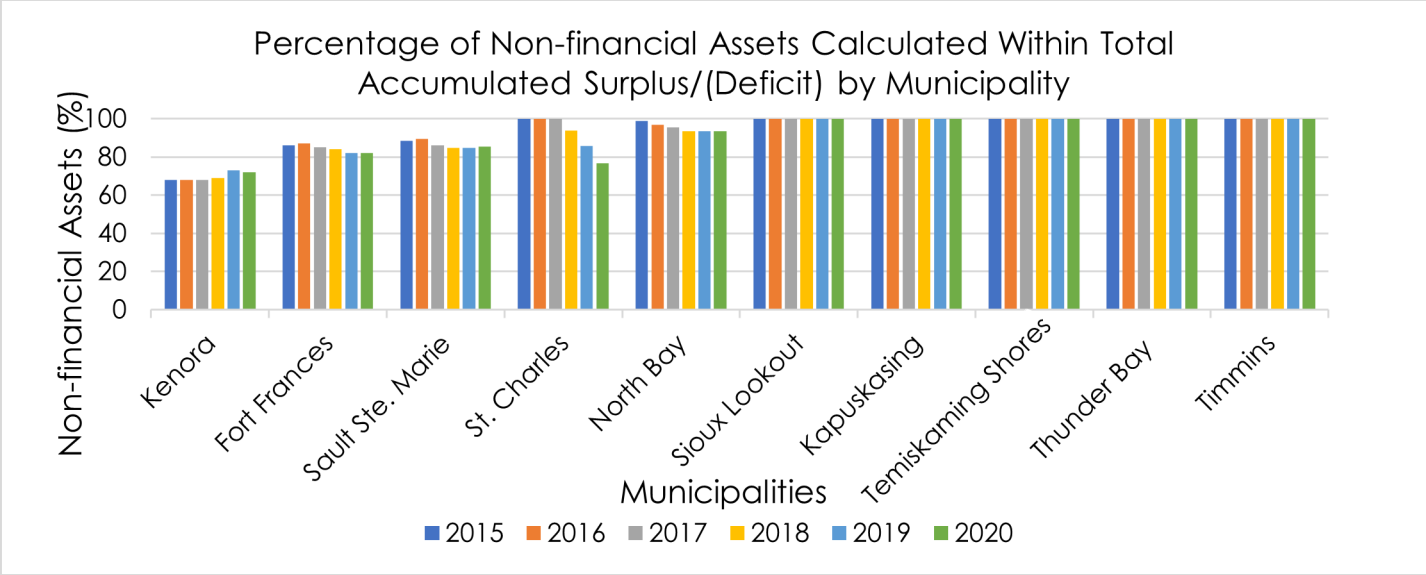
Municipal governments in Ontario play a unique role in community housing—housing that is owned, operated, and subsidized by non-profit organizations, municipal governments, or DSSABs for low-income individuals or families (Government of Ontario 2021a)—compared to the rest of the country. Municipal governments have acted as local planning authorities, administrators of local community housing systems, and funders of housing benefits and rent since the province downloaded responsibility for community housing in 2001 and 2002 (Government of Ontario 2021d). In Northern Ontario, DSSABs—and the 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 10-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, municipal governments serve as employers for health services and as 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, and by advocating for policy change within the health – and housing – sectors (AMO 2019b, 15).

Despite well-defined roles for governments in Canada, municipal governments, as the ones 'on the ground,' can face extraordinary pressure from their tax bases to solve homelessness, addiction, and mental health issues in the 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 no—funds 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 additional dollars on homelessness, addiction, and mental health.

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



Source: Author's calculations of net financial assets, end-of-fiscal-year total non-financial assets, and total accumulated surplus/(deficit) from municipal financial information returns.

