Addictions Service Mapping in the Greater Hamilton Health Network

Prepared for the GHHN Mental Health & Addictions Secretariat

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Overview

In January 2025 all members of the Greater Hamilton Health Network (GHHN) Mental Health and Addiction Secretariat who provide addictions services were asked to complete a service mapping survey intended to identify key barriers and opportunities for enhanced integration across the system, as well as examine the coordination of patient and clinical information as patients flow between services in the region. A total of 32 addiction-focused programs across 12 health service providers within the GHHN region participated, providing a non-exhaustive but representative sample of programs focused on a variety of substances and with a variety of core program objectives.

The results of the exercise revealed challenges with service visibility, information sharing, staffing shortages, and the increasing complexity of client needs. Key areas of growth were discussed: such as increased service hours, workforce development and retention, pathways and system coordination, clinical information sharing, and the need for stable long-term funding. Service mapping showed a heavy concentration of harm reduction and recovery support programs, lack of bed-based addictions services commensurate with need, and wide variation in outcome measures.

Contents

Who Was Included in this Service Mapping?

The following 32 programs were included in this service mapping exercise. Only those programs that voluntarily participated in the exercise were included, meaning that this is not an exhaustive review of all addictions-focused programs within the GHHN region; though it is likely representative.

Alternatives for Youth (AY)
- Youth Substance Use Program

Canadian Mental Health Association (CMHA)
- Community Enrichment Service Case Management
- Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course
- Hamilton Stop Program
- Hamilton Street Team
- Primary Health Care Clinic

Good Shepherd
- Community RAAM
- Barrett Centre: Harm Reduction and Addictions Worker
- Health on Wheels
- Integrated Health Team

Hamilton Public Health
- *Alcohol, Drug, and Gambling Services (ADGS)*
  - Mental Health Street Outreach
  - Problematic Gambling
  - Substance Use Program
- Harm Reduction Program
- Tobacco Control Program

Hamilton Urban Core CHC
- Harm Reduction Program

Mission Services
- Addictions Supportive Housing
- Harm Reduction Team
- SUNTRAC

St. Joseph's Healthcare Hamilton (SJHH)
- Concurrent Disorder Capacity Building Team
- Concurrent Disorder Outpatient Program
- Men's Addictions Services Hamilton
- Rapid Access to Addictions Medicine
- Substance Use Service
- Womankind
- Youth Addictions and Substance Use Program

Thrive Group
- Roxanne Program

Wayside House
- Wayside House

Wesley
- Special Care Unit

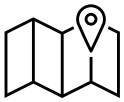
West Niagara Mental Health
- Mental Health Adult Substance Use & Youth Substance Use

YWCA
- Safer Use Space
- Transitional Living Program: Integrated Harm Reduction & Addictions Program

Integration and Coordination Barriers

Program leaders were asked about the barriers they face in the context of working within an integrated and coordinated addictions system in the GHHN region. The following themes emerged from the responses:

Program Visibility

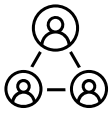


Mental health and addictions providers across the GHHN described barriers in maintaining awareness of available services, referral pathways, and eligibility criteria. Staying updated on services across sectors is challenging, impacting timely and informed referrals. Unclear expectations around referrals can lead to delays in accessing services and compounding wait times.

Information Sharing

Providers described a general lack of communication regarding client follow-ups. Clinical information sharing remains a challenge as clients must repeatedly disclose their histories, leading to disengagement. Limited communication among providers makes tracking lost-to-service clients difficult. While frontline staff benefit from relationship-building and case consultations, structured opportunities for interdisciplinary cooperation were seen to be lacking.

Health Human Resources



Staffing shortages, funding constraints, and workforce retention issues further delay service delivery, especially for programs that are in high demand or that involve specialized services that are reliant on certified personnel. Opportunities for cross-agency and cross-sector training were consistently highlighted as an area for growth.

Specialized Services and Increasing Complexity

Many programs identified a rising complexity of cases, including human trafficking and complex addictions in youth. Systemic barriers like the challenge of navigating multiple systems or having to seek services out-of-region (as in the case of youth residential treatment) leads to disengagement. Some programs identified the value of engaging families and caregivers but also spoke to the difficulties of engaging other sectors such as education, employment, or housing.

Affordable and Supportive Housing

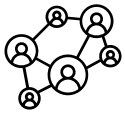
Housing remains a critical issue. Transitional and supportive housing programs struggle to secure long-term placements, especially for those requiring LTC or RCF beds. Affordable housing shortages further destabilize individuals transitioning from intensive care.

