



Reach Alliance

Improving Mental Healthcare in Northern Ontario through Ornge's Specialized Mental Health Team and Ambulatory Transport Services

Tereza Blahova, Mohammed Shihan, Irene Wu, Catherine Zhang, Joseph Wong



UNIVERSITY OF
TORONTO



Center for
Inclusive Growth

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Note: Authors are listed alphabetically with the faculty mentor listed last.

Cover photo: Ornge base in Thunder Bay, Ontario



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Contribution	Contributor (Initials)
Conception or design of the work	JW, TB, MS, IW, CZ
Data collection	JW, TB, MS, IW, CZ
Data transcription	TB, MS, IW, CZ
Data analysis and interpretation	TB, MS, IW, CZ
Drafting of case study report	TB, MS, IW, CZ
Critical revision of the case study report	JW, TB, MS, IW, CZ
Final approval of the version to be submitted	JW, TB, MS, IW, CZ

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Figure 1. Pickle Lake Health Clinic

Executive Summary

Northern communities in Ontario experience a higher rate of mental health challenges than the rest of the province, and yet remote Northern communities are vastly under-resourced when it comes to psychiatric facilities. Indigenous communities in particular are disproportionately afflicted when it comes to mental health and access to mental healthcare. Endemic poverty, the lack of healthcare resources, culturally inappropriate mental health practices, and the legacies of historic racism and marginalization have made the mental health crisis in remote, Northern Indigenous communities especially acute.

In Northwestern Ontario, the focus of this report, one of the main challenges when it comes to mental healthcare access is transporting patients in crisis to one of the two hospitals servicing the region equipped with inpatient psychiatric facilities. Ornge is Ontario's provider of air ambulance and critical care transport, operating in and servicing remote Northern communities. In 2022, Ornge piloted the Mental Health Team (MHT) initiative, which provides emergency mental health transportation from local communities to regional hospitals in Thunder Bay and Kenora with psychiatric mental health facilities.

Prior to 2022, mental health crisis patients were often neglected. Since its introduction in 2022, the MHT model has evolved and adapted to meet the specific needs of these remote, Northern communities. Currently (as of 2026), the MHT initiative includes both dedicated aircraft and dedicated mental healthcare teams — a specially trained mental health nurse, a paramedic, security personnel, and aircraft pilots. The creation of the MHT program increased Ornge's capacity to successfully transport emergency mental health patients. The number of mental health emergency transfers, for instance, has nearly doubled from 32 transports per month prior to the introduction of the MHT model to 58 monthly (as of January 2026).

This report provides an in-depth analysis of the MHT initiative: its origins, how it operates, and its performance in terms of transporting mental health emergency patients to the appropriate care in a timely and equitable manner. However, despite the overall success of the MHT initiative, accessing mental healthcare in remote Northern Ontario communities continues to present many challenges. Some of these challenges are related to geographic and weather-related issues. Some, however, reflect critical operational, clinical, and logistical bottlenecks when it comes to accessing mental healthcare in Northern Ontario. In the conclusion, this report offers insights and lessons for achieving more efficient and equitable transportation for emergency mental health patients in remote parts of the province.

Emergency Patient Transport in Northern Ontario: Issues of Geography, Infrastructure, and Health System Coordination

In 2017, Moses Beaver experienced an acute mental health crisis in Nibinamik First Nation, a remote Oji-Cree community in Northern Ontario. Although he was set to receive psychiatric care in the Thunder Bay hospital's psychiatric facilities, he was unable to access treatment after the hospital refused direct admission. While awaiting transport to another hospital, Beaver remained in crisis for several days and was found unresponsive in custody at the Thunder Bay District Jail. His death and the subsequent inquest into it exposed the profound challenges that remote and Northern communities face in accessing timely and appropriate mental health care.

The inquest examined the systemic factors contributing to Beaver's death and issued recommendations to improve coordination between healthcare, emergency response, policing, and transportation services. The jury specifically emphasized the need for more equitable mental health services in remote communities and greater recognition of how transportation delays and fragmented coordination can contribute to otherwise preventable adverse outcomes.

The Moses Beaver tragedy demonstrated that mental health emergencies in Northern Ontario

are not just clinical issues, but also logistical, infrastructural, and jurisdictional ones. In Northern Ontario, geography makes transportation a critical factor in accessing care. Many patients experiencing mental health crises must travel long distances to reach specialized services unavailable in their home communities. However, long-standing system-level challenges contribute to mental health patients getting deprioritized. The Moses Beaver tragedy was not an isolated breakdown in only one aspect of the mental health patient care process, but the result of multiple, interconnected bottlenecks spanning mental healthcare provision, policing, transport, and emergency response teams.

As Ontario's provider of air ambulance and critical care transport, Ornge operates extensively in remote and Northern regions of the province, where access to healthcare is often constrained by geography, weather, and infrastructure limitations. In response to the growing recognition of gaps in emergency mental health transportation, Ornge launched the Mental Health Team (MHT) program in April 2022 as a pilot initiative.

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In Northern Ontario, geography makes transportation a critical factor in accessing care. Many patients experiencing mental health crises must travel long distances to reach specialized services unavailable in their home communities.

The Ornge MHT model requires that a specially trained mental health nurse, a primary care flight paramedic, pilots, and security personnel work together to provide specialized and crisis-informed transport for patients experiencing acute mental health challenges. Before 2022, emergency mental



Figure 2. Phases of the Mental Health Team initiative development

health transports typically entailed just the pilots and a paramedic who were deployed in an ad hoc manner and only when other medical emergency priorities did not override the mental health cases.

The MHT model aimed to transform access to emergency mental health services for underserved Ontario communities. Since 2022, they have seen a significant increase in the number of mental health emergency transports, reflecting Ornge’s growing capacity and its commitment to both more efficient and equitable access to emergency mental health services.

The MHT program has evolved significantly since its introduction (Figure 2). The initiative has progressed from a scaled-down and ad hoc mental health team and aircraft in 2022, to a dedicated mental health team and an ad hoc aircraft in 2023, and most recently to a dedicated MHT and dedicated aircraft in early 2026. Since the advent of the MHT, Ornge has conducted over 2,500 transports for patients needing mental health services.

We examine how the introduction and adaptation of Ornge’s MHT program has contributed to more timely access to mental health emergency care and mental health equity. To characterize the evolution and performance of the MHT model, we analyze several key indicators, including operational metrics such as response times and transport volumes. We also identify operational challenges throughout the transport process, providing insights into factors affecting timeliness, coordination, and continuity of care.

The creation of a dedicated emergency team and process — akin to a “separate priority lane” — for mental health transportation reflects an approach to mental health efficiency and equity grounded in

differentiated care. Efficiency (timeliness) and equity (fairness) are achieved by delivering services for distinct needs and circumstances. By identifying the factors contributing to the effectiveness of Ornge’s mental health team program, as well as future directions for the initiative’s continued expansion, we explore how specialized transport models can begin to address long-standing gaps in mental health care access for remote, Northern, and Indigenous communities.

Impetus

The Ornge Mental Health Team (MHT) plays a specific role within the broader “circle of care” or “mental health journey” by addressing the transportation component of people’s access to psychiatric and crisis services in Northern and remote communities. In emergency medical evacuations, patients are triaged according to their condition and prioritized accordingly. The Canadian Triage and Acuity Scale (CTAS) scores patient conditions on a five-point scale, with level 1 meaning immediate threats to life or limb and thus requiring aggressive intervention, to level 5, which are non-urgent conditions for which care can be safely delayed. Ornge uses a modified CTAS scale, the Ornge Triage Acuity Scale (OTAS), which outlines how cases are triaged and prioritized by Ornge physicians, which in turn determines response times within the organization (Figure 3).

Because Ornge has limited resources, it prioritizes patients with the most urgent conditions. Most mental health patients fall under OTAS level 3 (e.g., urgent, but not requiring immediate emergency medical attention), meaning they are deprioritized vis-à-vis other more emergent cases, such as those assessed at OTAS levels 1 and 2. Under OTAS,

level 3 patients are generally expected to receive care within a 24-hour window, rather than requiring immediate transport. Consequently, patients experiencing mental health crises may face longer wait times, delayed transport, and reduced access to timely interventions, depending on the acuity of other cases at that time.

Although interviewees described mental health as a long-standing challenge in Northern and remote communities, it is an escalating issue due to growing service demands and limited local capacity to respond effectively. Many communities lack the infrastructure, workforce, and specialized programs needed to adequately address complex mental health needs, leaving individuals with few accessible supports that are close to home.