While data shown in Figure 6 was chosen by the author as the most suitable indicator for municipal budget constraints, it does not encapsulate the entire fiscal reality of northern municipalities perfectly. For example, data in Figure 6 suggests that the City of Kenora is experiencing a cash surplus, and therefore, has available funds that could be allocated towards additional homelessness, addiction and mental health services; but this is not the case. Instead, the cash surplus reflects a $40.79 million investment, named the Citizen's Prosperity Trust Fund, made by the City from the sale of Kenora Municipal Telephone Services in 2008 (email message to author, 2022). The City of Kenora chose to invest the proceeds from the sale to maintain a similar revenue stream to that of the operating revenue generated annually from the municipal telephone service (email message to author, 2022). If the Prosperity Trust Fund were to be spent gradually by the City, the depletion of the initial amount would mean less investment income generated, and a very likely increase in property tax for already burdened residents to offset the loss of revenue (email message to author, 2022). For this reason, the Prosperity Trust Fund was not established to be spent, and thus, the City of Kenora is as cash-strapped as other northern municipalities represented in Figure 6 (email message to author, 2022).

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] Financial Information Return, 2015-2020. Municipalities represented in Figure 6 were chosen as a representative sample size to describe the general fiscal capacity of municipalities in Northern Ontario

Methodology

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. To inform this paper, an engagement process was conducted by Northern Policy Institute with actors from across Northwestern and Northeastern Ontario during NOMA and FONOM's annual conferences, held in the spring of 2022 in Fort Frances and North Bay, respectively. The two-day engagement process involved roundtable discussions with mayors, municipal councilors, DSSABs, private organizations, and federal and provincial ministries. During roundtable discussions, participants were asked to identify opportunities that can be leveraged to solve the crisis, service gaps and barriers that are exacerbating the crisis in their communities, and specific community initiatives that have been successful in reducing the crisis. Overall, the following barriers were identified: shortage of medical professionals and resources, inadequate funding for housing and health services, lack of action taken by decision-makers, and poor coordination between organizations in the North (in-person author engagement, 2022). These barriers have contributed to service gaps in the housing continuum and continuums of care for addiction and mental health, such as short-term residential facilities for people in crisis, long-term recovery and wellness programs, and lack of affordable housing (in-person author engagement, 2022).

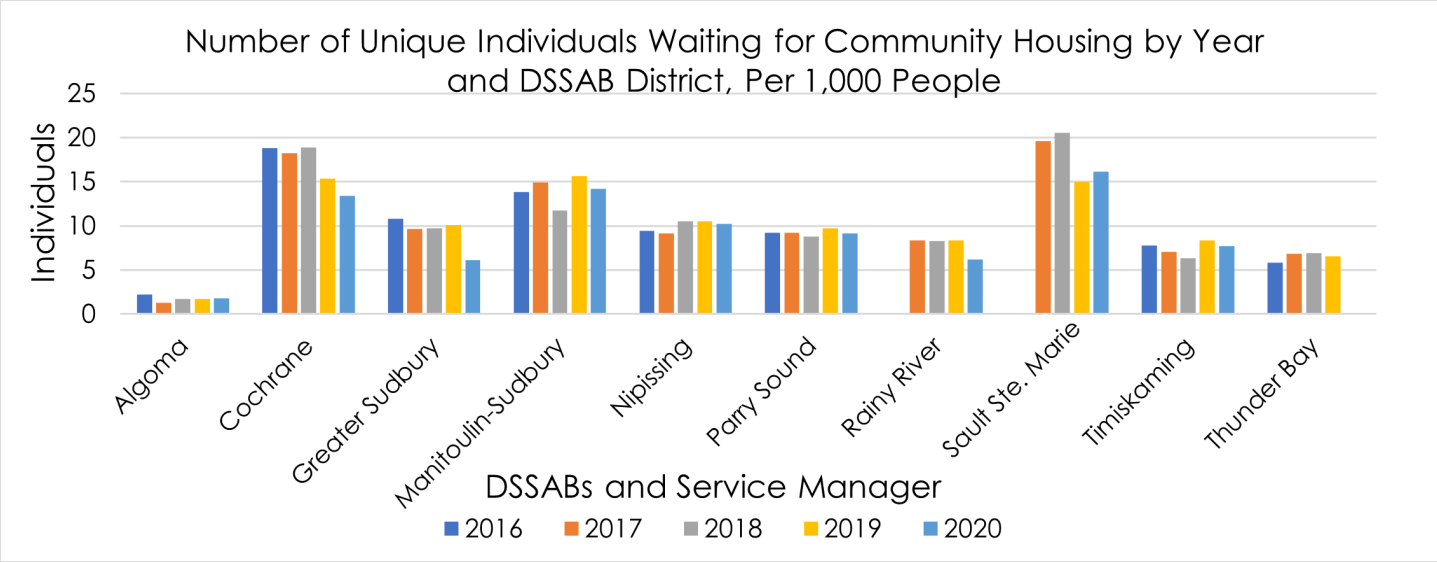
The following section provides eight evidence-driven strategies that decision-makers ought to adopt to address these barriers, both directly and indirectly. These strategies are based around opportunities that can be leveraged and community initiatives that have been successful in reducing the crisis, as identified by municipalities. This section is further informed by an encompassing literature review of government policies, programs, and services around community housing and public health from within Ontario, Canada, and abroad.

