Mental Health and Addictions System Performance in Ontario

A Baseline Scorecard

CHART PACK

March 2018

ICES

Mental Health and Addictions System Performance in Ontario: A Baseline Scorecard

Chart Pack

MHASEF Research Team

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Data

Data were provided by Access to Care; Immigration, Refugees and Citizenship Canada (IRCC); and the Institute for Clinical Evaluative Sciences (ICES). Data sets from IRCC and ICES were linked using unique encoded identifiers and analyzed at ICES.

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About the Institute for Clinical Evaluative Sciences

The Institute for Clinical Evaluative Sciences (ICES) is an independent, not-for-profit corporation that uses population-based health information to produce knowledge on a broad range of health care issues. ICES' unbiased evidence provides measures of health system performance, a clearer understanding of the shifting health care needs of Ontarians, and a stimulus for discussion of practical solutions to optimize scarce resources.

Key to ICES' work is its ability to link population-based health information, at the patient level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 13 million of 34 million Canadians allow researchers to follow patient populations through diagnosis and treatment, and to evaluate outcomes.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, ICES scientists and staff compete for peer-reviewed grants from federal funding agencies, such as the Canadian Institutes of Health Research, and project-specific funds from provincial and national organizations. ICES knowledge is highly regarded in Canada and abroad, and is widely used by government, hospitals, planners, and practitioners to make decisions about health care delivery and to develop policy.

Statement on Indigenous Mental Health Data

For over 15 years, mental health has been established as a key priority by First Nations in Ontario. Today, First Nations leaders across Ontario are still calling for action to address the mental health of their children and youth. In February 2016, First Nations leaders from Nishnawbe Aski Nation in Northern Ontario declared a State of Emergency related to the mental health crisis in their communities. In a parallel gathering, the Chiefs of Ontario, the Ontario SPOR Support Unit, the Centre for Rural and Northern Health Research, and ICES hosted a First Nations Health Research Symposium where First Nations community members set priorities for health research in Ontario. Mental health and addictions was the top priority.

In this provincial scorecard, we do not present Indigenous-specific mental health data. ICES has relationships and data governance agreements with Indigenous organizations that acknowledge the inherent rights of First Nations, Métis and Inuit peoples to determine how data are used to tell their stories and to heal their communities. As a result, ICES works directly with Indigenous partners and communities to ensure that indicators are contextualized in a way that supports the substantial work that Indigenous people are undertaking. This involves working in close partnership, respecting the diversity of Indigenous communities, integrating Indigenous perspectives and acknowledging the impacts of ongoing colonialism.

Since 2017, ICES has been working directly with the Métis Nation of Ontario to provide Métis-specific mental health indicators. In addition, we are working with First Nations communities and the Chiefs of Ontario to respond to the research priorities set in February 2016 for the analysis of First Nations mental health and addictions data.

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Abbreviations

ALC	alternate level of care
ED	emergency department
FTE	full-time equivalent
GP/FP	general practitioner/family physician
LHIN	Local Health Integration Network
MHA	mental health and addictions
YPLL	years of potential life lost

1.0 Mental Health and Addictions Indicators by Local Health Integration Network

EXHIBIT 1.1 Performance indicators for the mental health and addictions system, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Lowest rate — Highest rate

Indicator*	Ontario	Erie St. Clair	South West	Waterloo Wellington	Hamilton Niagara Haldimand Brant	Central West	Mississauga Halton	Toronto Central	Central	Central East	South East	Champlain	North Simcoe Muskoka	North East	North West
Safe															
Use of physical restraints on individuals hospitalized for MHA-related reasons per 100 standard population aged 16 to 105 years	4.7	3.3	4.5	3.7	3.3	5.4	3.7	4.6	5.5	6.1	4.3	5.5	4.4	4.2	5.7
Effective															
Number of deaths by suicide per 100,000 standard population aged 16 to 105 years	10.3	10.9	11.5	11.5	11.1	7.3	7.0	12.1	6.8	9.7	12.2	10.2	14.6	15.1	22.3
Timely															
Number of individuals for whom the ED was the first point of contact for MHA care per 100 standard population aged 16 to 105 years with an incident MHA-related ED visit	32.8	31.1	35.1	33.0	30.9	33.9	32.4	28.2	32.4	31.7	34.3	32.5	33.4	38.2	40.9
Efficient															
Number of repeat unscheduled ED visits within 30 days per 100 standard population aged 16 to 105 years with an incident MHA-related ED visit	9.2	10.1	8.7	8.7	9.5	7.7	7.6	10.9	7.9	8.9	8.8	9.0	8.5	9.7	11.4
Number of outpatient visits to any physician specialty within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident MHA-related hospital discharge	34.6	33.1	29.4	33.9	37.7	38.8	41.4	42.1	38.1	34.4	31.6	33.8	30.2	24.0	22.7
Number of outpatient visits to a GP/FP only within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident MHA-related hospital discharge	21.5	20.1	18.3	24.0	25.0	27.1	25.1	19.8	21.8	22.1	19.8	20.9	21.9	16.5	18.1
Number of outpatient visits to a psychiatrist only within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident MHA-related hospital discharge	10.2	10.5	9.1	7.6	9.7	8.4	12.0	17.4	12.6	9.5	9.0	10.7	6.6	6.3	3.7
Number of outpatient visits to a psychiatrist and a GP/FP within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident MHA-related hospital discharge	2.9	2.5	2.0	2.3	3.0	3.3	4.2	4.9	3.7	2.7	2.8	2.2	1.7	1.2	0.9
Number of inpatient readmissions within 30 days of discharge per 100 standard population aged 16 to 105 years with an incident MHA-related hospital admission	8.8	8.1	8.7	7.9	8.2	8.2	8.5	10.7	9.4	8.6	8.9	8.4	8.4	9.1	6.9
Median ALC wait time (in days) for supportive housing/group home/assisted living among discharged mental health cases aged 16 to 105, 2015	60.0	**	77.0	172.0	57.0	**	**	105.0	5.0	69.0	23.0	33.0	15.0	28.0	**

*Rates are age- and sex-standardized unless otherwise specified

** Suppressed due to small cell size

MHA = mental health and addictions; ED = emergency department; GP/FP = general practitioner/family physician

EXHIBIT 1.2 Contextual indicators for the mental health and addictions system, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Lowest rate — Highest rate

Indicator*	Ontario	Erie St. Clair	South West	Waterloo Wellington	Hamilton Niagara Haldimand Brant	Central West	Mississauga Halton	Toronto Central	Central	Central East	South East	Champlain	North Simcoe Muskoka	North East	North West
Annualized migration-adjusted proportion of general practitioner/family physicians' FTE allocated to MHA-related outpatient services for adults aged 16 to 105, three-year average for 2010/11 to 2012/13	10.3	7.9	11.4	10.0	9.7	7.4	9.0	15.6	9.1	8.4	12.3	12.3	10.5	8.6	7.7
Number of individuals seen for MHA care by a general practitioner/family physician per 1,000 standard population aged 16 to 105 years	131.8	149.3	131.1	119.2	141.8	126.4	124.7	138.7	120.4	128.2	135.4	141.4	141.2	145.6	120.0
Number of individuals seen by a psychiatrist per 1,000 standard population aged 16 to 105 years	35.8	38.5	37.4	31.1	36.5	27.7	31.9	58.6	34.3	34.0	39.0	38.6	29.0	25.2	15.8
Number of individuals who received telepsychiatry consultations per 10,000 standard population aged 16 to 105 years	3.9	4.7	1.8	3.2	5.7	1.0	0.6	0.6	0.6	5.2	8.6	1.9	12.5	17.0	17.4
Number of outpatient visits to any physician specialty related to MHA care per 100 standard population aged 16 to 105 years	56.3	56.8	63.9	41.0	58.3	44.1	46.1	94.8	50.5	51.2	60.9	59.4	57.0	48.0	44.5
Number of outpatient visits to a general practitioner/family physician related to MHA care per 100 standard population aged 16 to 105 years	38.1	40.2	43.8	30.8	44.3	33.2	31.9	47.4	32.3	37.2	45.8	37.1	44.6	39.2	38.0
Number of outpatient visits to a psychiatrist per 100 standard population aged 16 to 105 years	18.2	16.6	20.1	10.2	14.0	10.9	14.2	47.4	18.3	14.0	15.1	22.3	12.4	8.9	6.5
Median length of stay (in days) for psychiatric hospitalizations among individuals aged 16 to 105 years	8.0	10.0	9.0	7.7	7.7	6.7	7.7	9.0	7.0	7.7	7.3	9.0	6.0	6.3	4.7
Number of MHA-related hospitalizations per 1,000 standard population aged 16 to 105 years	5.9	5.5	6.9	6.3	6.1	4.7	4.1	7.4	4.5	5.2	6.2	5.7	8.2	11.0	9.2
Number of ED visits for deliberate self-harm per 10,000 standard population aged 16 to 105 years	15.1	15.7	18.2	17.9	17.2	12.0	10.8	16.6	8.4	14.7	20.5	17.1	19.8	25.2	34.4
Number of MHA-related ED visits per 1,000 standard population aged 16 to 105 years	19.0	20.7	20.7	17.1	19.8	13.6	12.6	25.4	12.1	17.5	22.1	19.4	21.8	32.9	44.1

*Rates are age- and sex-standardized unless otherwise specified.

MHA = mental health and addictions; ED = emergency department; FTE = full-time equivalent

2.0 Performance Indicators for the Mental Health and Addictions System

Safe

2.1 Use of physical restraints

Effective

2.2 Years of potential life lost among individuals with schizophrenia

2.3 Rate of death by suicide

Timely

2.4 First contact in the emergency department for mental health and addictions

Efficient

2.5 Repeat unscheduled emergency department visits within 30 days

2.6 Doctor visit within 7 days of leaving hospital after treatment for mental health and addictions

2.7 Rate of inpatient readmission within 30 days of discharge

2.8 Alternate level of care

2.1 Use of physical restraints

Rationale

In caring for individuals with severe mental illness who are in acute crisis, reducing risk for harm to self or others is a priority. Physical restraints can be defined as external devices, materials or equipment that are attached to or near a person's body and prevent that person from moving freely,[1] and thus may prevent suicidal or aggressive acts. Because of the highly restrictive nature of physical restraints and the possible medical risk from being immobilized, other methods for reducing agitation are preferred whenever possible. These include providing a hazard-free environment, using verbal de-escalation techniques and even administering sedative medications. Following a coroner's inquest in Ontario in 2008,[2] psychiatric health care facilities have been strongly encouraged to minimize the use of physical restraints.

Results

From 2006 to 2014, the use of physical restraints declined for both men and women. Restraint use was highest for men, older adults and those hospitalized for schizophrenia, although all of these groups saw decreasing rates over time. While restraint use for those with alcohol and substance use disorders was not as high as among those hospitalized with schizophrenia, this was the only group where there was no apparent reduction in use of restraints over time.

Physical restraint use did not vary by the neighbourhood income level of patients. A higher rate of restraint use was found among refugees and immigrants compared to non-immigrants. There was also variability in restraint use across the province, with the highest rate in the Central East Local Health Integration Network (LHIN) and the lowest in the Hamilton Niagara Haldimand Brant LHIN.

Interpretation

Physical restraint use has steadily declined over time for all age groups and diagnoses and for both sexes. Consistent with the current literature, restraint use was highest among those hospitalized for schizophrenia,[3] and was higher among refugees and immigrants than non-immigrants.[4]

[1] Retsas AP. Survey findings describing the use of physical restraints in nursing homes in Victoria, Australia. *Int Journal Nurs Stud.* 1998; 35(3):184–91.
[2] Canadian Institute for Health Information. *Restraint Use and Other Control Interventions for Mental Health Inpatients in Ontario: Executive Summary.* August 2011. Accessed July 18, 2017 at **https://secure.cihi.ca/free_products/Restraint_Use_and_Other_Control_Interventions_AIB_EN.pdf**.
[3] Stewart D, Bowers L, Simpson A, Ryan C, Tziggili M. Manual restraint of adult psychiatric inpatients: a literature review. *J Psychiatr Ment Health Nurs.* 2009; 16(8):749–57.
[4] Beghi M, Peroni F, Gabola P, Rossetti A, Cornaggia CM. Prevalence and risk factors for the use of restraint in psychiatry: a systematic review. *Riv Psichiatr.* 2013; 48(1):10–22.

EXHIBIT 2.1.1 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, the use of physical restraints was higher among men than women, with reductions in both sexes by about one-third over time.

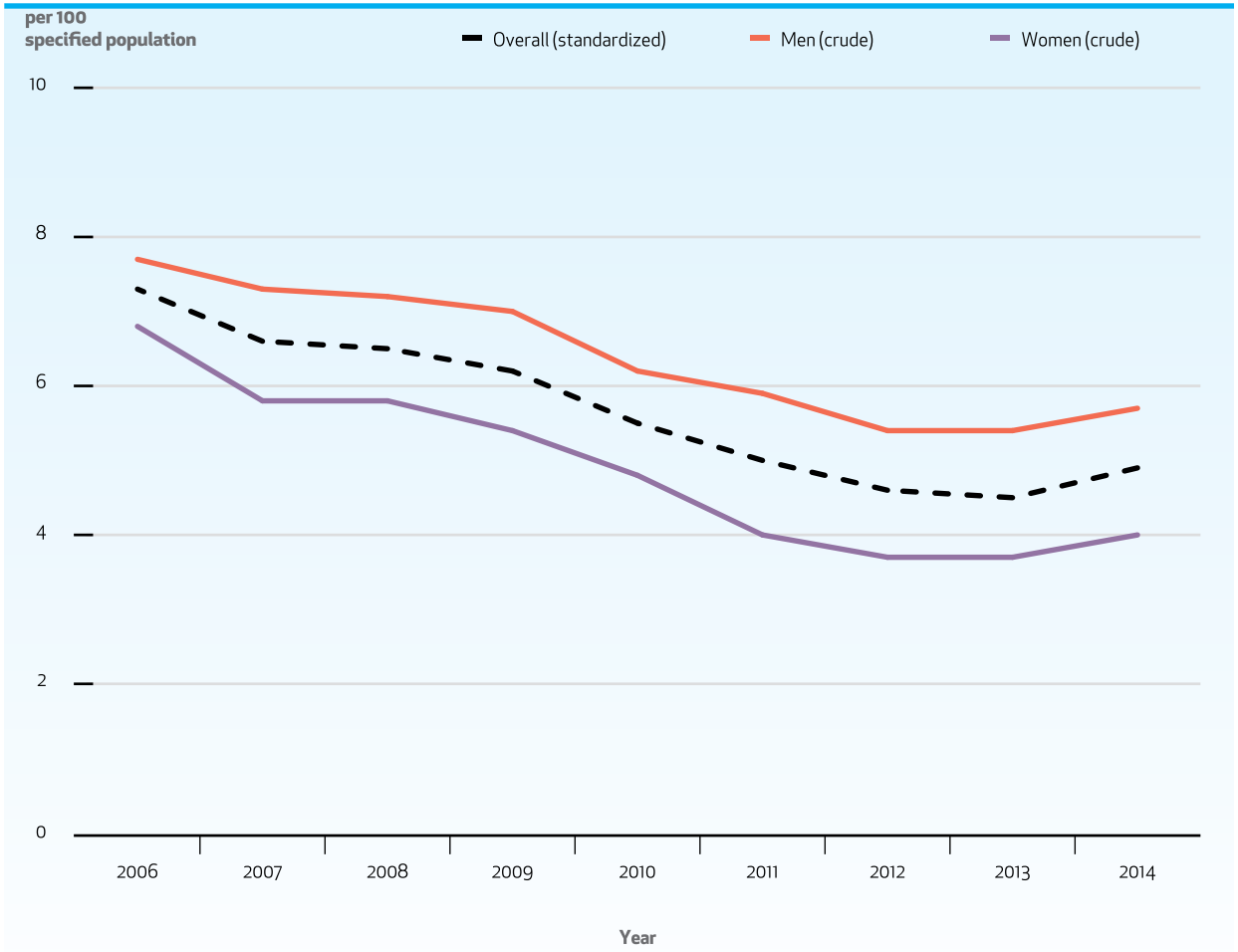


EXHIBIT 2.1.2 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by age group, in Ontario, 2006 to 2014

Key Finding

- The use of physical restraints was highest for adults aged 85 and older, but a dramatic reduction was observed in this age group over time. Restraint use also declined in other age groups.

EXHIBIT 2.1.3 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by type of disorder, in Ontario, 2006 to 2014

Key Finding

- Among individuals hospitalized for mental health disorders and addictions, the use of physical restraints was highest among those with schizophrenia and lowest among those with anxiety disorders. The rate of restraint use decreased across most diagnostic categories, with the exception of those hospitalized for substance-related disorders.

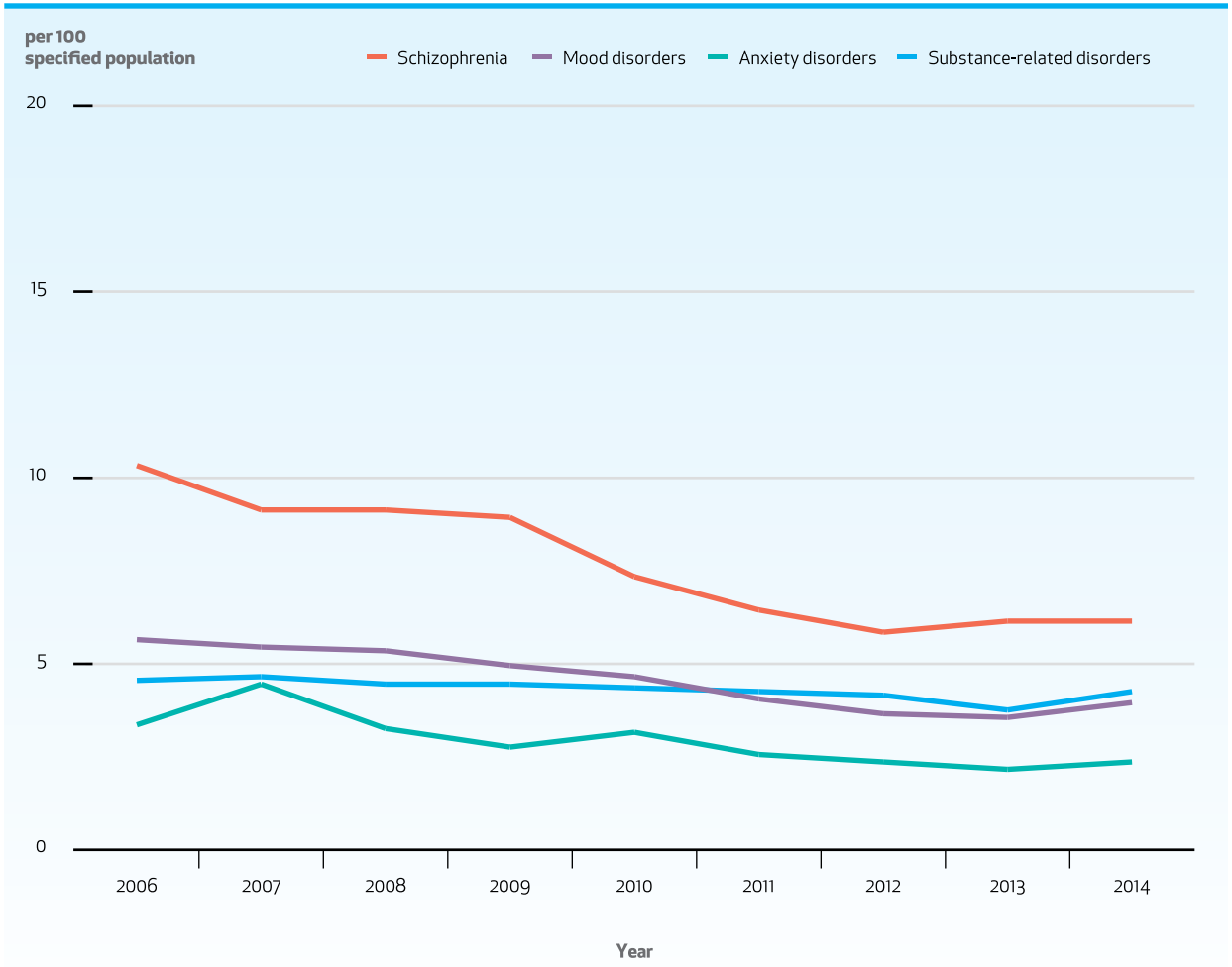


EXHIBIT 2.1.4 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- Between 2012 and 2014, the three-year average rate of physical restraint use among Ontario adults was higher for men than for women.

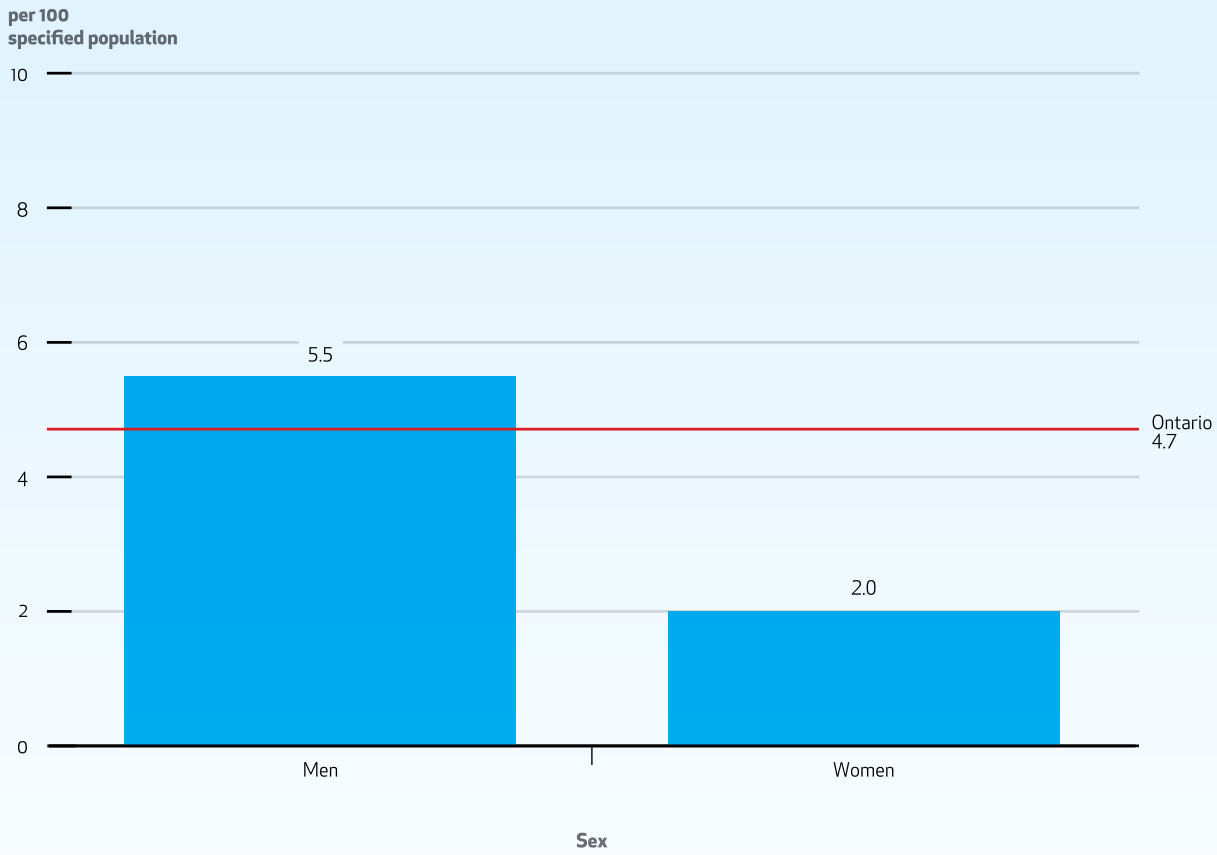


EXHIBIT 2.1.5 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The three-year average rate of physical restraint use was highest among adults aged 85 and over and youth aged 16 to 24.

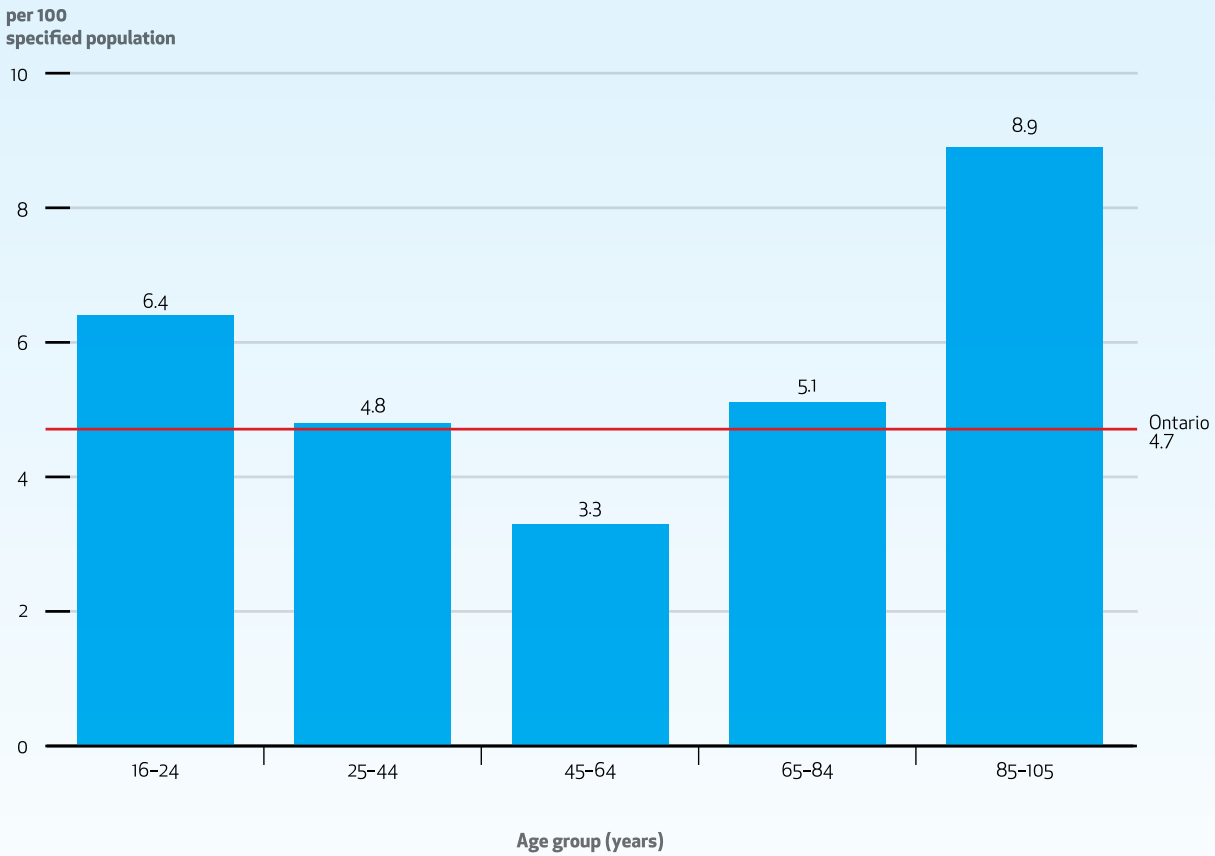


EXHIBIT 2.1.6 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

Key Finding

- Physical restraints were used most commonly on individuals hospitalized with schizophrenia and least commonly on those with anxiety disorders.

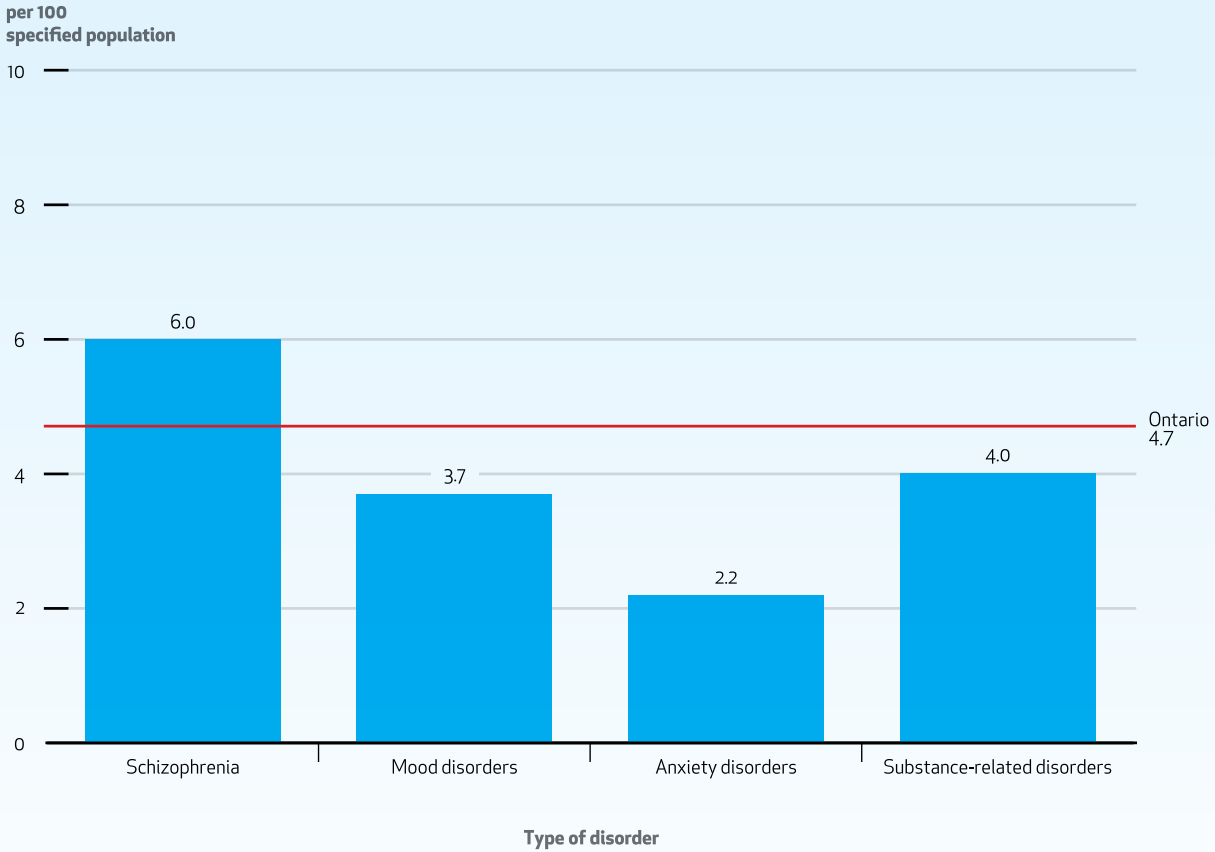


EXHIBIT 2.1.7 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- Income level did not influence the use of physical restraints on individuals hospitalized for mental illness and addictions.

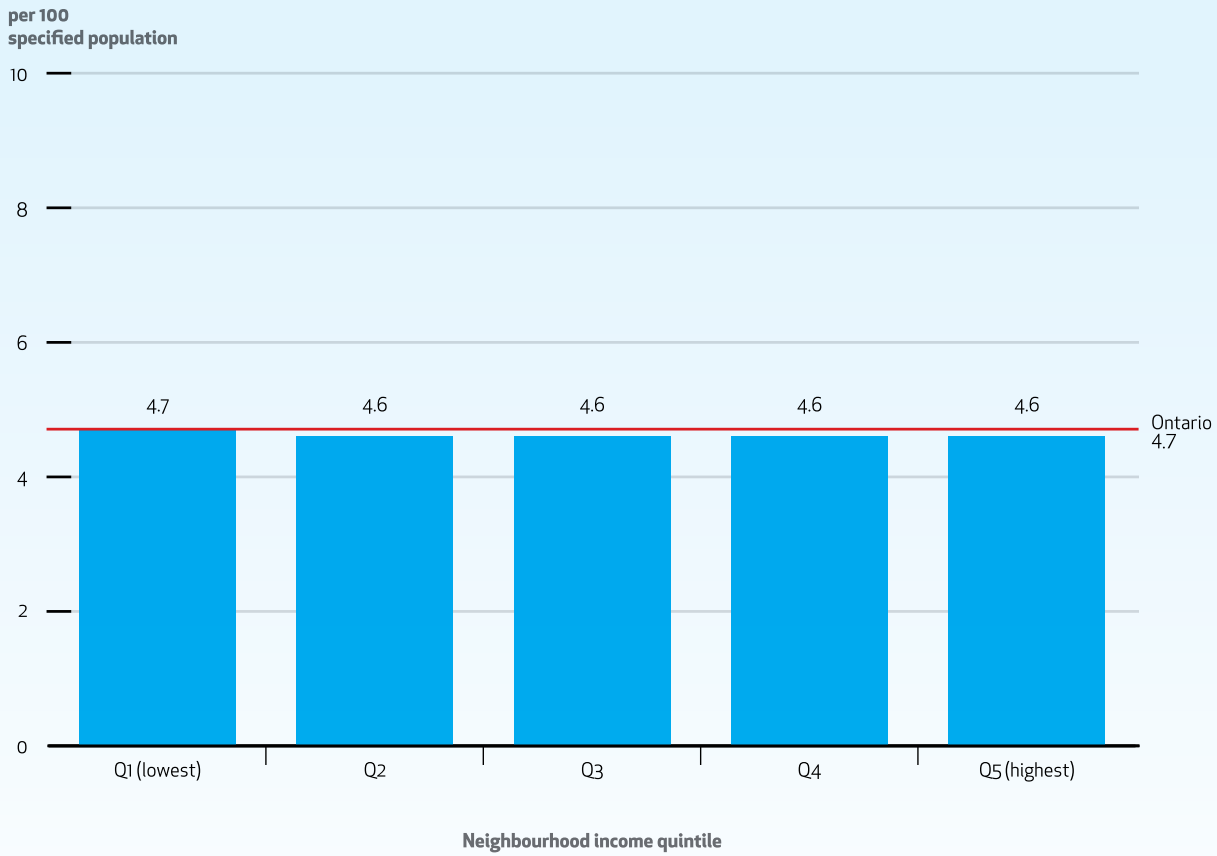


EXHIBIT 2.1.8 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 crude mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- Between 2010 and 2012, the three-year average rate of physical restraint use was higher among refugees and immigrants compared to non-immigrants.