In contrast, southern regions often have substantially greater access to mental health professionals, crisis services, treatment programs, and institutional resources, highlighting significant disparities in both human and institutional mental health resources across Ontario. Although access to timely and appropriate care in the southern regions of Ontario can be improved, access is comparatively better there than in the North. Southern residents are typically able to travel to a hospital within 30 minutes for mental health care, whereas Northern residents are unable to do so within the same time frame. Limited public transportation and emergency medical services exacerbates the barriers to accessing health care in the region. These geographic and transportation-related barriers are significant for individuals requiring hospital-based mental health services, which are the focus of the MHT initiative. Access to outpatient mental health services, including community-based clinics and other non-hospital-based supports, is also more limited in Northern Ontario than in the South.

Interviewees reported that existing mental health supports in Northern communities are fragmented, with healthcare providers, social services, emergency responders, and community organizations operating in jurisdictional silos rather than through coordinated systems of care. Fragmentation and jurisdictional tensions create gaps when it comes to service delivery, reducing continuity of care, and placing

additional burdens on individuals seeking support within already resource-constrained environments.

Ornge’s MHT provides timely and dedicated care by facilitating safe and efficient transport for individuals who require specialized mental health services not available in their communities. It aims to improve efficiency by reducing transport wait times while advancing more equitable access to mental health services by ensuring individuals in remote communities have more timely and dedicated access to care.

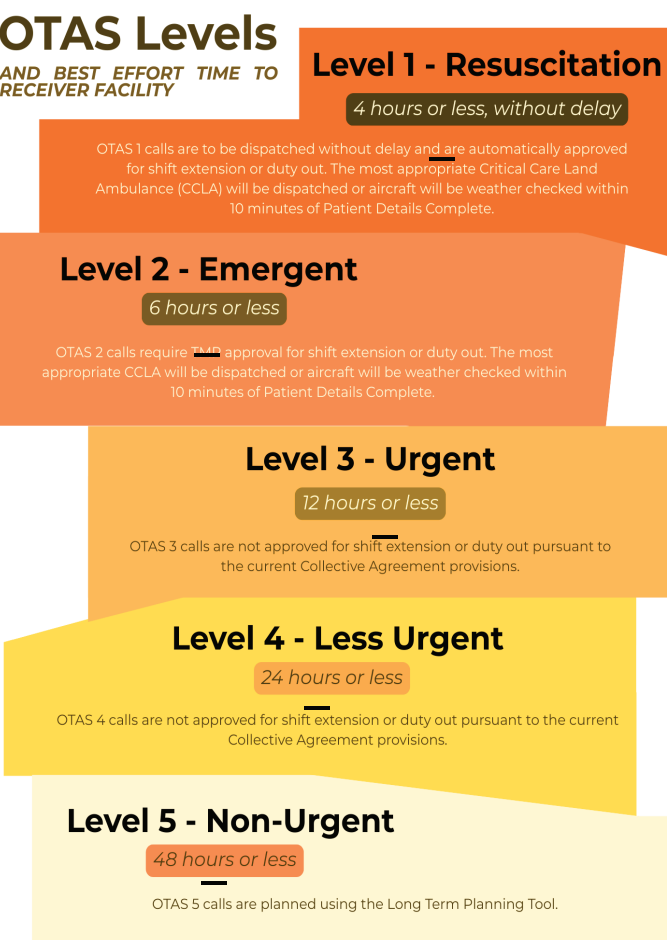


Figure 3. OTAS levels and best effort time to the receiver facility

Mental Health in the North

Northern and remote communities experience disproportionately high rates of mental health challenges, including depression, anxiety, substance use, and other co-occurring mental health and addiction-related conditions. Suicide rates are also significantly higher in many Northern regions, particularly among Indigenous youth, reflecting the profound impacts of historical and ongoing structural inequities. In some remote First Nations communities, the rate of suicide for youth under 15 years of age is almost 50 times higher than it is for non-Indigenous youth.

Mental health outcomes in communities are shaped by social and structural determinants of health, including the lasting effects of colonization and intergenerational trauma associated with the Canadian residential school system. Experiences of trauma, displacement, cultural disruption, and systemic discrimination continue to affect individual, family, and community well-being across generations.

These challenges are compounded by widespread poverty, food insecurity, housing shortages, and limited access to stable educational and employment opportunities. Geographic isolation and transportation barriers further restrict access to healthcare, mental health services, and social supports, particularly for individuals living in fly-in or hard-to-access communities. These sociostructural determinants of health mean that health outcomes in the North are generally poorer than in the rest of the province.

Healthcare providers in Northern and remote communities describe encountering individuals who repeatedly present in mental health crises due to underlying social, structural, and chronically unmet mental health needs. They become, as mental health workers told us in the field, “familiar faces.” Mental health patients can often become trapped in a continual state of crisis. This cyclical pattern places significant strain on healthcare providers, emergency services, and community resources.



Figure 4. Mental health unit entrance at Lake of the Woods District Hospital in Kenora, Ontario

Context: Northern Ontario

Northern Ontario is geographically vast and encompasses over 85 per cent of the province’s land mass, with sprawling forests and bodies of water. Six percent of Ontario’s population calls the North their home. Outside of the few cities (such as Thunder Bay and Kenora), most communities are very small; around 40 per cent of the population live in communities of fewer than 2,000 people. The region encompasses a diverse range of rural, remote, and fly-in communities. Of 150 municipalities and 106 First Nations communities, 28 are fully unconnected to Ontario’s paved road infrastructure, meaning they are accessible only by plane or ice-roads in the winter. Northern Ontario is home to over 850,000 people, 17 per cent of whom are Indigenous, compared to the provincial proportion of 2.4 per cent.

Stigma surrounding mental health remains a significant barrier to seeking care in Northern and remote communities, where privacy can be difficult to maintain and social networks are closely interconnected. Community members are often hesitant to speak openly about personal mental health struggles or the challenges they face in accessing mental health services. Concerns about confidentiality and visibility within small communities discourage individuals from seeking support due to fears of judgment, gossip, or social repercussions. (Some said “the walls are thin” to describe this issue.)

Mistrust toward mainstream healthcare systems persists, particularly in Indigenous communities. The legacies of mistrust are the result of historical and ongoing harms linked to colonial policies, systemic racism, and experiences such as the Canadian Indian residential school system. People perceive mental health services as insufficiently culturally appropriate or disconnected from community realities and Indigenous ways of knowing. There is an increasing recognition of the importance of culturally grounded and community-led approaches to mental wellness that prioritize local knowledge, relationships, and self-determination. Land-based healing, traditional practices, Elders’ knowledge, and cultural continuity are essential components of holistic mental health and healing within many Indigenous communities, though these approaches have only begun to be implemented.

Health Infrastructure

Healthcare facilities in the North have limited clinical capacity. For example, some Northern hospitals and nursing stations operate without physicians regularly on-site and rely largely on nursing staff and remote physician support. Regional hospitals serve large and geographically vast catchment areas spanning numerous rural and remote communities, placing additional pressure on already-limited resources. Healthcare staffing shortages are widespread, with many communities depending on locum physicians who rotate in for short periods. Health providers experience high turnover among nursing staff and mental health workers. Northern and remote communities especially face shortages of mental health professionals, specifically psychiatrists,

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Land-based healing, traditional practices, Elders’ knowledge, and cultural continuity are essential components of holistic mental health and healing within many Indigenous communities, though these approaches have only begun to be implemented.

psychologists, counsellors, and social workers, limiting access to timely and consistent care. In 2004, Ontario overall had an average of 13.1 psychiatrists per 100,000 people compared to just 3.3 in Northwest Ontario. Youth-specific mental health services are especially limited across much of Northern Ontario, with many communities lacking child psychiatrists, youth counsellors, or specialized crisis programs. There are only eight pediatric psychiatric beds for inpatient mental health care in the entire Northwest region, all of them in Thunder Bay.

Northwest Ontario is characterized by greater vastness and remoteness, smaller and more dispersed populations, and fewer available healthcare and mental health resources, contributing to heightened service inequities across the region. Interviewees also noted that each community differs considerably in terms of leadership, health provider capacity, and organization, which further contributes to variation within the region.

