City of Hamilton
Report for Information

To:	Chair and Members Public Health Sub-Committee
Date:	February 24, 2025
Report No:	BOH25004
Subject/Title:	Overview of Mental Health Institutions, Policy, and Implications for Hamilton's Homelessness, Mental Health, and Substance Use Crises (Outstanding Business List Item)
Ward(s) Affected:	(City Wide)

Recommendations

1) That Report BOH25004 respecting the Overview of Mental Health Institutions, Policy, and Implications for Hamilton's Homelessness, Mental Health, and Substance Use Crises **BE RECEIVED** for information.

Key Facts

- This report was developed in response to a motion at the September 30, 2024 Public Health Committee Meeting;
- Homelessness, mental health, and substance use are deeply interconnected issues that require a comprehensive, integrated approach that bridges health and social services, rather than addressing each issue in isolation;
- Ontario's mental health and substance use system provides a range of services, from prevention to intensive care, across settings like community-based and acute care environments;
- The current mental health and substance use system is fragmented and disconnected, with significant barriers to care, largely due to a lack of investment during the deinstitutionalization process, which shifted from institutional care to community-based support; and,
- The City of Hamilton can address these interconnected crises by continuing to invest in and advocate for sustainable funding focused on prevention through

crisis response, enhancing service coordination, and implementing the Housing First model principles.

Financial Considerations

Not Applicable.

Background

At the September 30, 2024 Public Health Committee Meeting, staff were provided the following direction via motion:

Historical Overview of Relevant Mental Health Policy and its Implications for the City of Hamilton (Item 11.1)

(a) That staff be requested to report back to the Public Health Committee by Q2 2025 with an overview of relevant mental health institutions, policy and implications for the City in its efforts to address the declared homelessness, mental health and substance use crises; specifically:

(i) An account of those mental health, addiction, and rehabilitation institutions in Hamilton working with the city and in what capacity in responding to the intersection of homelessness and mental health;

(ii) A historic overview of the deinstitutionalization process in Ontario and any specific impacts on Hamilton;

(iii) The *Mental Health Act of Ontario*; and,

(iv) The roles responsibilities and purview of authorities as set out in the *Mental Health Act of Ontario*.

Although mental health and substance use disorders impact a wide range of individuals, this report will focus on populations experiencing homelessness based on the request from the Public Health Committee.

Analysis

The Intersections of Homelessness, Mental Health, and Substance Use

In April 2023, the City of Hamilton declared a state of emergency to address the escalating crises of homelessness, mental health, and substance use - issues that are deeply interconnected and mutually reinforcing. Individuals experiencing homelessness experience mental health and substance use disorders at disproportionately high rates. A voluntary Point in Time Connection survey of 545 individuals experiencing homelessness in Hamilton conducted in November 2021, found that 60% reported

facing mental health challenges, while 59% reported issues with substance use.[1] In addition to higher rates, the complexity of mental health and substance use disorders is also greater among individuals experiencing homelessness.[2] At a national level, the Point in Time Connection survey found that 47% of respondents reported concurrent mental health and substance use disorders.[3] Mental health and substance use disorders can both be a cause and a consequence of homelessness.

Several factors increase the risk of homelessness for those with mental health and substance use disorders, including:

- Income and employment insecurity: Mental health and substance use issues can make it harder to secure and maintain stable employment, increasing their financial vulnerability;[4]
- Lack of support systems: Mental health and substance use issues can lead to withdrawal and estrangement from family, friends, and other support systems, reducing available resources and safety net;[2] and,
- Impaired cognition and decision-making: Mental health and substance use issues can impair judgment and decision-making, which may impact financial management, missed rent or bill payments, and failure to comply with housing agreements, all of which can result in eviction or housing loss.[2]

Mental health and substance use disorders not only increase the likelihood of becoming homeless but also make it harder to escape homelessness. Among the homeless population, 49% of those with mental health and substance use comorbidities experience chronic homelessness, defined as being homeless for six or more months in the past year, compared to 42% of those without these challenges.[3] Chronic homelessness is a key indicator of systemic failure, depicting a lack of affordable and suitable housing solutions.[5] For individuals living with mental health and substance use

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[1] City of Hamilton, Housing Services Division. (2022). Point in Time Connection Results 2021. https://www.hamilton.ca/sites/default/files/2022-10/PIT-2021-City-of_hamilton-Results.pdf

[2] Canadian Observatory on Homelessness. (2021). About homelessness. https://www.homelesshub.ca/about-homelessness/topics/mental-health

[3] Government of Canada. (2024). Homelessness Data Snapshot: Mental health, Substance Use, and Homelessness in Canada. https://housing-infrastructure.canada.ca/homelessness-sans-abri/reports-rapports/mental-health-substance-use-sante-mentale-consom-substances-eng.html

[4] Canadian Institute for Substance Use Research. (2021) Homeless, Mental Health and Substance Use: Understanding the Connections. https://www.heretohelp.bc.ca/sites/default/files/homelessness-mental-health-and-substance-use.pdf