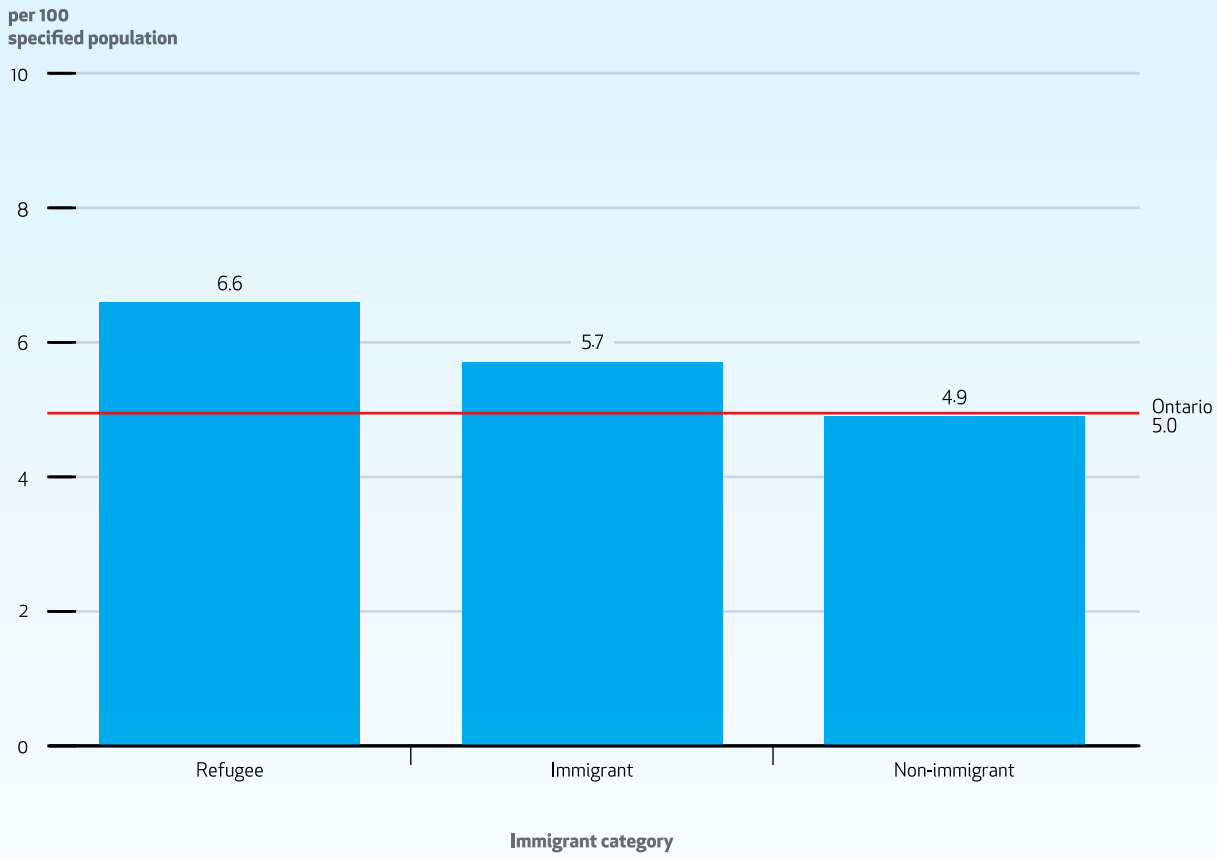


EXHIBIT 2.1.9 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 standard mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The use of physical restraints varied markedly among LHINs. The rate of restraint use in the Central East LHIN was nearly double that in the Hamilton Niagara Haldimand Brant LHIN.

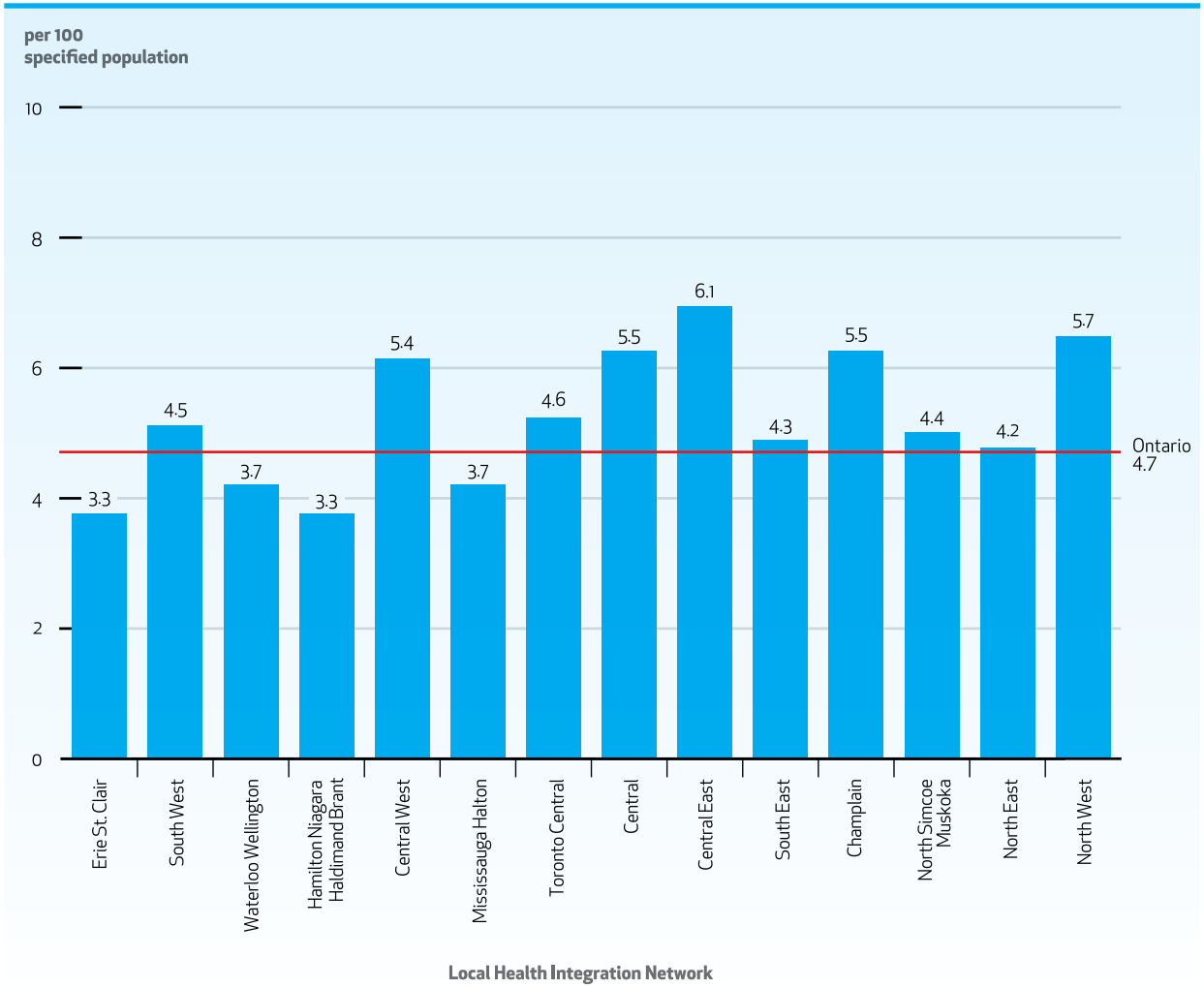
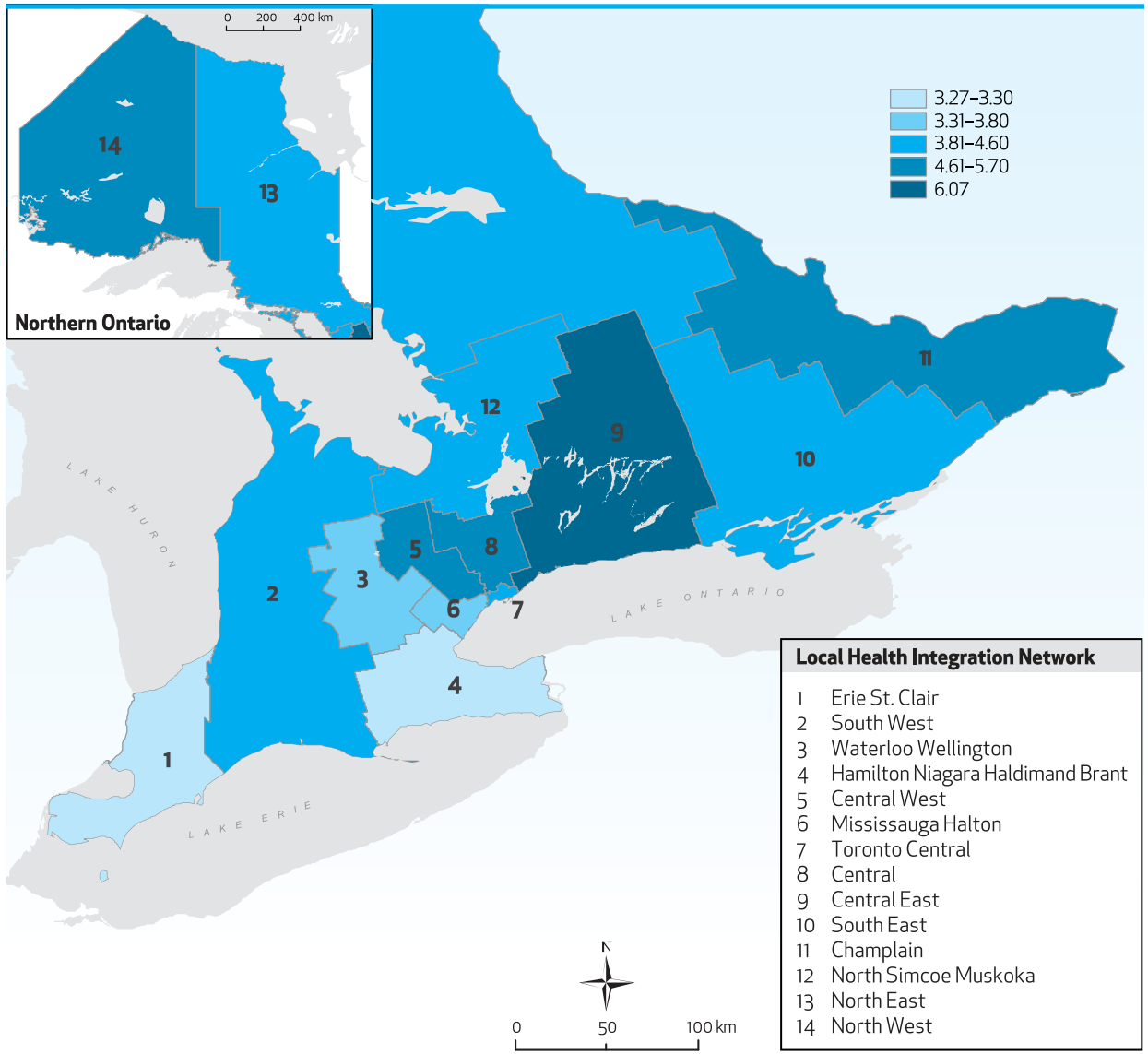


EXHIBIT 2.1.10 Number of mental health and addictions–related hospitalizations where physical restraints were used per 100 standard mental health and addictions–related hospitalizations among individuals aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- Physical restraint use varied across LHINs, with the highest rate observed in the Central East LHIN and the lowest in the Hamilton Niagara Haldimand Brant LHIN.



2.2 Years of potential life lost among individuals with schizophrenia

Rationale

Premature mortality is often assessed by analyzing years of potential life lost (YPLL), which measures years not lived, or "lost," by each individual who died before age 75. This indicator weights death at younger ages more heavily. Extensive public health efforts have led to longer lifespans in the general population. Examining premature mortality in a population with a serious mental illness, such as schizophrenia, helps to inform the need for specialized interventions in this population.

Results

The average age at death was about eight years younger among individuals with schizophrenia compared to those without. This corresponds to a YPLL rate that was five times higher among individuals with schizophrenia. The top three causes of premature mortality for individuals with schizophrenia were suicide, unintentional injury and cardiovascular disease; for those without schizophrenia, the top cause was cancer.

Interpretation

Specialized approaches to targeting chronic disease in patients with serious mental illness may be required to close the persistent gap in YPLL and reduce the burden of premature mortality in this population.

EXHIBIT 2.2.1 Average age at death of individuals aged 15 years and older with and without schizophrenia, in Ontario, 2006 to 2012

Key Finding

- On average, individuals with schizophrenia died eight years younger than those without schizophrenia, and their age at death was consistently below the premature mortality cut-off age of 75.

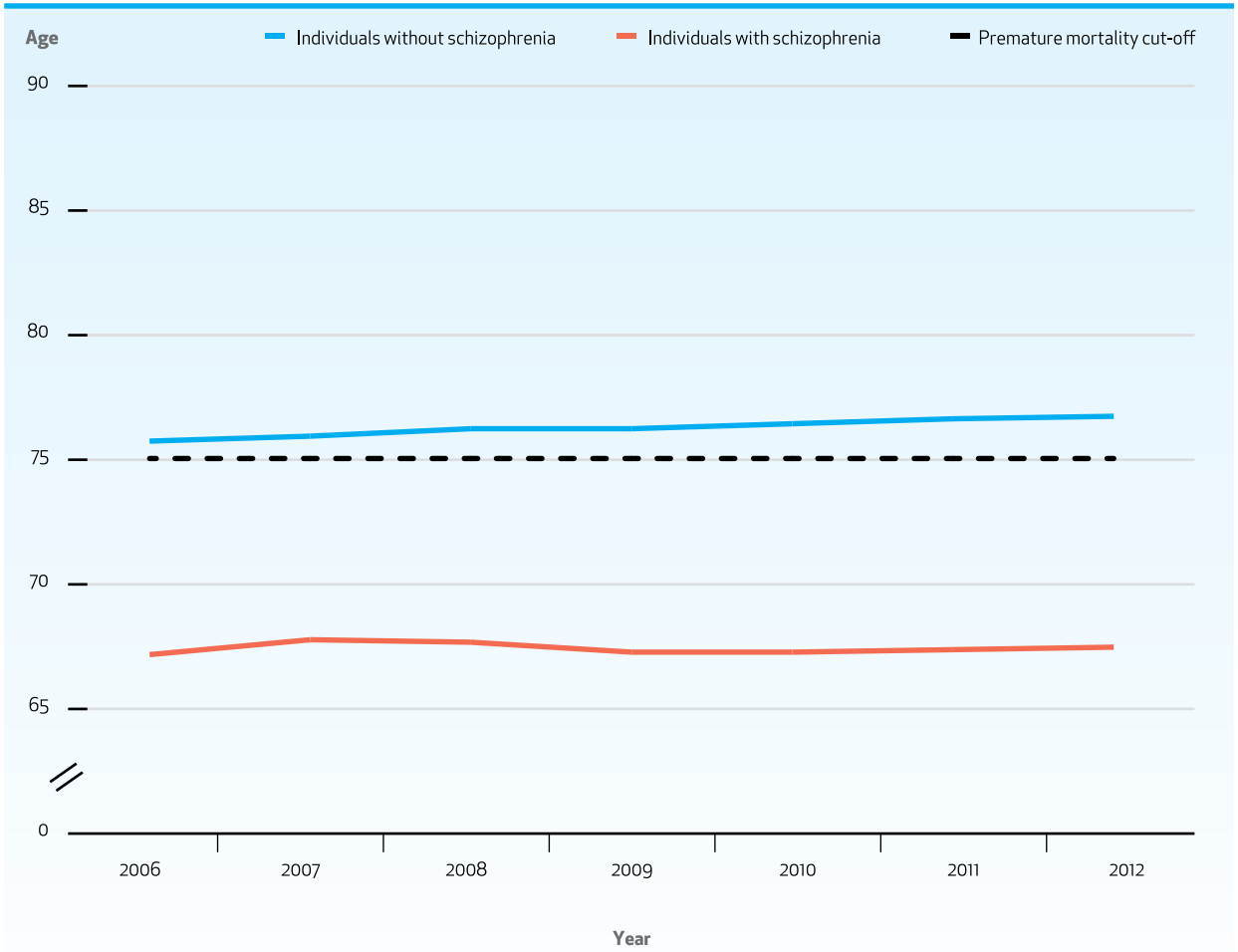


EXHIBIT 2.2.2 Number of years of potential life lost per 1,000 standard population aged 15 to 75 years with and without schizophrenia, in Ontario, 2006 to 2012

Key Finding

- Between 2006 and 2012, the age- and sex-standardized rate of years of potential life lost decreased for both those with and without schizophrenia; the rate was five times higher among those with schizophrenia.

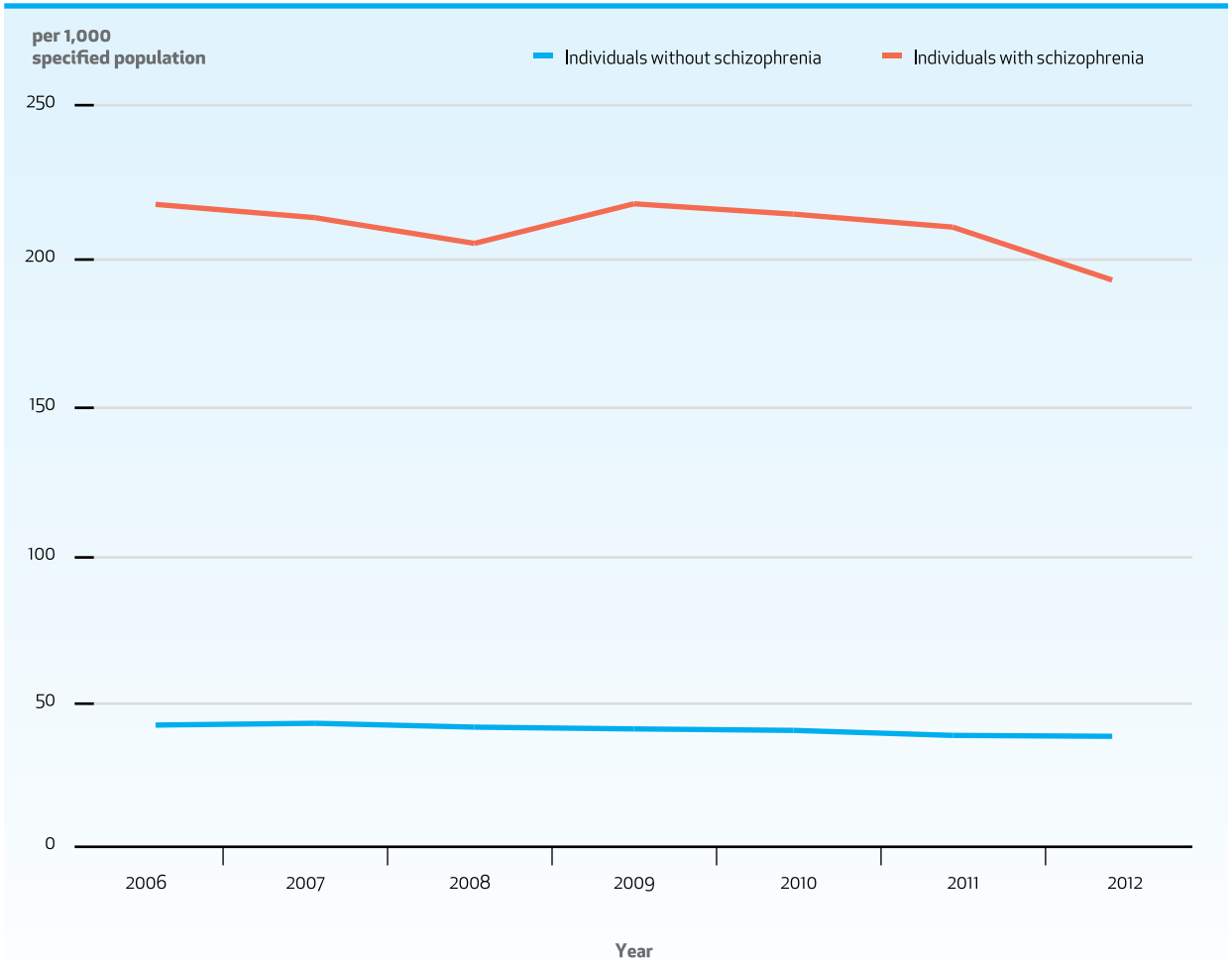
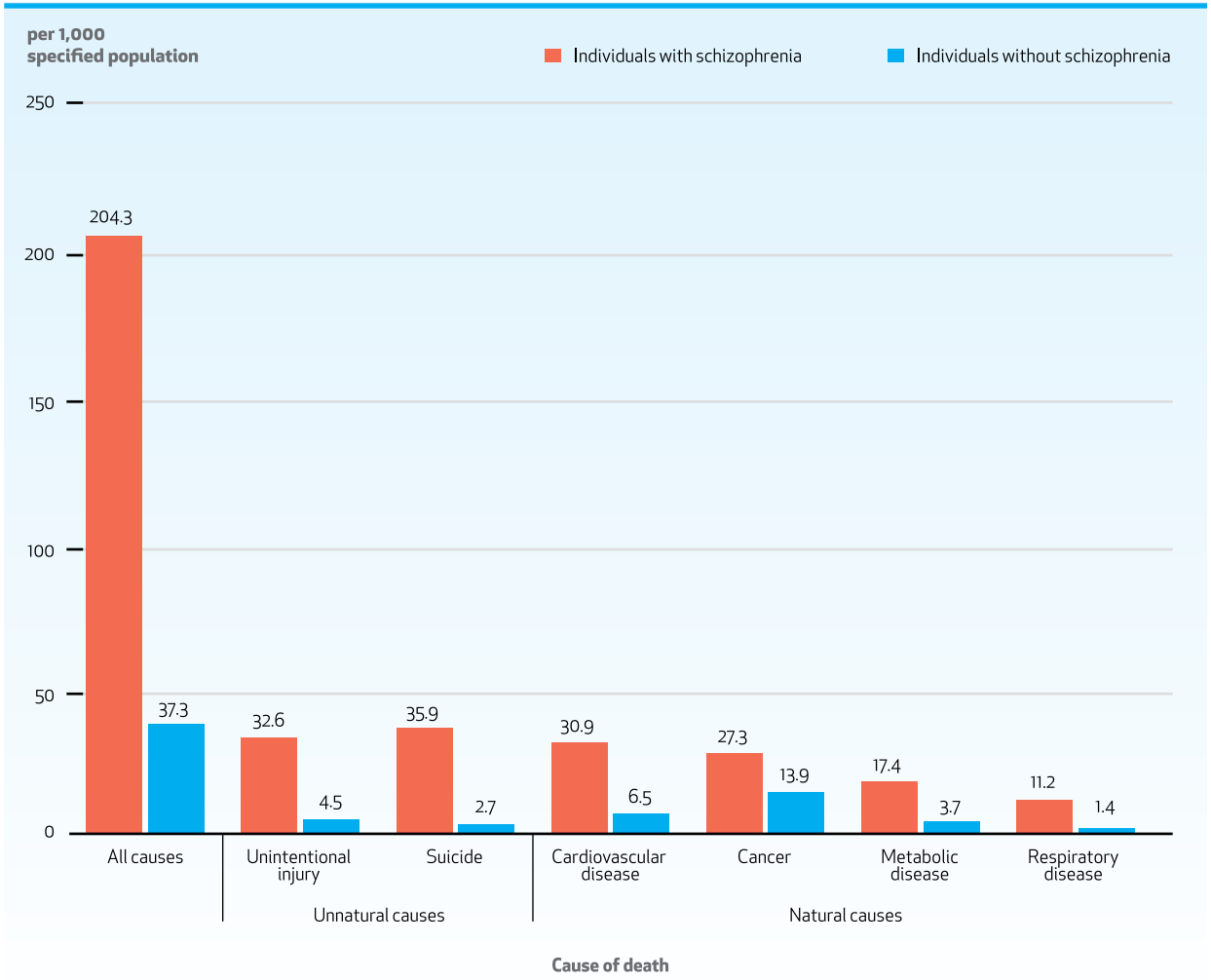


EXHIBIT 2.2.3 Number of years of potential life lost per 1,000 standard population aged 15 to 75 years with and without schizophrenia, by cause of death, in Ontario, three-year average for 2010 to 2012

Key Findings

- Between 2010 and 2012, the average age- and sex-standardized rate of years of potential life lost was higher among individuals with schizophrenia for each cause of death.
- Suicide accounted for the highest rate of years of potential life lost among individuals with schizophrenia.



2.3 Rate of death by suicide

Rationale

Death by suicide is a major public health issue. Understanding variations and trends in the rate of death by suicide may assist in identifying high-risk groups and designing appropriate interventions to reduce the occurrence of suicide.

Results

From 2006 to 2012, the rate of death by suicide was constant over time. The rate was highest among men, those aged 45 to 64, and residents of lower-income neighbourhoods. Across LHINs, the rate of death by suicide was highest in the North West, where the rate was more than double the Ontario average.

Interpretation

The rate of death by suicide remained stable between 2006 and 2012, a trend consistent for both men and women and across all age groups. The higher rates of death by suicide found among men and middle-aged adults are consistent with existing evidence.[5] The observed demographic and geographic variability can inform public health policy and intervention opportunities.

[5] American Foundation for Suicide Prevention. Suicide Statistics. Accessed March 16, 2017 at **https://afsp.org/about-suicide/suicide-statistics/**.

EXHIBIT 2.3.1 Number of deaths by suicide per 100,000 population aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2012

Key Finding

- From 2006 to 2012, the overall rate of death by suicide remained consistent. The rate was higher among men than women.

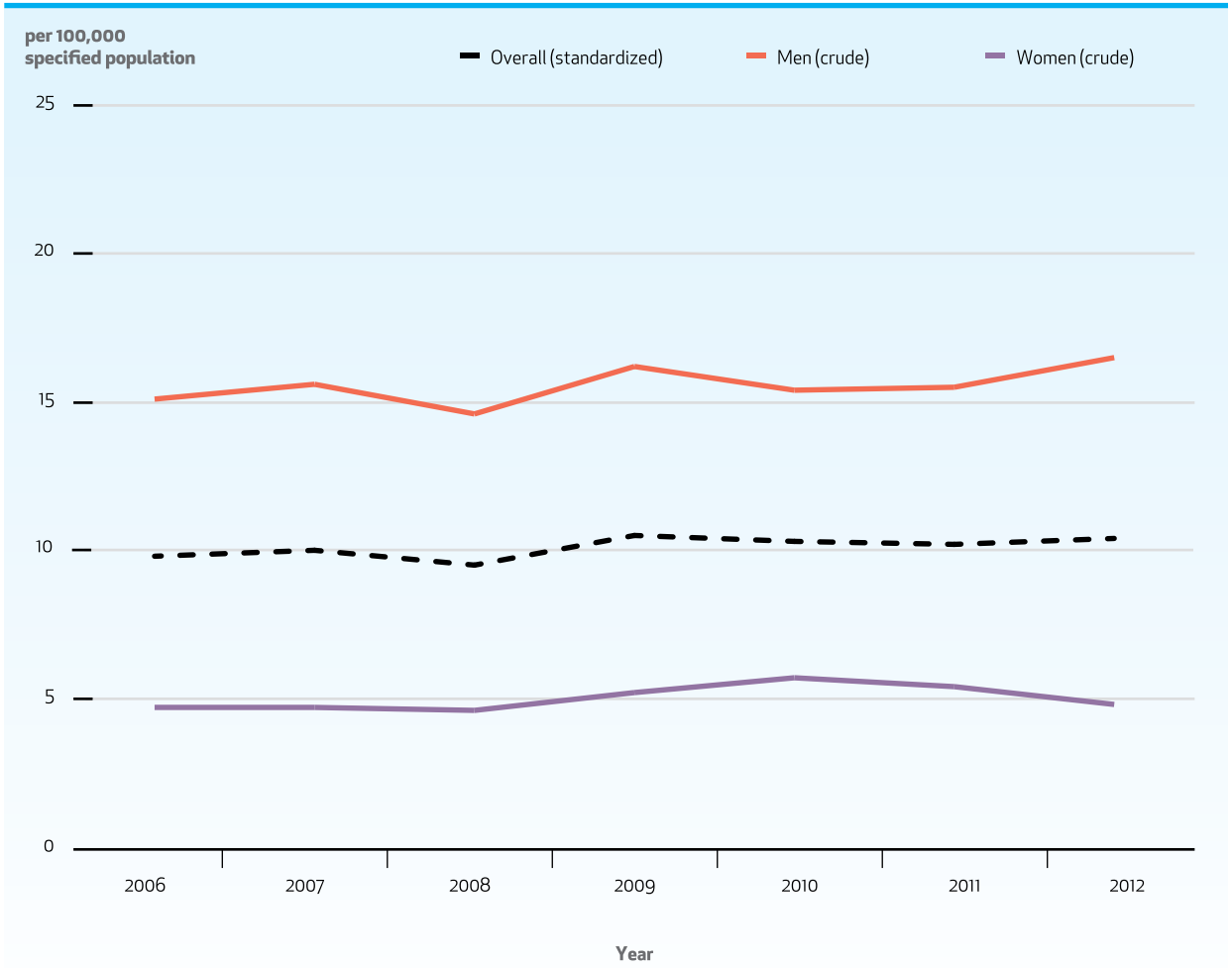


EXHIBIT 2.3.2 Number of deaths by suicide per 100,000 crude population aged 16 to 105 years, by age group, in Ontario, 2006 to 2012

Key Finding

- Between 2006 and 2012 ,the rate of death by suicide did not change significantly across age groups. The rate was notably highest among those aged 45 to 64.

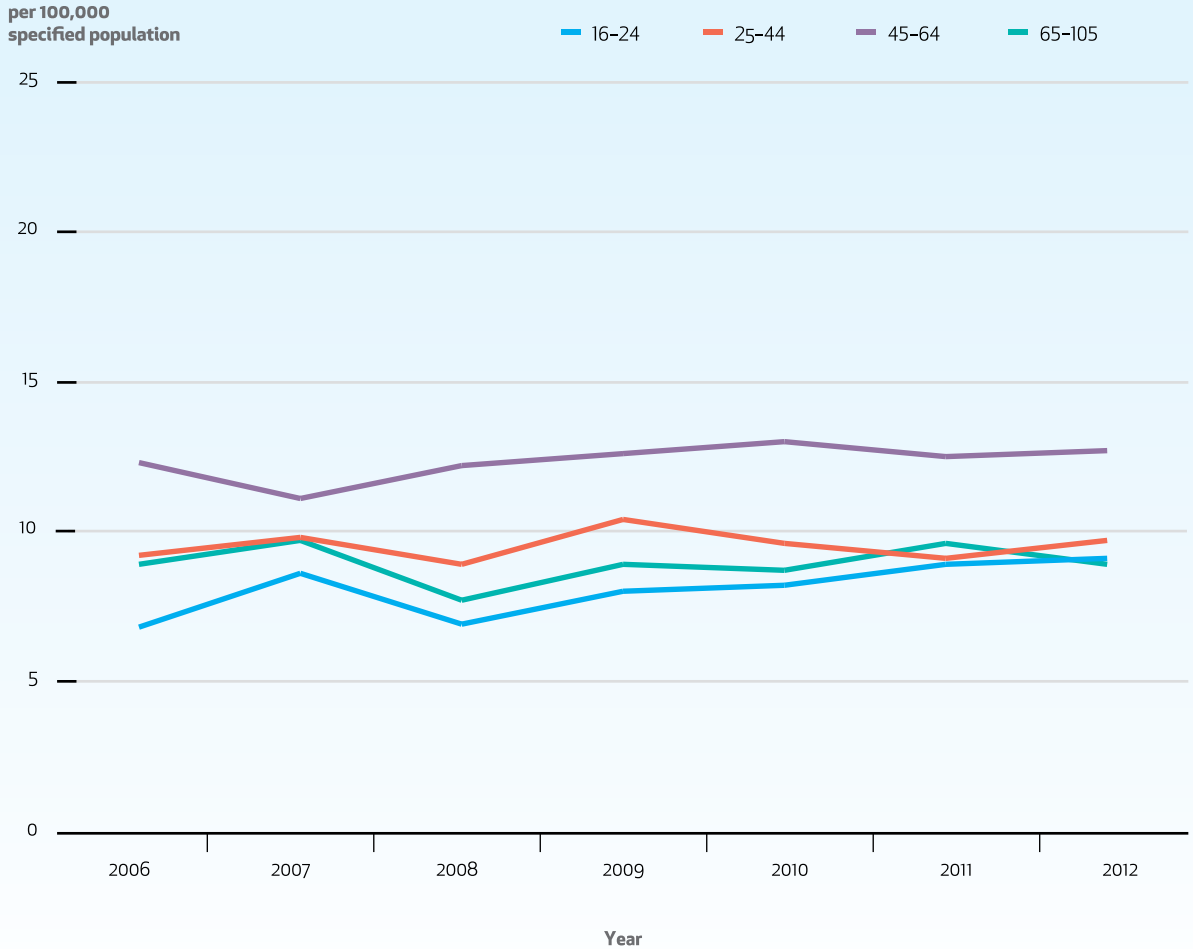


EXHIBIT 2.3.3 Number of deaths by suicide per 100,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average, between 2010 and 2012, the rate of death by suicide was approximately three times higher for men than women.