High turnover among nurses and other healthcare providers disrupts continuity of care and relationship building within communities, which is especially critical when it comes to mental health. Challenges in recruitment and retention of medical professional

staff are a major structural issue, influenced by geographic isolation, demanding workloads, and limited professional support. Medical facilities face many challenges in recruiting health professionals to the region.

In remote communities when healthcare staff are unavailable, other members of the community — like family or local law enforcement — have to intervene instead. Mental health patients often cycle through the healthcare, justice, and family systems in their community without receiving the help and sustained medical attention they need. Community members, who are untrained as medical professionals, also experience burnout from caring for patients, which lowers community resilience against poor mental health.

These challenges are further complicated by what stakeholders described to be the “duplication of scarce services,” a reality in which multiple providers, including those supported and funded by provincial governments, federal agencies, municipal services, and Indigenous organizations, operate within overlapping jurisdictions, often in an uncoordinated way. Indigenous communities, for instance, receive a mix of health funding through federal programs, notably Indigenous Service Canada (ISC), as well as provincial resources. Fragmented mandates and parallel healthcare delivery systems create inefficiencies, gaps in communication, and coordination problems across an already resource-constrained healthcare delivery system. These challenges are especially pronounced in the delivery of appropriate and timely mental healthcare.

Delivering Mental Health Care in the North

Geographical and systemic challenges shape how mental health care is delivered to remote communities in Northern Ontario. Many different

stakeholders are involved in delivering mental health care in the region. Ornge, responsible for emergency transport, plays a critical role in connecting remote Northern communities to secondary and tertiary hospitals by facilitating access to mental health services through its Mental Health Team (MHT) program.

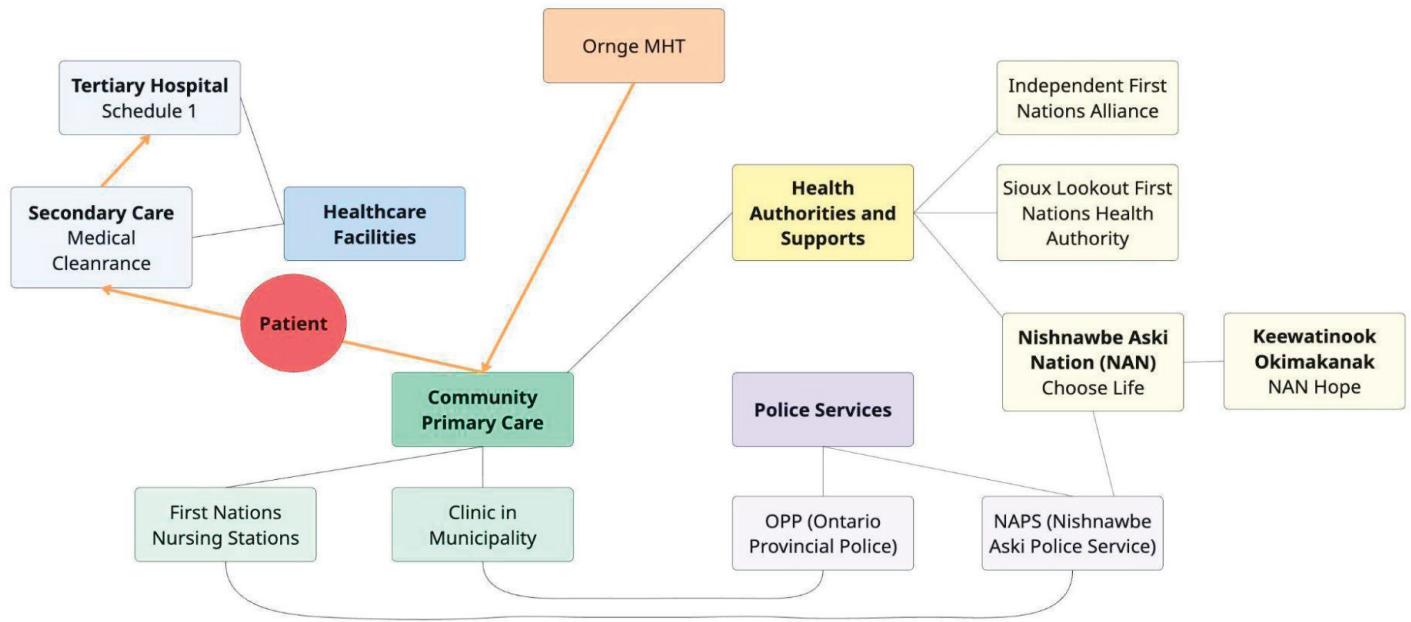
Mental Health Care Pathways and Key Stakeholders

The region of Northwestern Ontario (NWO) (our focus here) has a population of approximately 250,000 people, though it accounts for over 50 per cent of the entire province’s geographical area. The large distances and lack of connectivity between communities limit timely access to mental healthcare and contribute to overall resource dispersion and scarcity across the region.

There are several stakeholders involved in delivering mental health care, of which Ornge, responsible for emergency transport, is just one. Figure 5 illustrates how these stakeholders interact across the continuum of care. One interviewee described mental health services in NWO as a “plot of sandboxes rather than a beach” — by which they meant that while multiple supports exist, they are each limited in their capacity, and often operate independently and far from each other, creating a fragmented system where individuals fall between the gaps. In this context, Ornge provides the emergency transport services for mental health patients who require a level of care above what the community can provide.

Community primary care facilities, such as nursing stations and clinics, are a patient’s first point of contact for mental health support (Figure 5, green). Outside of the three urban centres of Thunder Bay, Sioux Lookout, and Kenora, primary health care in NWO is mostly delivered by nurses in community primary care facilities. In municipalities (i.e., non-First Nations communities), provincially funded clinics provide primary care, while locum physicians travel into communities on rotational schedules. In First Nations communities, healthcare is primarily delivered through nursing stations, which are federally funded through Indigenous

Map of MH Stakeholders in NWO



Notes: Patients present to community primary care facilities (green) as their first point of contact for medical and mental health concerns. Regional health authorities and Indigenous-led organizations (yellow) provide community-based prevention, counselling, crisis intervention, and service navigation, often virtually. Police services (purple) may assist community providers in maintaining patient and staff safety while patients await transport. Ornge's Mental Health Team (orange) facilitates transport from community facilities to receiving hospitals, where patients access secondary and tertiary psychiatric services (blue).

Figure 5. Key stakeholders in delivering and supporting mental health care in Northwestern Ontario

Services Canada (ISC). These providers conduct initial assessments, provide immediate support and stabilization, and determine whether patients can be safely managed within the community or require access to specialized services.

Indigenous organizations and authorities also provide certain mental health services to their communities. For example, Sioux Lookout First Nations Health Authority (SLFNHA) provides critical social services to 33 First Nations, including primary healthcare, counselling, and housing accommodation in the region. The health authority also oversees the Nodin Mental Health Services program, which provides support, counselling, and intervention services for First Nations children, adults, and families. Nishnawbe Aski Nation (NAN) is a political territorial organization representing 49 First Nations communities in Northern Ontario that supports the Choose Life program, a specialized

mental health initiative focused on youth suicide prevention in NAN First Nations. The Independent First Nations Alliance (IFNA), a member tribal council within NAN, manages a mobile mental health team that visits communities every two weeks and offers virtual support between visits. Another tribal council within NAN, Keewatinook Okimakanak (KO), leads the NAN Hope program, which provides 24/7 access to mental health and addictions crisis support for all ages through a phone and webchat line for all 49 NAN First Nations.

Together, these regional health authorities and Indigenous-led organizations reflect the critical role that community stakeholders play in delivering culturally grounded mental health services across Northern Ontario. Through a combination of prevention, crisis response, counselling, service navigation, and continuity of care, these organizations help fill gaps in an otherwise

geographically dispersed and under-resourced health system. While these organizations and programs offer important supports, the gaps between service type, population served, and capacity still result in some patients falling through.

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Specialized mental health services are often unavailable within communities. When patients experience a mental health crisis and require secondary or tertiary care, staff at the community's primary care facility contact Ornge to request a transfer to a hospital for advanced care. The MHT, after conducting its own patient assessment and logistical due diligence, dispatches to the community to safely transport the patient to a more advanced healthcare facility (Figure 5, orange). The Nishnawbe Aski Police Service (NAPS) may also support nursing stations and community providers by providing additional security when a safe room is unavailable, helping to ensure patients' safe holding as they await transport (Figure 5, purple).