Areas of Prospective Growth

When looking to the future, however, health service providers identified key areas for investment that would foster deeper integration and coordination across the health system. Common themes across programs highlight the need for:

Increased Staffing & Service Hours

Many health service providers identified the hope for increased funding to expand staffing levels and service hours, particularly for outreach, peer support, and case management. This includes the expansion of services to better reach new populations (particularly youth and people experiencing homelessness) and expanded hours of operation especially into evenings and weekends.

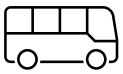


Increased Service Offerings and Skillsets

There was a strong value placed on the inclusion of additional supports, such as: peer support, NP-led interventions, and harm reduction services. Included in this was a focus on training and workforce development.

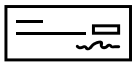
Improved System Navigation & Coordination

Enhanced referral systems and case management, including centralizing intake processes, improving interagency coordination, and implementing shared electronic health records for seamless communication were identified as opportunities.



Outreach

Outreach services – both as a mechanism of referral into programs and as a way to enhance discharge and follow-up – was identified by several programs. At the same time, programs identified a need to coordinate among existing outreach programs to avoid duplication.



Sustainable & Long-Term Funding

Several programs emphasized the importance of stable, permanent funding to build strong provider networks and ensure continuity of care.

Mapping Services by Substance

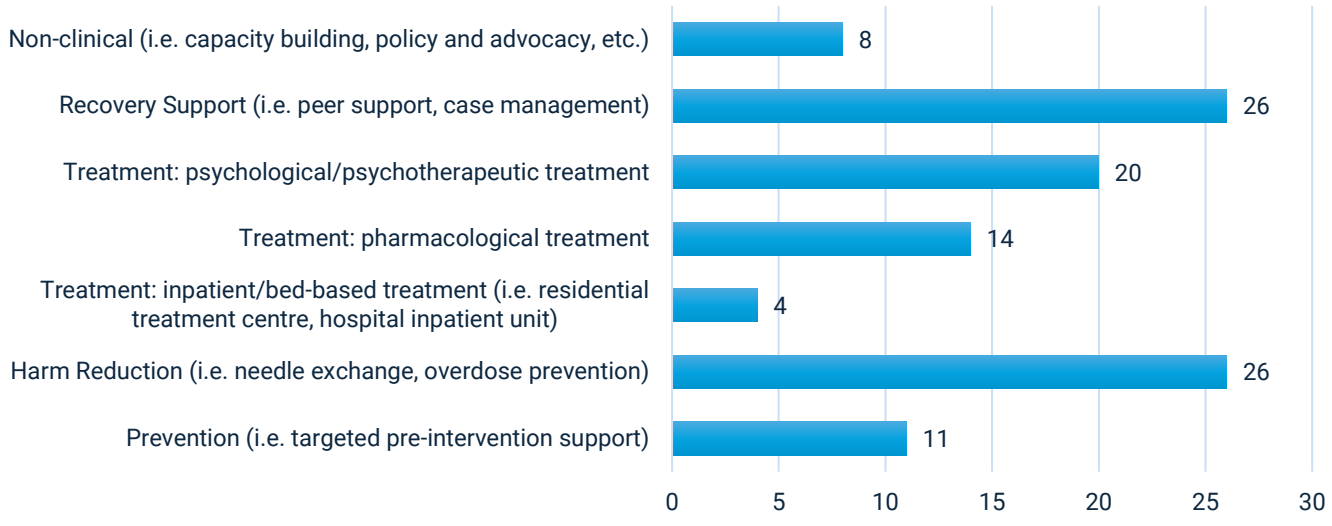
Nearly all programs surveyed (27 out of 32) identified that their services were accessible to people using any substance, or any combination of substances. See *Appendix A* for a full list of services mapped by substance. There were some exceptions to this:

- Rapid Access to Addictions Medicine (SJHH) has a specific focus on alcohol and opioids.
- There were two programs surveyed that focused on tobacco: the Hamilton Stop Program (CMHA) and the Tobacco Control Program (Hamilton Public Health).
- Four programs identified that their services were accessible to individuals with process addictions (i.e. gambling, sex, shopping, etc.): Gambling Service (ADGS), Community Enrichment Service Case Management (CMHA), Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course (CMHA), Primary Health Care Clinic (CMHA)

There were no programs that identified that they specifically target stimulant, cannabis, or sedative addictions.

Mapping Services by Program Objective

Twenty-six programs identified that the core objectives of the program were either harm reduction (i.e. needle exchange, overdose prevents) or recovery support (i.e. peer support, case management), though rarely were these objectives the sole focus of the program. See *Appendix B* for a full listing of services mapped by program objective. Of particular note in this data is the low capacity for bed-based treatment within the GHHN catchment, which stands in contrast to the data in the next section suggesting that bed-based treatment is one of the more commonly referred-to programs.