[5] Association of Municipalities of Ontario. (2025). Municipalities Under Pressure: The Human Financial Cost of Ontario's Homelessness Crisis. https://www.amo.on.ca/sites/default/files/assets/DOCUMENTS/Reports/2025/2025-01-08-EndingChronicHomelessnessinOntario.pdf

disorders, this often means a lack of supportive housing, which offers long-term housing while providing integrated support needed for stabilization, recovery, and long-term independence. There is a particular need for supportive housing that meets the complex, high acuity needs of individuals with severe mental health and substance use conditions.[5]

This situation creates a cyclical problem, where mental health and substance use challenges make it harder to escape homelessness, while homelessness itself exacerbates these challenges. The stress of experiencing homelessness can exacerbate existing mental illness and addiction, triggering or intensifying anxiety, fear, depression, sleeplessness, and further substance use, ultimately deepening the cycle of homelessness and instability.[4]

When exploring the interconnected nature of these issues and their root causes, it is important to consider the profound impact of trauma. Past experiences of trauma, whether physical, emotional, or psychological, serve as significant risk factors for a range of complex challenges, including homelessness, mental health disorders, and substance use disorders.[4] Trauma, particularly in early life, can shape an individual's mental health, emotional wellbeing, and future stability. Adverse childhood experiences are potentially traumatic events that occur before the age of 18 years of age that can have a lasting impact on an individual's health and wellbeing.[6] Adverse childhood experiences include physical, emotional, or sexual abuse; physical and emotional neglect; witnessing domestic violence; growing up in a household with substance abuse, mental illness, or criminal behaviour; and experiencing parental separation or divorce.[6] The more adverse childhood experiences an individual faces, the greater the risk for negative outcomes in adulthood.

Research has shown that 90% of adults experiencing homelessness have been exposed to at least one adverse childhood experience, with over half being exposed to four or more adverse childhood experiences.[6] Adverse childhood experiences are also associated with a higher prevalence of mental health and substance use disorders.[6] Trauma isn't limited to childhood; it can also result from later life events, such as intimate partner violence, divorce, job loss, or eviction. Certain groups are more vulnerable to trauma, including those from marginalized communities, such as Indigenous people, racialized people, 2SLGBTQ+ individuals, newcomers, and women.[4,7] These groups often face systemic violence and discrimination, which can cause lasting emotional and psychological harm.[4] A critical approach to addressing the root causes of trauma and its long-term effects lies in focusing on prevention and building protective factors that can help mitigate its impact.

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[6] The Lancet. (2021) Adverse Childhood Experiences and Related Outcomes Among Adults Experiencing Homelessness: A Systematic Review and Meta-Analysis. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00189-4/fulltext

[7] City of Hamilton. (2014). Housing Services Homelessness Prevention Review https://www.hamilton.ca/sites/default/files/2022-08/homelessness-prevention-research.pdf

Furthermore, trauma often occurs during homelessness. Individuals who experience homelessness are often subjected to unsafe and degrading conditions, including lack of privacy, exposure to violence, theft, exploitation, and discrimination.[4,8] These factors can contribute to worsened mental health and increased substance use as a way to cope.[4]

These challenges are further exacerbated by the current state of income and housing insecurity. The systemic issues and the complex relationships between homelessness, mental health, and substance use highlight the urgent need for an integrated, comprehensive approach that addresses all factors simultaneously. A spectrum of coordinated high-quality services that address diverse needs can promote long-term stability, recovery, and improved wellbeing for individuals in this cycle.

The History of Institutionalization and Deinstitutionalization

To better understand the current mental health and substance use system, it is essential to examine the historical models of care that shaped it, including institutionalization and deinstitutionalization. In Canada, institutionalization emerged in the late 19th and early 20th centuries as a means of managing individuals with mental health conditions, developmental disabilities, and others thought to be unable to integrate into society.[8] While these large state-run facilities were intended to provide care, treatment, and supervision for individuals, many residents experienced inadequate care, neglect, and dehumanizing conditions.[8] Life within these institutions was often characterized by isolation, a lack of autonomy, and systemic abuse.[8] Over time, the institutional model was criticized for perpetuating harm and deepening the marginalization of groups disproportionately represented in these settings, including Indigenous people, Black people, immigrants, women, and those experiencing poverty or homelessness.[8] The overrepresentation of these groups can be traced back to a long history of oppression, including colonialism and racism, which have shaped the structures of these institutions.[8] Although distinct, these institutions share parallels to Canada's history of institutionalizing Indigenous people with underlying roots of control, segregation, and systemic discrimination.[8]

Criticisms of this model, among other factors, led to a gradual shift toward deinstitutionalization and the development of community-based care models. Deinstitutionalization refers to the process of closing large state-run facilities and transitioning individuals with mental illnesses, developmental disabilities, and other conditions into community-based care settings.[9,10] The process began in the 1960s and

[8] Inclusion Canada et al.. (n.d.). Truths of Institutionalization: Past and Present. https://truthsofinstitutionalization.ca/