Once transported, patients enter the hospital-based component of the mental health system, where emergency stabilization and inpatient psychiatric treatment can be provided. Three hospitals serve the NWO region. Sioux Lookout Meno Ya Win Health Centre (SLMHC), located in central NWO, is a major healthcare hub serving Sioux Lookout and 31 First Nations communities in the surrounding region. SLMHC provides primary, secondary, and, at times, tertiary care to its large catchment area. However, Meno Ya Win is not a Schedule 1 facility and therefore does not have inpatient psychiatric capacity. When it comes to mental health emergencies, SLMHC functions as a secondary

care facility where patients in its catchment area are initially transported following assessment in a community nursing station or clinic.

There are two tertiary mental health hospitals in NWO with Schedule 1 facilities designated under the Ontario *Mental Health Act* to provide inpatient psychiatric care. Only these Schedule 1 hospitals are authorized to admit and treat patients involuntarily. For example, Lake of the Woods District Hospital (LWDH) in Kenora, located west of Sioux Lookout, has 17 adult beds in its Schedule 1 facility. Thunder Bay Regional Health Sciences Centre (TBRHSC), east of Sioux Lookout, has 30 adult beds as well as the only eight pediatric psychiatric beds in NWO. Patients transported to these facilities first receive any immediate and necessary medical care prior to admission to a psychiatric department (Figure 5, blue). In total, there are 47 adult psychiatric beds and eight pediatric psychiatric beds available to serve the entire NWO region for inpatient psychiatric care.



Note: Figure illustrates stakeholders' relationships in mental health care in NOW — with the patient and one another.

Figure 6. The circle of patient care centring the patient

Emergency Mental Health Transportation

The stakeholders collectively support the delivery of mental health care across Northern Ontario. However, the remoteness of many communities and the distance between service providers create complex pathways to care, particularly for individuals experiencing acute mental health crises and who require access to specialized emergency services unavailable locally.

The following examples or vignettes (described by interviewees in the field) illustrate the complexities of navigating mental health access and the role that Ornge plays in transportation as well as stakeholder coordination to improve patient access to timely and appropriate mental health care. While the baseline patient described here is considered a “best case” scenario, the more complicated ones are not atypical.

Pediatric transport

A child presents at the nursing station and is evaluated by the nursing staff who determines that additional care is needed. A physician evaluates the child and decides that admission to an inpatient psychiatric department is most appropriate. However, pediatric patients require an escort, though no one in the child’s family can accompany them. The patient is in Kenora’s catchment area and is transported by Ornge and met with an assigned escort by Tikinagan, the local child and family services agency. From this point onward, communication with the child’s family relies almost solely on the escort, who may not know the child or their family. The patient is eventually medically cleared and admitted to a Schedule 1 facility. However, Kenora does not have a Schedule 1 pediatric facility and there is no vacancy in Thunder Bay Hospital. The patient waits for an extended period of time before a bed becomes available in Thunder Bay.

Baseline patient

An adult presents at the nursing clinic during the day with suicidal ideation. The nurse contacts a physician who services the community to evaluate the client and authorizes a transfer. The Ornge MHT arrives within 12 hours and the patient does not require sedation. The patient arrives at Sioux Lookout Medical Health Centre (SLMHC) and is medically cleared for admission to a Schedule 1 hospital. Ornge is contacted again, and the patient is transported to a Schedule 1 hospital, either in Kenora or Thunder Bay.

Pickle Lake

A patient presents at the Pickle Lake clinic, several hundred kilometres from Sioux Lookout, where they are assessed. Pickle Lake is the northernmost community reachable by paved road in the Northwestern region. The Pickle Lake clinic nurse and then the physician, who is not on site, virtually recommends additional mental health care. SLMHC is three-and-a-half hours away from Pickle Lake by road. The patient is inebriated and shows signs of aggression. They cannot be transported by Pickle Lake’s transport vehicle, since they cannot share this vehicle with other patients. They also cannot be transported by ambulance because that would take the vehicle and a paramedic out of service from the community for several hours. Therefore, the patient waits in Pickle Lake for several hours for an air transport, despite being within driving distance.

These examples highlight how access to emergency mental health care in Northwestern Ontario is constrained by a series of interconnected bottlenecks. Patients may face delays related to medical clearance requirements, shortages of



Figure 7. Reach team photo at Ornge Thunder Bay base (photo by Joe Wong)

psychiatric beds, transportation limitations, and the coordination required among multiple healthcare providers and facilities. In remote communities, these challenges are further amplified by distance, weather, and limited local healthcare capacity. As a result, the timeliness of care depends not only on the severity of the patients' case, but also on how efficiently patients navigate a complex system of operational and logistical constraints.

The Ornge MHT Transportation Process and Performance

Ornge plays a critical role by providing safe emergency transport for patients requiring emergency care. The MHT transportation process involves several stages or discrete steps, beginning when a patient presents at a community healthcare (sending) facility, and ending when they arrive at a receiving hospital for specialized mental health care (Figure 5). The process requires coordination at every step between local community clinic or nursing station staff, dispatch coordinators at Ornge headquarters, transport medicine physicians, other health professionals, and hospital teams.

Our research team worked with Ornge staff to disaggregate the entire transport process, from the time a local clinic contacts Ornge requesting emergency transport to when the patient arrives and is processed at the "receiving" facility. Each discrete step is time stamped for every emergency case (OTAS Level 1, 2, and 3). Using this data — 402 cases prior to the MHT and 2,641 cases with the MHT onward — we calculated the total response time for each patient case, as well as the time elapsed at each discrete step of the patient's journey.

From Ornge's perspective, the MHT initiative is supposed to reduce overall response and transport times to increase access to mental health patients in emergencies. Prior to the MHT's implementation, Ornge transported on average 31.6 mental health patients per month. After the MHT was established (and available initially only on an ad hoc basis along with an ad hoc aircraft, that is, Phase 1), the average number of monthly transports increased to 46 and increased to 57.6 following the implementation of a dedicated MHT (Phase 2). Preliminary data from the first two months of 2026 when a dedicated aircraft was introduced (Phase 3) indicates that the average monthly number of transports has slightly increased.



Note: This graphic demonstrates the steps taken in a mental health emergency case. The time stamps are approximations based on aggregated data, and illustrate a hypothetical scenario.

Figure 8. Patient journey during the MHT transportation process with approximate time stamps

Table 1. The mean number of transports on a monthly basis during each phase of the MHT

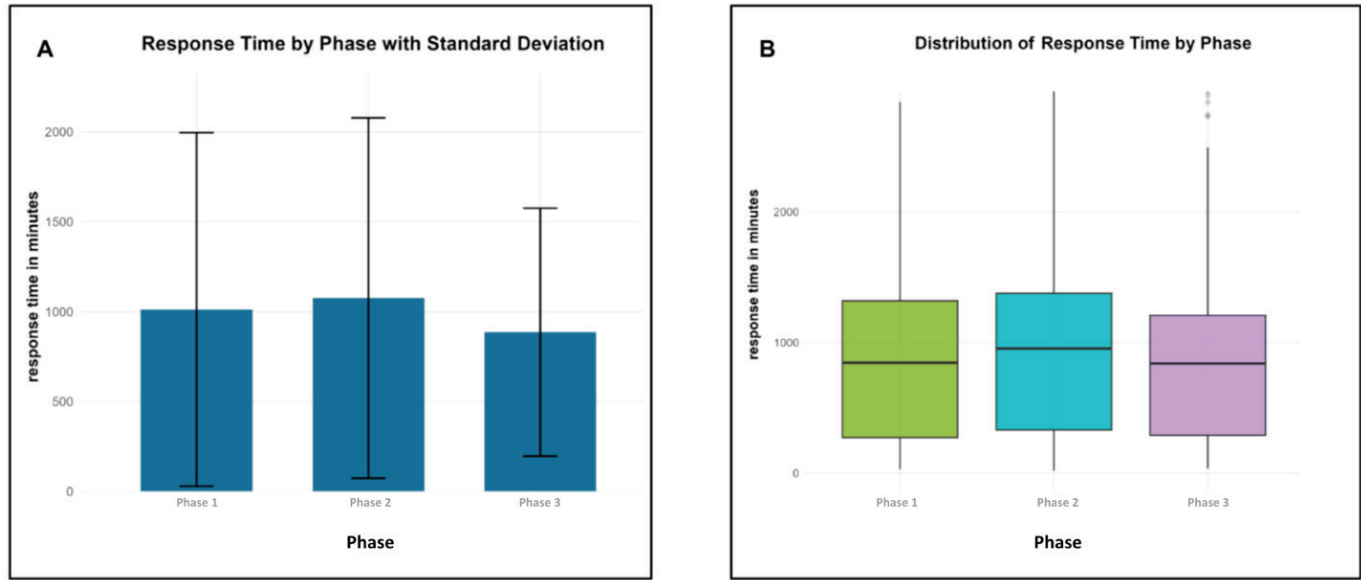
MHT phase	Resource availability	Total # of transports	Mean # of transports
Phase 1 (18 April 2022 – 31 March 2023)	Ad hoc MHT Ad hoc aircraft	531	46.0
Phase 2 (1 April 2023 – 31 January 2026)	Dedicated MHT Ad hoc aircraft	1,993	57.6
Phase 3 (1 February 2026 – 31 March 2026)	Dedicated MHT Dedicated aircraft	117	61.3

Overall, the average number of patients transported increased as ad hoc and dedicated personnel and fleet resources were allocated to the MHT program, allowing for more emergency patients to reach necessary mental health care. In short, the introduction of the MHT program in 2022 has increased Ornge’s capacity to transport more emergency mental health patients.