System Flow

Programs were asked to identify where referrals into the program typically originated, as well as to identify the next program that the service user was most likely to encounter should they successfully complete the program or be discharged or leave prematurely. The chart below shows the most common responses. See *Appendix C* for a visual representation of patient flow throughout the system using a network analysis tool.

Referral Origin

When asked where referrals to programs tended to stem from, the most common responses were:

1. Self-referral.
2. Another health service provider.
3. Hospital/Emergency department.
4. Primary care.
5. Family and friends.
6. Shelters and outreach services.

Successful Discharge

When asked about the most likely service or program the individual would encounter after successfully completing the addictions program, the most common responses were:

1. Primary care.
2. Another program internal to the agency.
3. Another health service provider.
4. Bed-based addictions programs.
5. Housing providers.
6. RAAM clinic.

Unsuccessful Discharge

When asked about the service that the individual would be most likely to encounter after leaving or being discharged prematurely, the most common responses were:

1. Primary care.
2. Another program internal to the agency.
3. Another health service provider.
4. Shelters or outreach services.
5. Hospital/Emergency department.

Health service providers were also asked about whether transfers between programs tended to involve warm transfers (i.e. direct coordination between providers) and/or whether clinical information was provided.

	Is there a warm transfer (i.e. direct coordination between providers) to this program?	**Is there clinical information provided to this next service or program?**
Upon receiving a referral into the program.	78% of programs said “yes.” 19% of programs said “no.”	72% of programs said “yes.” 19% of programs said “no.”
When discharging a patient after they have successfully completed the program.	75% of programs said “yes.” 13% of programs said “no.”	56% of programs said “yes.” 22% of programs said “no.”
If an individual has left or been discharged prematurely.	63% of programs said “yes.” 28% of programs said “no.”	58% of programs said “yes.” 26% of programs said “no.”

Outcome Measures

Based on responses to the survey, there appears to be substantial variability in the way that programs assess outcomes. No specific clinical outcome tools were mentioned in any responses, though some did mention “pre/post measures” and “assessments” more generally. Two organizations reported evaluation mechanisms that are likely to include outcome measures: CMHA uses the CMHA National Recovery KPIs, and Wayside House reported using the Performance Outcome Monitoring being piloted through Homewood Research Institute. One program mentioned that they conduct more rigorous retrospective and prospective cohort studies.

Many noted that their programs are evaluated through output measures, rather than outcome measures: such as the number of clients served or the number of visits. The OPOC tool was mentioned several times, which is more a client experience tool and does not necessarily measure clinical outcomes. Some programs note that outcomes are measured through discharge summaries and treatment plans, while other programs measure outcomes through population health data like national surveys, census data, or mortality data.

Appendix A: Programs by Substance Focus

The following programs identified that their service users come for a variety of substances (either polysubstance use or the program does not discriminate between substances):

- Mental Health and Street Outreach Program: Substance Use (ADGS)
- Substance Use Program (ADGS)
- Youth Substance Use Program (AY)
- Community Enrichment Service Case Management (CMHA)
- Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course (CMHA)
- Hamilton Street Team (CMHA)
- Primary Health Care Clinic (CMHA)
- Community RAAM (Good Shepherd)
- Barrett Centre: Harm Reduction and Addictions Worker (Good Shepherd)
- Health on Wheels (Good Shepherd)
- Integrated Health Team (Good Shepherd)
- Harm Reduction Team (Hamilton Public Health)
- Harm Reduction Program (HUCCHC)
- Addictions Supportive Housing (Mission Services)
- Harm Reduction Program (Mission Services)
- SUNTRAC (Mission Services)
- Concurrent Disorder Capacity Building Team (SJHH)
- Concurrent Disorder Outpatient Program (SJHH)
- Men's Addictions Services Hamilton (SJHH)
- Substance Use Service (SJHH)
- Womankind (SJHH)
- Youth Addictions and Substance Use Program (SJHH)
- Roxanne Program (Thrive)
- Special Care Unit (Wesley)
- Wayside House
- Mental Health Adult Substance Use & Youth Substance Use (West Niagara Mental Health)
- Safer Use Space (YWCA)
- Transitional Living Program: Integrated Harm Reduction & Addictions Program (YWCA)

Some programs identified specific substances of focus:

- Alcohol: Rapid Access to Addictions Medicine (SJHH)
- Opioids: Rapid Access to Addictions Medicine (SJHH)
- Tobacco: Hamilton Stop Program (CMHA) and Tobacco Control Program (Hamilton Public Health)
- Process (i.e. gambling, sex, shopping, etc.): Gambling Service (ADGS), Community Enrichment Service Case Management (CMHA), Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course (CMHA), Primary Health Care Clinic (CMHA)

No programs identified that they specifically target stimulants, cannabis, or sedatives.