[9] Healthcare Quarterly. (2014). Improving First-Line Mental Health Services in Canada: Addressing Two Challenges Caused by the Deinstitutionalization Movement. https://www.longwoods.com/content/24116/healthcare-quarterly/improving-first-line-mental-health-services-in-canada-addressing-two-challenges-caused-by-the-deins

[10] Canadian Journal of Psychiatry. (2004). Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment. https://journals.sagepub.com/doi/pdf/10.1177/070674370404900405

accelerated through the 1970s and 1980s.[9,10] Several key drivers influenced the move toward deinstitutionalization, including:

- Human rights and social reform: There was a growing recognition that institutional care often led to neglect, abuse, and isolation and that people with mental illnesses and developmental disabilities had the right to live in the community with appropriate support;[9,11]
- Economic considerations: Institutions were expensive to operate, and consumed a significant portion of the healthcare budget, whereas community-based care was seen as a more cost-effective solution;[9,11] and,
- Advancements in medicine and therapy: New psychiatric medications and therapies improved the ability to manage mental health conditions outside institutional settings.[9,11]

While deinstitutionalization led to positive outcomes, such as greater autonomy, improved quality of life, and better integration into the community for many individuals, uncoordinated and under-resourced implementation of the process resulted in significant challenges. With the transfer of care to community settings, deinstitutionalization was intended to be coupled with a significant increase in funding for community-based services to support better integration into the community.[9,10,11] The transition received criticism for not being accompanied by adequate funding for community-based services, leading to gaps in support.[9,11] The possible supports for full integration extended beyond mental health services to broader social policy initiatives, including group homes, supported living arrangements, and life skills and vocational training programs. From the late 1980s to the late 1990s, funding patterns revealed a clear disparity, with institutional expenditures decreasing by $157 M, while funding for community-based psychiatric services only increased by $104 M.[10] This financial shortfall was exacerbated by the longstanding trend of underfunding social policy compared to health care funding. Overall health care funding during this time increased rapidly, while social spending remained relatively flat.[12] Consequently, the development of a comprehensive, integrated system was limited, resulting in fragmented and reactive service provision.

This under-resourcing of community-based services led to "trans-institutionalization".[10,11,13] Instead of achieving full community integration, many former residents of large institutions were relocated to smaller institutional settings such as boarding houses, group homes, foster homes, nursing homes, long-term care homes,

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[11] American Medical Association. (2013). Deinstitutionalization of People with Mental Illness: Causes and Consequences. https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10

[12] Canadian Medical Journal. (2018). Effect of Provincial Spending on Social Services and Health Care on Health Outcomes in Canada: An Observational Longitudinal Study. https://pmc.ncbi.nlm.nih.gov/articles/PMC5780265/

[13] Madness Canada. (2022). The Last Asylums Exhibit. https://madnesscanada.com/after-the-asylum/policy-and-practice/the-last-asylums/

or jails.[11,13] These settings often lack the resources and support systems necessary to meet the unique needs of individuals with mental health disorders. Moreover, the shortage of affordable housing further intensified the issue, significantly increasing the risk of homelessness for many former institutional residents.[11,14] The gap in community-based services led to the development of housing options such as supportive housing, residential care facilities, and shelters to meet the growing demand for alternative housing supports. These options struggled to keep up with the demand created by de-institutionalization and often lacked the capacity to fully address the scale of the problem.

Hamilton has a deep-rooted history of psychiatric care, beginning with the establishment of the Hamilton Asylum in 1875, which grew over time to become one of the largest in the province.[13,15] Initially, the facility primarily offered custodial care, where individuals were supported with the daily tasks of living; however, as new treatments began to evolve in the 1950s, the care offered at the institution began to change.[13] Treatment expanded to include drug therapies, electroconvulsive therapies, and psychotherapy. The facility was renamed the Hamilton Psychiatric Hospital in 1966, which coincided with the start of deinstitutionalization.[13,15] This led to a slow decline in the number of inpatients at the site in the subsequent decades and a new philosophy of care to treat patients and help them reintegrate into the community.[13] This resulted in the development of outpatient clinics, day programs, and community outreach.[13] At this time, other community-based mental health organizations began increasing services such as case management and housing assistance to respond to this transition of care.[13] The facility closed in 2001, with fewer than 200 inpatients remaining at that time.[13] The site has since been redeveloped into St. Joseph's West 5th Campus, which continues to offer a wide range of mental health services, including both outpatient and inpatient care.