Ornge also measures its “response time” from when it is initially contacted requesting transport of a patient from a community clinic or nursing station to transporting that patient to another facility. For Ornge, the “response time” concludes when the

MHT begins their air transport with the patient from the community (“wheels up”) to a receiving hospital.

When the MHT initiative was established with the ad hoc MHT and aircraft (Phase 1), the average response time was 963.24 minutes (Figure 9A). Following the dedicated MHT’s introduction in 2023, the average response time during Phase 2 from 2023 to 2026 was 993.94 minutes (Figure 8A). However, since a dedicated aircraft came available in January of 2026, marking the beginning of the current Phase 3, average response time has decreased to 833.12 minutes (Figure 9A). The standard deviation (Figure 8A) and variance (Figure 9B) of the response



Note: (A) The mean response time of mental health transports at each phase with standard deviation. (B) The distribution of response time at each phase with variance.

Figure 9. Response time (mean) from when Ornge is first contacted to when transport to the receiving facility begins

time during Phase 3 has also decreased, suggesting that the dedicated aircraft has contributed to reducing the response time.

Clinical assessments. Although Ornge internally determines eligibility for MHT emergency transport, the initial clinical assessment of a mental health case occurs in the community clinic or nursing station. In our time-stamped disaggregation, T-2 and T-1 occur prior to when Ornge is contacted at T0 requesting emergency transportation (Figure 10).

Urgent mental health patients can be transported to a psychiatric facility in a hospital when the hospital executes an Application for Psychiatric Assessment, commonly referred to as a Form 1. This is a document compliant with Ontario’s *Mental Health Act*, completed by a physician to order an involuntary 72-hour psychiatric assessment at a Schedule 1 hospital, provided there is reasonable cause to believe someone is suffering from a mental health crisis that will result in harm to themselves or others.

In a remote community context, where an in-person physician presence is rare, the physician often orders and signs the form following a virtual assessment. The time for this initial assessment’s completion is constrained by the availability of virtual or in-person physicians serving the community. This can take a long time and, not unexpectedly, is quite variable. All of this is determined before Ornge is called at T0.

The Form 1 is valid for seven days and provides authorization for any person or service, such as Ornge, to transport the individual to a Schedule 1 hospital equipped with the appropriate psychiatric facility. If the patient does not reach a Schedule 1 hospital within the seven days, the form becomes invalid. Following the Form 1 assessment, a 14-day Certificate of Involuntary Admission, or Form 3, can be issued, which can then be followed by a Certificate of Renewal (Form 4) to further increase the length of stay if necessary.

After Ornge is contacted (T0) and the medical intake call is completed (T1), the Transport Medicine Physician (TMP) at Ornge determines whether a patient is appropriate for the mental health team (T2), allowing for the deployment of the dedicated mental health emergency personnel and aircraft.



Figure 10. Stages of the patient transport journey

This decision made at T2 is based on the Ornge Triage Acuity Scale (OTAS) assessment of the patient’s clinical details. Most mental health patients are assigned an OTAS Level 3: an urgent situation, which requires transport within 12 hours though not immediately. Most mental health cases

are not assessed to reach the threshold of “life or limb” and therefore do not reach an OTAS assessment of either Level or 1 or 2, which would require immediate transport.

However, when a mental health case is presented with potential life-threatening injury and requires immediate medical attention, it is coded as a life-or-limb case. If this occurs, the mental health case is taken out of the mental health transport queue and a critical care team and aircraft can be dispatched. In other words, in life-or-limb situations, the patient essentially “jumps the queue” and is transported separately as a critical case.

Following OTAS assignment and an assessment of whether dispatching a mental health team is the appropriate response, the Ornge TMP completes a risk assessment based on the person’s current and past medical history to determine the need for sedation and to prepare the mental health team. Once Ornge completes a weather assessment and its logistical due diligence (T3), the call is officially accepted and preparations for transport are carried out (T4). The MHT heads to the sending community (T5), and upon arrival (T6) stabilizes the patient to prepare them for transport (T7). The MHT then departs the community (T8) to transport the patient to the receiving hospital where they immediately receive medical and psychiatric care (T9). Figure 11 outlines the full sequence of operational steps, from initial patient presentation to handover at the receiving hospital.

Two legs, one journey. In Northwestern Ontario, 61 per cent of patients experiencing mental health crises have to endure a two-stage transport pathway before they can access inpatient psychiatric care at a Schedule 1 hospital in Thunder Bay or Kenora.