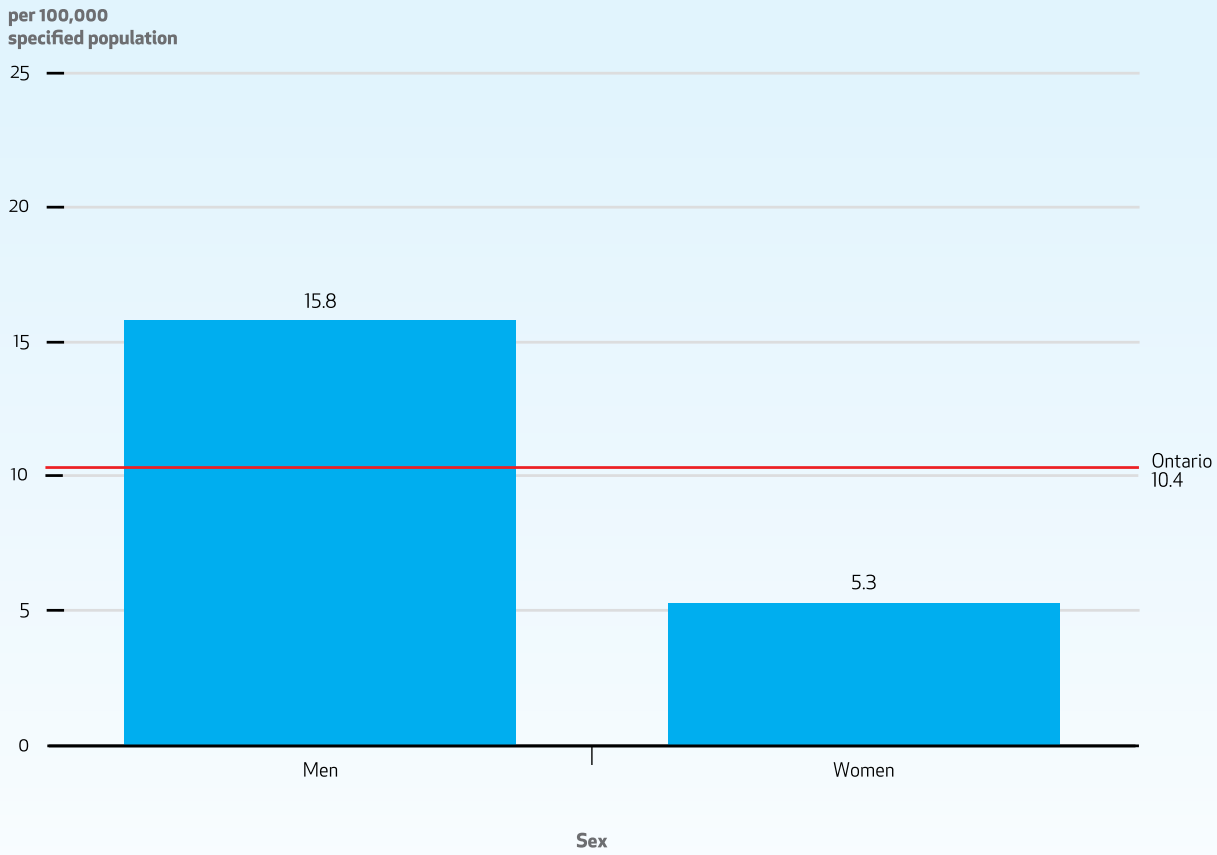


EXHIBIT 2.3.4 Number of deaths by suicide per 100,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average between 2010 to 2012, adults aged 45 to 64 years had the highest rate of death by suicide.

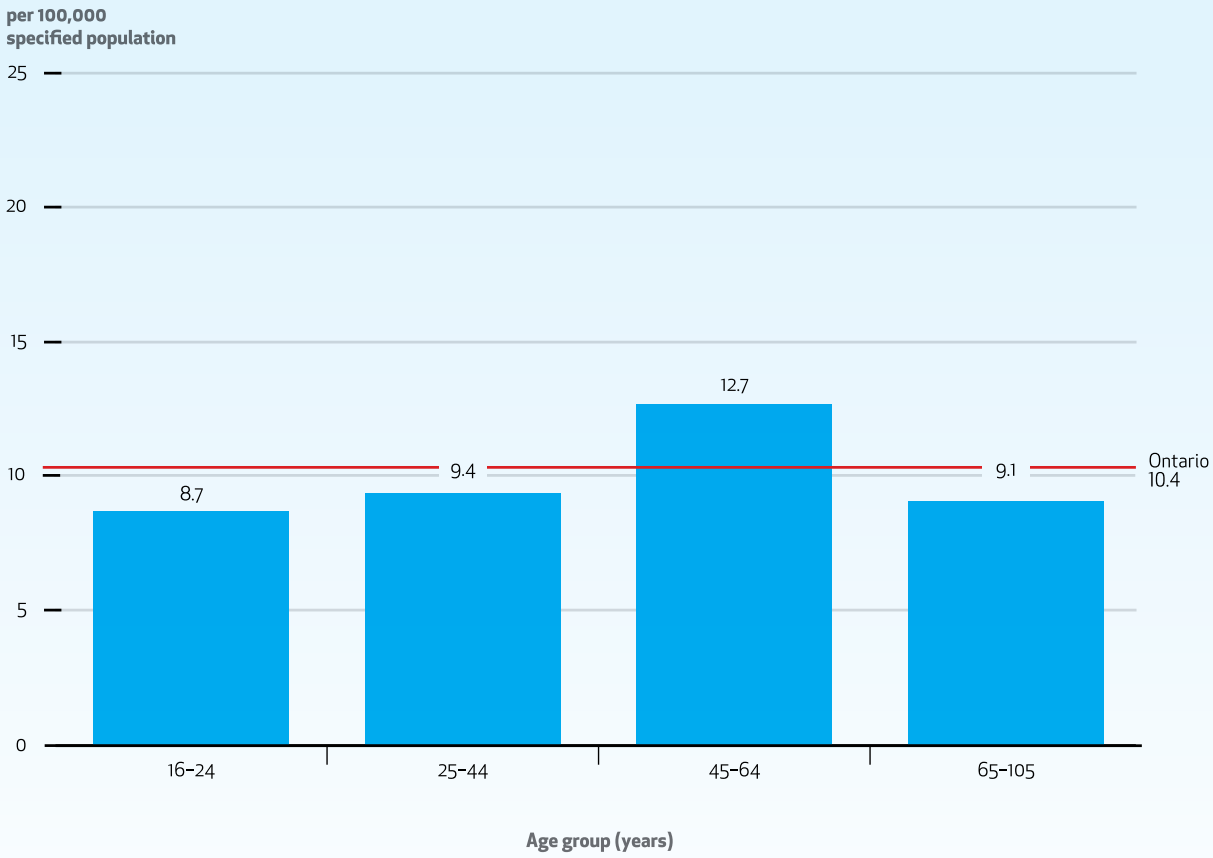


EXHIBIT 2.3.5 Number of deaths by suicide per 100,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2010 to 2012

Key Finding

- Adults living in lower income neighbourhoods had higher rates of death by suicide than those living in higher income neighbourhoods.

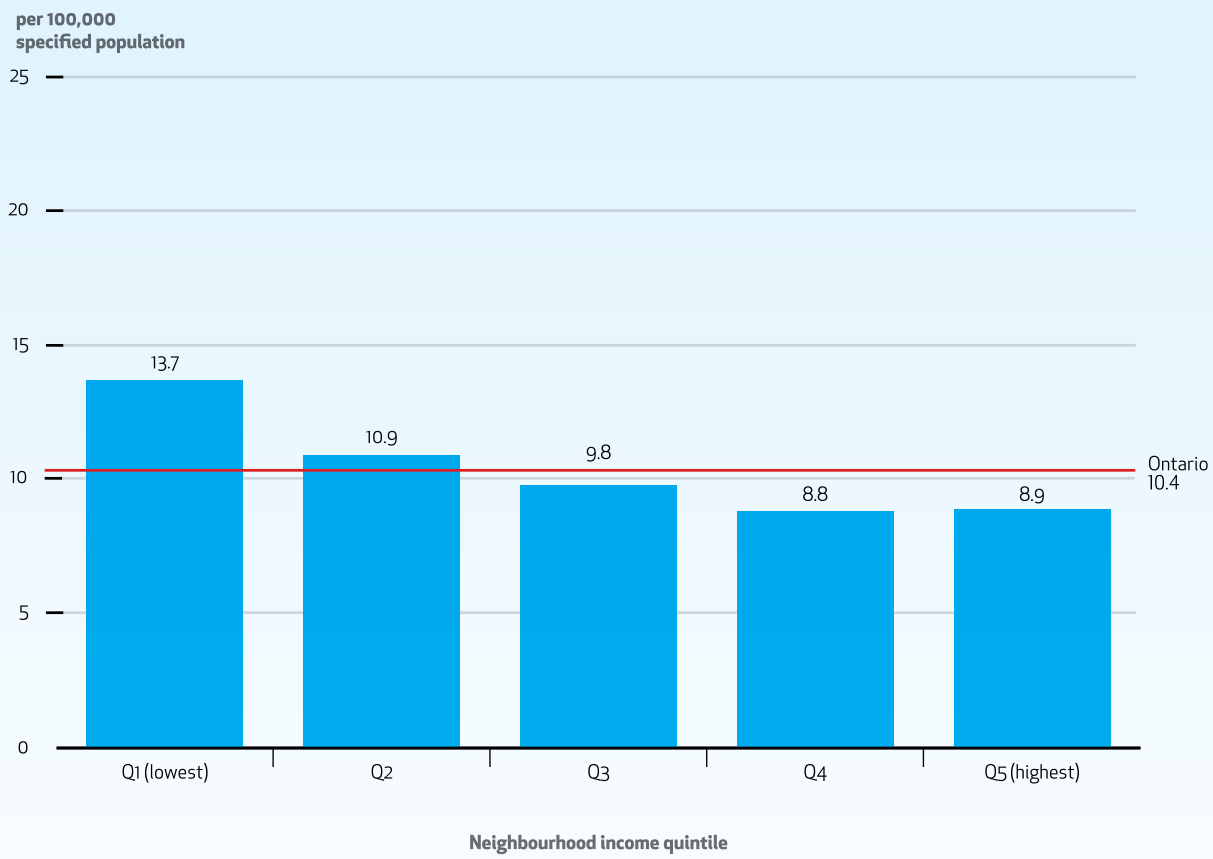


EXHIBIT 2.3.6 Number of deaths by suicide per 100,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- Non-immigrant adults had the highest rate of death by suicide, and immigrants had the lowest rate.

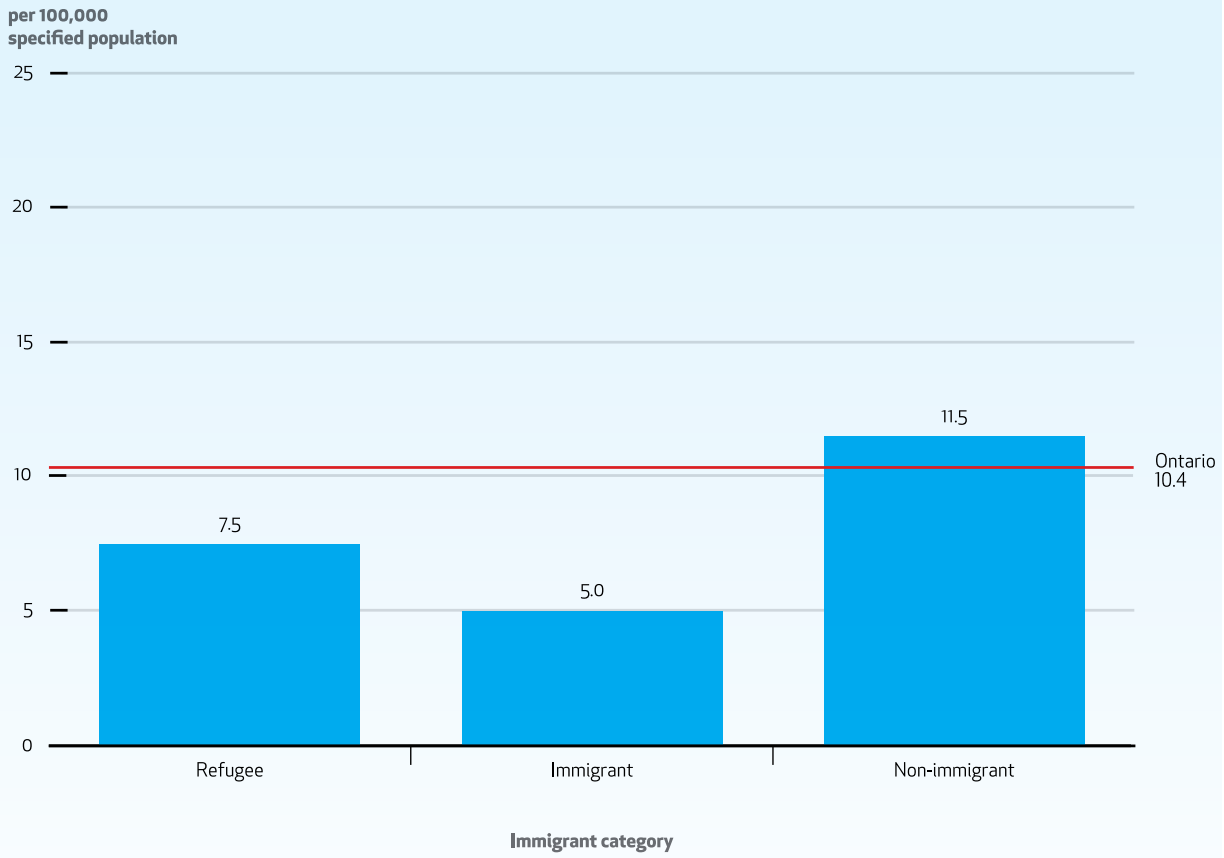


EXHIBIT 2.3.7 Number of deaths by suicide per 100,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012

Key Finding

- Between 2010 and 2012, the North West LHIN had the highest average rate of death by suicide, a rate that was more than two times higher than the Ontario average.

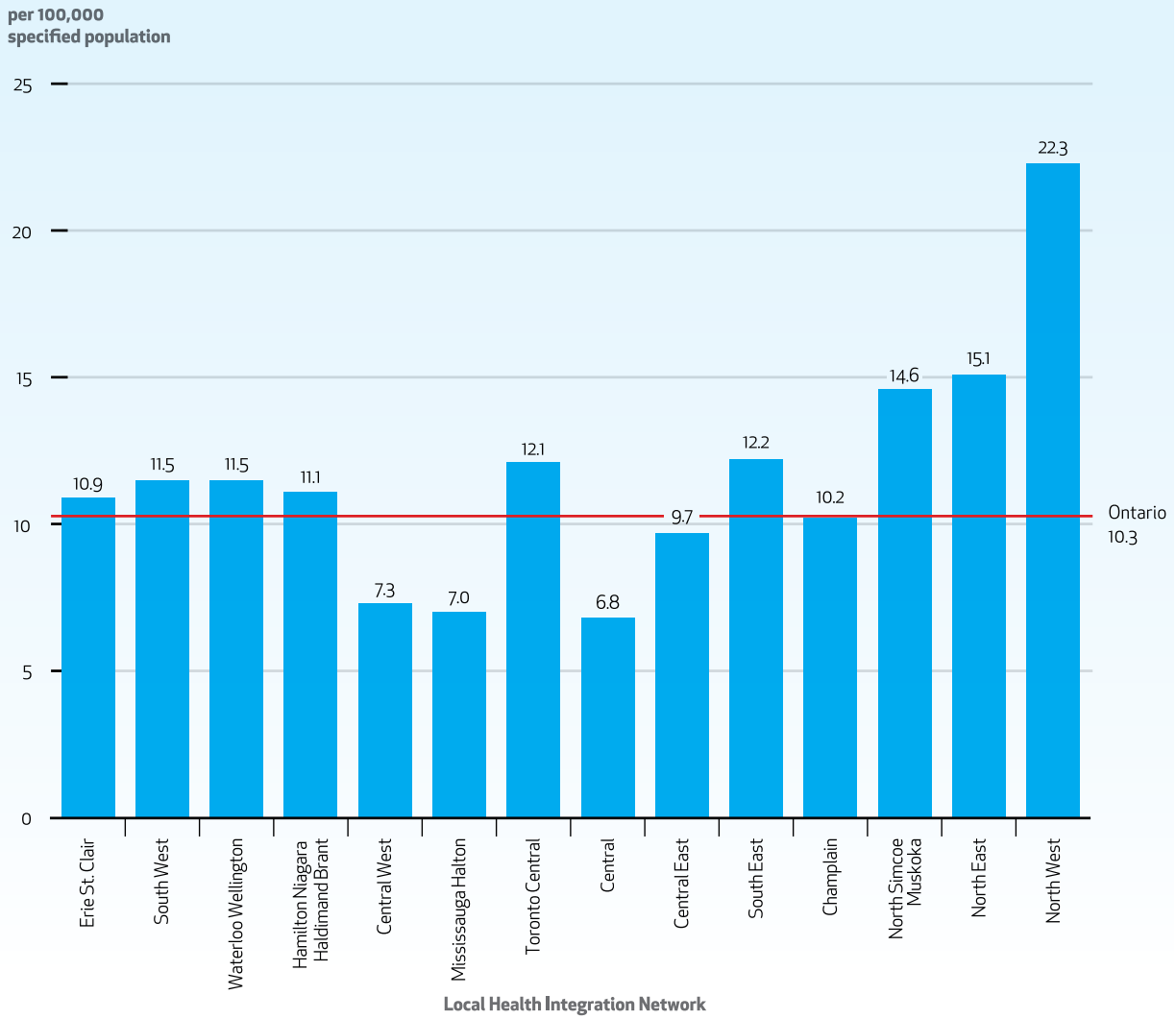
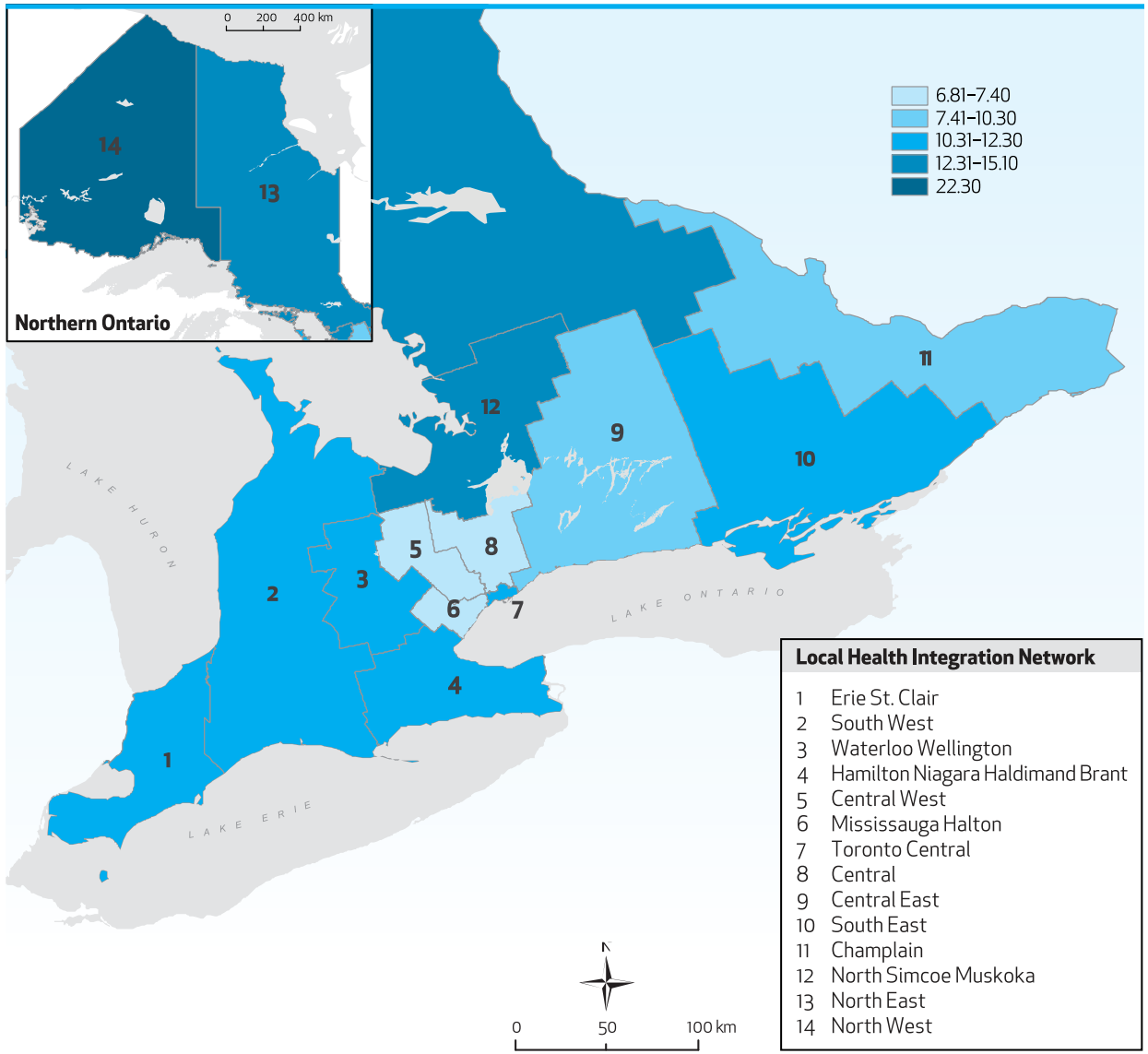


EXHIBIT 2.3.8 Number of deaths by suicide per 100,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012

Key Finding

- Between 2010 and 2012, the North West LHIN had the highest average rate of death by suicide, a rate that was more than twice the Ontario average.



2.4 First contact in the emergency department for mental health and addictions

Rationale

When access to timely community-based mental health assessment and treatment is insufficient, individuals who require services may use the emergency department (ED) as their first point of contact. Therefore, a high rate of use of the ED as a first point of contact for mental health and addictions (MHA) care may be a useful indicator of inadequate access to outpatient physician- and community-based care.

Results

Rates of first contact in the emergency department for MHA care remained stable over time. Men had a higher rate of ED first contact than women. The rate of first contact was highest among older adults aged 85 to 105, for whom there was an observed increase. The second highest rate was among individuals aged 16 to 24, for whom there was a slight decline. Those diagnosed with anxiety and substance-related disorders were the most likely to use the ED as their first point of contact for MHA-related care. Immigrants had higher ED first-contact rates than non-immigrants. Age- and sex-standardized rates of first contact were highest in the North West and North East LHINs and lowest in the Toronto Central LHIN.

Interpretation

About one-third of adults presenting in the emergency department for MHA care did not have prior contact with the MHA system. Although the rate remained stable over time, this finding may signal inadequate access to outpatient physician- and community-based services.

EXHIBIT 2.4.1 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 population aged 16 to 105 years with an incident MHA-related ED visit, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, use of the emergency department as the first point of contact for MHA care remained relatively stable. The rate was higher among men than women.

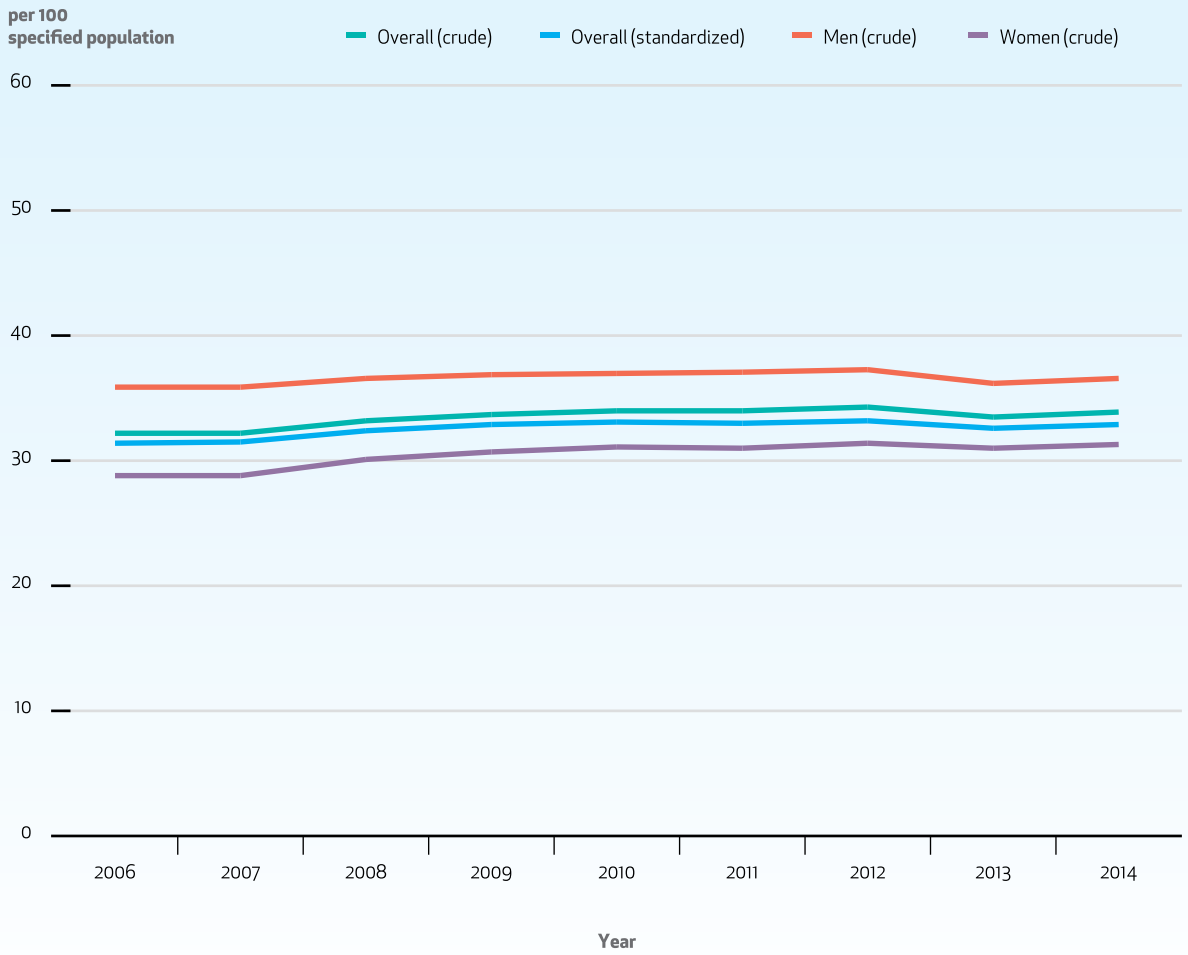


EXHIBIT 2.4.2 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 population aged 16 to 105 years with an incident MHA-related ED visit, by age group, in Ontario, 2006 to 2014

Key Finding

- The rate of first contact in the emergency department for MHA care was highest for adults aged 85 to 105, where it increased over time. Individuals aged 16 to 24 had the second highest rate of first contact in 2006, with a decrease observed in subsequent years.

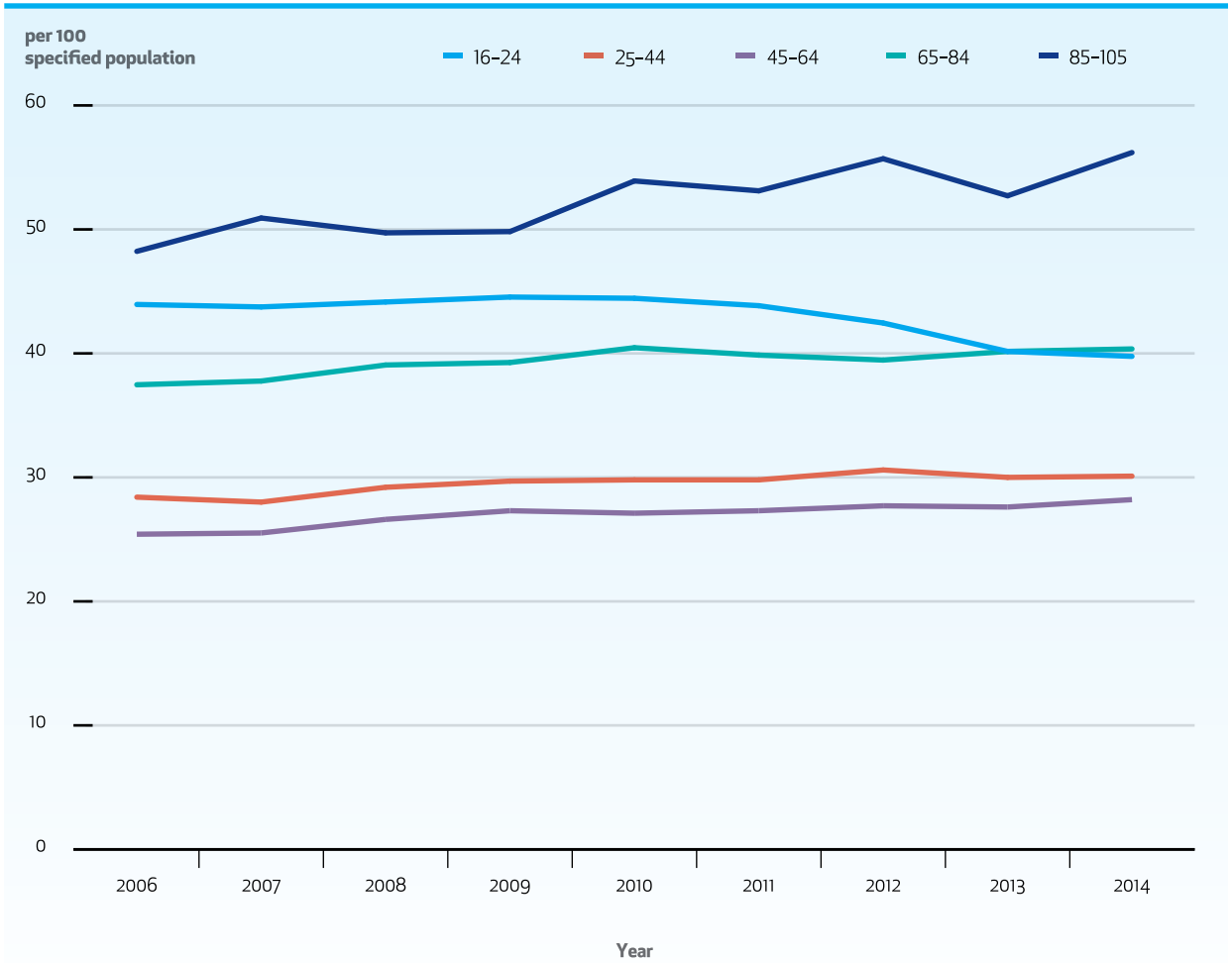


EXHIBIT 2.4.3 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 population aged 16 to 105 years with an incident MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

Key Finding

- The rate of first contact in the emergency department for MHA care was highest among individuals diagnosed with anxiety and substance-related disorders. For each type of disorder, the rate of ED use was stable over time.

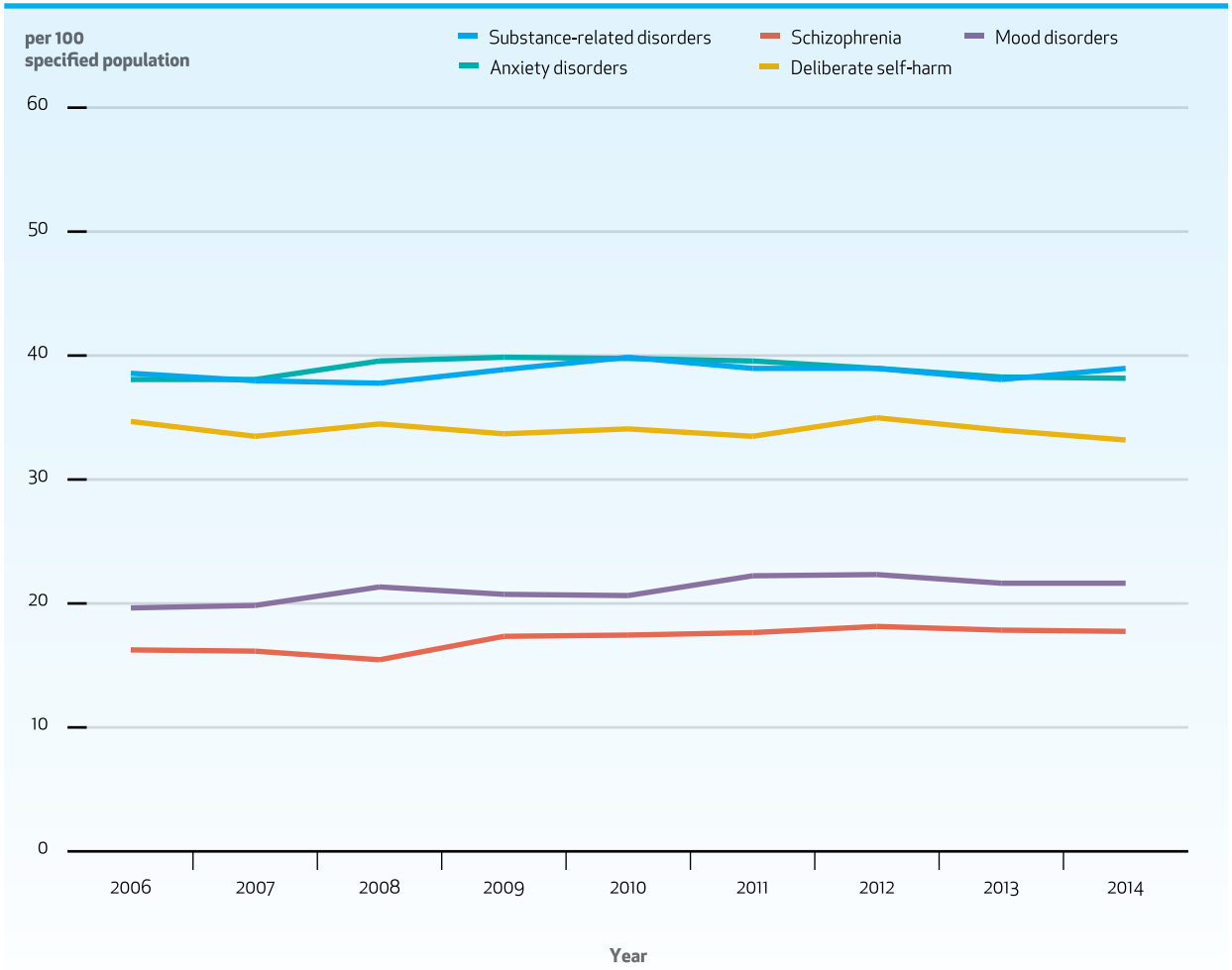


EXHIBIT 2.4.4 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 16 to 105 years with an incident MHA-related ED visit, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- Between 2012 and 2014, men were more likely than women to use the emergency department as the first point of contact for MHA care.