Service Gaps and Policy Strategies

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 to stock that is overdue for routine maintenance and repairs (AMO 2019c, 23). As DSSABs struggle financially to keep up with the growing backlog of capital repairs, much-needed community housing units are left vacant despite growing demand (AMO 2019c, 24).

The most time-effective and financially responsible way to address the shortage of community housing in Northern Ontario is to maintain and repair the existing stock (AMO 2019c, 23). However, when the province downloaded community housing to municipalities, the transfer was completed without a corresponding transfer of adequate reserve funds for current and projected future capital repairs (AMO 2019c, 24). Although DSSABs do not have the fiscal capacity to properly address the backlog of capital repairs for community-housing, federal and provincial governments could. Importantly, northern municipalities define 'adequate funding' as continuous and long-term funding – as opposed to one-time payments or expensive loans – with minimal 'red-tape'. To that extent, funding for capital repairs should be released annually over a 10-year span so DSSABs can incorporate a capital repair strategy in their 10-year housing and homelessness plans and provide an update on progress in their 5-year review reports (AMO 2019c, 24).

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

2. Migration to service hubs

Service hubs in Northern Ontario face unique challenges in terms of their homeless populations: 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 communities. 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" (KDSB 2014, 8) in service hub communities that are already under resourced to meet growing demands from within their own community (in-person author engagement, 2022). The districts of Kenora and Cochrane are particularly impacted by this migration trend. 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 the homeless population within their service boundaries were migrants from surrounding areas (TBDSSAB 2018, 5).

To ensure service hubs in Northern Ontario have adequate resources for their service areas, 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.

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, serves the towns of Sioux Lookout, Pickle Lake, and Savant Lake as well as 28 First Nations (Sioux Lookout Meno Ya Win Health Centre 2021a). Collectively, the health centre provides health services for a population of 30,000 dispersed over 385,000 square kilometres (Sioux Lookout Meno Ya Win Health Centre 2021b). The health centre and Sioux Lookout's Out of the Cold Emergency Shelter, which both services roughly the same area and communities, are significantly under-resourced for the population 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—which amounts to 13 per cent of Sioux Lookout's 2021 population (14.5 per cent in 2016)—for a total of 5,888 annual stays (Municipality of Sioux Lookout 2021, 20). If this ratio was true for the City of Toronto with a population of 2,794,356 (Statistics Canada, 2021), it would mean 363,266 (or 396,077 in 2016) unique individuals stayed at an emergency shelter in one year, compared to the actual number: 3,876 (City of Toronto 2018, 7). Of course, it is not accurate to say 13 per cent of Sioux Lookout's population stayed at the emergency shelter; it was a mix of migrants from within the District of Kenora and residents of the town.