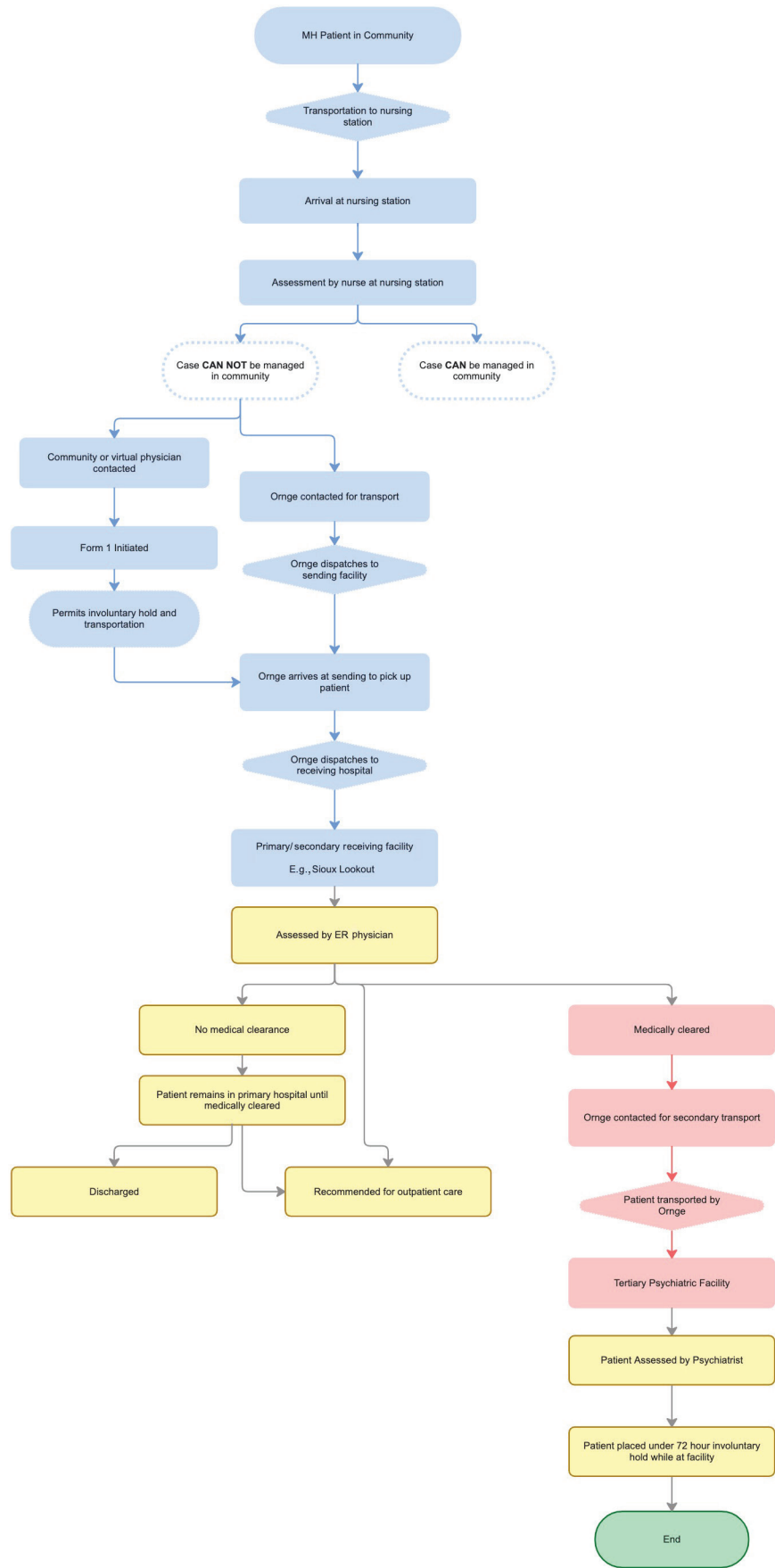


Figure 11. Patient retriaging (“Two Legs, One Journey”) process map



Figure 12. The Reach team with Thunder Airlines staff in Thunder Bay, Ontario

Rather than travelling directly to a hospital with a Schedule 1 psychiatric facility, in many instances patients are first transported to Sioux Lookout Medical Health Centre (SLMHC), a regional hospital without a Schedule 1 psychiatric facility, for medical clearance. Only after they have been medically cleared in the emergency room (ER) of the SLMHC can they be transferred and transported to a Schedule 1 facility in Thunder Bay or Kenora. In other words, patients may experience “two legs” within a single mental health emergency journey. This elongates their time to appropriate care.

Figure 10 illustrates how the medical clearance process, combined with wait times for onward transportation and bed availability, can result in patients remaining at Sioux Lookout hospital for several days. From Ornge’s point of view, these two legs are separate transport cases — they are not considered to be the same patient case.

Medical clearance. Prior to admission to the psychiatric unit in a Schedule 1 hospital, patients present to the ER to be medically cleared for any immediate medical concerns or to undergo a mandatory 24-hour substance detox, if applicable.

In an urban context, this process occurs in the ER of the same hospital with the Schedule 1 facility. In NWO, however, medical clearance for patients whose catchment area falls outside of the Schedule 1 hospitals in either the Thunder Bay or Kenora catchment area is conducted in Sioux Lookout. This process significantly increases pressure on staff and bed capacity in Sioux Lookout’s ER, leading to longer wait times for both mental health and medically acute patients there. The need for initial medical clearance at Sioux Lookout is a bottleneck slowing patients from reaching the Schedule 1 hospital, which can compromise timely access to emergency mental health care.

Provincial requirements *do not require* patients to be medically cleared at a secondary hospital before admission to a hospital with a Schedule 1 facility. However, the “two-legs, one-journey” problem emerges when a patient is coming from outside the catchment area of the Schedule 1 facility. Discussions with stakeholders in the region revealed that Schedule 1 hospitals commonly request or expect patients to be medically cleared at their local catchment-area hospital prior to transfer. While this helps preserve emergency department capacity at

Schedule 1 hospitals, it adds an additional step in the patient journey, delaying access to emergency psychiatric care.

This structural bottleneck in access to mental health care across Northern and remote Ontario — and the underlying shortage of psychiatric resources — falls beyond the mandate of emergency air transportation. Ornge plays a critical role in facilitating timely transportation between Sioux Lookout and Schedule 1 facilities. By establishing the MHT and ongoing efforts to improve response times and operational capacity, Ornge facilitates timely transportation from the community to hospitals and strengthens interfacility connection to improve access to the highest level of mental health care for patients across Northern Ontario.

Evolution and adaptation. The evolution of the MHT model represents an adaptive response to long-standing gaps in emergency mental health transport in Northern Ontario. Over time, the MHT program has demonstrated meaningful improvement in stages that are more directly shaped by operational processes. Physician triage now averages 13 minutes, while patient stabilization averages 21 minutes. This reflects notable gains in efficiency. However, the weather and resource check stage remains the most variable component of the patient journey, averaging 11 hours 42 minutes and having more than 800 cases involving at least one staffing-, asset-, weather-, runway-, or visibility-related constraint. As many of these factors fall outside of Ornge’s direct control, this stage continues to represent a persistent challenge despite broader advances.

Ornge’s Strategic Plan, *We Respond*, “is a blueprint for the future of our organization and our commitment to health equity, operational excellence, and patient-centred care.” Since 2022, the MHT program has evolved as a specialized model for mental health emergency transport, with dedicated resources in terms of medical staffing and aircraft. The program’s adaptation over the past four years reflects Ornge’s responsiveness to front-line challenges and evolving needs, and its commitment to improving access to emergency mental health services.

For example, interviews with operations personnel, front-line clinical staff, and supporting regional health organizations suggest significant improvements in continuity of care for the patient, increased appropriateness of response to mental health crises, and a reduced reliance on law enforcement in transport. These are all important indicators of improved transport service for the patient. Quantitative data reinforce these qualitative observations. Sedation was used in nearly a quarter of cases (23.9%) before the introduction of the MHT program and decreased to just over 11 per cent in 2026 (see Table 2). Similarly, the use of physical restraints decreased from 16 per cent of transports before 2022 (Phase 1) to 9 per cent in Phase 3.

Table 2. Use of sedation and restraints during transport by Ornge (%)

	Sedation	Restraints
Pre-MHT	23.9	16.4
Phase 1	13.2	8.3
Phase 2	12.3	8.6
Phase 3	11.1	9.4

A key driver in the MHT’s evolution has been the creation and continuous refinement of a dedicated pathway for mental health transport. Before the MHT’s introduction in 2022, mental health transports were often managed through generalized response models involving mixed teams, ad hoc coordination, and, at times, law enforcement. While Standing Agreement Carriers (SACs), which are contracted private aircraft and paramedic teams to supplement Ornge’s operations, were able to manage and respond to some mental health calls, they were challenged when responding to higher-acuity and more complex cases.

Since 2022, the program has evolved considerably. Currently, there are two dedicated MHTs and aircraft. The current model of a dedicated MHT, particularly the presence of a mental health nurse, has had a

particularly strong effect on the clinical assessment, patient stabilization during transport, and coordination with sending and receiving facilities. Meeting the emergency mental health needs in Northern Ontario requires not just an increase in resources, both in terms of personnel and aircrafts, but *dedicated* resources for mental health transports.

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Meeting the emergency mental health needs in Northern Ontario requires not just an increase in resources, both in terms of personnel and aircrafts, but *dedicated* resources for mental health transports.