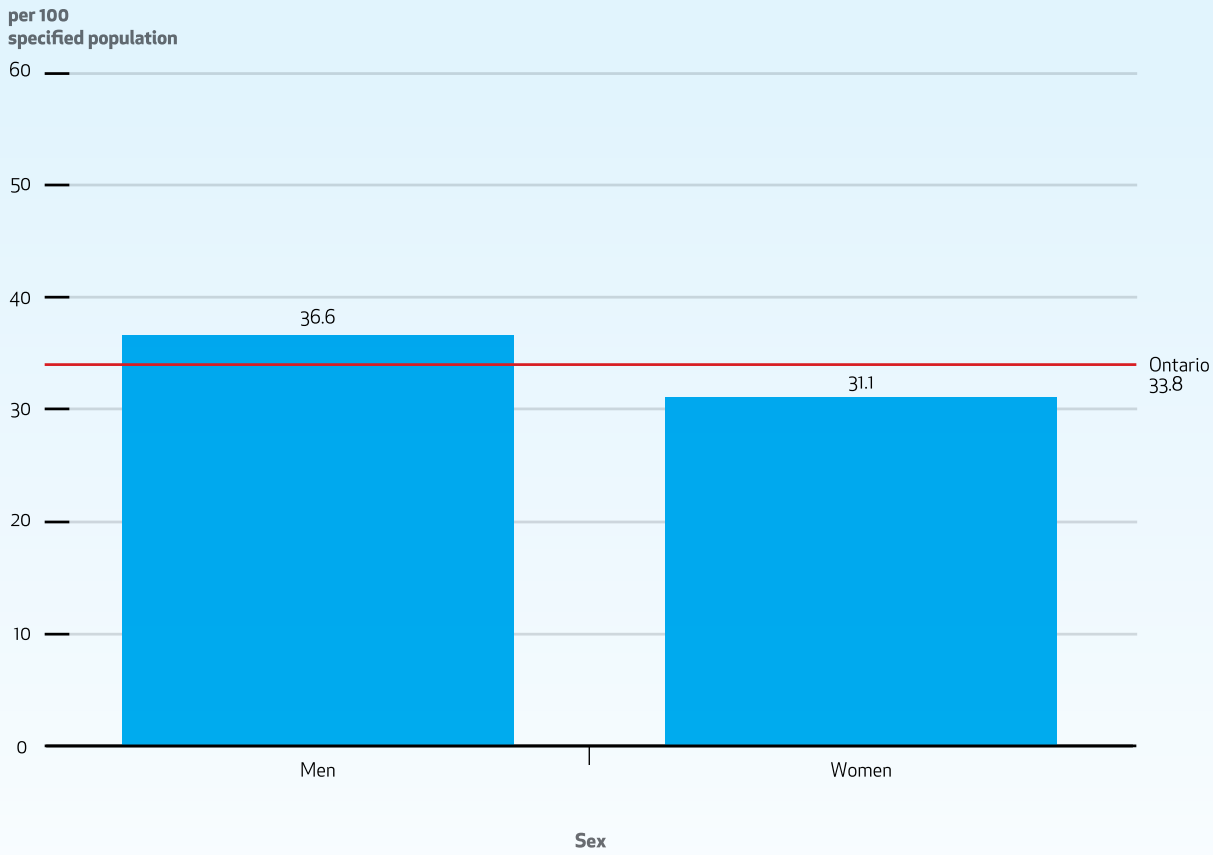


EXHIBIT 2.4.5 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 16 to 105 years with an incident MHA-related ED visit, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of first contact in the emergency department for MHA care was highest in the youngest and oldest age groups.

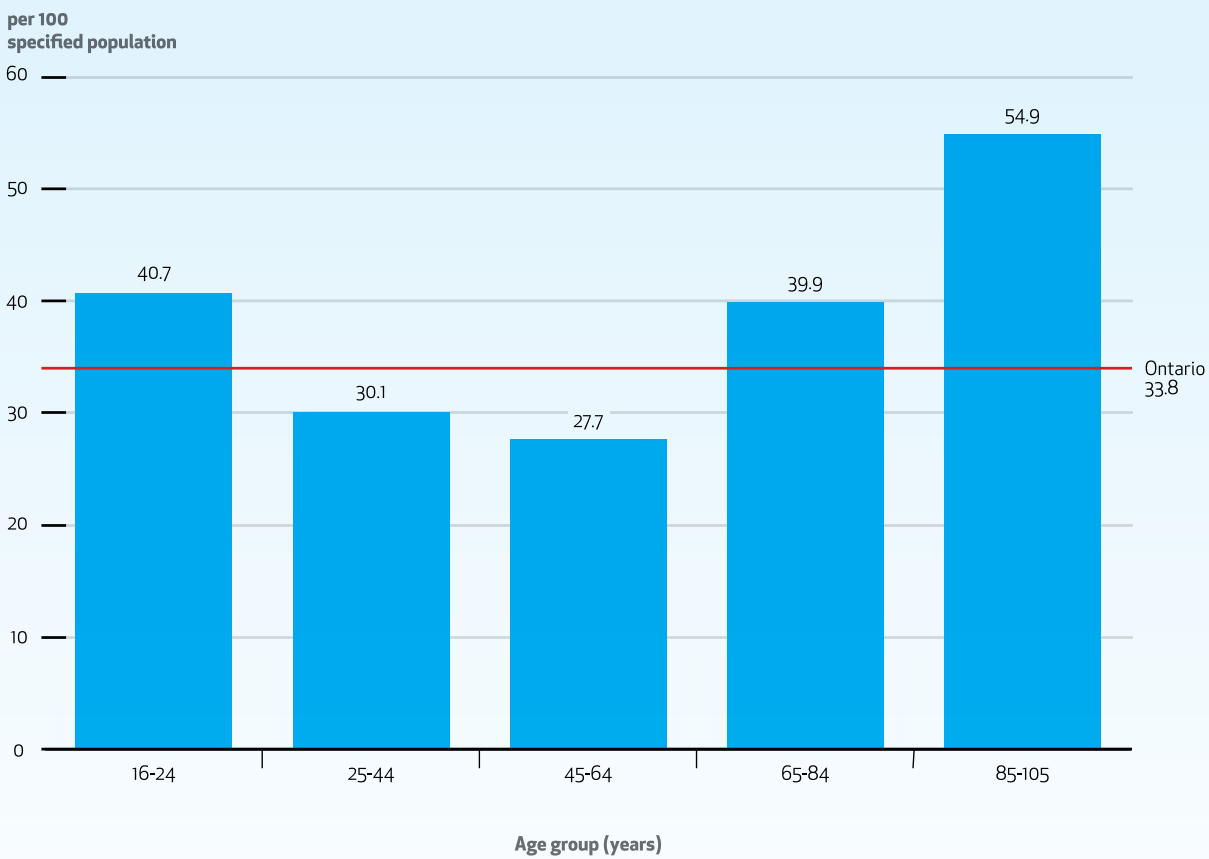


EXHIBIT 2.4.6 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 16 to 105 years with an incident MHA-related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of first contact in the emergency department for MHA care was highest among individuals with substance-related disorders and anxiety disorders.

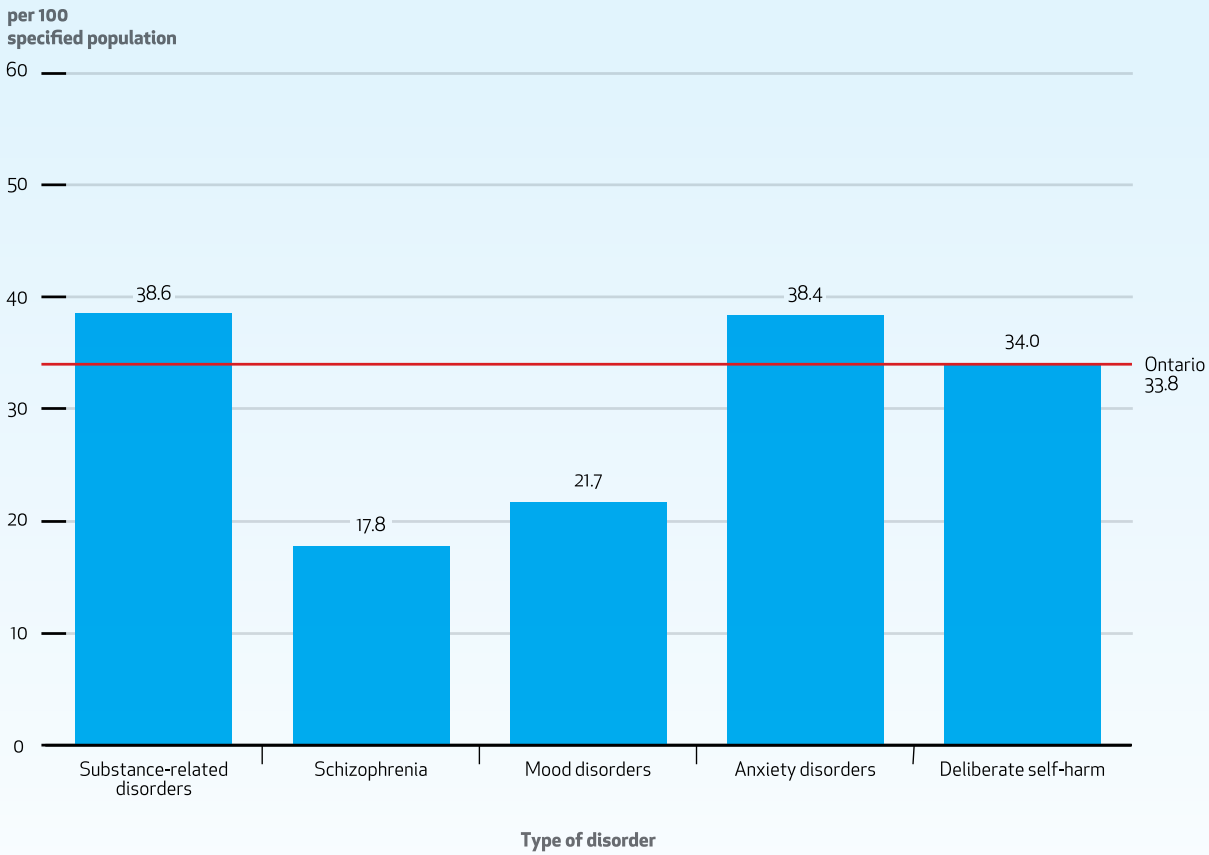


EXHIBIT 2.4.7 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 16 to 105 years with an incident MHA-related ED visit, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of first contact in the emergency department for MHA care was slightly higher among individuals living in higher-income neighbourhoods.

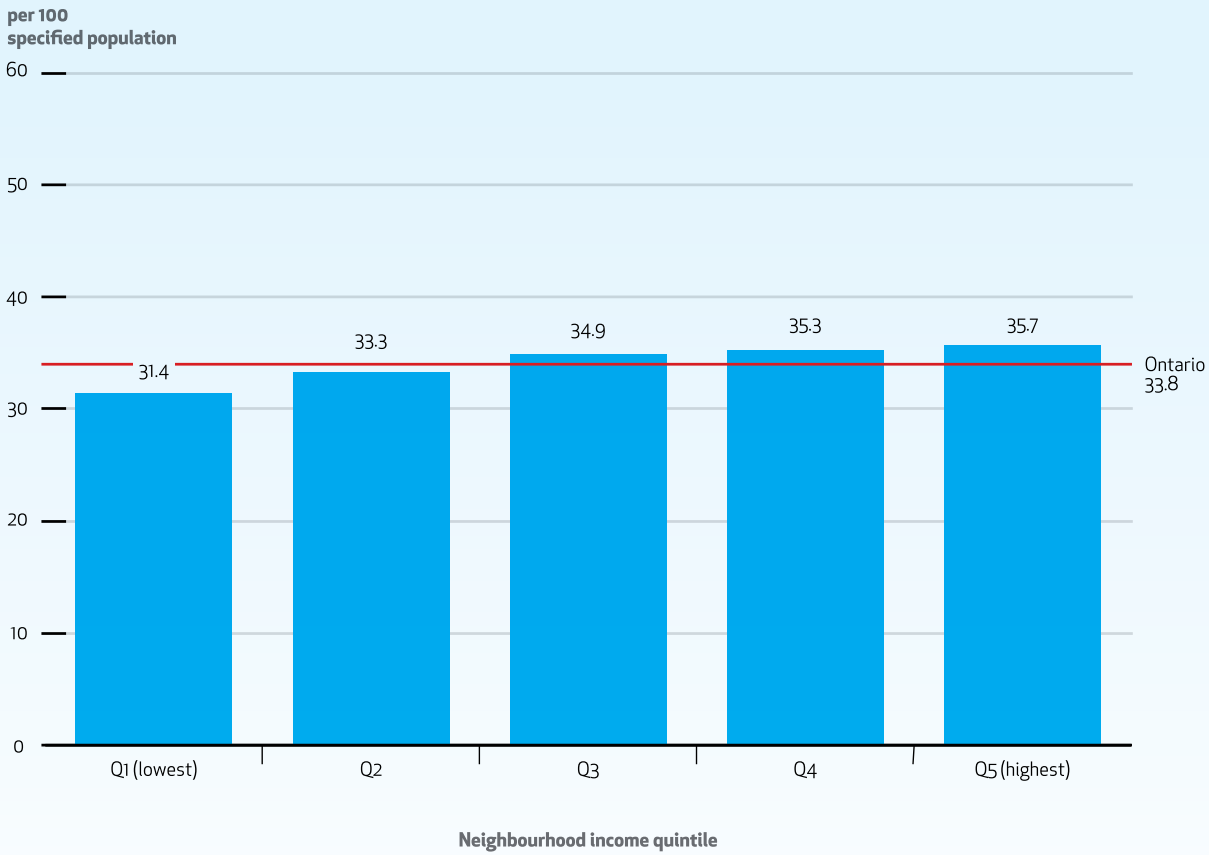


EXHIBIT 2.4.8 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 16 to 105 years with an incident MHA-related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average, between 2010 and 2012, the rate of first contact in the emergency department for MHA care was higher for immigrants than for refugees and non-immigrants.

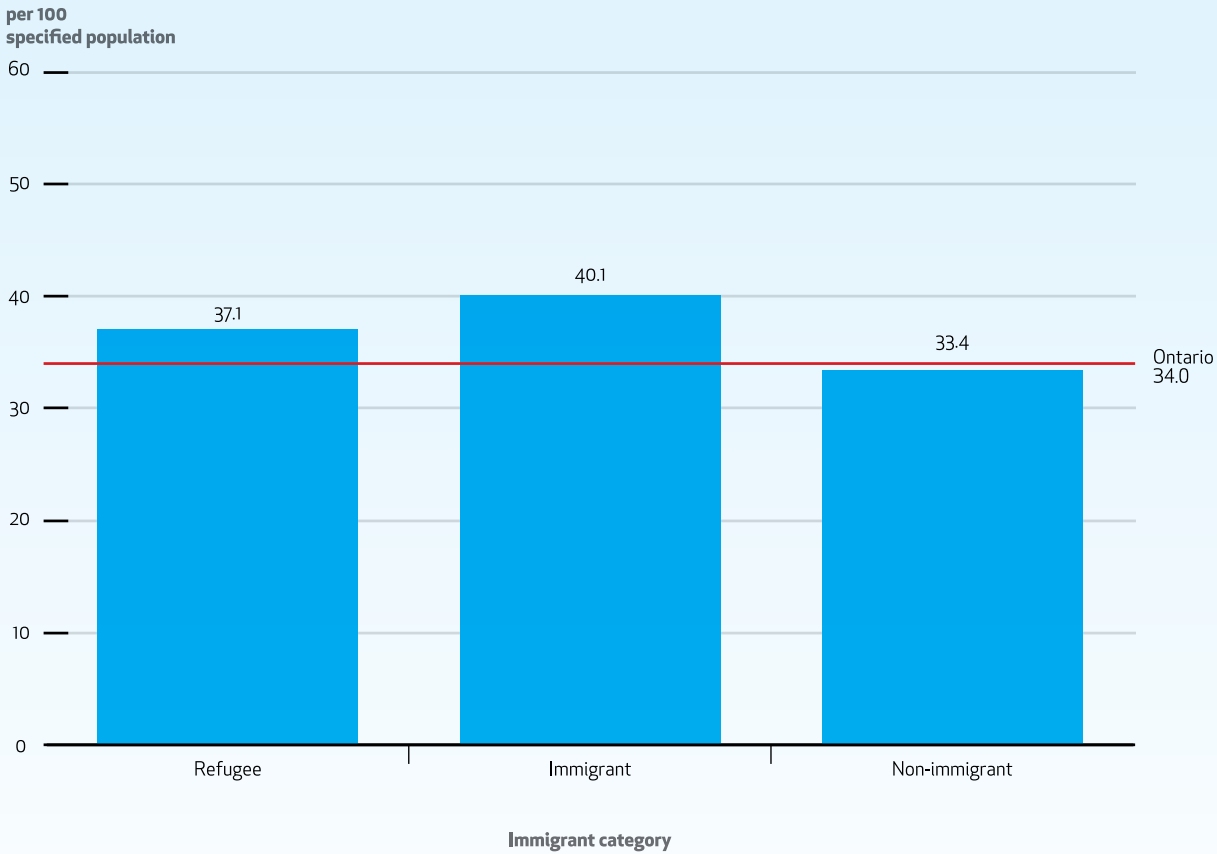


EXHIBIT 2.4.9 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 16 to 105 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the age- and sex-standardized rate of first contact in the emergency department for MHA care was highest in the North West and North East LHINs, and lowest in the Toronto Central LHIN.

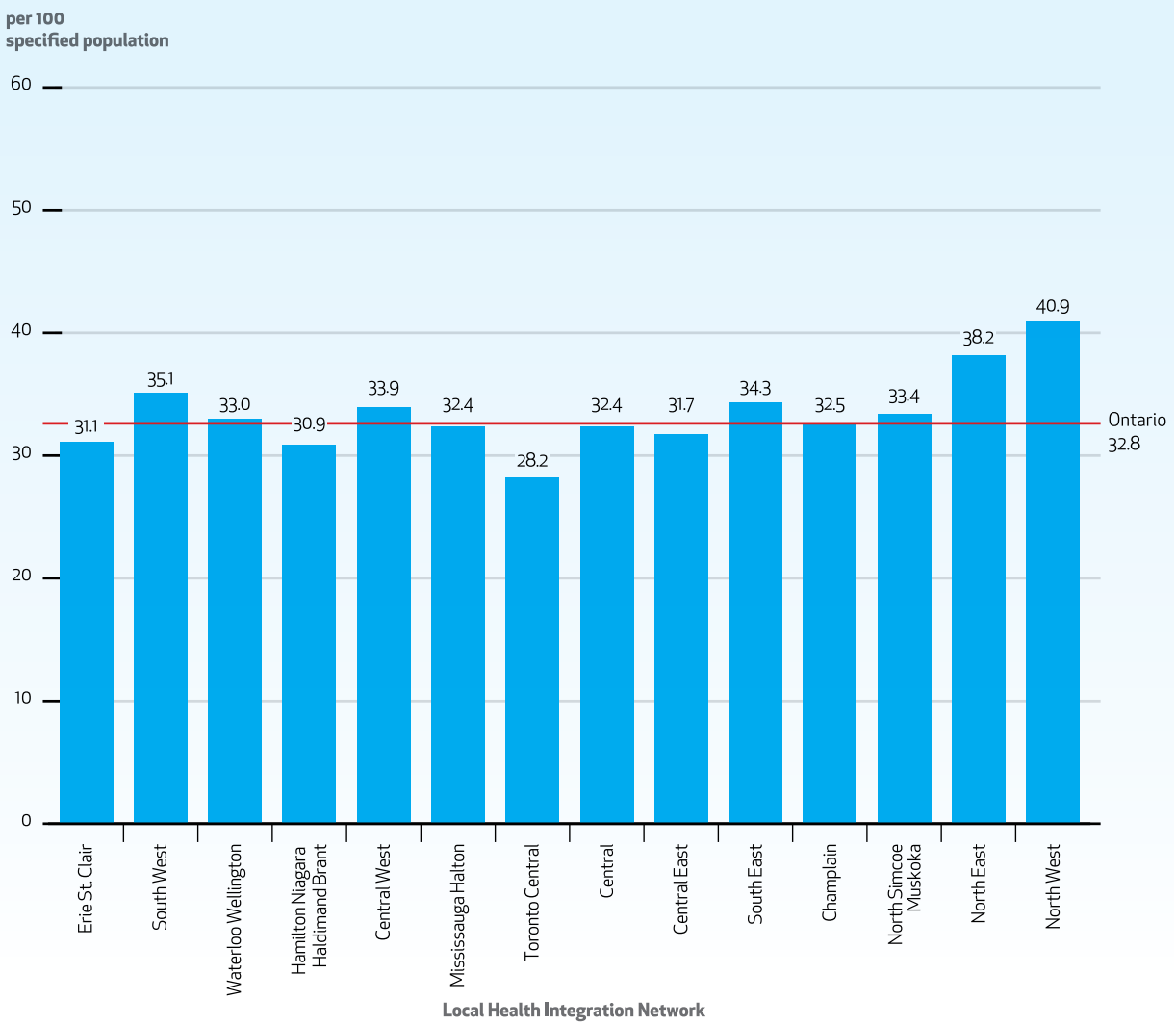
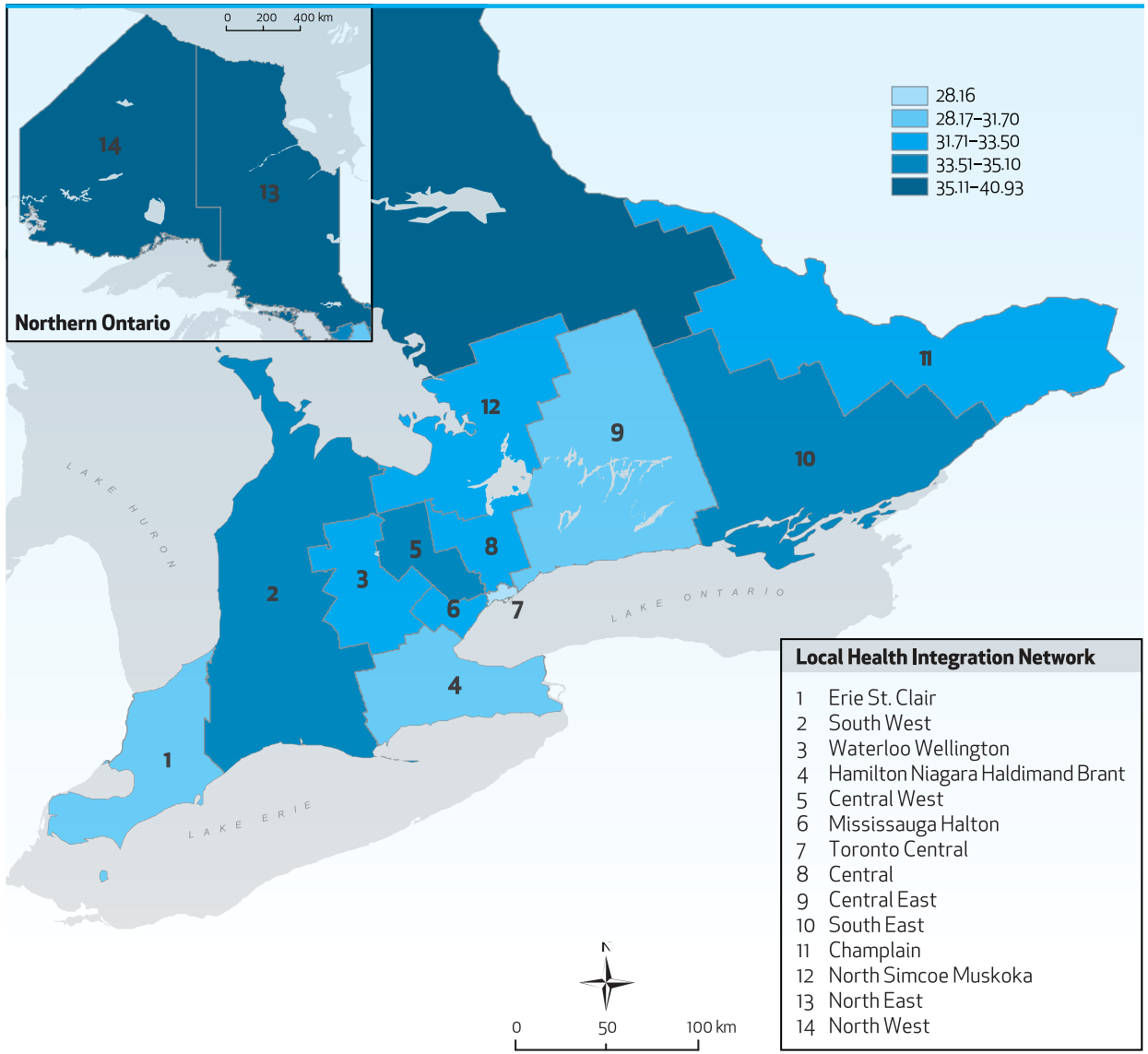


EXHIBIT 2.4.10 Number of individuals for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 16 to 105 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the age- and sex-standardized rate of first contact in the emergency department for MHA care was highest in the North West and North East LHINs, and lowest in the Toronto Central LHIN.



2.5 Repeat unscheduled emergency department visits within 30 days

Rationale

Repeat unscheduled emergency department visits for mental health and addictions care could signal inadequate transitions in care between hospital or ED settings and outpatient or community settings.

Results

The rate of repeat unscheduled ED visits within 30 days of an incident mental health and addictions–related ED visit remained stable over time, with 1 in 10 persons revisiting the ED. Schizophrenia-related ED visits that resulted in a discharge home were the most likely to be followed by a repeat unscheduled ED visit within 30 days. The highest rates of repeat unscheduled ED visits were found among men, 25- to 64-year-olds, non-immigrants, and those living in the lowest-income neighbourhoods. The Toronto Central and North West LHINs had the highest age- and sex-standardized rates of repeat unscheduled ED visits for mental health and addictions care.

Interpretation

About 10% of individuals had an unscheduled return to the ED for mental health and addictions–related reasons within 30 days, suggesting a need to improve transitions in care from the ED to outpatient- and community-based support and health care systems.

EXHIBIT 2.5.1 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 population aged 16 to 105 years with an incident mental health and addictions–related ED visit, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, the overall rate of repeat unscheduled ED visits within 30 days of an incident mental health and addictions–related ED visit remained stable over time. The rate was higher among men than women.

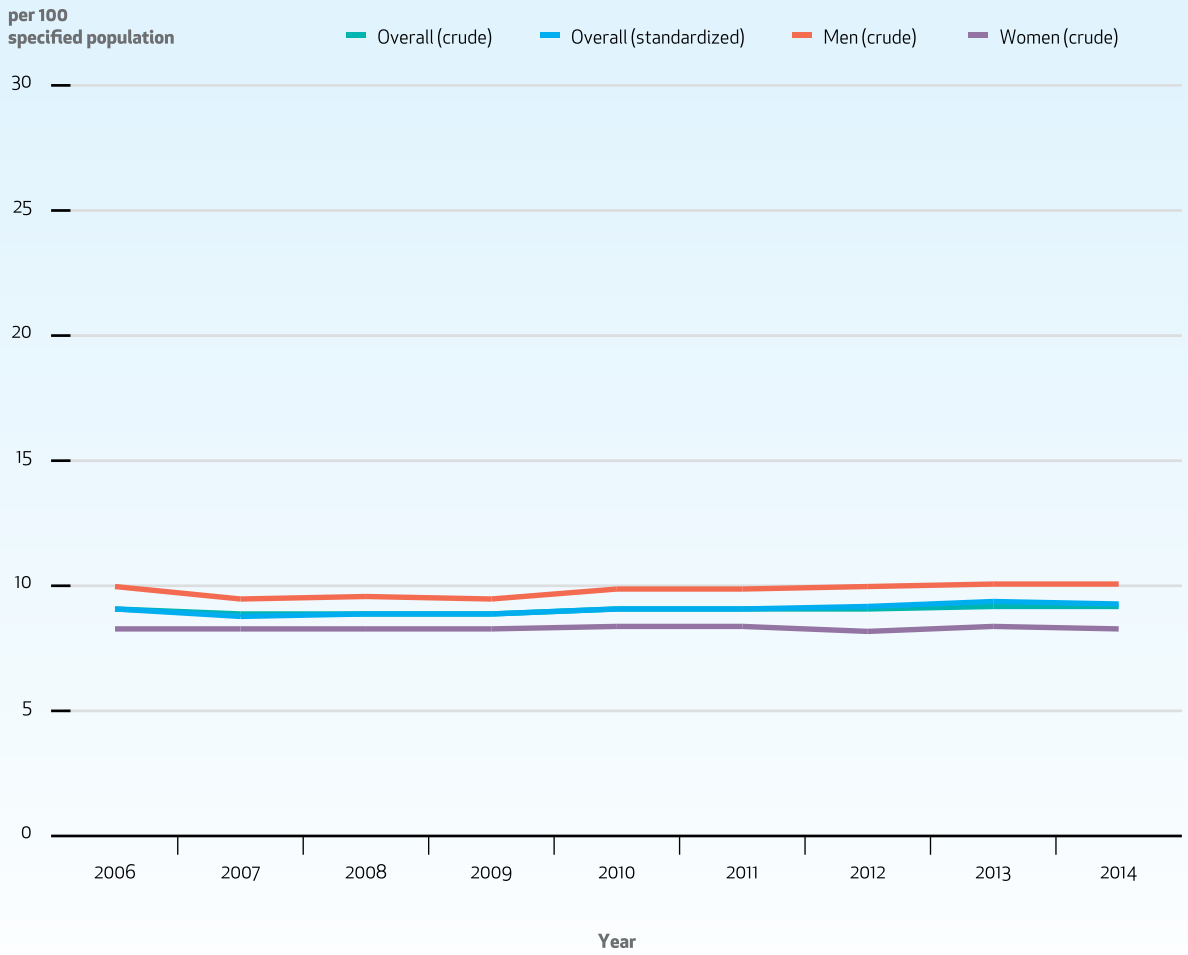


EXHIBIT 2.5.2 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by age group, in Ontario, 2006 to 2014

Key Finding

- The rate of repeat unscheduled ED visits within 30 days was highest among individuals aged 25 to 64.

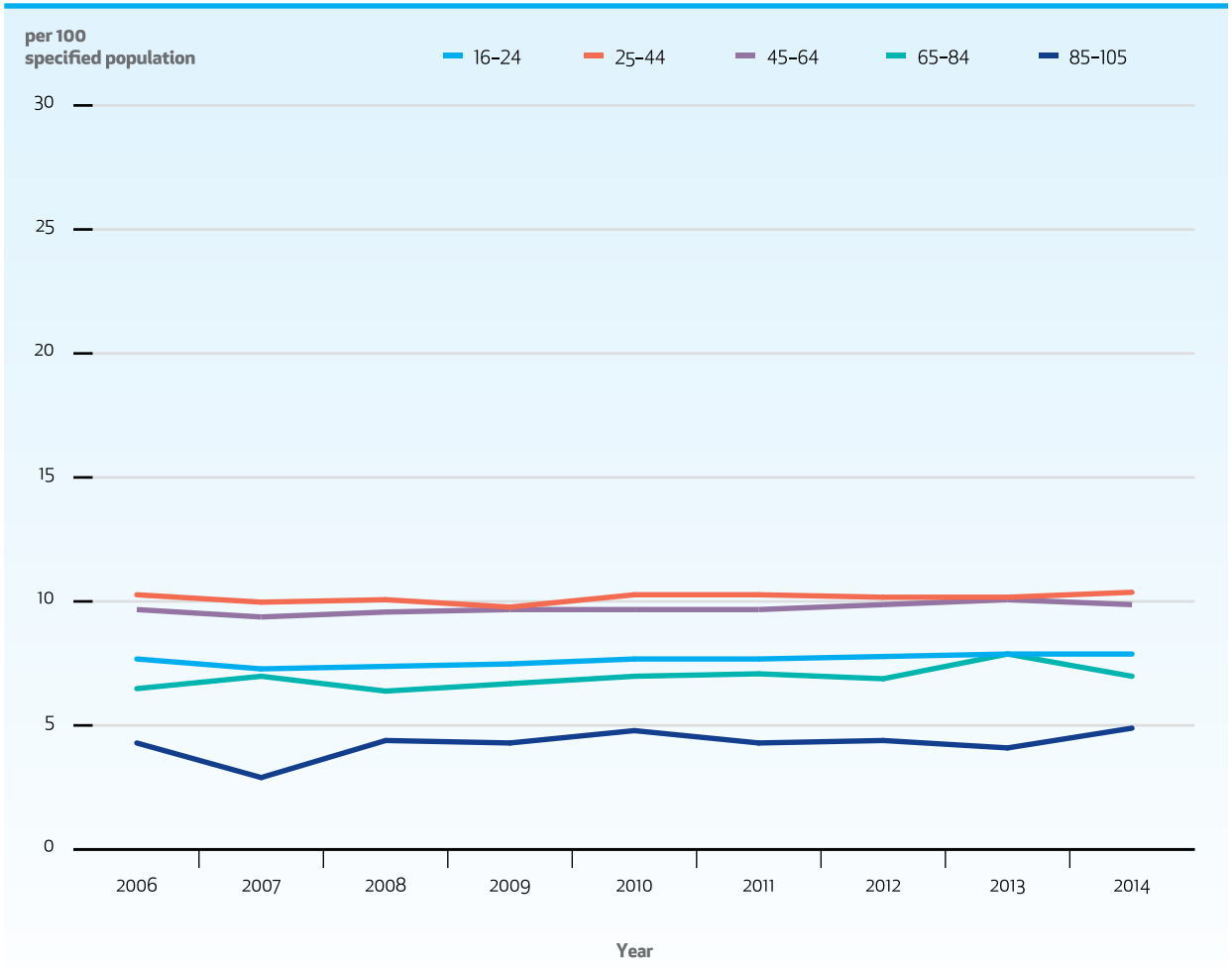


EXHIBIT 2.5.3 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by type of disorder, in Ontario, 2006 to 2014

Key Findings

- The rate of repeat unscheduled ED visits within 30 days was highest for individuals with schizophrenia or mood disorders, and lowest for those discharged with a diagnosis of deliberate self-harm without a psychiatric diagnosis.
- There was a slight reduction over time in the rate of repeat visits for mood disorders. Rates for other types of disorders remained relatively unchanged.