The Mental Health and Substance Use System in Ontario

The insufficient investment in community-based services during the deinstitutionalization process has had a lasting impact on Ontario's mental health and substance use system. Without adequate resources, these services were developed in a reactive and fragmented way, rather than being built as a comprehensive, integrated network of care.[9]

In the Provincial government's Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System ("Roadmap"), the Province recognizes that the current

[14] Ontario Human Rights Commission. (2024). The Rental Housing Landscape in Ontario. https://www3.ohrc.on.ca/en/human-rights-and-rental-housing-ontario-background-paper/rental-housing-landscape-ontario

[15] Government of Ontario. Record: Hamilton Psychiatric Hospital. https://aims.archives.gov.on.ca/scripts/mwimain.dll/144/ORGANIZATION_VAL_SYN/WEB_ORG_DET_OPAC?SESSIONSEARCH&exp=ORG_ID%20O500

system is fragmented, disconnected, and has significant barriers to care.[16] Many individuals seeking help face difficulties navigating a complex and often overwhelming system, which is further complicated by long waitlists for essential services.[16] As a result, many individuals do not seek care or turn to emergency departments, even when more appropriate care is available in community-based settings.[16] This overreliance on emergency services not only places added pressure on hospitals but also denies individuals the continuous, coordinated care needed to effectively address their mental health or addiction challenges.

In Ontario, mental health and substance use services are provided across a range of settings, each playing a distinct yet complementary role. These settings are intended to work together to ensure a holistic approach, addressing the diverse needs of individuals at every stage— from prevention and mental health promotion to treatment, stabilization and recovery. This collaborative framework aims to ensure that individuals receive the most appropriate care at each point in their journey. Given the chronic and fluctuating nature of these conditions, individuals may access different levels of care as the severity of their needs change. Below is an overview of these key settings and the services they offer.

- **Primary Care:** These settings are often the first point of contact for individuals seeking help, primary care plays a crucial role in early identification and management of mental health and substance use issues. It provides ongoing support and helps individuals navigate the system. Types of supports in this setting include: screening; medication management; and referrals to other services;
- **Community-Based Services:** These settings offer comprehensive, specialized mental health and addiction services that are tailored to the needs of individuals and the community. They aim to reduce barriers to treatment, build trust, and offer flexible ongoing support. Types of supports in this setting include: psychotherapy, peer support; case management; outreach services; and substance use treatment programs;
- **Out-Patient Services:** This setting provides structured, intensive care without the need for full hospitalization. It allows individuals to manage their mental health and substance use disorders, receive ongoing treatment, and maintain their daily routines and responsibilities. Types of supports in this setting include peer support; case management; substance use treatment programs; and day programs;
- **Supportive Housing:** This setting provides stable, long-term housing with integrated support services for individuals with chronic mental health or substance use conditions. Although not traditionally seen as part of the health care system, supportive housing plays a critical role in reducing the demand for health services by stabilizing patients and addressing underlying social needs. By providing a safe space that promotes recovery and long-term well-being,

[16] Ministry of Health. (2020). Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System. https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system

supportive housing eases pressure on hospitals, shelters, emergency services, and the justice system.[17] Types of supports in this setting include medication support; case management; life skill training; and social activities.

- **Bed-Based Treatment:** These facilities provide intensive, short-term care for individuals seeking substance use treatment. This setting offers structured, 24-hour care with a focus on stabilization and recovery. Types of supports in this setting include psychotherapy; peer support; withdrawal management; and substance use treatment programs; and,
- **In-Patient Services:** This setting offers 24-hour supervision and care for individuals in acute crisis. These services are designed for those who pose a risk to themselves or others and cannot manage their condition in the community. Types of supports in this setting include assessments; medication management; crisis intervention; and discharge planning.

Public health is rooted in community-based services, with a focus on prevention, early intervention, and the promotion of mental wellbeing. At Public Health Services, this includes mental health promotion in schools, educational campaigns to increase the knowledge and awareness of substance use, and mental health counselling and evidence-based therapies for children, youth, and their families. Additionally, Public Health Services offers various interventions and supports to young families and parents that promote positive parent-child relationships and enhance social and emotional development to prevent adverse childhood experiences and contribute to long-term mental well-being. Beyond these efforts, Public Health Services also provides interventions focused on treatment. This includes alcohol, drug, and gambling support for adults, street outreach for individuals experiencing homelessness, intensive case management for adults with serious mental health conditions, and harm reduction services, such as distribution of naloxone and harm reduction supplies, opioid surveillance and monitoring, and sexually transmitted infection (STI) testing.

For more information about the organizations involved in providing these services across these settings in Hamilton, see Appendix "A" to Report BOH25004.

The Roadmap outlines a vision for a more integrated, accessible, and patient-centred system.[16] It aims to create a system that is easier to navigate, where individuals can access the appropriate level of care based on their needs.[16] In addition to improving service integration across different settings, the roadmap prioritizes investment in community-based services to enhance access to care.[16] This includes early interventions to ensure individuals receive timely and effective care, ultimately reducing unnecessary emergency department visits and the inappropriate use of acute services for those whose needs do not require this level of care.[16]

To support the work highlighted in the Roadmap, Ontario is investing $3.8 B over 10 years to expand existing programs and fill gaps in care with innovative solutions and services. Despite the Province's investment, Ontario's system is estimated to be

[17] City of Hamilton. (2024). Housing Sustainability and Investment Roadmap. https://www.hamilton.ca/sites/default/files/2023-12/housing-sustainability-investment-roadmap-nov23-update.pdf

underfunded by approximately $1.5 B.[18] This continues to put strain on the services, where the demand for mental health and substance use supports far exceeds the available capacity, resulting in long wait times for services. For instance, in Ontario, the average wait time for children and youth to access counselling is 67 days, and 92 days for more intensive treatment.[19] Hamilton has the fifth highest wait times for child and youth mental health services across Ontario, with waitlists extending up to 710 days.[19]