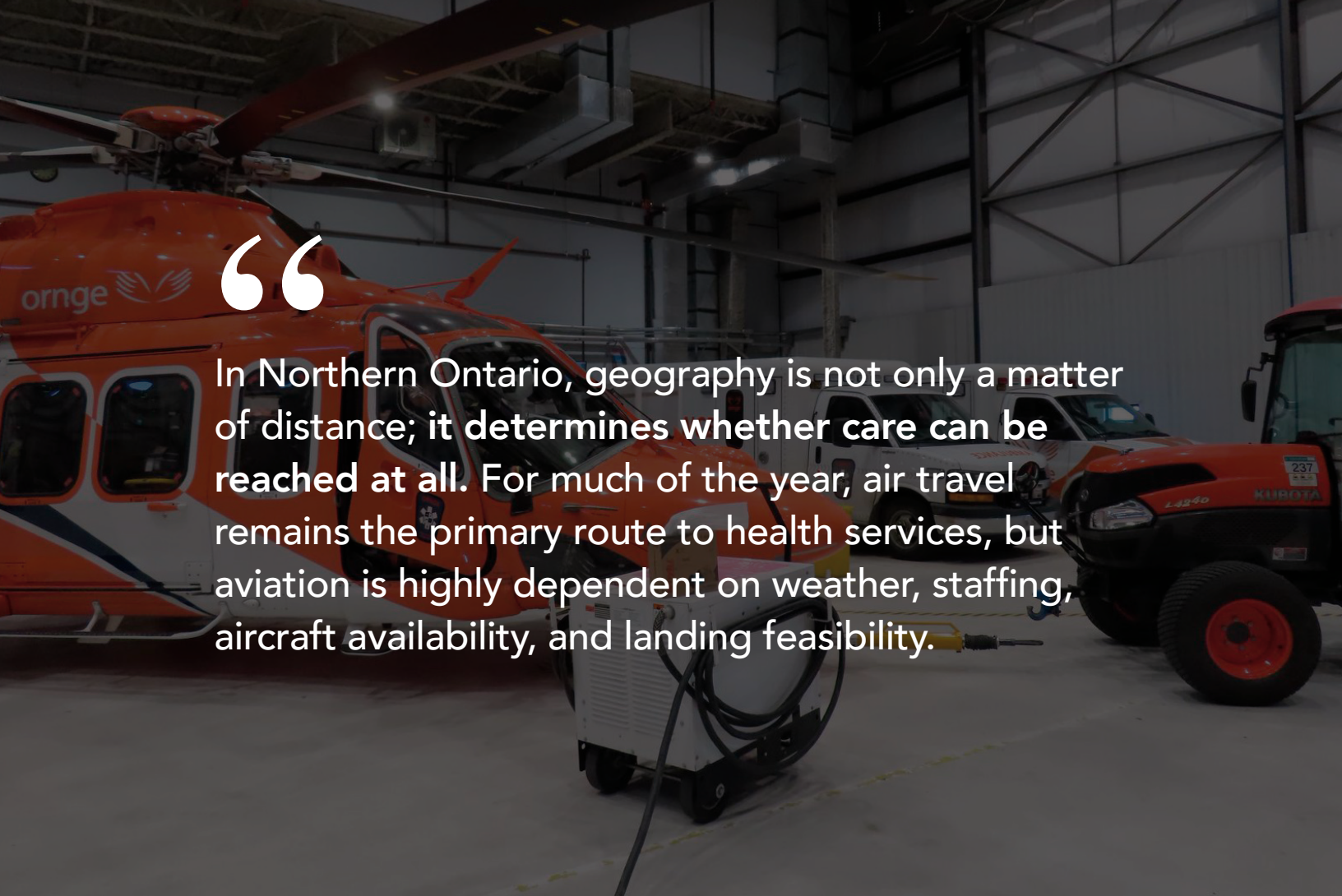
The efficiency and equity promise of the MHT initiative is reinforced by real-time adaptation and context-sensitive problem solving by those at the front lines. Paramedics, nurses, and transport medicine physicians actively adapt in real time, based on the patient's changing acuity, situational constraints, and rapidly evolving contexts. For example, triage designations can be adjusted based on risk escalation. We learned through our interviews that patients initially categorized as a non-urgent OTAS level 4 are sometimes upgraded to a more urgent OTAS level 3 following reassessment by Ornge Transport Medicine Physicians and in consultation with clinical staff at sending facilities. Front-line workers also described the common practice of coordinating resources informally across institutions, including “calling in favours” at receiving hospitals to facilitate smoother and more timely transfers.

The long-term sustainability of Northern emergency response systems depends on continually strengthening local community capacity to care for patients and prepare them for transport efficiently.

Ornge recently introduced a pilot initiative called the Emergency First Response Team (EFRT) program, which is separate from MHT, to strengthen community-based emergency response capacity. The EFRT program provides training and compensation to local emergency first responders, in addition to equipment, such as medically kitted-out transport vehicles. By resourcing and improving communities' local ability to deliver front-line crisis responders and to facilitate transport logistics to and from nursing stations or evacuation points, communities can improve and complement the MHT's ability to safely and efficiently transport emergency mental health patients. This initiative expects to contribute to reduced reliance on police involvement, improved response times, and greater community ownership of emergency care pathways.

Stakeholders in the field reported to us that the MHT program's effectiveness has been strengthened through culturally “safer” approaches to care. As we noted earlier, mental health crises in Indigenous contexts are influenced by historical trauma, colonial legacies of racism, systemic socioeconomic inequities, the lack of medical care resources, and experiences of discrimination within healthcare systems. Ornge's leadership in Operation Remote Immunity (ORI), which was responsible for delivering vaccines during the COVID-19 pandemic, revealed the importance of training paramedic staff in the ways of culturally safer approaches to medicine and care. Cultural training and the recruitment of Indigenous vaccinators were critical in ORI's success. The MHT initiative has similarly evolved to reflect respectful, safe, culturally sensitive, and trustworthy approaches to mental health care.

Overall, the evolution of the MHT model since 2022 reflects an adaptive response to addressing the long-standing gaps in mental health transport in Northern Ontario. Its effectiveness is not attributable to a single adaptation, but rather to a constellation of interrelated changes: the creation of a dedicated pathway for mental health transport, front-line worker adaptation, community capacity building for emergency situations, and culturally safer approaches to service delivery. These factors illustrate that the effectiveness of Ornge's MHT can be achieved only through a responsive and evolving process.



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In Northern Ontario, geography is not only a matter of distance; it determines whether care can be reached at all. For much of the year, air travel remains the primary route to health services, but aviation is highly dependent on weather, staffing, aircraft availability, and landing feasibility.

Challenges. Where a mental health crisis happens can determine how quickly, safely, and smoothly a patient receives care. In Northern Ontario, geography is not only a matter of distance; it determines whether care can be reached at all. For much of the year, air travel remains the primary route to health services, but aviation is highly dependent on weather, staffing, aircraft availability, and landing feasibility. This challenge is reflected most clearly in the weather and resource check stage (T3) where Ornge must determine whether conditions are safe to fly, whether an aircraft and crew are available, whether the sending and receiving locations are accessible, and whether the broader transport pathway can proceed. This step of the transport process takes, on average, approximately 11 hours 42 minutes with a standard deviation of 15 hours 54 minutes, making it the longest and most unpredictable interval in a mental health patient's journey.

Weather-related issues had the strongest effect on the total response time. These are conditions that

affect whether an aircraft can be safely dispatched, prepared, flown, landed, or cleared to complete transport, including storms, icing risk, de-icing requirements, high winds, or unsafe landing conditions. In cases where weather issues were a factor, the resource and weather check step (T3) alone averaged 23 hours 41 minutes, compared with just 8 hours 43 minutes without weather issues. Staffing requirements, aircraft availability, and bed-capacity constraints at the sending and receiving health facilities can further compound these delays. In some cases, patients waited up to four days for a bed to become available. For mental health patients, these delays can mean waiting longer while in crisis and with limited local support at the community clinic, nursing station, or police holding facility.

The “two legs, one journey” pathway reveals a deeper problem when it comes to emergency mental health care in Northern Ontario. A patient's emergency journey ideally should be continuous and as efficient as possible. But the system in NWO is

fragmented. Patients from remote communities may reach their catchment-area hospital in Sioux Lookout (SLMHC), but since it is not a Schedule 1 psychiatric facility it cannot provide inpatient psychiatric care. This means patients remaining in the ER while waiting for their initial medical clearance, psychiatric assessment, bed availability, and finally a secondary transfer to Kenora (LWDH) or Thunder Bay (TBRHSC). Patients wait at SLMHC an average of 1.8 days and 2.2 days before transfer to LWDH and TBRHSC, respectively. For patients in crisis, these delays can mean repeated hand-offs and assessments, worsening distress, and a disjointed care experience. Despite Ornge's efforts to improve the patients' timely and efficient transportation to mental health care, delays caused by the health system may not result in better mental health outcomes, as evidenced by the two-legs, one-journey challenge.

Ontario's *Mental Health Act* protects patients through standardized protocols and practices when it comes to physician assessment, documentation, rights advice, and transportation guidelines. However, the *Mental Health Act* presumes that physicians are reasonably and readily available and that psychiatric facilities are reachable. These assumptions often break down in remote parts of Northern Ontario; they may work for most people living in the South, but they rarely work in the remote North. For instance, the *Mental Health Act* requires a physician's examination and assessment for a Form 1 for a patient to gain admission in one of the two Schedule 1 hospitals in the North. Physician shortages in the North make this requirement hard to meet.

The language of the act is also quite ambiguous. For instance, it does not explicitly require medical clearance to occur before psychiatric care, despite the insistence of Schedule 1 hospitals to do so. This means, technically speaking, that emergency mental health patients can be directly admitted to a Schedule 1 mental health facility in Thunder Bay and Kenora, thus bypassing being admitted first to Sioux Lookout for a medical clearance. However, Schedule 1 hospitals interpret the act to say that the hospitals in Thunder Bay and Kenora can insist patients first receive medical clearance at the regional hospital in Sioux Lookout.