3. 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). Then, once housed, additional support services are provided based on self-determination of the client and an individual assessment of needs conducted by case managers (Government of Canada 2022). Support services include clinical supports such as referral to existing health services to more intensive support delivered by multi-professional specialists, as well as complementary supports such as employment and education supports where appropriate (Government of Canada 2022). The Housing First model prioritizes coordination between housing, clinical, and complementary services to provide comprehensive wraparound services, while also prioritizing an individualized approach to care (Government of Canada 2022); two service gaps municipalities identified as exacerbating the homelessness, addiction and mental health crisis in the North (in-person author engagement, 2022).

Since gaining popularity in the 1990s, Housing First is now described as a 'best practice' for ending homelessness in Canada, in 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 subpopulations, such as individuals struggling with substance abuse in Vancouver and the urban Indigenous population in Winnipeg. The study found that 80 per cent of the 1,000 randomized participants remained housed after one year (Homelessness Hub 2021). Moreover, a 2013 study of eight Housing First programs (Vancouver, Hamilton, Lethbridge, Victoria, Fredericton, Edmonton, and two in Calgary) by the Canadian Homelessness Research Network, the Homeless Hub, and the Government of Canada reported similar findings. In Vancouver, the study found that no program participants were discharged to the streets within a four-year period (Gaetz, Scott, and Gulliver 2013, 67). In Hamilton, 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). In Lethbridge, the study revealed that 90 per cent of participants remained housed within a 12-month period (Gaetz, Scott, and Gulliver 2013, 95). In Victoria, 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 six months, while 86 per cent of participants remained housed within a three-year period (Gaetz, Scott, and Gulliver 2013, 132). In Calgary, 92 per cent of participants in one program remained housed within a five-year period; in the other program, 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 the Canada Mortgage and Housing Corporation (CMHC) to support Housing First programs. The federal government committed $1 billion in 2020 for 3,000 affordable housing units; in the 2021-22 budget, it made a second commitment: $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. RHI funding could support existing Housing First programs in the North, such as Housing Now, a program established in 2020 by Cochrane DSSAB in partnership with the Canadian Mental Health Association.

4. Medical professionals

According to *Rural and Northern Community Issues in Mental Health,* a CMHA report, Northern Ontarians are disadvantaged by "limited availability and access to primary health care, specialists, hospitals and community services and supports" (CMHA 2009, 3). In 2010, the report's publication date, CMHA identified 34 northern communities that the Ministry of Health and Long-Term Care (MOHLTC) considered 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). During the engagement process, municipal governments asserted that the scarcity of general physicians in Northern Ontario acts as a major barrier in establishment of necessary addiction and mental health services, such as medical detox centers and treatment facilities, which is exacerbating the addiction and mental health crisis in the North (in-person author engagement, 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).