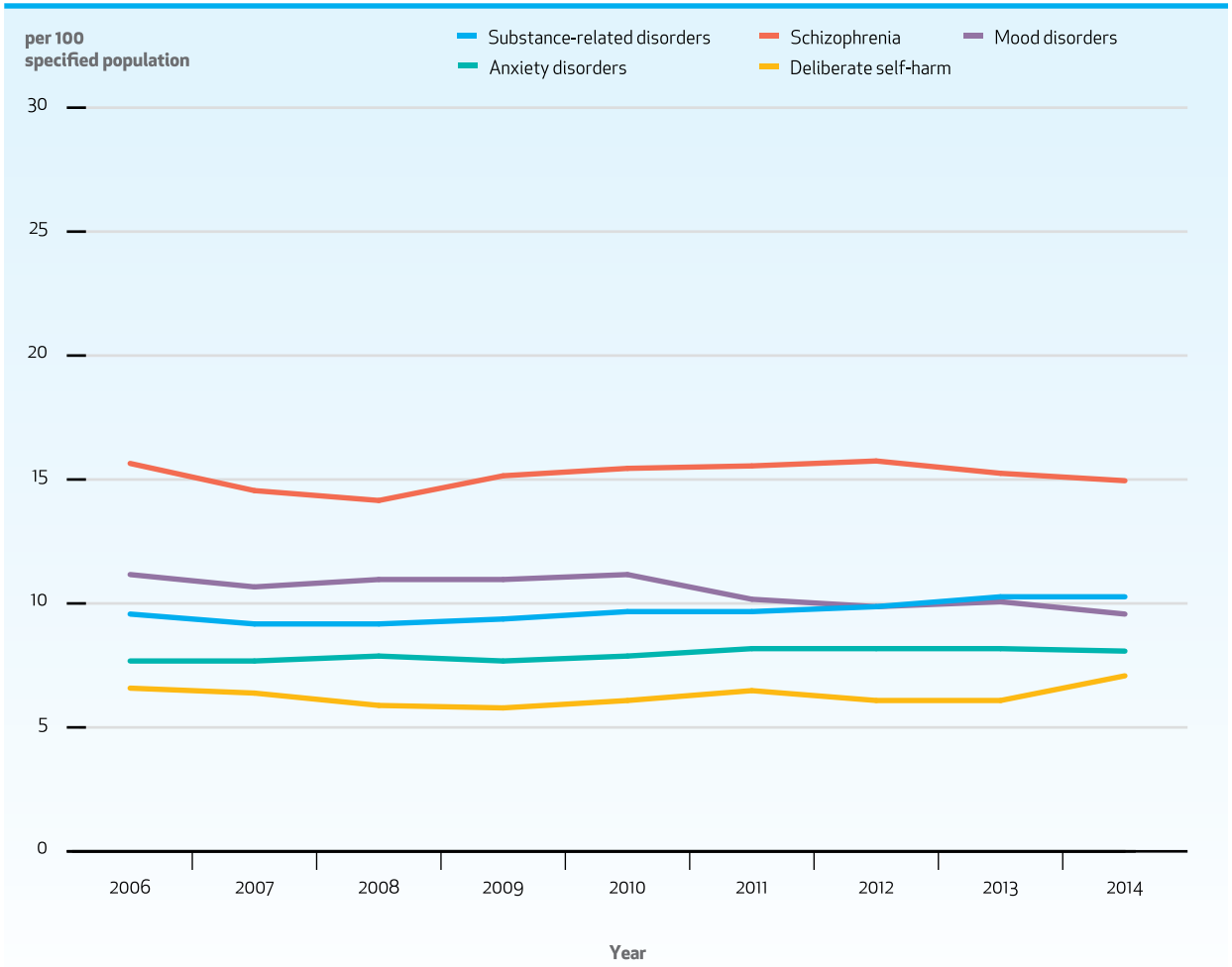


EXHIBIT 2.5.4 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of repeat unscheduled ED visits within 30 days was higher for men than women.

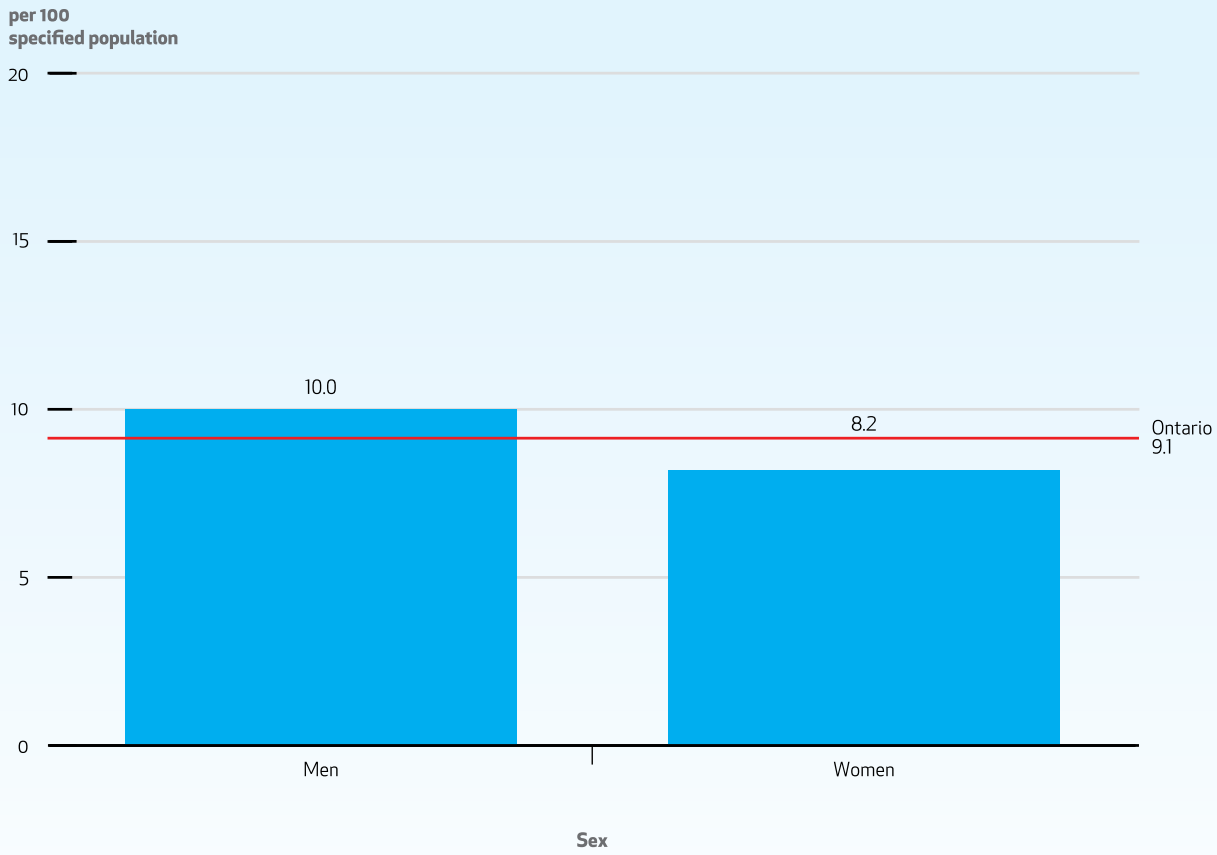


EXHIBIT 2.5.5 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- Adults in the 25 to 44 and 45 to 64 age groups had the highest rates of repeat unscheduled ED visits within 30 days.

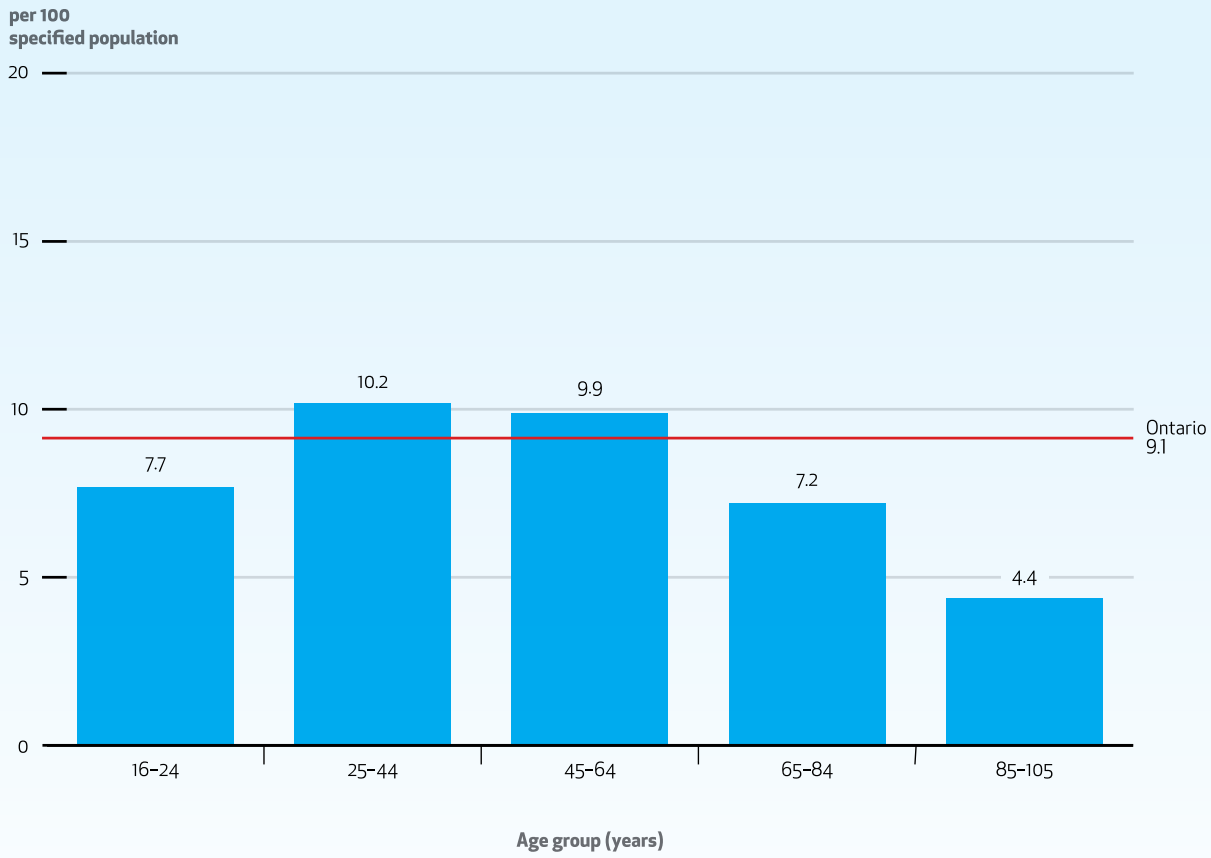


EXHIBIT 2.5.6 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

Key Finding

- Among types of disorders, the rate of repeat unscheduled ED visits within 30 days was highest for schizophrenia.

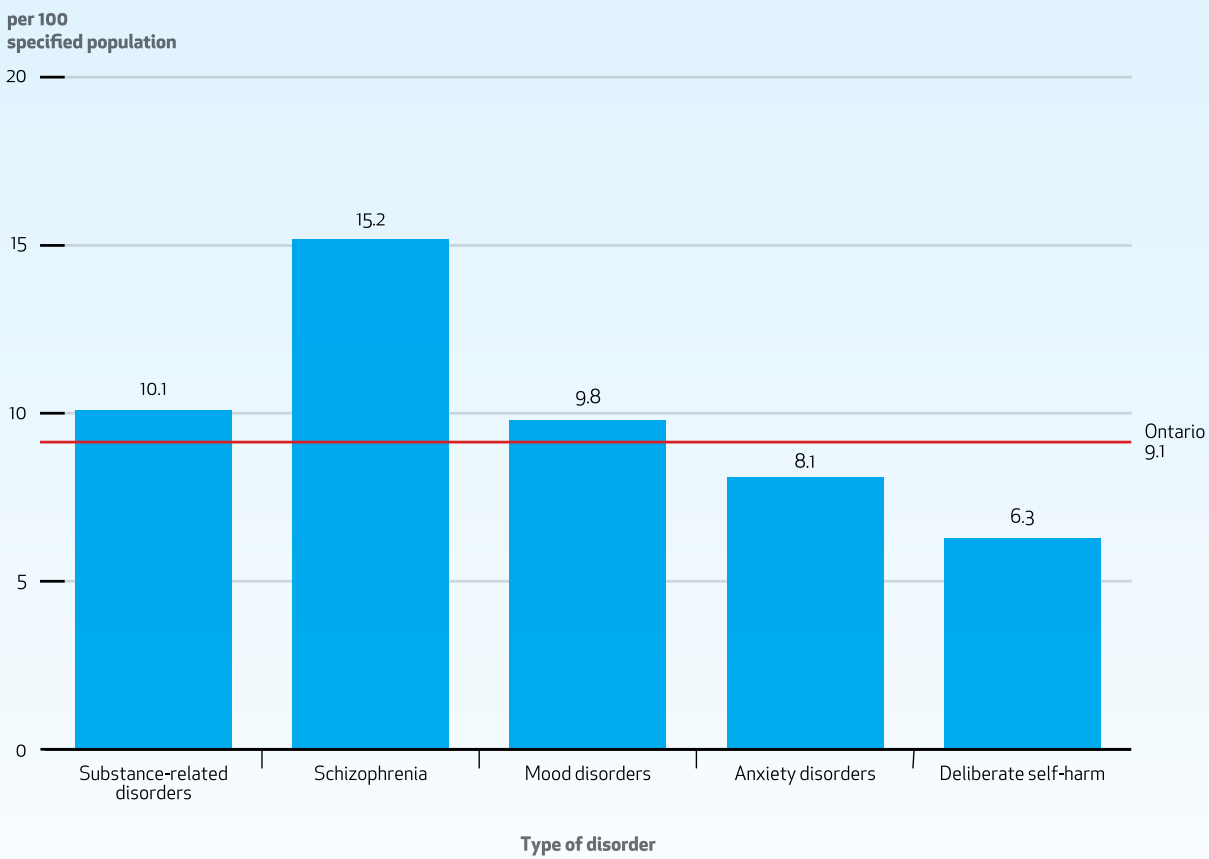


EXHIBIT 2.5.7 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of repeat unscheduled ED visits within 30 days was highest for individuals in the lowest-income neighbourhoods. The rate decreased as neighbourhood income increased.

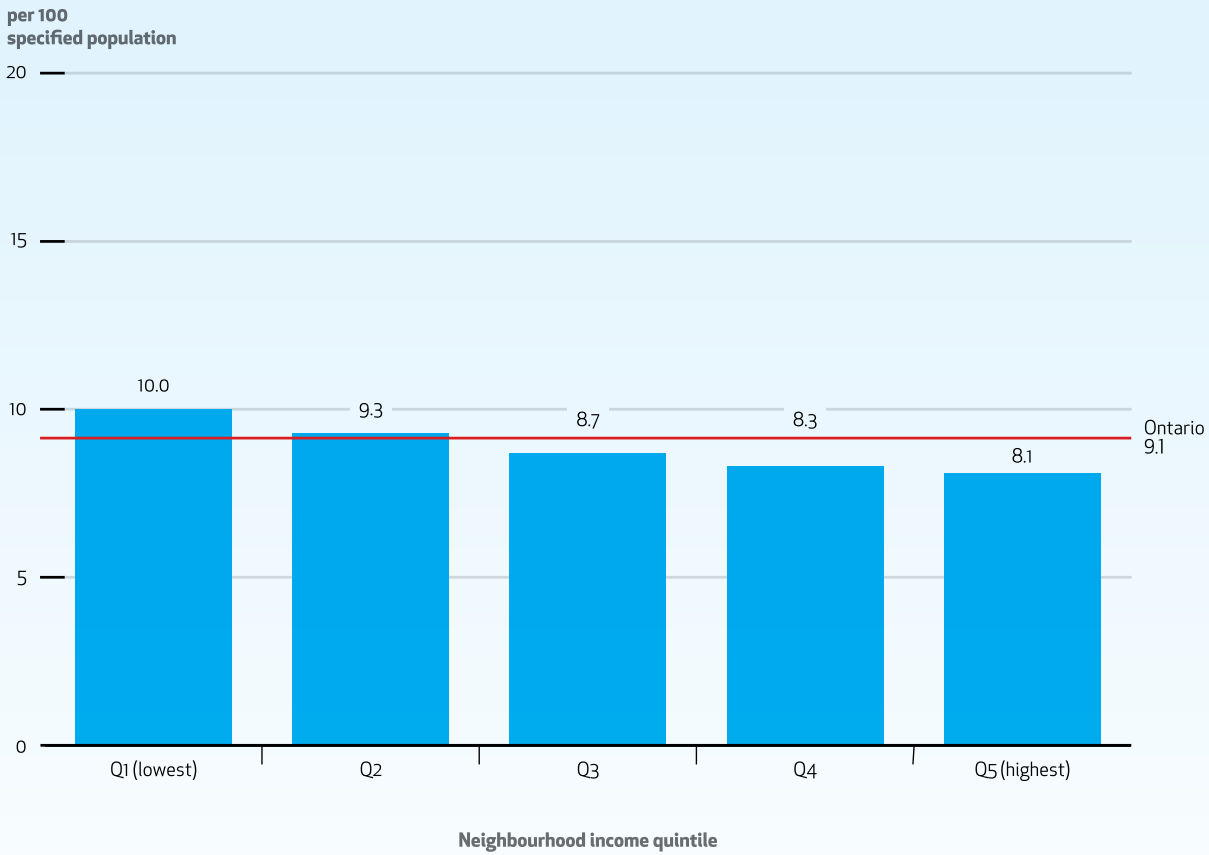


EXHIBIT 2.5.8 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- Between 2010 and 2012, the three-year average rate of repeat unscheduled ED visits within 30 days was higher for non-immigrants than for refugees and immigrants.

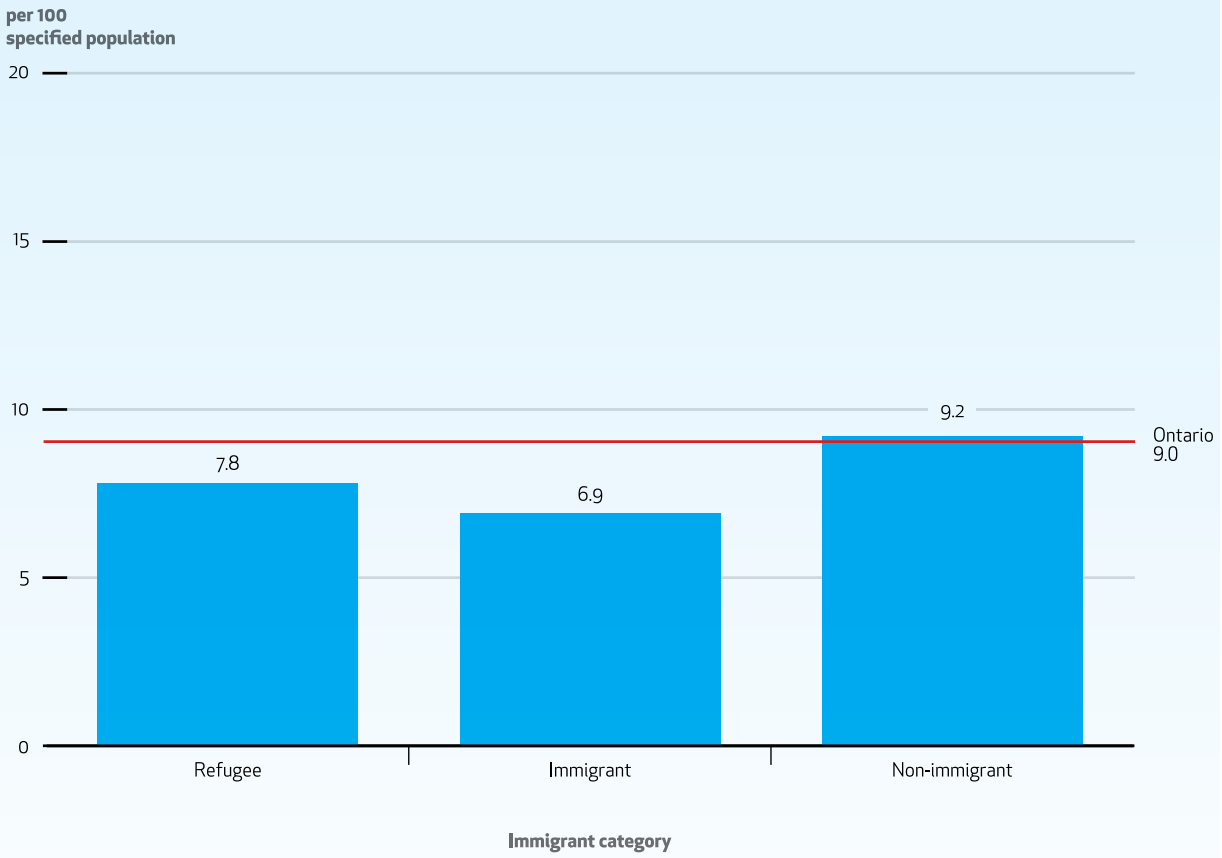


EXHIBIT 2.5.9 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average age- and sex-standardized rate of repeat unscheduled ED visits within 30 days was highest in the Toronto Central and North West LHINs.

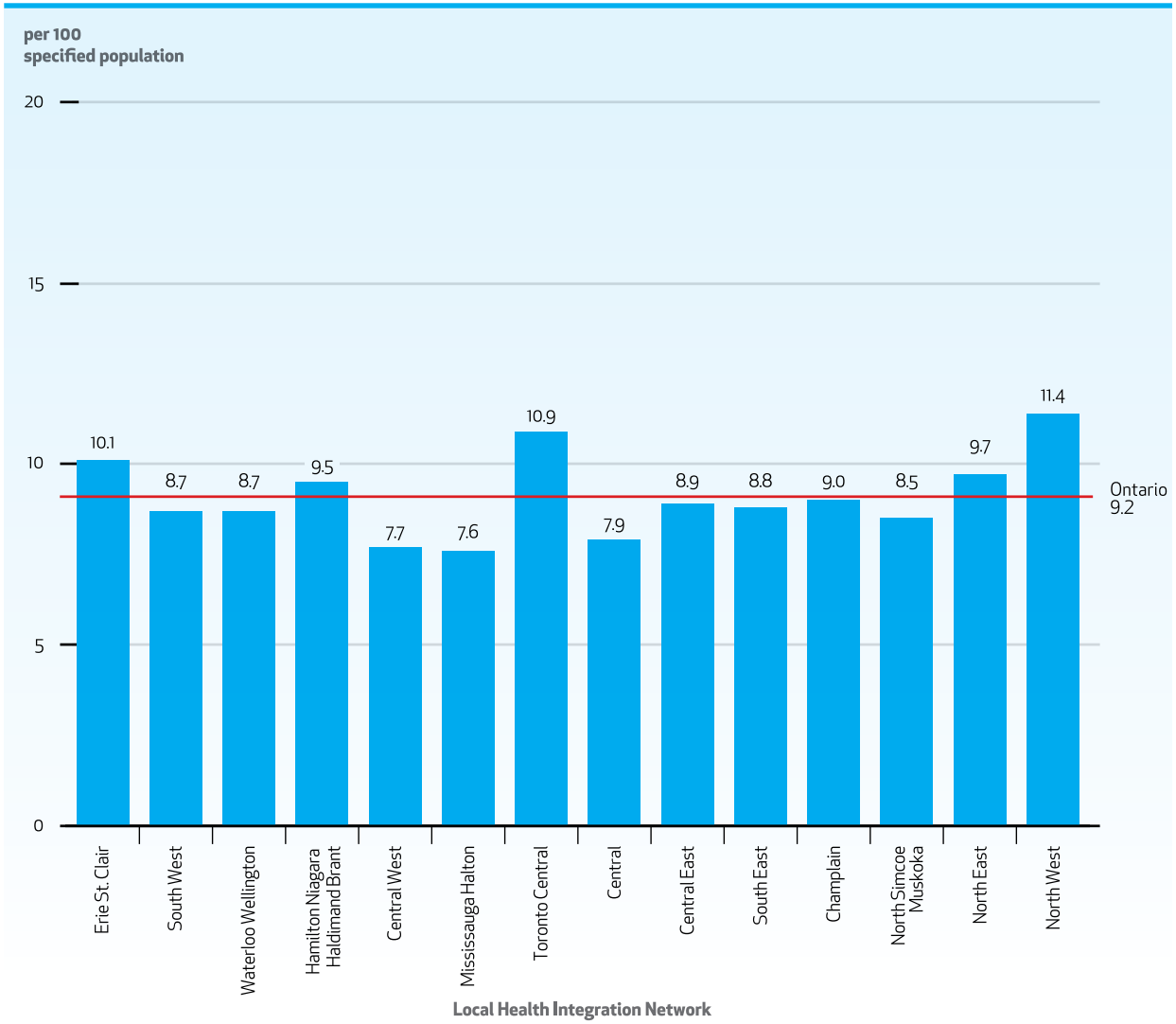
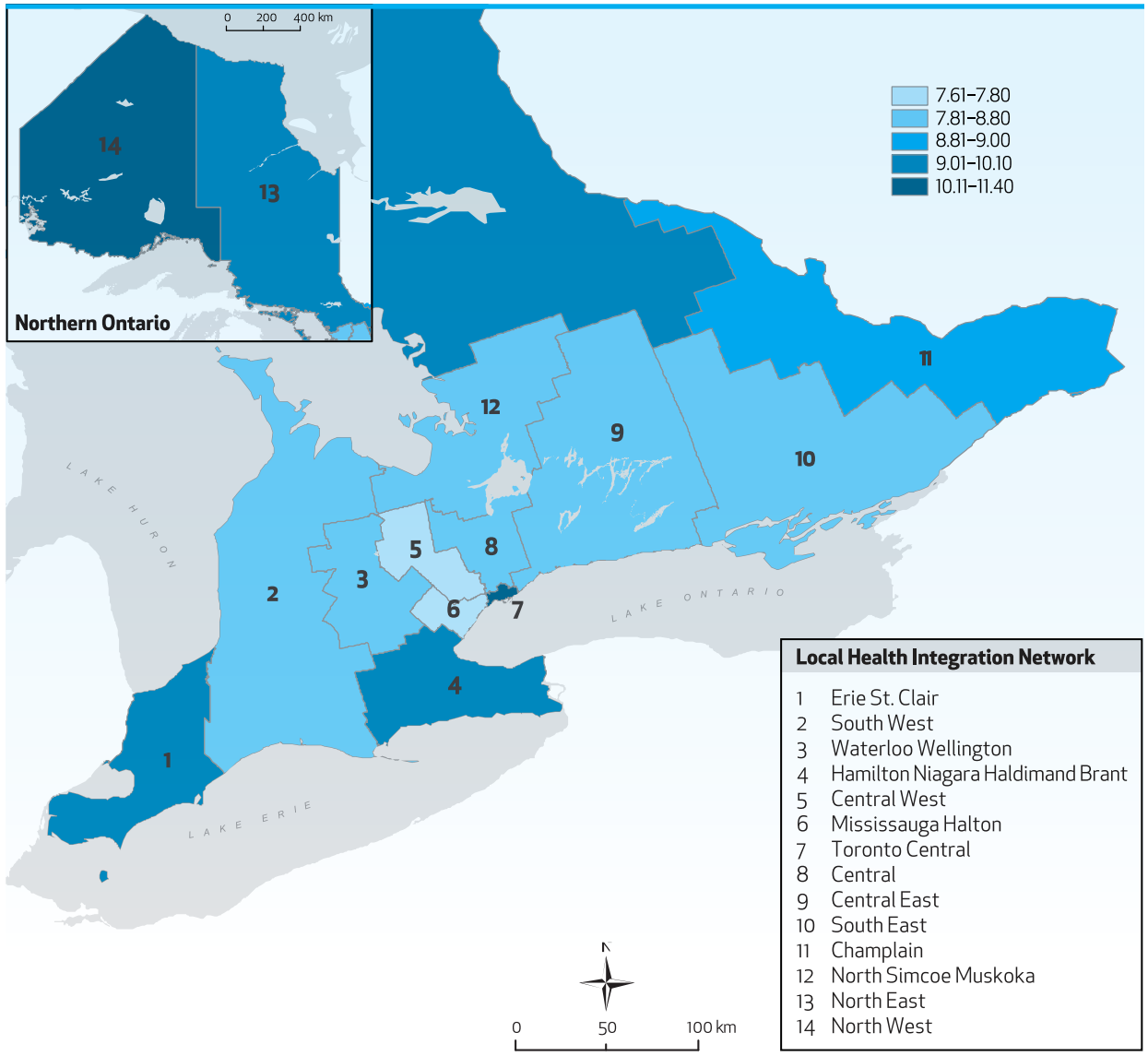


EXHIBIT 2.5.10 Number of repeat unscheduled emergency department (ED) visits within 30 days per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average age- and sex-standardized rate of repeat unscheduled ED visits within 30 days was highest in the Toronto Central and North West LHINs.



2.6 Doctor visit within 7 days of leaving hospital after treatment for mental health and addictions

Rationale

Early follow-up after hospital discharge, a universally measured performance indicator, likely helps to improve adherence to treatment and communication between care providers and patients, and may prevent hospital readmissions.

Results

The rate of doctor visits within 7 days of hospitalization for mental health and addictions care declined over time. This was driven by a reduction in the rate of follow-up visits with general practitioners/family physicians (GP/FPs). Among psychiatrists, the overall rate of follow-up visits was constant over time, but a specific increase was observed among patients aged 16 to 24.

Higher follow-up rates were observed for women, older patients, immigrants and residents of high-income neighbourhoods. For follow-up visits to GP/FPs, the rates were highest among patients who were hospitalized with substance-related disorders. Among psychiatrists, follow-up rates were highest for patients who were hospitalized with schizophrenia and mood disorders.

The rate of follow-up visits with psychiatrists was highest in the Toronto Central LHIN, which also had the highest overall follow-up rate. The highest rate of follow-up visits with GP/FPs was in the Central West LHIN.

Interpretation

About one-third of individuals were seen by either a psychiatrist or a GP/FP for mental health and addictions care within 7 days of a psychiatric hospitalization. The increase in psychiatrist follow-up for transitional-aged youth suggests that a targeted approach for this population is likely having an effect. Variation by geographic region suggests inequities in access to care.

EXHIBIT 2.6.1 Number of outpatient visits within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by physician specialty, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, the declining rate of follow-up visits to any physician specialty within 7 days of hospital discharge was driven primarily by a decrease in follow-up visits with GP/FPs. The rate of follow-up visits with psychiatrists remained relatively stable.

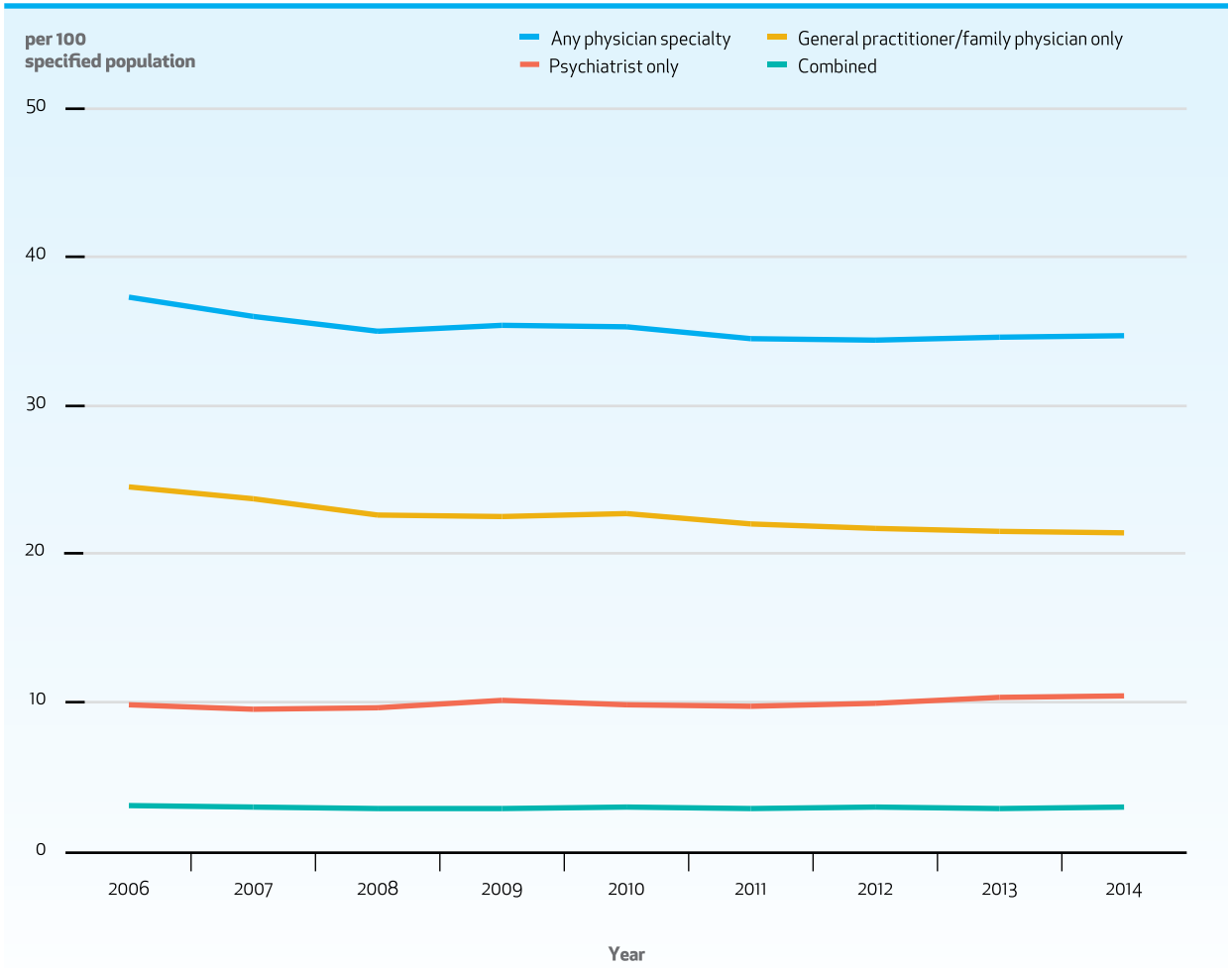


EXHIBIT 2.6.2 Number of outpatient visits within 7 days of leaving hospital per 100 population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by physician specialty and sex, in Ontario, 2006 to 2014

Key Finding

- Compared to men, women had a higher rate of follow-up visits with physicians within 7 days of hospital discharge, by any physician specialty.