Lessons Learned

Ornge's Mental Health Team (MHT) program does more than move patients across distance; it also exposes the parts of the mental health system in the North where access to mental health care is delayed, fragmented, and disconnected from the community. In this respect, the MHT offers important lessons and insights into how a more coordinated, culturally safer, and prevention-oriented mental health system could emerge in the North.

Prioritizing Patient Needs

Emergency mental health transport has to be designed to accommodate the patient's entire journey, rather than as disconnected steps. The "two legs, one journey" challenge, for instance, demonstrates how uncoordinated stakeholders, ambiguous regulation, and resource constraints exacerbate emergency mental health cases. Better coordination between Ornge and sending and receiving health facilities could reduce transport delays and, where clinically appropriate, support direct transfer to Schedule 1 or tertiary care for acute mental health emergencies. This approach to developing a patient-centred mental health pathway can also support the expansion of wrap-around care, including the recruitment of family escorts and support networks, effective discharge planning, and follow-up support that occurs before and after the emergency transport.

Beyond Crisis Transport

Ornge's role need not begin only at T0 or end at T9 — from when Ornge is first contacted to when it drops off the patient at the receiving hospital. Operation Remote Immunity (ORI), the COVID-19 vaccine campaign led by Ornge in remote Northern Ontario, established a strong precedent for how Ornge's infrastructure and capacity can be used beyond emergency transport. As outlined in the Reach report, Ornge orchestrated COVID-19 vaccine delivery to remote communities in Ontario through advanced reconnaissance flights, community preparation, and by continuously

engaging Indigenous leadership to co-create the vaccine campaign. When it comes to mental health, expanding Ornge's capacity and mandate could include transporting psychiatric nurses, crisis workers, or telepsychiatry equipment into communities; coordinating follow-up after discharge with local community partners; and helping connect patients back to local support. The introduction of Ornge's Emergency First Responder Team (EFRT) program is a good example of how Ornge's interventions beyond just transport can improve the health system in Northern Ontario.

Community Co-Creation

Community co-creation can strengthen Ornge's MHT operations by creating culturally safer and more trusted care pathways, especially in Indigenous communities. Co-creating emergency transport processes, and medical health care more generally, improves mental health care, engenders greater trust within communities, improves communication and mental health awareness, and empowers local and Indigenous leadership. The Thunder Bay Regional Health Sciences Centre's (TBRHSC) Indigenous Care Coordinator program, where Indigenous support staff and networks are recruited in partnership with First Nations communities, offers potentially important lessons in how mental health patients engage in the mental health system with greater trust, cultural understanding, and continuity.

More Data, Better Data

More data and better data can help improve the emergency mental health transport process, and the mental health system more generally in the North, to deliver on the promise of more timely and equitable access to mental health care. The disaggregated and time-stamped data we collected — of which we have shared only a small portion here — can help Ornge and its partners identify where in the emergency transport process improvements can be made, and where other exogenous factors, such as weather, may not be mitigated through process improvements alone. We found, for instance, that the largest standard deviation (i.e., variance in time) occurs during T3, when Ornge is conducting weather

assessments and its logistical due diligence. The disaggregated, time-stamped data also helped identify areas of progress, with the average number of mental health transports increased from 46 per month in Phase 1 to 61.3 per month in the most recent phase — a significant improvement in Ornge's transport capacity.

As we noted, Ornge currently reports each transport "leg" as a complete transport case. Ornge's data do not capture the time the patient spends at a medical facility awaiting medical clearance and before the patient can then be transported to a Schedule 1 facility. The "two legs" are counted as separate cases in Ornge's database and are de-linked. Linking the patient's record between legs 1 and 2, Ornge could gain more accurate information about the length of time of the patient's total transport journey, from when they first present in their community to when they arrive at the Schedule 1 facility.

Ornge starts counting its response time at T0, or when the community clinic or nursing station first calls to request transport. The time the patient spends in the clinic, from when they first present (T-2) to the time the clinic makes the call to Ornge (T0), is not recorded. Recording the time stamp for T-2 and T-1 could inform Ornge about how long the in-crisis patient has already been in the community health facility. These data can also provide a more accurate account of the patient's total mental health journey, beyond just the transport step.

Better data, more data, and more integrated data will require investments in data-sharing protocols and interoperability between data systems operating in Ornge, community health care providers, and hospitals.

Ornge and Policy Advocacy

As the primary emergency transport mechanism in Northern Ontario, Ornge connects local communities, physicians, hospitals, aircraft providers, paramedic emergency services, Indigenous organizations and health authorities, and provincial policy decision makers. Ornge operates across the bottlenecks that determine the patient journey from weather delays to bed shortages, and is best



Figure 13. Team with Mishkeegogamang stakeholders

positioned to identify where patients are prevented from reaching the mental health care they need and in a timely manner. In other words, as the transport “connector” to all stakeholders providing mental health in Northern Ontario, Ornge is more than an operational actor. Ornge has a unique system-wide perspective that can advocate for and legitimate policy change. Grounded in community priorities and front-line evidence, Ornge can help advocate for clearer pathways, fewer unnecessary transfers, and stronger Northern mental health infrastructure.

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Research Team



Tereza Blahova is graduating with a master's of applied science in biomedical engineering at the University of Toronto. She completed her HBSc in pharmacology and global health at the University of Toronto where she developed a computational model to track the bioaccumulation of pharmaceutical waste in marine organisms, investigated the connection between sleep disturbances and Rett Syndrome, and assisted in characterizing the function of an Autism Spectrum Disorder associated gene which contributed to a publication. Tereza is an incoming PhD student at the University of North Carolina Chapel Hill in biomedical engineering where she will focus on preventative multiple-drug delivery for women's health indications.



Mohammed Shihan graduated with an HBSc from the University of Toronto, with majors in public policy and environmental science. He received the Karta Catalysts Scholarship and the International Scholar Award. Shihan has contributed to energy and environmental policy initiatives through research, policy analysis, and data-driven planning. He has held leadership positions such as co-chair of the public policy division at the Global Governance Initiative and as the environmental policy director at Policython. His expertise spans environmental advocacy, impact litigation, and community mobilization in India. Shihan currently works as an impact analyst at New Market Funds and is dedicated to fostering public policy engagement and professional development.



Irene Wu graduated with an HBA from the University of Toronto, specializing in peace, conflict, and justice studies. During her undergraduate career, she assisted with research on global and sexual health in Sub-Saharan Africa. Through her compliance work with the G20 Research Group, she contributed to the monitoring and assessment of G20 commitments, an experience that brought her to Brazil and South Africa where she engaged with policymakers and delegates. Irene is an incoming MPhil candidate at the University of Cambridge at the Centre for the Study of Existential Risk focusing on strategic foresight and developing early warning systems in fragile and conflict-affected regions.



Catherine Zhang completed her HBA in health, aging, and society from McMaster University and MPH in health promotion from the University of Toronto. She has a strong interest in health equity, health policy, and population health. Her research and academic work focus on addressing structural barriers to care, improving health outcomes for underserved populations, and advancing evidence-informed policy. She has supported research initiatives at the University of Toronto in sexual and reproductive health and at the Princess Margaret Cancer Centre in substance use.



Joseph Wong is the PI and founder of the Reach Alliance at the Munk School of Global Affairs & Public Policy, where he is also the Ralph and Roz Halbert Professor of Innovation, and professor of political science. He has published academic articles in leading journals in political science, development studies, political economy, and global health. Wong has published five books, including most recently with Princeton University Press, and has a forthcoming volume with Cambridge University Press. Wong's 2017 TEDx talk provides a short and compelling introduction to the challenges of "reaching the hardest to reach." He has been a visiting scholar at leading universities in Asia (Seoul National University), the US (Harvard), and the UK (Oxford). He has advised international organizations such as the United Nations, the Economic Commission for Latin America, and the World Health Organization, as well as governments in Europe, Africa, Latin America, and Asia. In 2020, Professor Wong was appointed to be the University of Toronto's vice-president, international.



Ornge is Ontario's not-for-profit provider of air ambulance and critical care transport services, operating under the direction of the provincial Ministry of Health. Serving more than 14 million people across over one million square kilometres, Ornge delivers approximately 20,000 patient-related transports annually through a network of 14 bases across the province. Its services include emergent scene responses, urgent and emergent interfacility transfers, non-urgent transport based on geographic and population needs, patient repatriation, organ transplant transportation, and support for healthcare delivery in remote communities.

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