In addition to the growing demand on the current system, there are concerns about its ability to adapt to the changing landscape of substance use. With the rise of toxic drug supplies and increasing poly-substance use, the potency and unpredictability of these drugs elevate the risks of overdose, poisoning, and severe withdrawal symptoms. Unfortunately, the substance use treatment system is not adequately equipped to manage the intensity of withdrawal associated with these highly potent substances. Many facilities lack the necessary resources or specialized care to handle complex, high-risk withdrawals, resulting in a significant gap in care.

Mental Health and Substance Use Disorder Services in Hamilton

In addition to the services above, is it important to understand the mental and substance use services specifically tailored to support individuals experiencing homelessness and the unique barriers to care they experience. For individuals experiencing homelessness, challenges include a lack of stable living conditions or means of communication, difficulties navigating the healthcare system, and negative experiences such as stigma and discrimination that have led to the mistrust of the healthcare system. Acknowledging these challenges, the Roadmap focuses on funding for targeted initiatives that break down these barriers, such as specialized outreach teams, mobile crisis intervention units, and supportive housing programs tailored for individuals experiencing homelessness.[16]

In early 2024, the Greater Hamilton Health Network conducted a scan of the mobile and outreach services available to those living in encampments.[20] The scan identified 16 unique organizations and programs offering mobile services to encampments within Hamilton.[20] These included municipal programs like the Hamilton Police Service's Social Navigator Program and the Rapid Intervention and Support Team, Hamilton Public Health Services' Harm Reduction and Mental Health and Street Outreach Programs, and Hamilton Housing Services Divisions' Housing-Focused Street Outreach Workers.[20] Of the 16 programs, seven offered mental health support and counselling,

[18] Centre for Addiction and Mental Health. According Equitable Funding for Mental Health Care. https://www.camh.ca/en/camh-news-and-stories/according-equitable-funding-for-mental-healthcare

[19] Children's Mental Health Ontario. (2020). Kids Can't Wait. https://cmho.org/wp-content/uploads/CMHO-Report-WaitTimes-2020.pdf

[20] Greater Hamilton Health Network. (2024). Mobile and Outreach Service Mapping: A Current State Analysis of the Greater Hamilton Health Network Service Areas. https://greaterhamiltonhealthnetwork.ca/wp-content/uploads/2024/08/GHHN-Mobile-and-Outreach-Worker-Final-Report.pdf

eight provided substance use treatment, 13 distributed harm reduction supplies, and eight facilitated referrals for wraparound mental health services.[20] The report recommended enhanced service integration and coordination across mobile and outreach services, ensuring that these models include effective mechanisms for referrals and shared care plans.[20] For an adapted version of the Greater Hamilton Health Network scan of mobile and outreach services, see Appendix "B" to Report BOH25004.

This recommendation of increased integration and coordination underscores the importance of a systems-level approach to delivering effective and efficient mental health and substance use services. It should be noted that there is no designated lead that has a mandate to work with community organizations to build a cohesive spectrum of services in alignment with local needs and provincial strategies. Organizations deliver independent programs and services, and are accountable to multiple funders, including various provincial and federal ministries, as well as foundations and private donors. Locally, the Greater Hamilton Health Network's Mental Health and Addictions Secretariat is leading the effort to coordinate and connect health system partners. The City of Hamilton actively contributes to the work of the Mental Health and Addiction Secretariat, with representation from Children's and Community Services, Paramedic Services, and Public Health Services at the Secretariat. For a full list of community partners involved in the Mental Health and Addictions Secretariat, refer to Appendix "C" to Report BOH25004.

The Greater Hamilton Health Network's Mental Health and Addictions Secretariat's efforts to enhance integration and coordination within the sector were highlighted in the November 21, 2024 report on Hamilton's mental health crisis response to the Emergency and Community Services Committee (Report HSC24040). The Emergency and Community Services Committee subsequently approved the report recommendations to support efforts to improve coordination of services, advocate for sustained funding, explore alternative crisis response approaches tailored to Hamilton, and also referred a commitment to resources to support this work to the 2025 budget process. These measures signify the City's commitment to addressing existing service gaps, fostering a coordinated care continuum, and improving our collective response to the escalating crises of homelessness, mental health, and substance use in Hamilton.