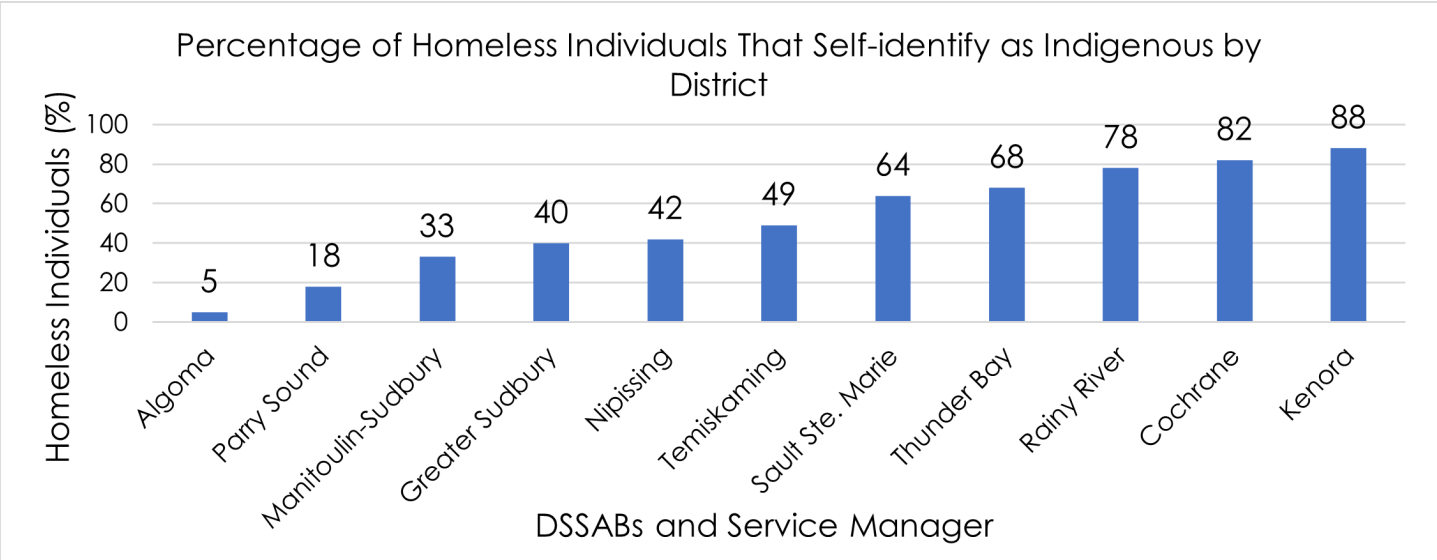
The European Union (EU) faces many similar challenges to Northern Ontario and Canada when it comes to the shortage of health care workers. All member states expressed serious concerns about the sustainability and robustness of their health sectors due to demographic shifts, increased demand for services, 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 Joint Action Health Workforce Planning and Forecasting (JAHWF). This three-year project has a mandate to collect intelligence and data from 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 – one in Italy and one in Portugal – and a feasibility study in Germany (Health Workforce EU 2021). The Canadian Federation of Nurses Unions has 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). An action taskforce also aligns with the aspirations of northern municipalities to "find root causes" of the addiction and mental health crisis, while new pilot projects established by an action taskforce would demonstrate steps being taken by decision-makers to reduce the homelessness, addiction, and mental health crisis in their communities (in-person author engagement, 2022).

Additionally, there is opportunity for government and others to support the work of the Northern Ontario School of Medicine and its physician recruitment efforts. 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 family physicians and rural generalists (NOSM n.d.). As such, the action taskforce could also aid data collection efforts as continuous data collection and measurement of job demand and supply in this sector is a must.

5. Culturally sensitive community housing

A significant proportion of the homeless population in Northern Ontario self-identify as Indigenous. Figure 8 shows Indigenous peoples 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 peoples accounting for an overwhelming proportion of the homeless population in the North, there are limited culturally sensitive services and programs to address their specific needs, another service gap identied during the engagement process (in-person author engagement, 2022).

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



Source: 2021 enumeration reports from DSSABs and City of Greater Sudbury.
Note: Thunder Bay is based on 2018 data.

To tackle this problem, Kenora District Services Board (KDSB), Ontario Aboriginal Housing Services, North West Local Health Integration Network, Sioux Lookout Meno Ya Win Health Centre, and Nishnawbe-Gamik Friendship Centre co-led 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 peoples (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 discussions have recently begun between the District of Sault Ste. Marie Social Services Administration Board and Ontario Aboriginal Housing Service 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 peoples and communities to co-develop 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 aspiration of municipal governments in the North to increase the number of supportive housing units and wraparound services, as mentioned above (in-person author engagement, 2021).