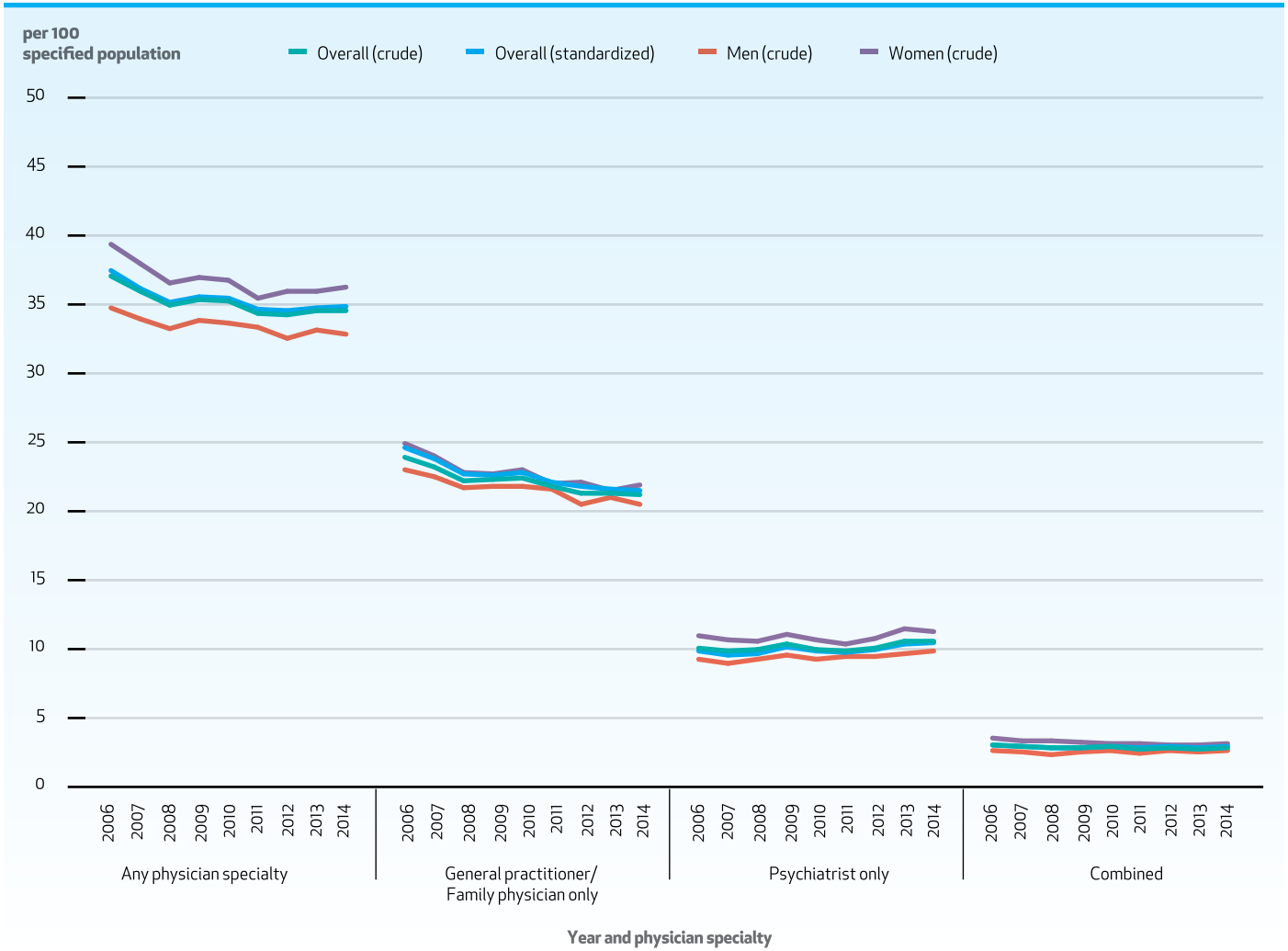


EXHIBIT 2.6.3 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by age group and physician specialty, in Ontario, 2006 to 2014

Key Finding

- The rate of follow-up visits with physicians decreased for most age groups. An age gradient was observed for GP/FP follow-up, with higher rates of follow-up among the older age groups. The opposite gradient was observed for psychiatrists, where an increase in follow-up visits was observed among those aged 16 to 24.

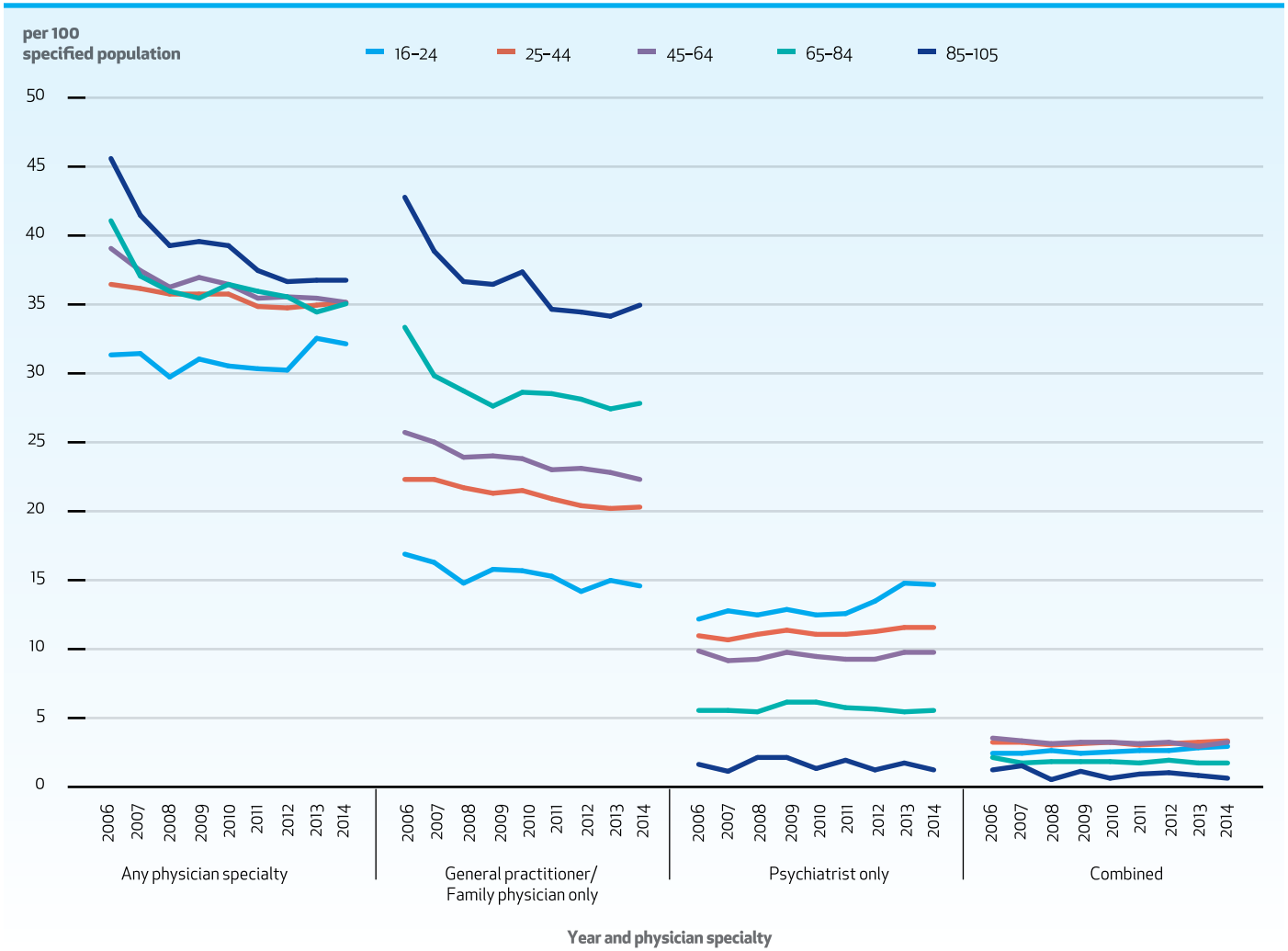


EXHIBIT 2.6.4 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by type of disorder and physician specialty, in Ontario, 2006 to 2014

Key Findings

- The rate of outpatient visits to doctors within 7 days of leaving hospital was highest for patients discharged with a diagnosis of deliberate self-harm without a psychiatric diagnosis.
- Among GP/FPs, the rate of follow-up visits was highest among patients with substance-related disorders and lowest among those with schizophrenia; however, there was a reduction in the follow-up rate for all diagnostic categories.
- Among psychiatrists, the rate of follow-up visits was highest for patients with mood disorders and schizophrenia; the rate of follow-up visits for substance-related disorders and for deliberate self-harm without a psychiatric diagnosis increased over time.

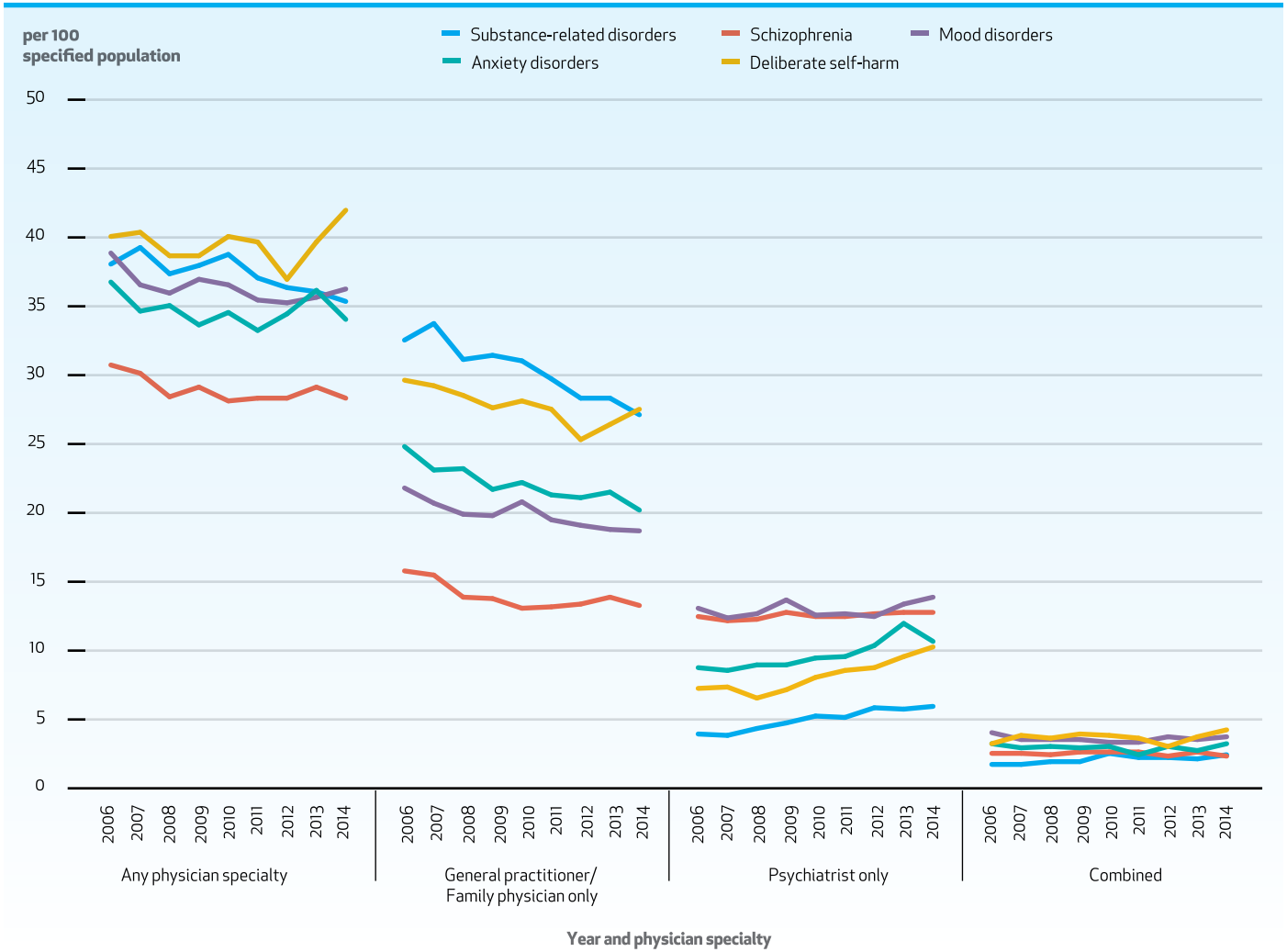


EXHIBIT 2.6.5 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of follow-up visits to physicians within 7 days of leaving hospital was slightly higher among women than men for all physician specialities.

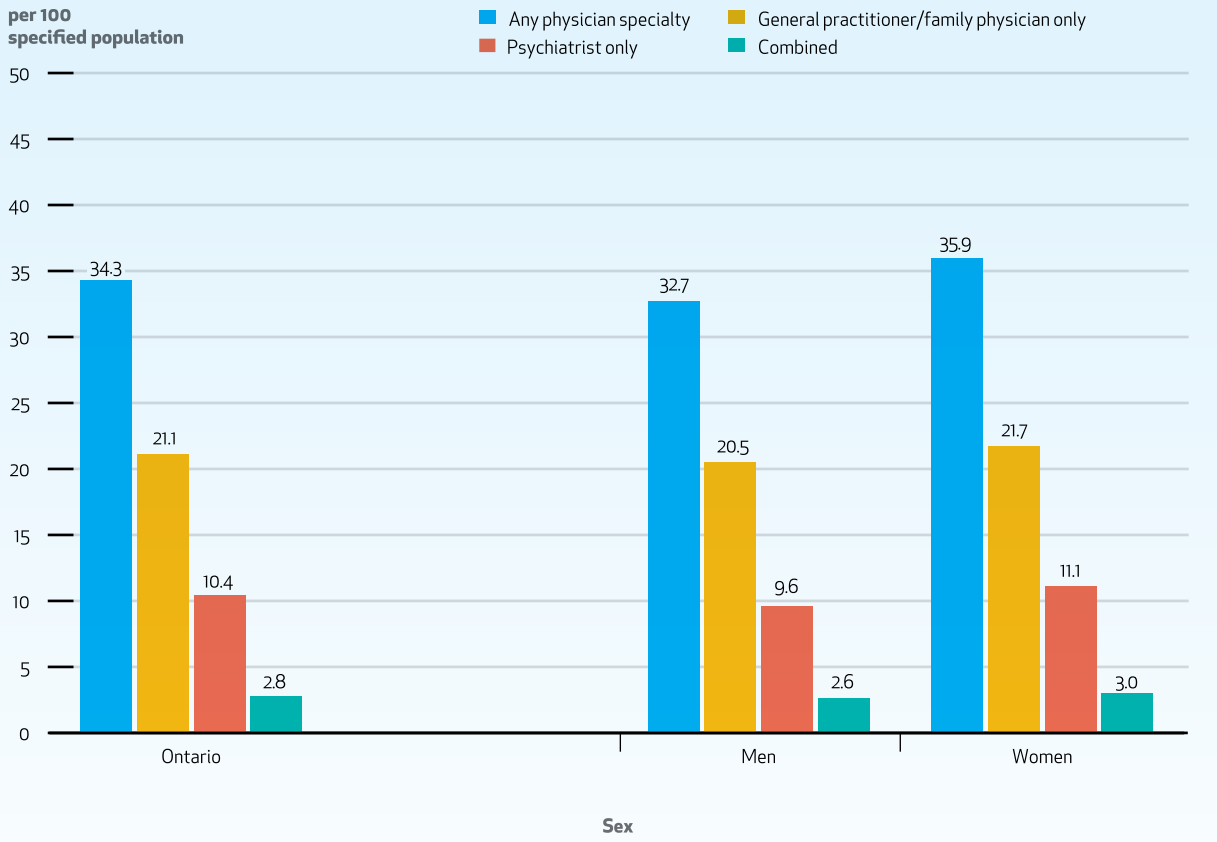


EXHIBIT 2.6.6 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Findings

- The overall rate of follow-up visits to physicians within 7 days of hospital discharge was higher among the older age groups.
- Compared to the other age groups, individuals aged 16 to 24 years had higher psychiatrist follow-up rates and adults aged 85 and older had higher GP/FP follow-up rates.

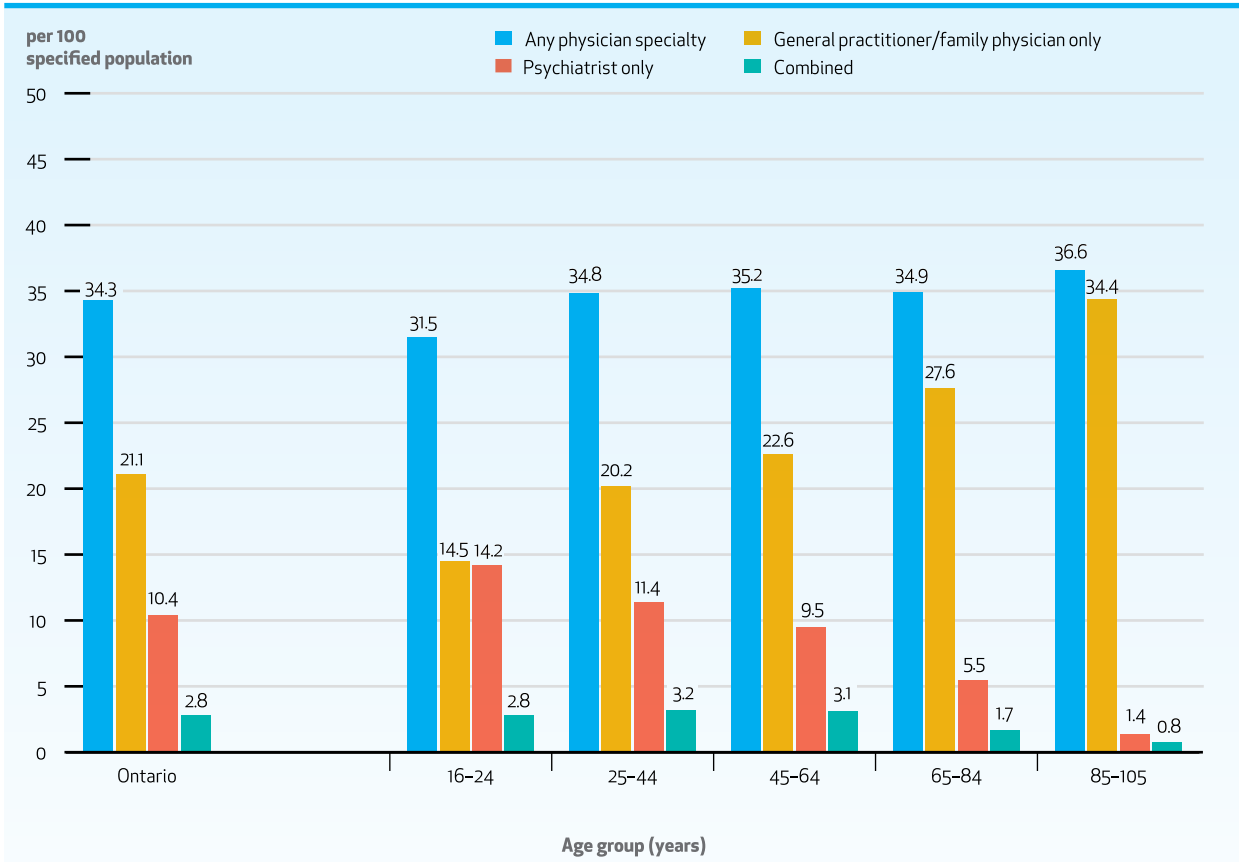


EXHIBIT 2.6.7 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by type of disorder and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Findings

- The overall rate of follow-up visits to physicians within 7 days of leaving the hospital was highest among patients discharged with a diagnosis of deliberate self-harm without a psychiatric diagnosis.
- The rate of follow-up with GP/FPs was highest for patients with substance-related disorders. The follow-up rate with psychiatrists was highest for patients with mood disorders and schizophrenia; the combined care follow-up rate was highest for patients with mood disorders and deliberate-self harm without a psychiatric diagnosis.

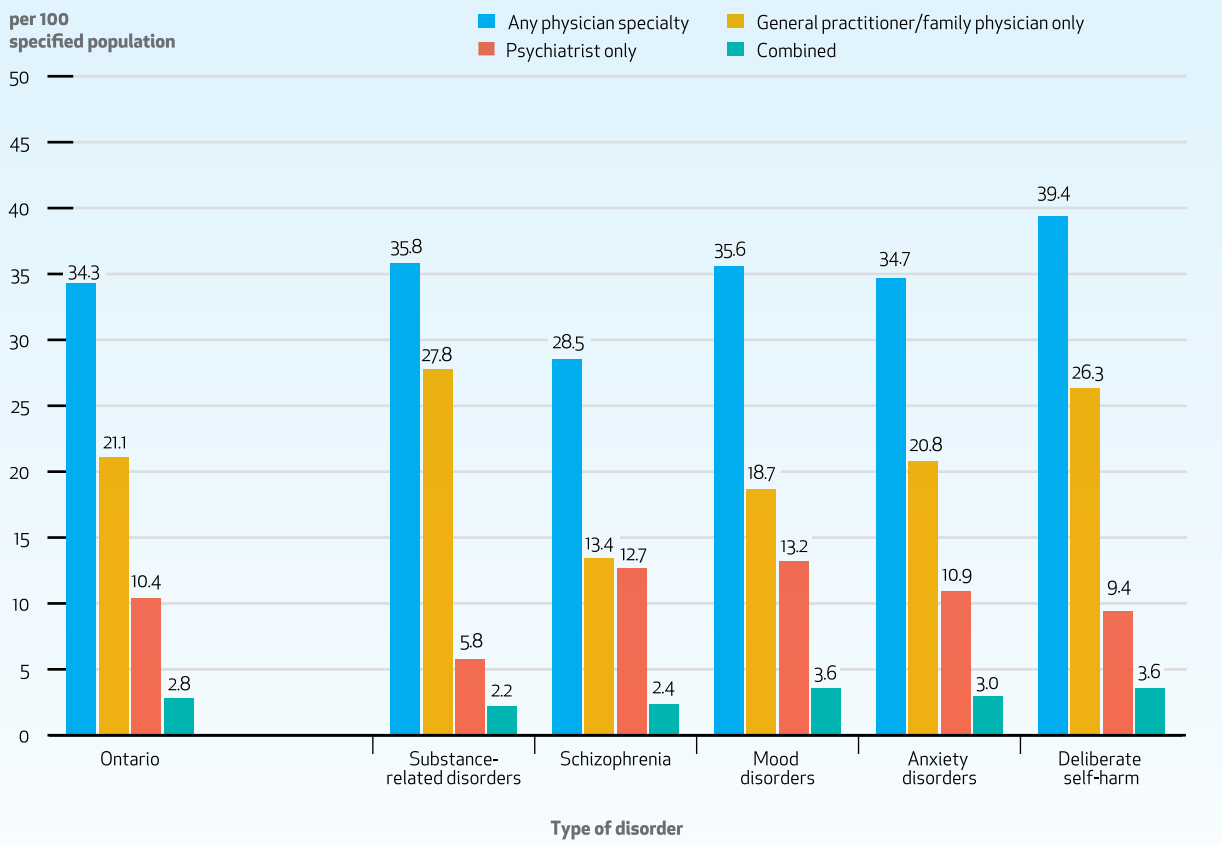


EXHIBIT 2.6.8 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- The overall rate of follow-up visits with physicians within 7 days of leaving hospital was higher for individuals from wealthier neighbourhoods.

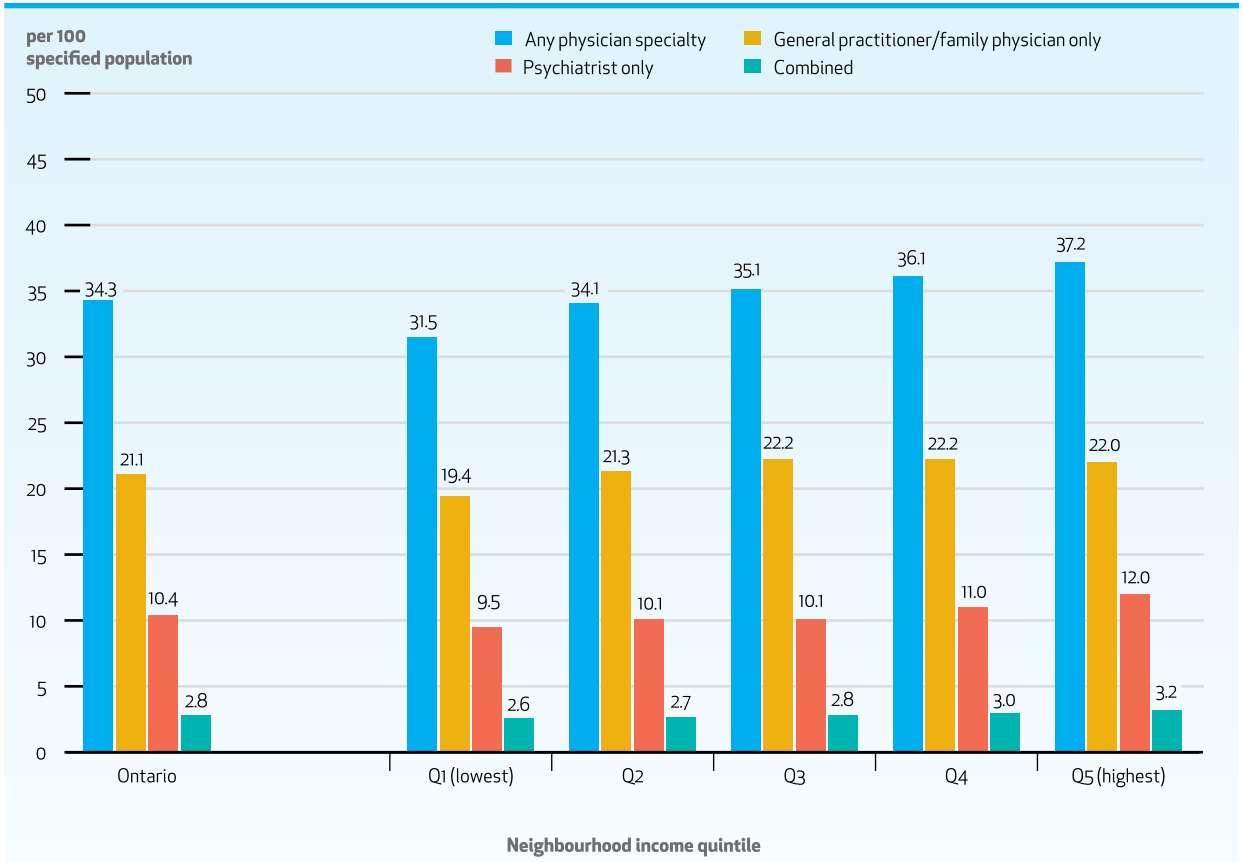


EXHIBIT 2.6.9 Number of outpatient visits within 7 days of leaving hospital per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

Key Finding

- Between 2010 and 2012, the overall average rate of follow-up visits to physicians within 7 days of leaving hospital was slightly higher among immigrants. There were minimal differences in GP/FP follow-up by immigrant category.

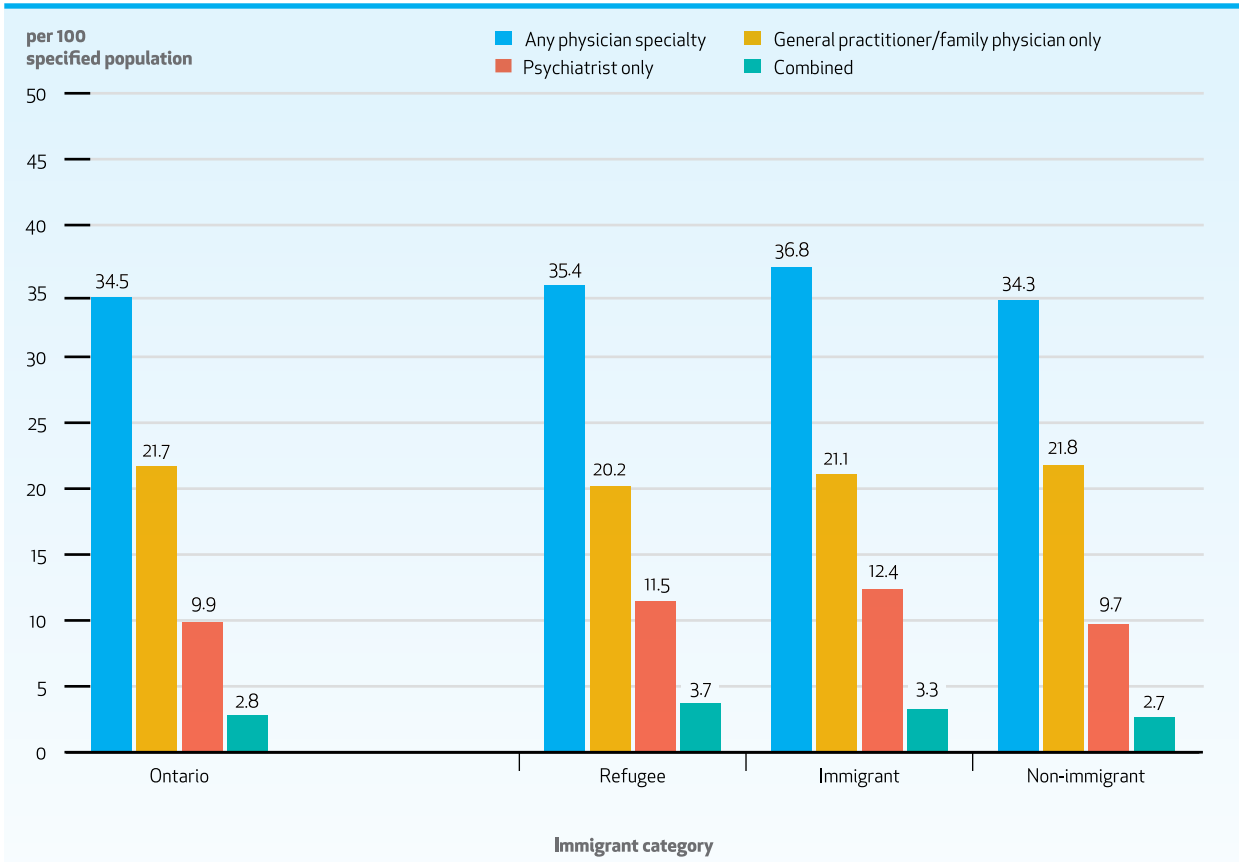


EXHIBIT 2.6.10 Number of outpatient visits within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of follow-up visits to physicians within 7 days of leaving the hospital was highest in the Toronto Central LHIN; this was largely driven by psychiatrist and combined care follow-up. The highest rate of GP/FP follow-up visits was observed in the Central West LHIN. All LHINs had higher rates of GP/FP follow-up than psychiatrist follow-up.

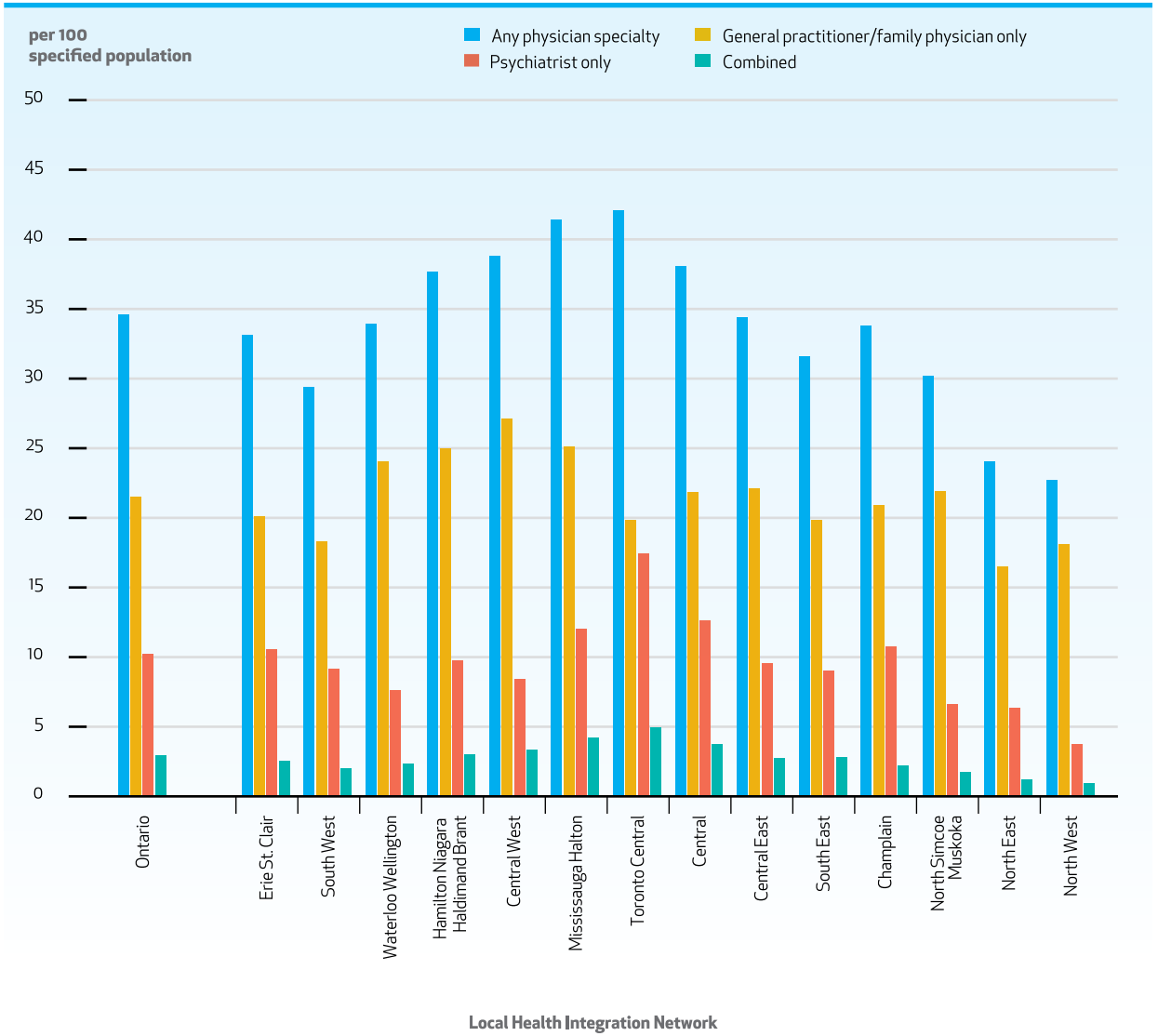


EXHIBIT 2.6.11 Number of outpatient visits to any physician specialty within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The overall age- and sex-standardized rate of follow-up visits to physicians within 7 days of leaving the hospital was highest in the Toronto Central LHIN and lowest in the North West LHIN.