The Mental Health Act

To support the deinstitutionalization movement in Ontario, the *Mental Health Act* was introduced in 1967. The *Mental Health Act* aims to protect individuals' rights while

ensuring people with serious mental health issues receive the care they need.[21,22] It outlines the criteria for involuntary psychiatric assessment, treatment, and admission to a hospital or psychiatric facility, as well as patients' rights to be informed about their treatment, refuse treatment, and appeal decisions regarding their care.[21,22] The *Mental Health Act* seeks to strike a balance between respecting individual autonomy and ensuring public safety through appropriate mental health care.[21]

Within the *Mental Health Act*, involuntary care refers to situations where a person is admitted to a hospital or psychiatric facility for assessment or treatment under the order of someone else because they are deemed a significant risk to themselves or others.[21,23] Under the *Mental Health Act*, an individual may be placed under involuntary care if they are likely to seriously harm themselves or others due to a mental health condition, or if they are unable to care for themselves, which may lead to serious physical impairment or deterioration.[21,22,23] The *Mental Health Act* defines clear timeframes for involuntary detention, starting with an initial 72-hour assessment period, which can be extended to longer periods—up to two weeks and then renewable for up to one month—if the criteria for involuntary care continue to be met.[21,23] These time limits are in place to ensure regular reassessment of the individual's condition and the necessity of ongoing detention.[21,23]

Recent reforms to the *Mental Health Act* introduced Community Treatment Orders as a less restrictive alternative to hospitalization.[21] Community Treatment Orders allow individuals with severe mental health conditions to live in the community under specific conditions, such as adhering to structured outpatient treatment plans, attending regular appointments, and taking prescribed medications.[21] These provisions balance individual autonomy with the need for ongoing care and public safety.

In situations where an individual does not meet requirements for involuntary care under the *Mental Health Act*, meaning they are not posing a significant risk to themselves or others, the individual must consent to care. Under the *Health Care Consent Act*, individuals have the right to make decisions about their own healthcare, provided they are capable of doing so.[24] To provide informed consent, a patient must be able to understand the relevant information about the proposed treatment and comprehend the consequences of their decision.[23]

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[21] Ontario Hospital Association. (2023). A Practical Guide to Mental Health and the Law in Ontario. https://www.oha.com/Legislative%20and%20Legal%20Issues%20Documents1/A%20Practical%20Guide%20to%20Mental%20Health%20and%20the%20Law%2C%20Fourth%20Edition%2C%202023.pdf

[22] Your Support Services Network. (2024). Understand Involuntary Admission to a Psychiatric Facility. https://yssn.ca/understanding-involuntary-admissions-to-a-psychiatric-facility/

[23] Province of Ontario, (2015). Mental Health Act, R.S.O. 1990. https://www.ontario.ca/laws/statute/90m07#BK11

[24] Wise Health Law. (2018). Ontario's Health Care Consent Act in Action. https://wisehealthlaw.ca/blogs/blog/ontarios-health-care-consent-act-in-action

For definitions of the terms used in the *Mental Health Act* and *Health Care Consent Act*, see Appendix "D" to Report BOH25004.

Under the *Mental Health Act*, involuntary care is specifically permitted for individuals with mental health disorders and does not extend to those with substance use disorders.[20] While individuals with substance use disorders can be involuntarily admitted to a hospital or psychiatric facility if they have a concurrent mental health disorder, involuntary care for substance use alone is not authorized under the *Mental Health Act*.[20] This distinction emphasizes the legal boundaries and differing clinical approaches to addressing mental health and substance use disorders.

With the system's limited capacity and the escalating crisis, there have been increasing discussions around expanding involuntary care. Citing concerns for public safety, in 2024, British Columbia's Premier David Eby announced the intention to establish facilities that offer involuntary care to individuals with severe mental health issues, addiction, and brain injuries.[25,26] Similarly, Ontario's Big City Mayors have called on the Provincial government to review the relevant mental health laws and explore whether involuntary care should be strengthened.[27] As of yet, the Ontario government has not taken a public stance on the issue.

In response, critics have expressed concerns about the overall effectiveness of involuntary care. Research shows mixed results on involuntary treatment. Studies suggest that involuntary treatment can lead to short-term benefits, such as symptom stabilization, and reduced immediate harm; however, long-term outcomes, like sustained mental health improvements, risk of suicide, enhanced social integration, or voluntary engagement with the health system, are less consistent.[28,29,30] Supporters of

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[25] BC Government News. (2024). Province Launches Secure Care for People with Brain Injury, Mental Illness, Severe Addiction. https://news.gov.bc.ca/releases/2024PREM0043-001532

[26] CBC. (2024). B.C. to expand involuntary care for those with addiction issues. https://www.cbc.ca/news/canada/british-columbia/bc-involuntary-care-addiction-1.7324079

[27] Guelph Today. (2024). Mayors Call on Ontario to Review Whether Involuntary Treatment Needs to be 'Strengthened'. https://www.guelphtoday.com/local-news/big-city-mayors-call-on-province-to-review-whether-involuntary-treatment-needs-to-be-strengthened-9679982

[28] Canadian Mental Health Association British Columbia. (2024). Involuntary Care Already Exists in BC, But Is It Working? https://bc.cmha.ca/news/involuntary-care-in-bc/

[29] Psychiatry, Psychology and Law. (2024). The Benefits and Harms of Inpatient Involuntary Psychiatric Treatment: A Scoping Review. https://www.tandfonline.com/doi/full/10.1080/13218719.2024.2346734#d1e232