6. A Northern Centre for Addiction and Mental Health

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 Addictions 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, and these must be considered by the provincial government before the establishment of a new standardized and centralized system of care for Ontario. Although the *Roadmap to Wellness* addresses many of the 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 for Addiction and Mental Health. 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 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 to consult with Northern decision-makers and reassess the benefits of establishing a Northern Centre – whether it be bricks and mortar, a virtual system or another set up. A Centre could help to tackle the barrier of poor coordination between northern organizations, and as an alternative to one-size-fits all policies that exacerbate current challenges (in-person author engagement, 2021).

7. Interfacility transportation

The opioid crisis, as well as the Covid-19 pandemic, is causing "frontline burnout" amongst paramedics across Northern Ontario (in-person author engagement, 2022). In the third quarter of 2021, Superior North Emergency Medical Services 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; by October 2021, 259 calls had been recorded (Porcupine Health Unit 2021). Adding 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). Interfacility transfers are a costly expense for municipal governments, and are avoided in other areas of the province through contracts with private and non-profit operators that are funded by the province (AMO 2019a, 6)

To alleviate the workload of paramedics, reduce frontline burnout, and demonstrate coordination in Northern Ontario to solve long-standing issues. AMO recommended in their report *A Compendium of Municipal Health Activities and Recommendations* that the provincial government provide and fund a third-party operator for interfacility patient transfers in Northern Ontario. AMO also recommended that municipal paramedic services should only be used in situations where there is no alternative and, when this occurs, the cost should be reimbursed from the provincial government to municipalities from Local Health Integration Networks (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 officers are typically required to remain in Emergency Departments (ED)s 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 of South Simcoe's Crisis Outreach and Support Team (COAST) conducted 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 for patrol officers responding to mental health calls resulted in savings of $47.43 per call and SSPS also saved on calls where COAST responded compared to patrol officers (Semple et al. 2021, 14). A similar study conducted in Thunder Bay of the Joint Mobile Crisis Response Team Pilot Project (JMCRT) by Thunder Bay Police Service, Thunder Bay Regional Health Sciences Centre, and CMHA also found reductions in the number of apprehensions and the time officers spent in EDs. Since 2018, JMCRT has been successful in diverting 661 people from EDs 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 was announced, with one set to open in Northern Ontario on Manitoulin Island. In June 2021, OBCM called on the federal government to address the mental health crisis through the establishment of a consistent provincewide MCIT program based on its "tried and true" success (OBCM 2021). Federal, provincial, municipal governments and the OPP could work collaboratively to introduce MCIT in communities across Northern Ontario.

Conclusion

Current efforts are not enough to address the worsening homelessness, addiction, and mental health crisis in Northern Ontario. The strategies identified in this paper have been proven successful, with evidence-based data, in reducing homeless populations and addressing those struggling with addiction and mental health issues. Furthermore, these strategies have been recommended based on their potential for long-term economic viability, the successful implementation in other jurisdictions, and their alignment with some policy priorities already made by the federal and provincial governments..

Importantly, however, it must be noted that homelessness, addiction and mental health issues in Northern Ontario are extremely complex and difficult to solve; in part, because they are largely interconnected, requiring coordinated policy initiatives that prioritize and address all three issues simultaneously, and secondly, because there are huge service gaps and barriers to overcome in the North that have been years – even decades – in the making. Now, service gaps and barriers require massive amounts of resources, and dedicated and coordinated action from various actors to resolve. Due to the complexity of these issues, and the uniqueness of each community in Northern Ontario, the strategies recommended in this paper should be considered only as a starting point for decision-makers and community practitioners towards solving the homelessness, addiction, and mental health crisis in the North.

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 Services 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)

Northwestern Ontario Municipal Association (NOMA)

Northern Ontario School of Medicine (NOSM)

Northern Ontario Service Deliverers 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 Services Administration Board (TBDSSAB)

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About Northern Policy Institute

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.

Our permanent offices are in Thunder Bay, Sudbury, and Kirkland Lake. During the summer months we have satellite offices in other regions of Northern Ontario staffed by teams of Experience North placements. These placements are university and college students working in your community on issues important to you and your neighbours.

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