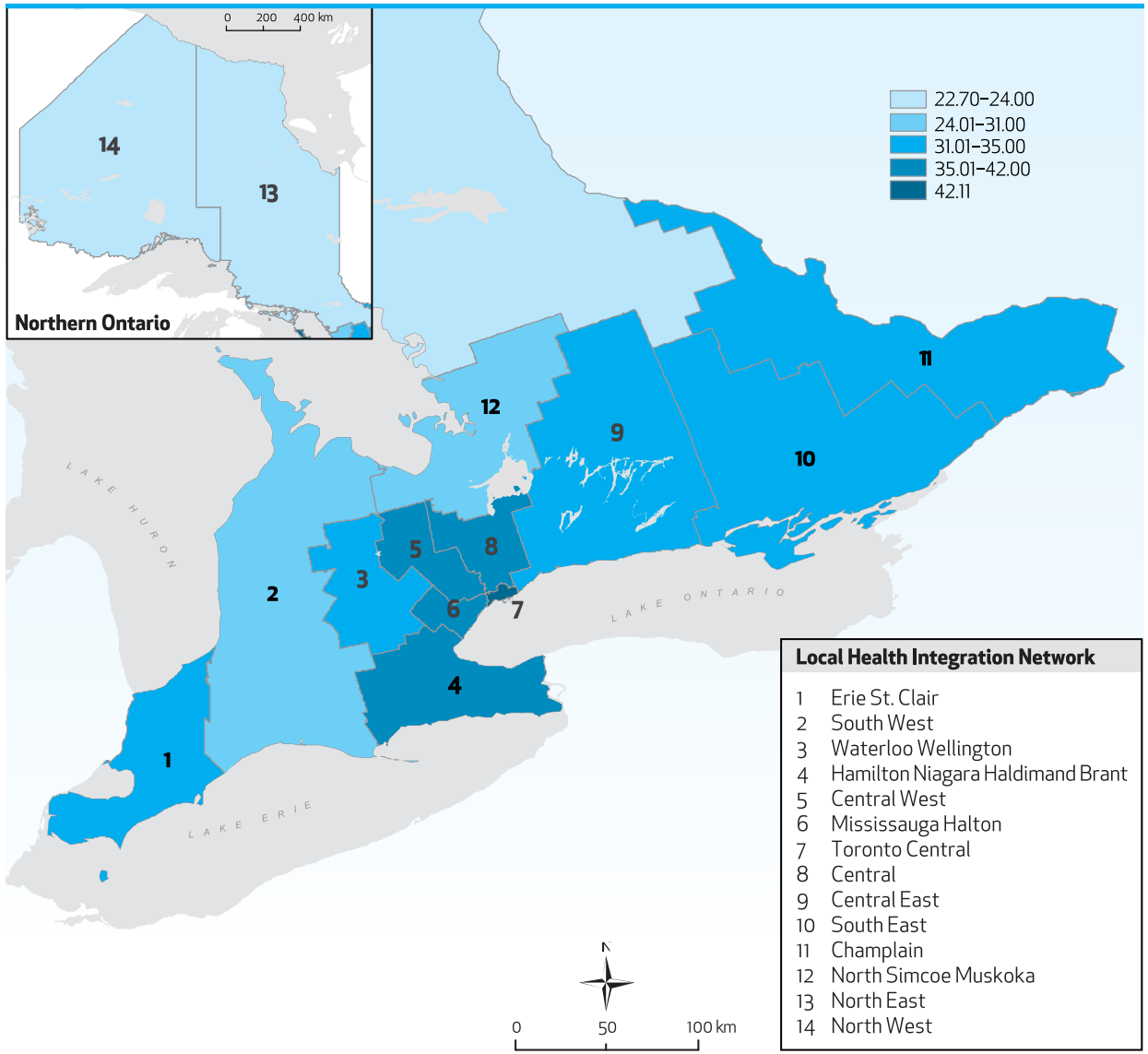


EXHIBIT 2.6.12 Number of outpatient visits to a general practitioner/family physician within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of follow-up visits to GP/FPs within 7 days of leaving the hospital was highest in the Central West LHIN.

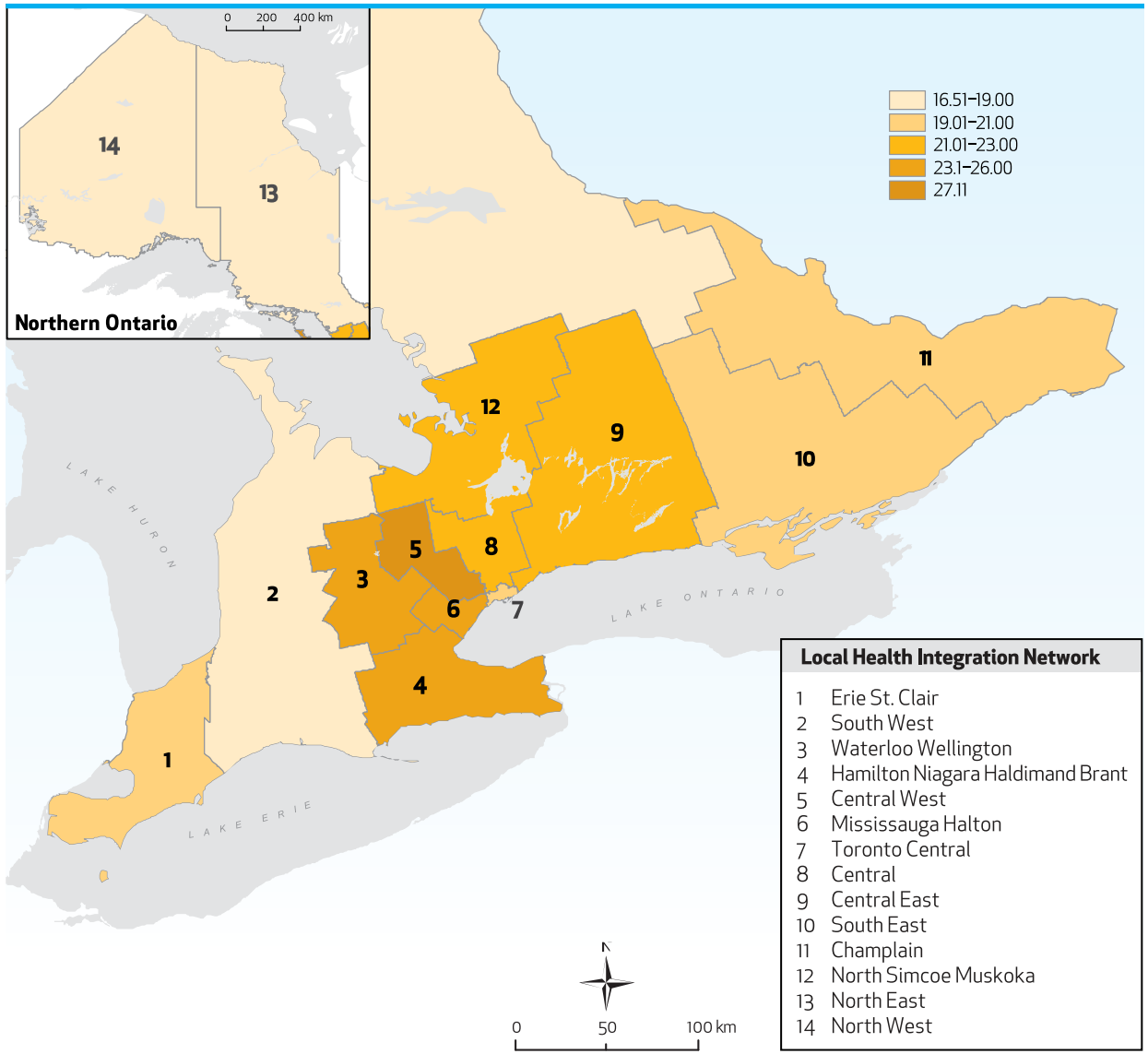


EXHIBIT 2.6.13 Number of outpatient visits to a psychiatrist within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of follow-up visits to psychiatrists within 7 days of leaving the hospital was highest in the Toronto Central LHIN and lowest in the North West LHIN.

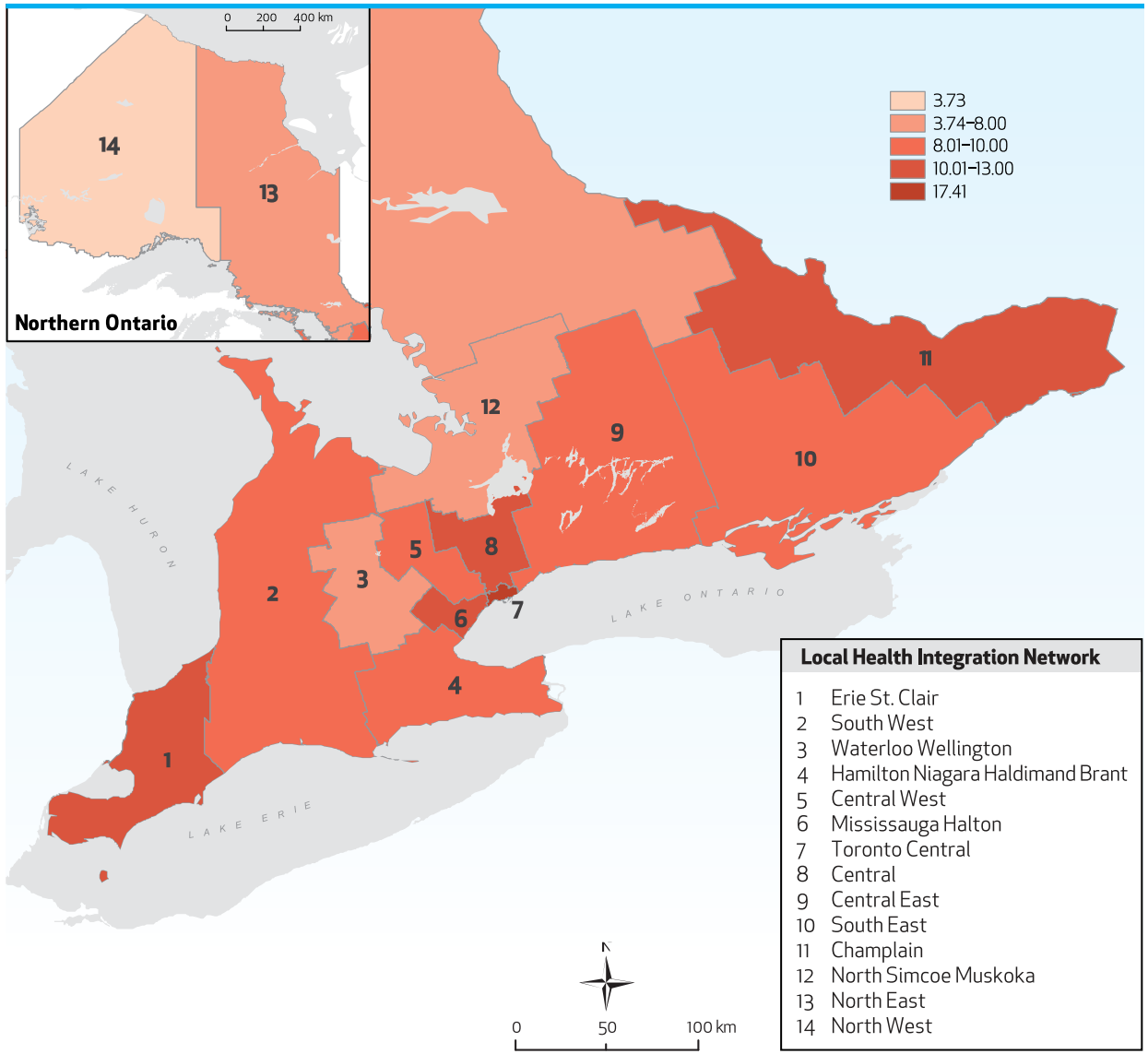
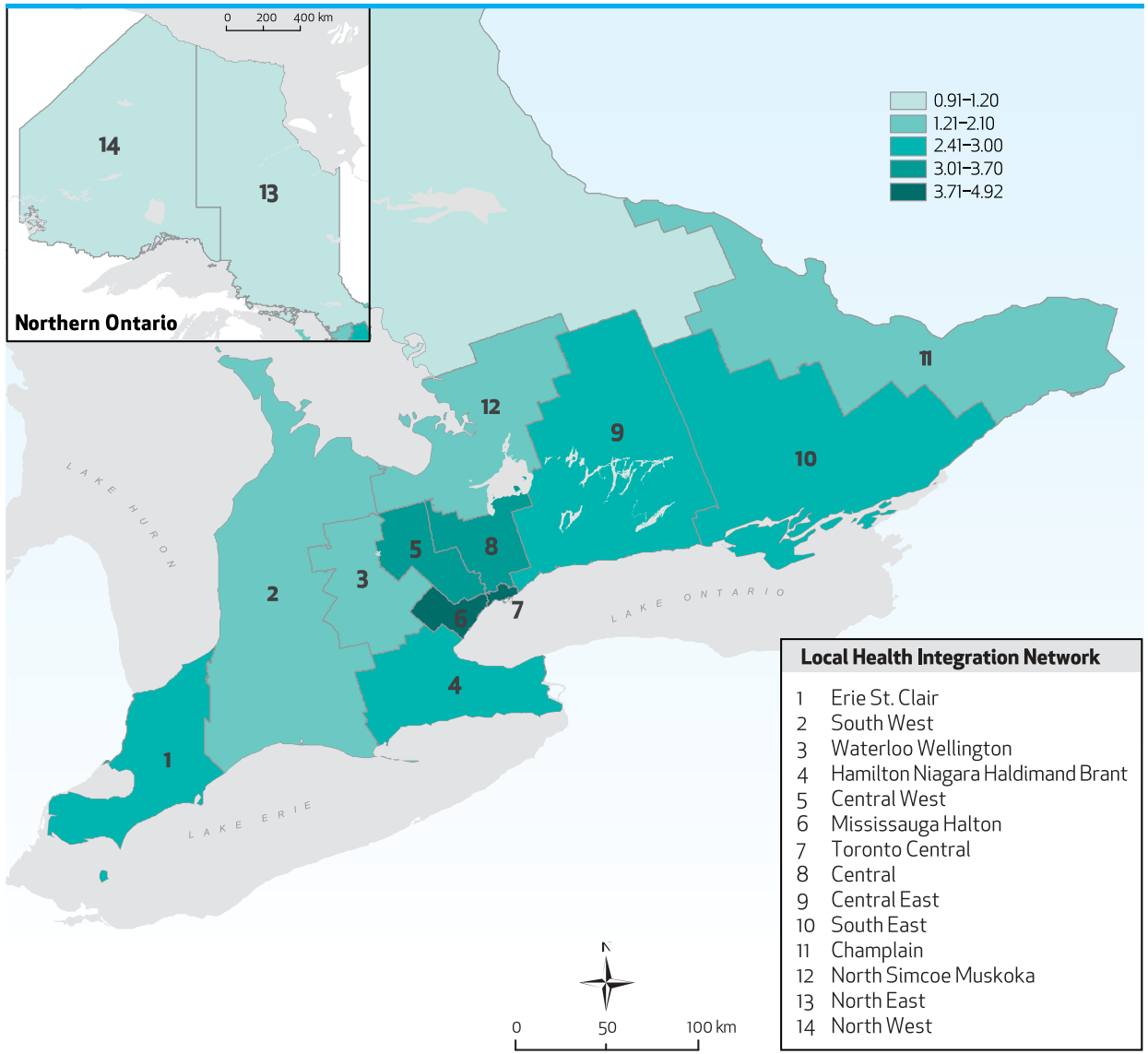


EXHIBIT 2.6.14 Number of outpatient visits to both a psychiatrist and a general practitioner/family physician within 7 days of leaving hospital per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of follow-up visits to both GP/FPs and psychiatrists within 7 days of leaving the hospital was highest in the Toronto Central LHIN and lowest in the North West LHIN.



2.7 Rate of inpatient readmission within 30 days of discharge

Rationale

The rate of inpatient readmissions within 30 days of discharge is a universally reported performance indicator and could reflect inadequate community support and outpatient physician-based mental health and addictions services.

Results

The rate of readmission remained relatively stable over time at about 10%. It was highest among the younger age groups and for those with schizophrenia and mood disorders. Readmissions were lowest among those with deliberate self-harm without a psychiatric diagnosis. Immigrants and individuals living in the lowest-income neighbourhoods had slightly higher readmission rates. The Toronto Central LHIN had the highest age- and sex-standardized rate of readmission; the lowest rate was observed in the North West LHIN.

Interpretation

Approximately 1 in 10 individuals were readmitted to hospital for mental health and addictions care within 30 days of discharge. This rate has not decreased over time. Attention to improving community- and outpatient physician-based resources for the highest-risk populations is likely warranted.

EXHIBIT 2.7.1 Number of inpatient readmissions within 30 days of discharge per 100 population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- From 2006 to 2014, the rate of inpatient readmission within 30 days of discharge was stable and similar for men and women.

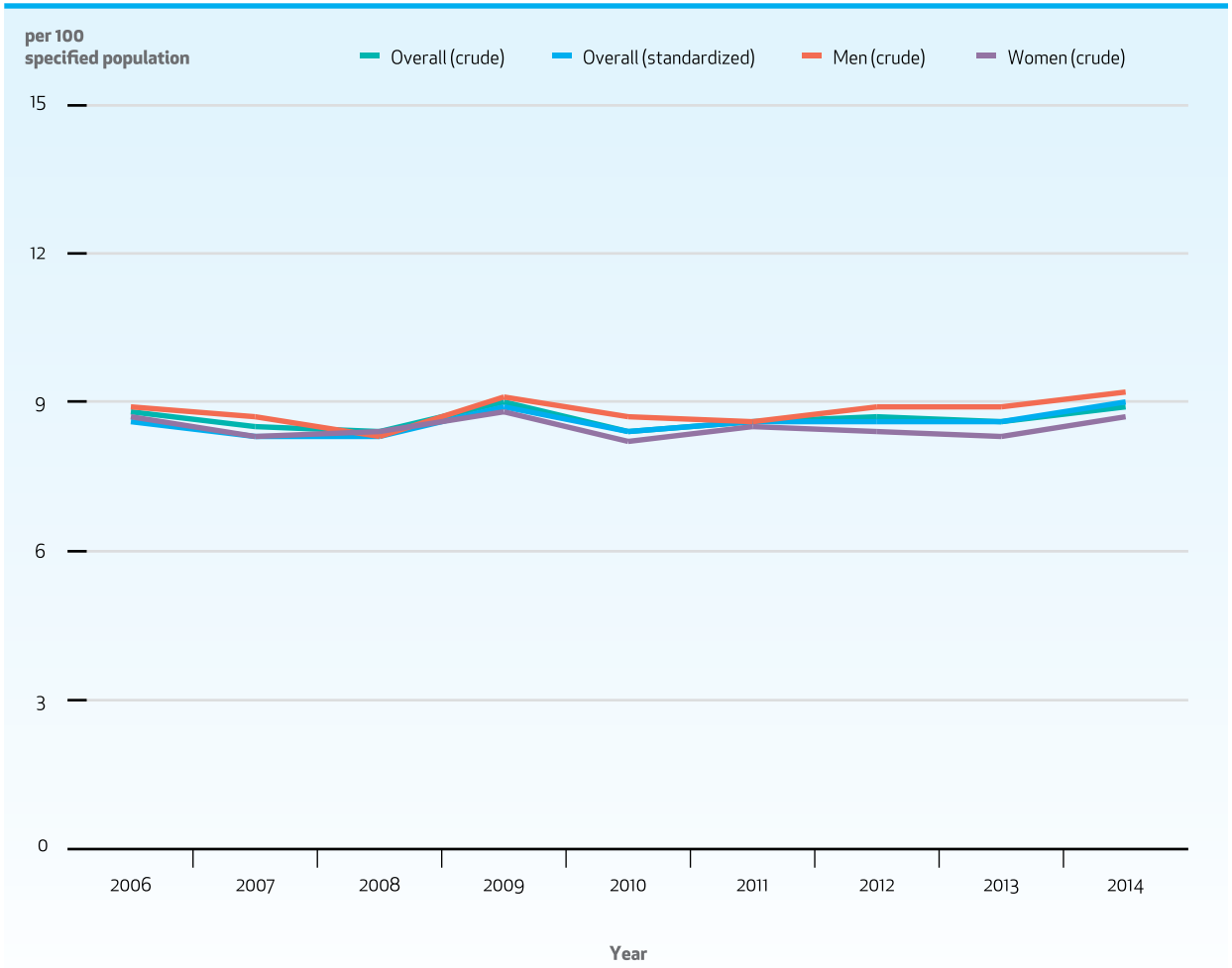


EXHIBIT 2.7.2 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by age group, in Ontario, 2006 to 2014

Key Finding

- From 2006 to 2014, the 30-day hospital readmission rate was highest among younger adults.

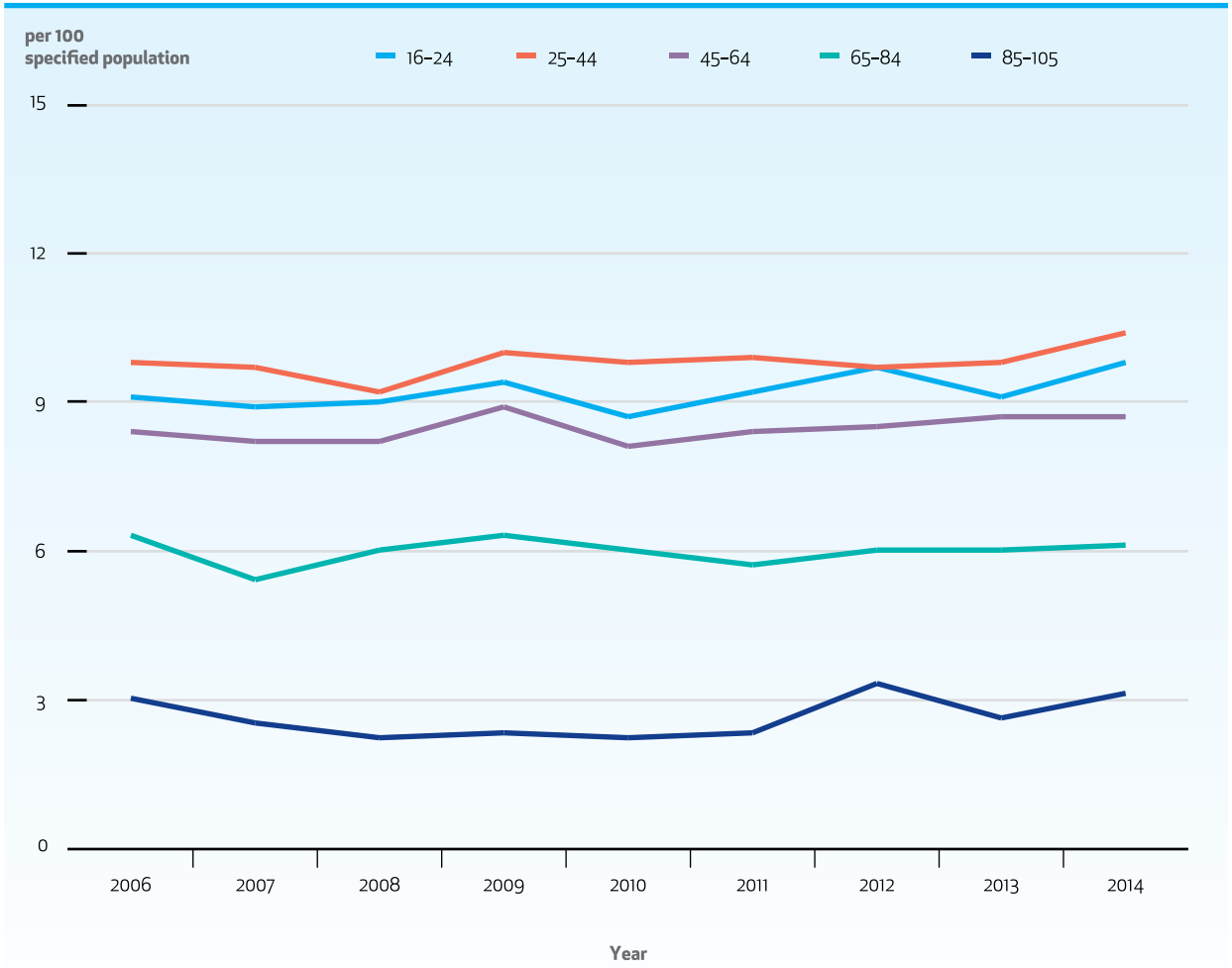


EXHIBIT 2.7.3 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by type of disorder, in Ontario, 2006 to 2014

Key Finding

- The 30-day hospital readmission rate was highest for patients with schizophrenia and mood disorders, and lowest for those with deliberate self-harm without a psychiatric diagnosis.

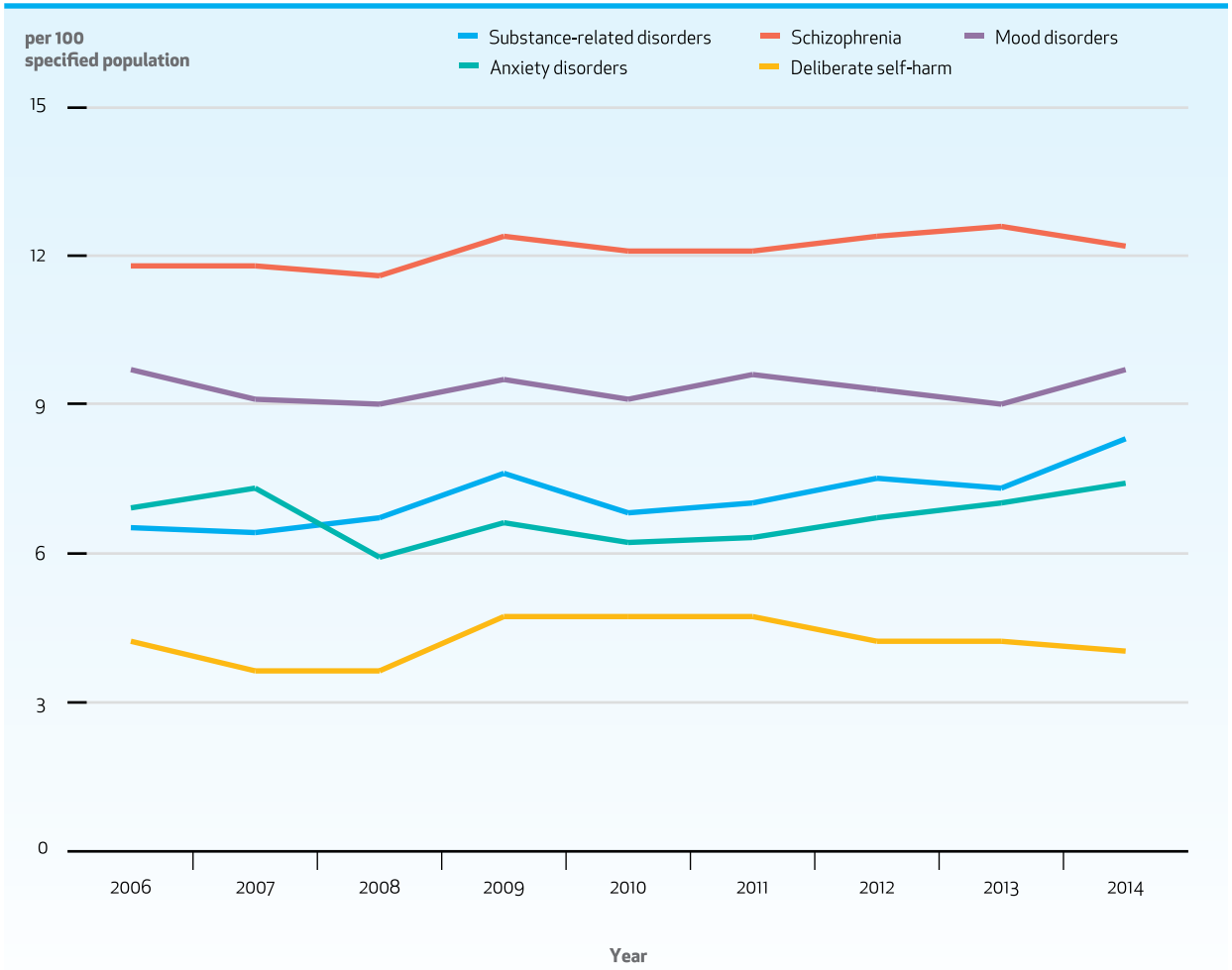


EXHIBIT 2.7.4 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- Between 2012 and 2014, the three-year average 30-day readmission rate was similar for men and women.

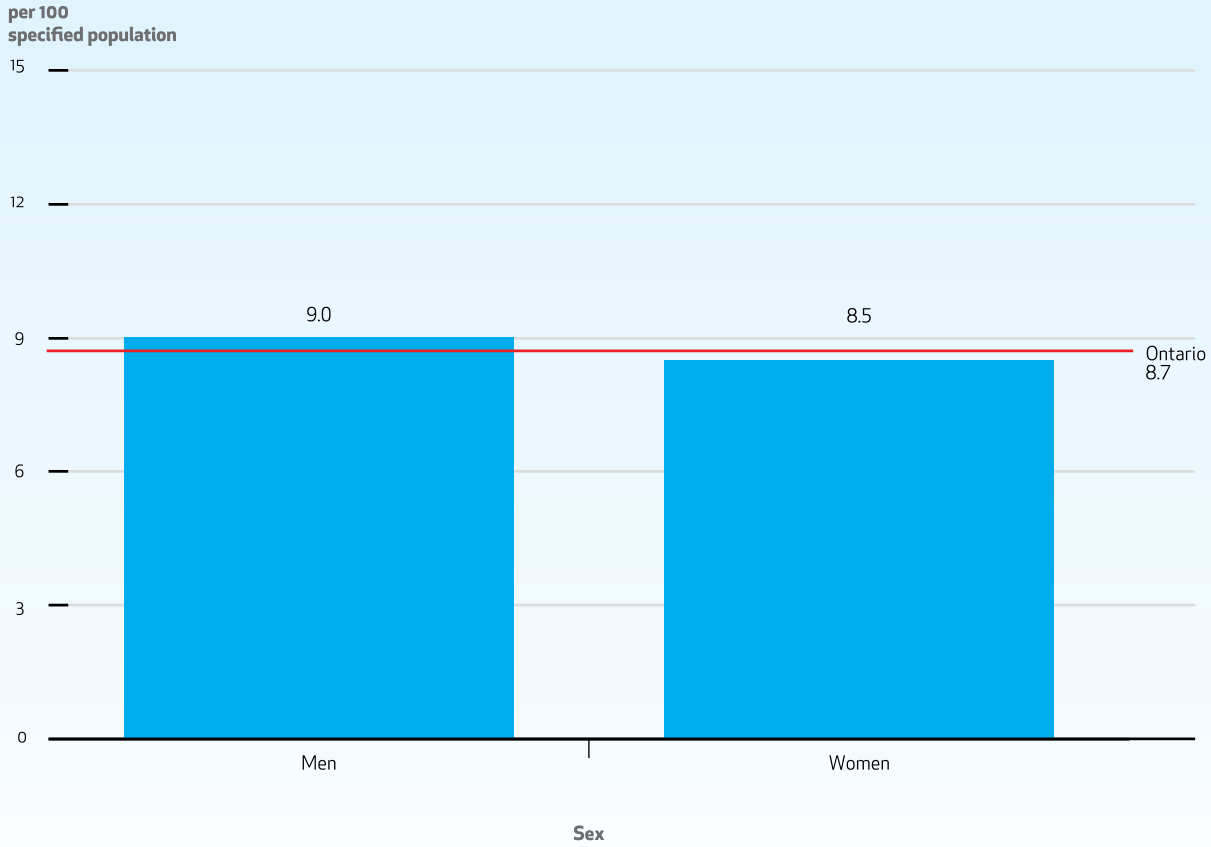


EXHIBIT 2.7.5 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of readmission within 30 days was highest among those aged 16 to 44.

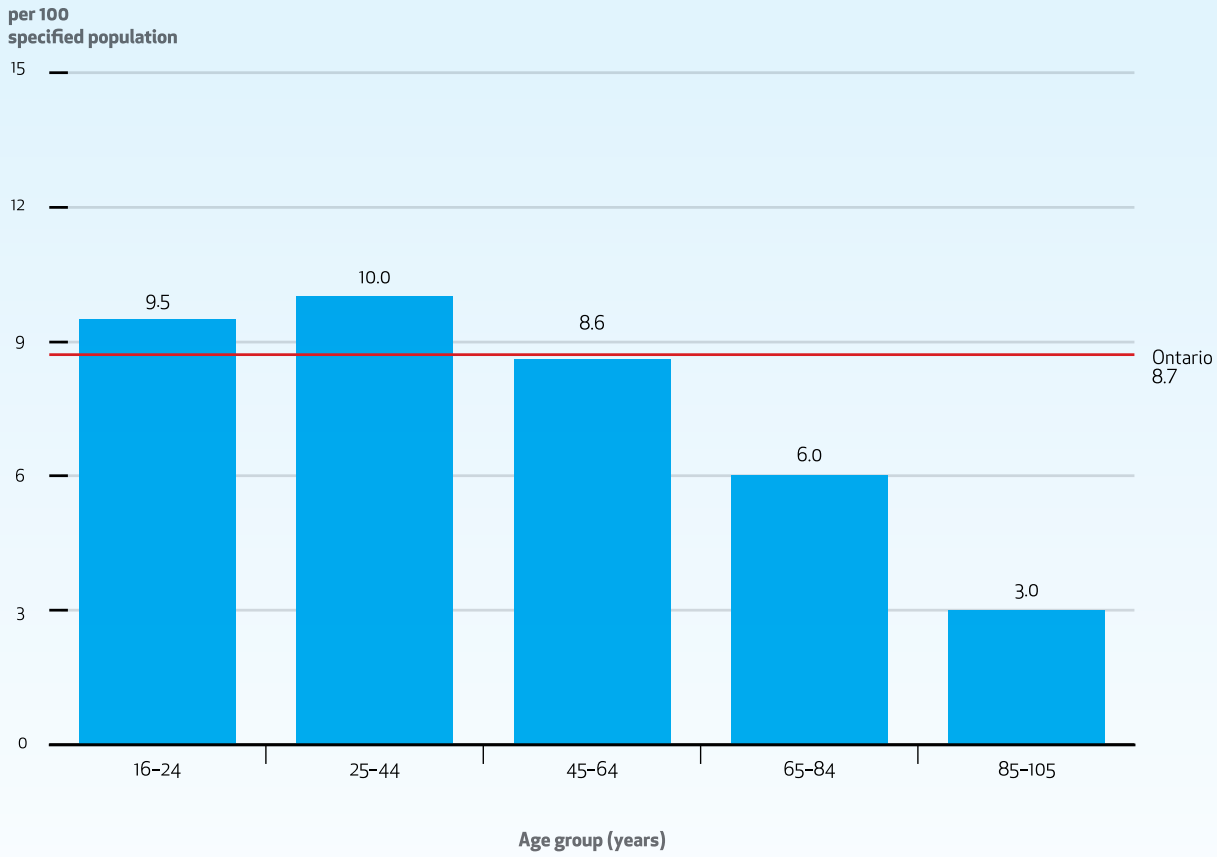


EXHIBIT 2.7.6 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by type of disorder, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of readmission within 30 days was highest for patients with schizophrenia and lowest for those with deliberate self-harm without a psychiatric diagnosis.