Appendix B: Programs by Core Objectives

Programs were asked to select the core program objectives for each of their programs. Multiple responses were allowed. The following lists showed the programs that fit under each objective:

Prevention (i.e. targeted pre-intervention support):
- Gambling Service (ADGS)
- Youth Substance Use Program (AY)
- Hamilton Stop Program (CMHA)
- Primary Health Care Clinic (CMHA)
- Barrett Centre: Harm Reduction and Addictions Worker (Good Shepherd)
- Integrated Health Team (Good Shepherd)
- Harm Reduction Team (Hamilton Public Health)
- Harm Reduction Program (HUCCHC)
- Addictions Supportive Housing (Mission Services)
- Harm Reduction Program (Mission Services)
- SUNTRAC (Mission Services)

Harm Reduction (i.e. needle exchange, overdose prevention)
- Mental Health and Street Outreach Program: Substance Use (ADGS)
- Gambling Service (ADGS)
- Substance Use Program (ADGS)
- Youth Substance Use Program (AY)
- Hamilton Stop Program (CMHA)
- Hamilton Street Team (CMHA)
- Primary Health Care Clinic (CMHA)
- Barrett Centre: Harm Reduction and Addictions Worker (Good Shepherd)
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- Special Care Unit (Wesley)
- Safer Use Space (YWCA)
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Treatment: inpatient/bed-based treatment (i.e. residential treatment centre, hospital inpatient unit)
- Men's Addictions Services Hamilton (SJHH)
- Substance Use Service (SJHH)

- Womankind (SJHH)
- Wayside House

Treatment: pharmacological treatment
- Substance Use Program (ADGS)
- Hamilton Stop Program (CMHA)
- Primary Health Care Clinic (CMHA)
- Community RAAM (Good Shepherd)
- Tobacco Control Program (Hamilton Public Health)
- Harm Reduction Program (HUCCHC)
- Concurrent Disorder Capacity Building Team (SJHH)
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- Youth Addictions and Substance Use Program (SJHH)
- Mental Health Adult Substance Use & Youth Substance Use (West Niagara Mental Health)
- Safer Use Space (YWCA)

Treatment: psychological/psychotherapeutic treatment
- Mental Health and Street Outreach Program: Substance Use (ADGS)
- Gambling Service (ADGS)
- Substance Use Program (ADGS)
- Youth Substance Use Program (AY)
- Community Enrichment Service Case Management (CMHA)
- Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course (CMHA)
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Recovery Support (i.e. peer support, case management)
- Mental Health and Street Outreach Program: Substance Use (ADGS)
- Gambling Service (ADGS)
- Youth Substance Use Program (AY)
- Community Enrichment Service Case Management (CMHA)
- Hamilton Recovery College: SMART Recovery Drop-In & Addictions Foundations Course (CMHA)
- Hamilton Stop Program (CMHA)

- Hamilton Street Team (CMHA)
- Primary Health Care Clinic (CMHA)
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Non-clinical (i.e. capacity building, policy, advocacy, etc.)

- Barrett Centre: Harm Reduction and Addictions Worker (Good Shepherd)
- Health on Wheels (Good Shepherd)
- Harm Reduction Team (Hamilton Public Health)
- Addictions Supportive Housing (Mission Services)
- Harm Reduction Program (Mission Services)
- Concurrent Disorder Capacity Building Team (SJHH)
- Special Care Unit (Wesley)
- Safer Use Space (YWCA)

Appendix C: Network Map of Referrals into Programs

Social network analysis maps, such as the one below, are a visual way of representing the relationships within a system. This analysis involves nodes (represented as dots in the image below), which in this case are "addiction programs" and the people and places who refer individuals into them; and edges (represented as the lines that connect each dot), which are the relationships or interactions between them. When graphed, it shows the degree to which programs are interconnected: nodes that are more densely interconnected are located closer to the center of the graph, and nodes that are less densely interconnected are more to the periphery. The following image is a visual representation of the interconnectedness of the GHHN addictions system based on responses to the questions about where referrals into programs tended to originate from and the most likely program the service user is likely to encounter following successful completion or premature discharge. For example, if a provider (1) identified that referrals tended to come from "outreach teams" (2) and tended to result in a referral to "primary care," (3) a line would be drawn between all three. The size of the dots below correspond with the number of connections it has, and the colouring represents densely interconnected sub-groups within the network.