[30] European Psychiatry (2018). Interventions for Involuntary Psychiatric Inpatients: A Systematic Review. https://web.archive.org/web/20220521090450id_/https:/www.cambridge.org/core/services/aop-cambridge-core/content/view/D228246E12304917ECE5561EA193FE19/S0924933800008725a.pdf

involuntary care argue that it can be a crucial intervention for individuals who may not recognize their need for treatment and are unable to make decisions about their care due to the severity of their mental health disorder. Due to the inconsistent long-term outcomes, involuntary care is thought to contribute to the "revolving door phenomenon", where individuals are frequently re-hospitalized for psychiatric care, often without improvements to their mental wellbeing.[31] This can be highly resource-intensive, requiring the repeated involvement of paramedics, police, and healthcare workers. This puts further strain on already overburdened systems, and diverts resources away from more sustainable, long-term solutions, such as voluntary care and preventive mental health and substance use strategies. Advocates have also specifically highlighted the lack of evidence to either support or refute involuntary treatment for individuals with substance use disorders.[32,33] Involuntary care has not been shown to decrease substance use or relapse rates.[33] Instead, concerns have been raised about potential harms, such as a higher risk of drug poisoning following treatment discharge due to reduced tolerance.[28,32]

The Application of the *Mental Health Act*

When an individual is deemed at risk of harming themselves or others due to a mental health disorder, the *Mental Health Act* uses specific legal forms to authorize involuntary care.[21] These forms, which can be completed by Physicians or Justices of the Peace, ensure that actions taken during mental health crises comply with the law, protecting patient rights while enabling necessary interventions.[21,23] The forms guide processes like involuntary psychiatric assessment and ongoing treatment, community treatment plans, and law enforcement involvement when needed for safety. For information on relevant forms under the *Mental Health Act*, including who has authority to complete, eligibility criteria, and the purpose and duration of the involuntary care, see Appendix "E" to Report BOH25004.

Under Ontario's *Mental Health Act*, police play a key role in ensuring that individuals experiencing mental health crises receive timely care. If needed, police can detain an individual after the appropriate form has been completed by a physician or Justice of the Peace to safely transport them to the hospital or psychiatric facility for assessment.[21,33] Under Section 17 of the *Mental Health Act*, police officers have the authority to

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/div-class-title-interventions-for-involuntary-psychiatric-inpatients-a-systematic-review-div.pdf

[31] Psychiatry Research. (2021). Searching for Factors Associated with the "Revolving Door Phenomenon" in the Psychiatric Inpatient Unit: A 5-year Retrospective Cohort Study. https://www.sciencedirect.com/science/article/abs/pii/S0165178121003772

[32] Canadian Journal of Addiction. (2023). Effectiveness of Involuntary Treatment for Individuals With Substance Use Disorders: A Systematic Review. https://www.researchgate.net/publication/376978918_Effectiveness_of_Involuntary_Treatment_for_Individuals_With_Substance_Use_Disorders_A_Systematic_Review

[33] Centre for Addictions and Mental Health et al. (2004). Not Just Another Call…Police Response to People with Mental Illnesses in Ontario. https://www.forcescience.org/wp-content/uploads/2011/11/Not_Just_Another_Call.pdf

apprehend a person without the completion of a form by a physician or Justice of the Peace if they have reasonable grounds to believe the person is acting or has acted in a disorderly manner due to a mental health disorder and poses an immediate danger to themselves or others, or is at risk of serious physical impairment.[21,33] This is used in situations where there are immediate concerns, and it would be "dangerous" to wait for a form to be completed by a Physician or Justice of the Peace. The police officer must assess the situation based on the information available to them and decide whether it is appropriate to detain an individual under Section 17.[21,33] For more details about the roles of the police under the *Mental Health Act*, see Appendix "E" to Report BOH25004.

Hamilton Police Services has implemented various programs to better support individuals experiencing mental health crises, particularly among vulnerable populations such as those experiencing homelessness. These initiatives focus on de-escalating situations and connecting individuals to appropriate community resources, helping to prevent arrests, reducing involvement in the criminal justice system, and minimizing emergency department visits.[34] For more information on these approaches, see Appendix "F" to Report BOH25004.

Paramedics are not specifically mentioned in the *Mental Health Act*, however, they play an important role in responding to mental health and addiction crises under the guidance of the *Ambulance Act*. Hamilton Paramedic Services are often the first responders to individuals in crisis, involved in assessing and stabilizing individuals, and addressing any physical health concerns. When necessary, paramedics transport individuals to hospitals or psychiatric facilities for further assessment and treatment, including when a form has been completed by a physician in the community or a Justice of the Peace.

The response to mental health and addiction crises demonstrates a collaborative approach between paramedics, police, and healthcare professionals, where alternate care pathways are explored that allow emergency services to take individuals directly to mental health facilities or community-based services, rather than emergency departments, to better meet their needs.

Conclusion

The mental health, addictions, and homelessness crises in Hamilton are complex and deeply interconnected. It demands a comprehensive, integrated response that bridges health and social services. Addressing these issues effectively means moving beyond siloed approaches that address only a single aspect of the issue. A holistic response must prioritize high-quality services across the entire spectrum of care, from prevention and early intervention to intensive, long-term support. The spectrum of services must be well-coordinated across organizations, settings, and sectors to ensure efficiency and seamless transitions, promoting continuity of care. The *Mental Health Act* provides a

[34] Hamilton Police Services. (2022). Crisis Response Branch 2021 Annual Report. https://www.hamiltonpsb.ca/media/kdrhd044/2021-year-end-report-crisis-response-branch.pdf

critical framework for this response, supporting individuals in crisis while balancing personal autonomy, individual rights, and public safety.

The City of Hamilton can play a continued role in this work, with certain responsibilities being tied to mandates or funding from senior levels of government. This includes supporting efforts to:

- Enhance the coordination of mental health and substance use services;
- Continue investing in mental health and substance use services provided by the City of Hamilton, including Public Health Services' Child and Adolescent Services, Alcohol, Drug and Gambling Services, as well as Paramedic Services, to ensure comprehensive support from prevention to crisis response;
- Advocate for consistent, sustained funding across the mental health, substance use and housing systems;
- Apply the principles of the Housing First approach to address the interrelated issues of homelessness, mental health, and substance use; and,
- Adopt a balanced approach to the housing and homelessness crisis, addressing immediate needs through emergency shelters while investing in long-term solutions like supportive housing.

Extensive consultations were conducted to inform Report BOH25004 and enhance the local context. The information provided above reflects the discussions had with City of Hamilton and external partners.

Alternatives

Not Applicable.

Relationship to Council Strategic Priorities

The recommendations in this report support the following 2022-2026 Council Priorities, Outcomes, and Measures of Success:

2. Safe & Thriving Neighbourhoods
   2.1. Increase the supply of affordable and supportive housing and reduce chronic homelessness

This report examines the root causes of the homelessness, mental health and substance use crisis in Hamilton and highlights strategies to address these interrelated issues in a comprehensive, integrated response. By implementing these strategies, the community could see long-term reductions in homelessness and prevent future occurrences.

Previous Reports Submitted

- HSC24040 - Community Safety and Well-Being: Toronto Community Crisis Centre and Hamilton's Mental Health Crisis Response
  This report to the Emergency and Community Services Committee addressed a

motion requesting an analysis of the feasibility of implementing a similar model to Toronto's Community Crisis Service in Hamilton.

Consultation

City of Hamilton, Housing Services Department

- Al Fletcher, Acting Director, Housing Service Division, Healthy and Safe Communities Department
- Shannon Honsberger, Manager of Homelessness Policy and Program, Housing Services Division, Healthy and Safe Communities Department

City of Hamilton, Hamilton Paramedic Services

- Michael Sanderson, Chief, Hamilton Paramedic Services, Healthy and Safe Communities Department

City of Hamilton, Children's & Community Services

- Brenda Bax, Director, Children's & Community Services, Healthy and Safe Communities Department
- Rachelle Ihekwoaba, Manager of Community Strategies, Children's & Community Services, Healthy and Safe Communities Department

City of Hamilton, Hamilton Police Service

- Lisa Gajewicz, Coordinator of Social Navigator Program, Hamilton Police Services
- David Mackenzie, Staff Sergeant, Hamilton Police Services
- Alexis Petrovic, Sergeant, Hamilton Police Services

Healthcare Partners

- Sue Phipps, Chief Executive Officer, Canadian Mental Health and Addictions, Hamilton Branch
- Ryan Janssen, Project Manager of Health Equity, Haldimand, and Mental Health and Addictions, Greater Hamilton Health Network
- Dr. Haider Saeed, Family Physician, Shelter Health Network
- Michelle Lawford, General Council, St. Joseph's Healthcare Hamilton
- Dr. Maxine Lewis, City-Wide Chief of Psychiatry, St. Joseph's Healthcare Hamilton and Hamilton Health Sciences
- Dr. Randi McCabe, Clinical Head of Psychiatry, St. Joseph's Healthcare Hamilton
- Regan Anderson, Chief Executive Officer, Wayside House of Hamilton

Housing and Other Social Service Partners

- Emily Dakers, Director of the Barrett Centre, Good Shephard
- Jess Brand, Regional Director of Hamilton and Peel Region, Indwell
- Steven Rolfe, Director of Health Partnerships, Indwell
- Chelsea Kirkby, Vice President of Strategic Initiatives and Program Development, YWCA Hamilton
- Sandra Parker, Director of Child, Youth & Developmental Services**,** YWCA Hamilton

Appendices and Schedules Attached

Appendix A:	Mental Health and Addictions Support for Individuals Experiencing Homelessness in Hamilton
Appendix B:	Mobile and Outreach Health Services provide to Encampments in Hamilton
Appendix C:	Mental Health and Addictions Secretariat Membership
Appendix D:	Mental Health Act and Health Care Consent Act Terms
Appendix E:	Relevant Forms and Sections under the Mental Health Act
Appendix F:	Hamilton Police Services' Crisis Response

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