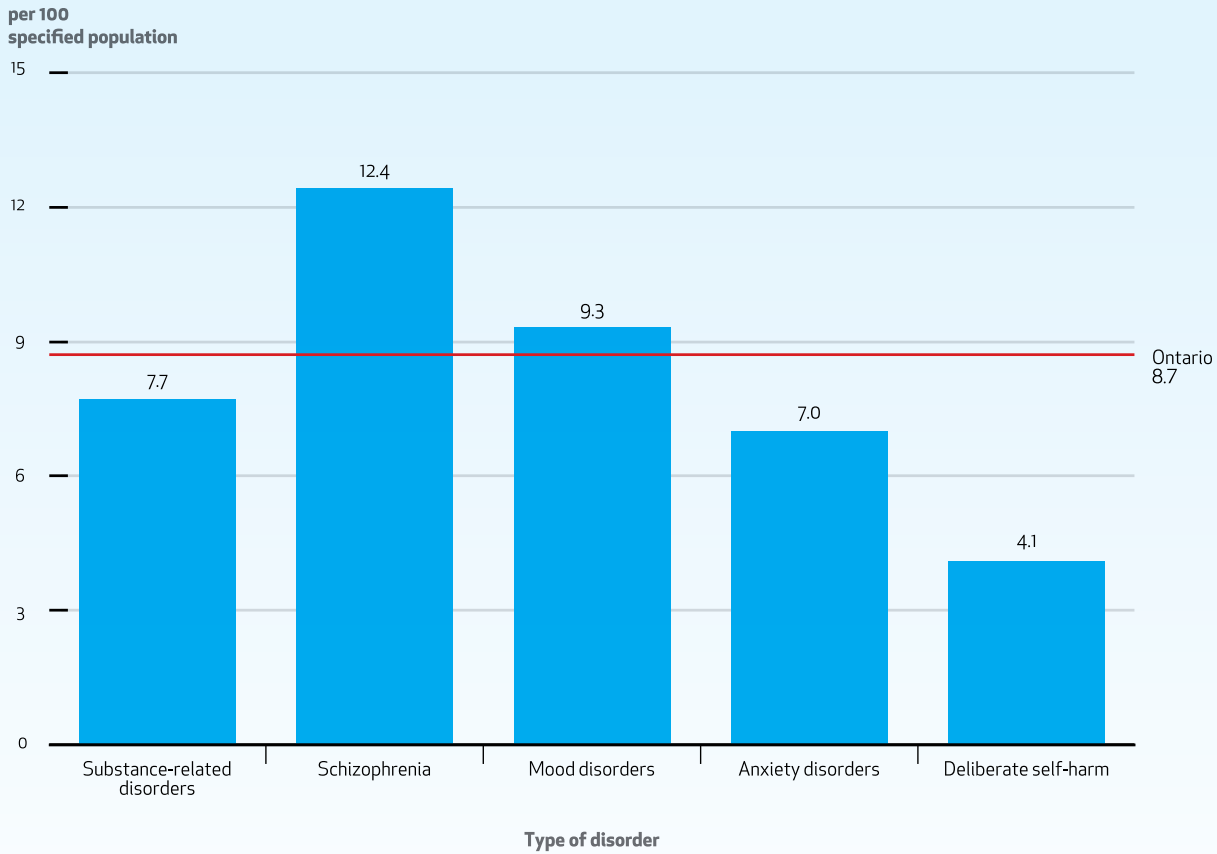


EXHIBIT 2.7.7 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of readmission within 30 days was slightly higher for individuals from lower-income neighbourhoods.

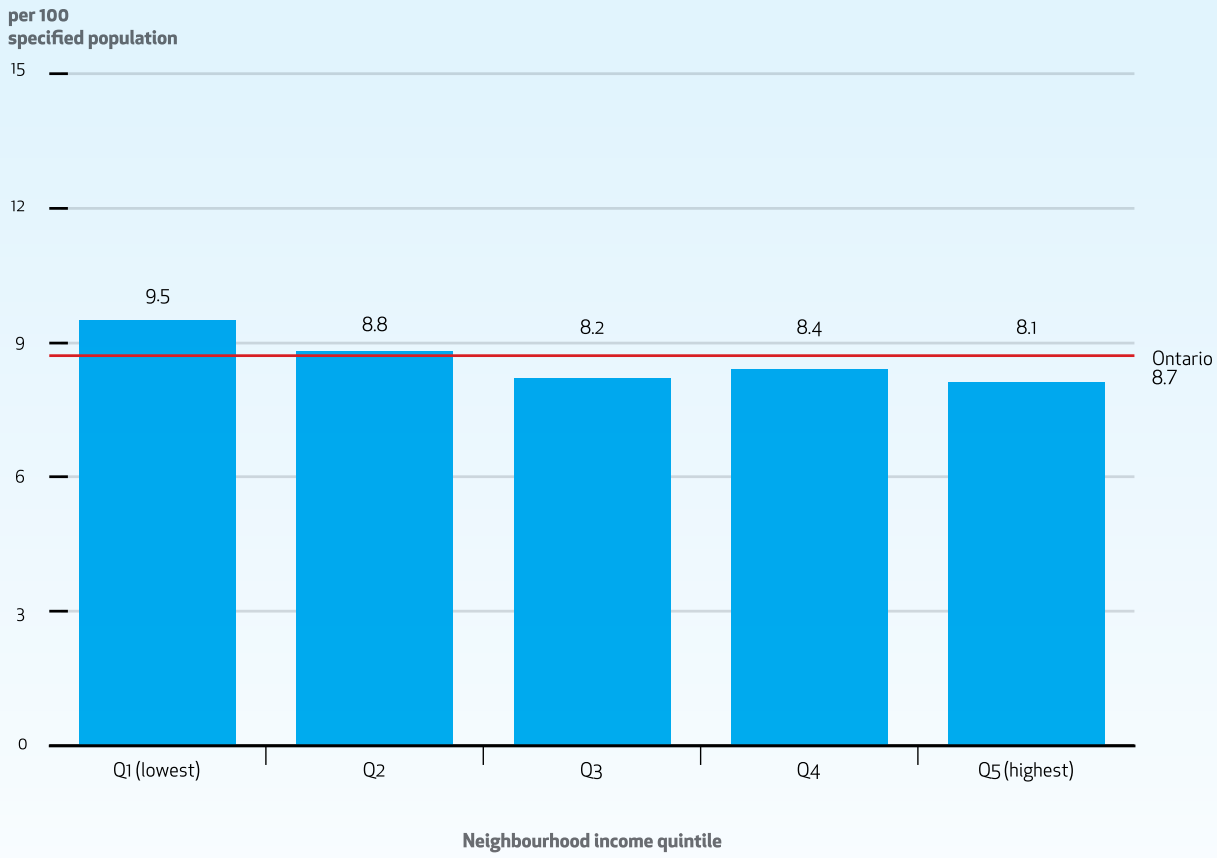


EXHIBIT 2.7.8 Number of inpatient readmissions within 30 days of discharge per 100 crude population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- In the three years between 2010 and 2012, the average rate of readmission within 30 days did not differ by immigrant category.

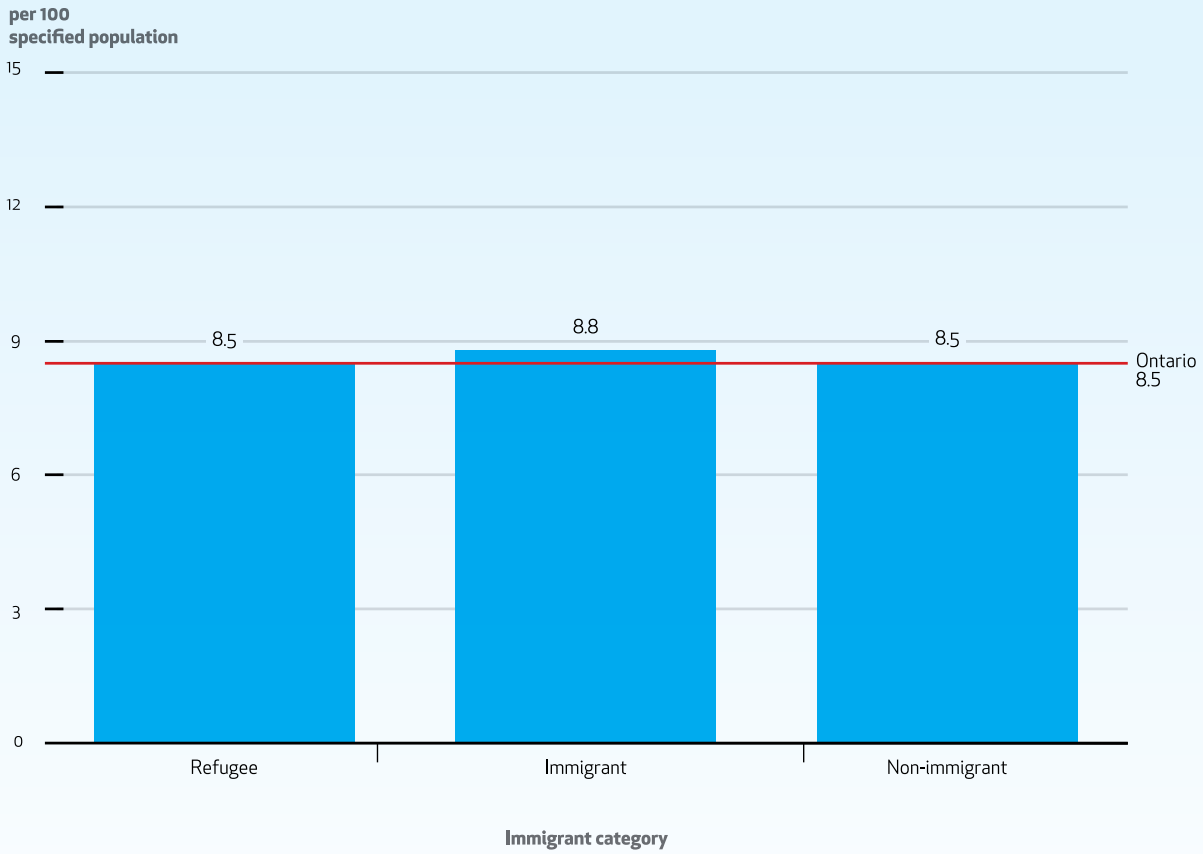


EXHIBIT 2.7.9 Number of inpatient readmissions within 30 days of discharge per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of readmission within 30 days was highest in the Toronto Central and Central LHINs and lowest in the North West LHIN.

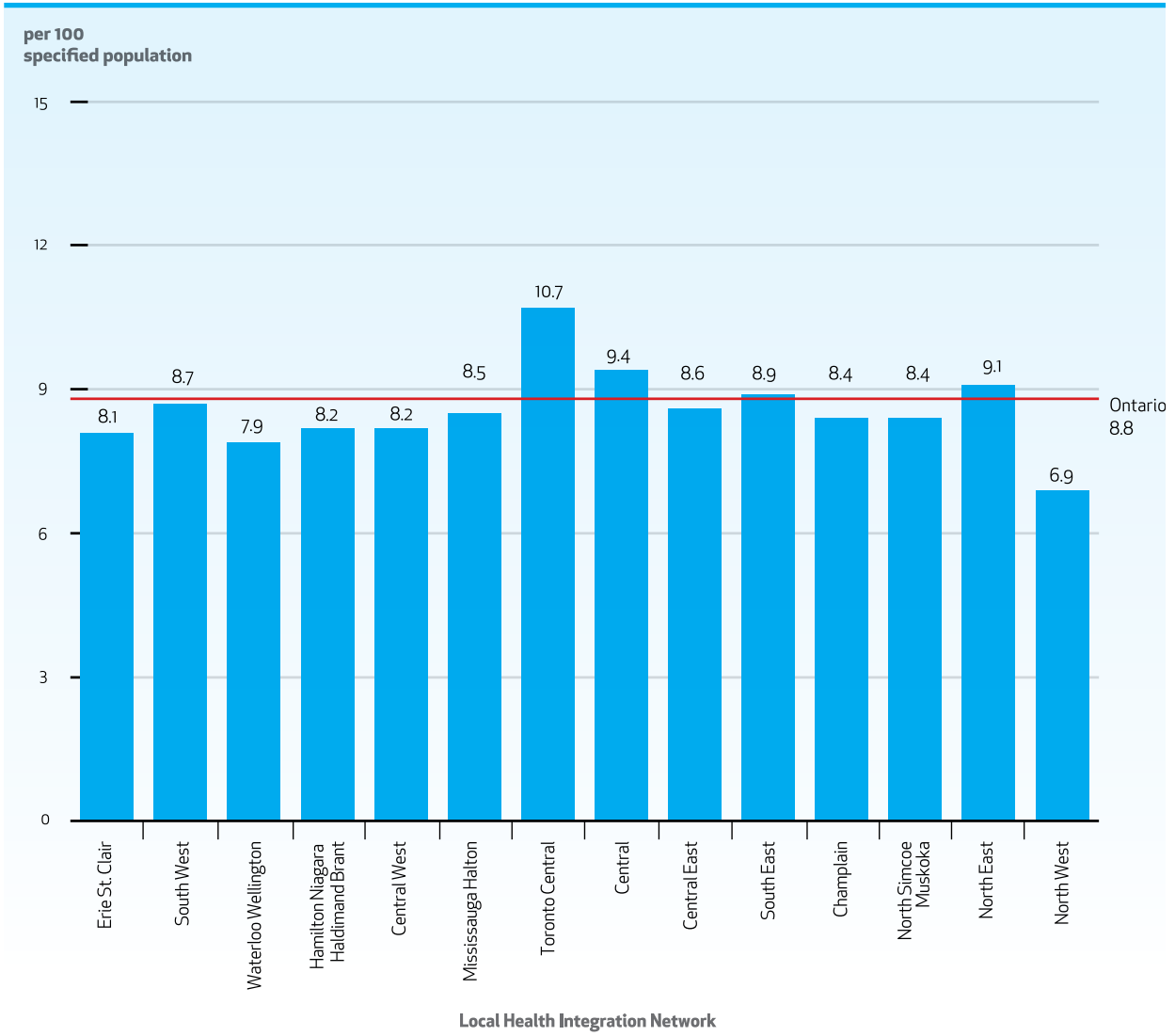
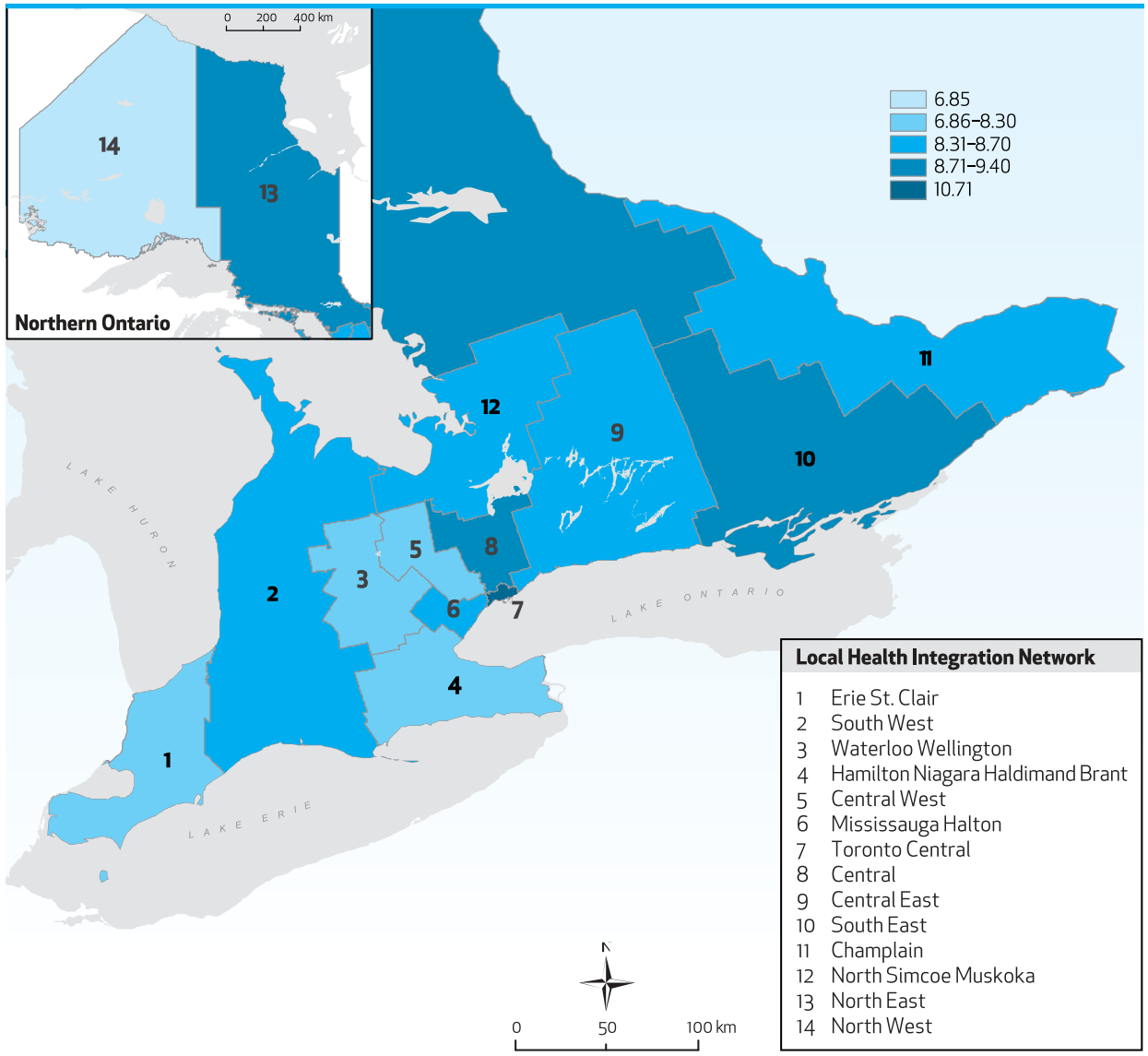


EXHIBIT 2.7.10 Number of inpatient readmissions within 30 days of discharge per 100 standard population aged 16 to 105 years with an incident mental health and addictions–related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- In the three years between 2012 and 2014, the average rate of readmission within 30 days was highest in the Toronto Central and Central LHINs and lowest in the North West LHIN.



2.8 Alternate level of care

Rationale

Alternate level of care, or ALC, is a designation assigned to patients who occupy acute care hospital beds but do not require the intensity of care provided in the inpatient setting. For mental health–designated beds, ALC typically occurs because resources that would support an appropriate discharge, such as supportive housing, are in relatively short supply. There are two types of ALC cases: open cases, where the patient remains in ALC at the end of the reporting period, and discharged cases, where the patient has been discharged from ALC into appropriate care. This indicator measures ALC cases, where a case refers to each instance that a patient is designated ALC. A patient may contribute more than one case if they were designated and discharged from ALC multiple times in a reporting period.

Results

In 2015, 4% of mental health bed-days were occupied by patients designated ALC for supportive housing. Wait times increased for both open and discharged cases from 2012 to 2015, and were higher for men than women. For open cases in 2015, median ALC wait times varied across time and were longest for 45- to 64-year-olds and shortest for 25- to 44-year-olds. For discharged cases, 25- to 44-year-olds had the longest wait times, except in 2014, when 45- to 64-year-olds had the longest wait times. Among discharged cases in 2015, the longest wait times were in the Waterloo Wellington LHIN and the shortest were in the Central LHIN.

Overall, the volume of cases in mental health beds who were ALC for supportive housing decreased over time, driven by a decrease in the number of open cases. Men contributed more ALC cases than women. The volume of cases who were men decreased over time whereas the volume of cases who were women remained stable. The highest volume of ALC cases was among those aged 45 to 64, although this number decreased over time. The Toronto Central LHIN experienced the highest volume of cases.

ALC days remained stable over time except for a spike in 2014. The number of days contributed by discharged cases increased over time and converged with the number of days contributed by open cases. Men contributed more ALC days than women, due to their higher volume and longer wait times. The Toronto Central LHIN had the most ALC days and the Central LHIN had the least.

The Toronto Central and North West LHINs experienced the highest percentage of mental health bed-days occupied by patients who were designated ALC for supportive housing.

Interpretation

Patients who are designated ALC in mental health beds experience long waits for supportive housing. The high rate of mental health bed-days occupied by patients designated ALC for supportive housing indicates that a large proportion of patients in hospital beds do not require that level of care.

EXHIBIT 2.8.1 Median ALC wait time for supportive housing/group homes/assisted living among mental health cases aged 16 to 105, overall and by sex, and by type of case, in Ontario, 2012 to 2015

Key Finding

- Between 2012 and 2015, median ALC wait times for both open and discharged cases increased. Wait times were higher among men for both types of cases.

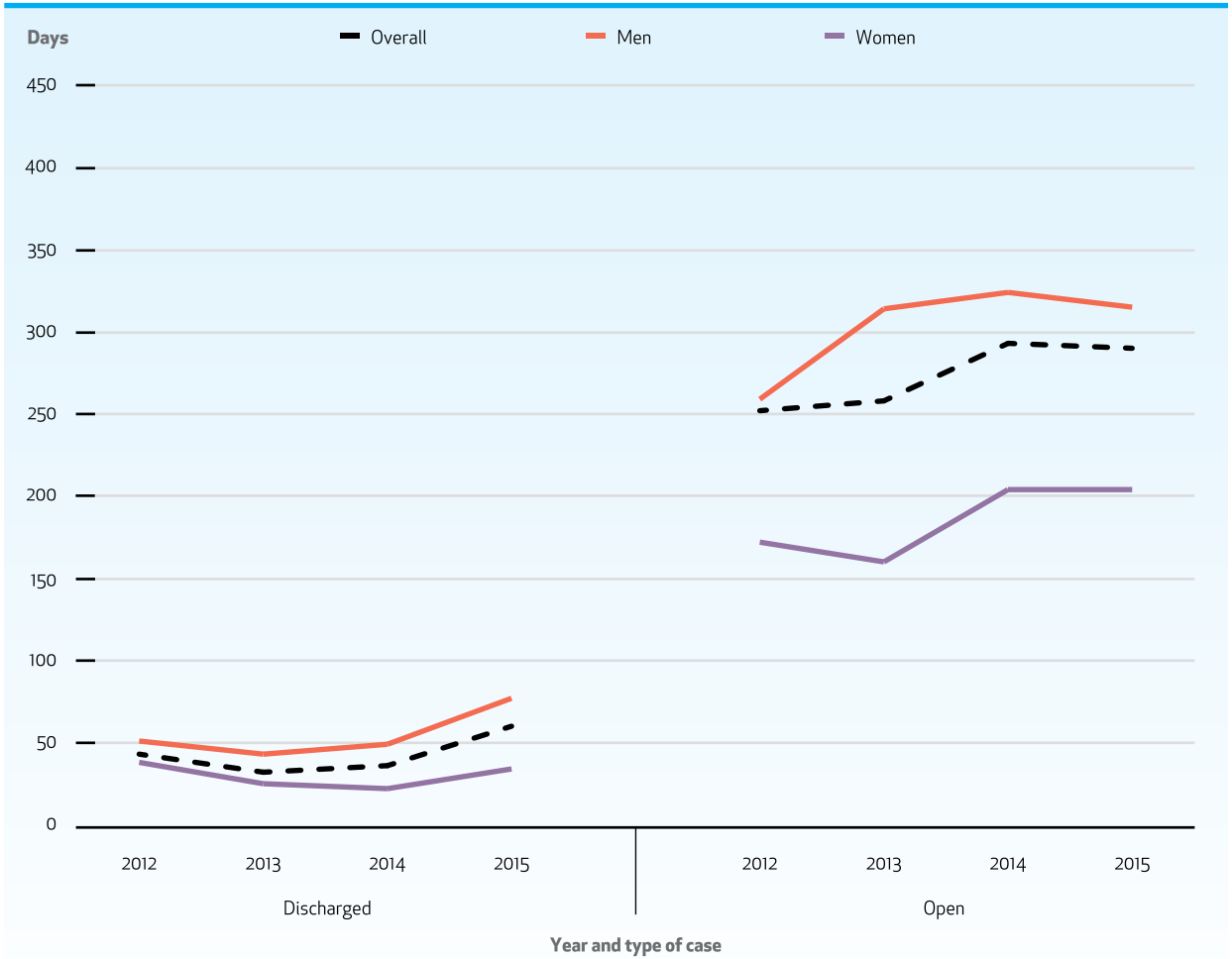


EXHIBIT 2.8.2 Median ALC wait time for supportive housing/group homes/assisted living among mental health cases aged 16 to 105, overall and by age group for open and discharged cases combined, in Ontario, 2012 to 2015

Key Finding

- Among open and discharged cases combined, 25- to 64-year-olds had the longest median wait times for alternate level of care.

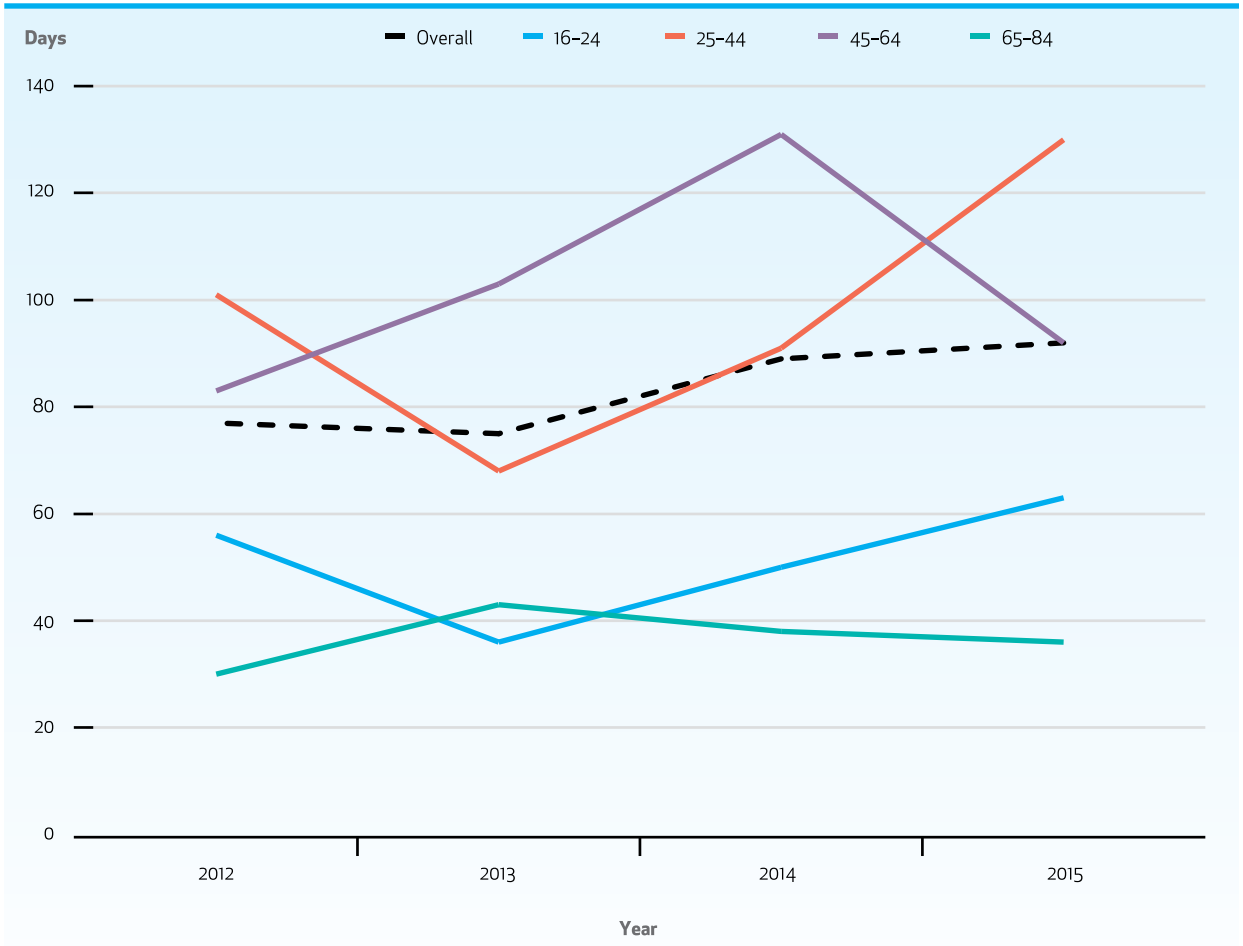
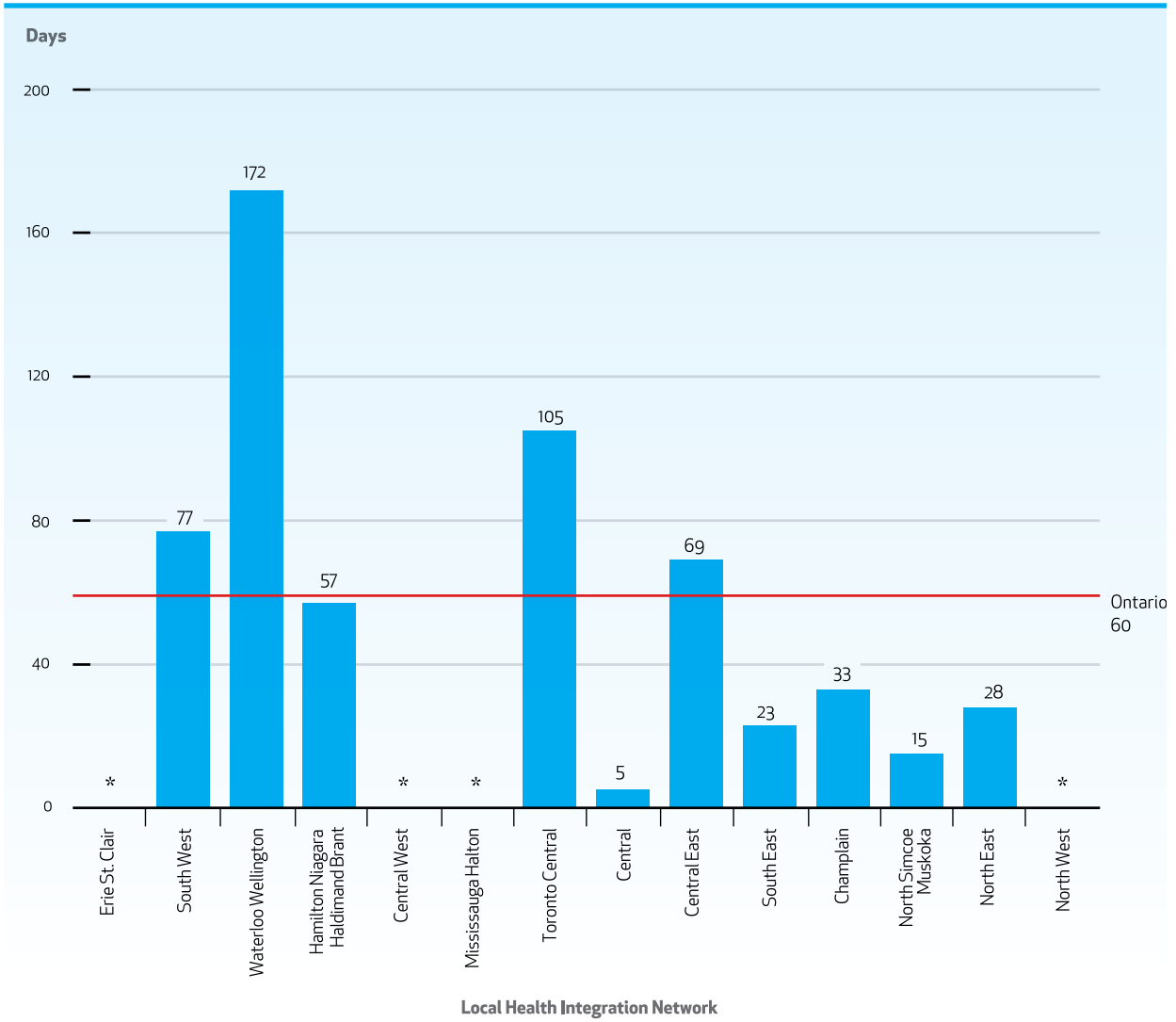


EXHIBIT 2.8.3 Median ALC wait time for supportive housing/group homes/assisted living among mental health cases aged 16 to 105, by Local Health Integration Network, in Ontario, 2015

Key Finding

- Among discharged cases, the median wait time for ALC was longest in the Waterloo Wellington LHIN and shortest in the Central LHIN.



*No volume or volume less than 10 cases

EXHIBIT 2.8.4 Volume of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, by type of case, in Ontario, 2012 to 2015

Key Finding

- The volume of cases designated ALC declined from 2012 to 2015, driven by a decline in open cases.

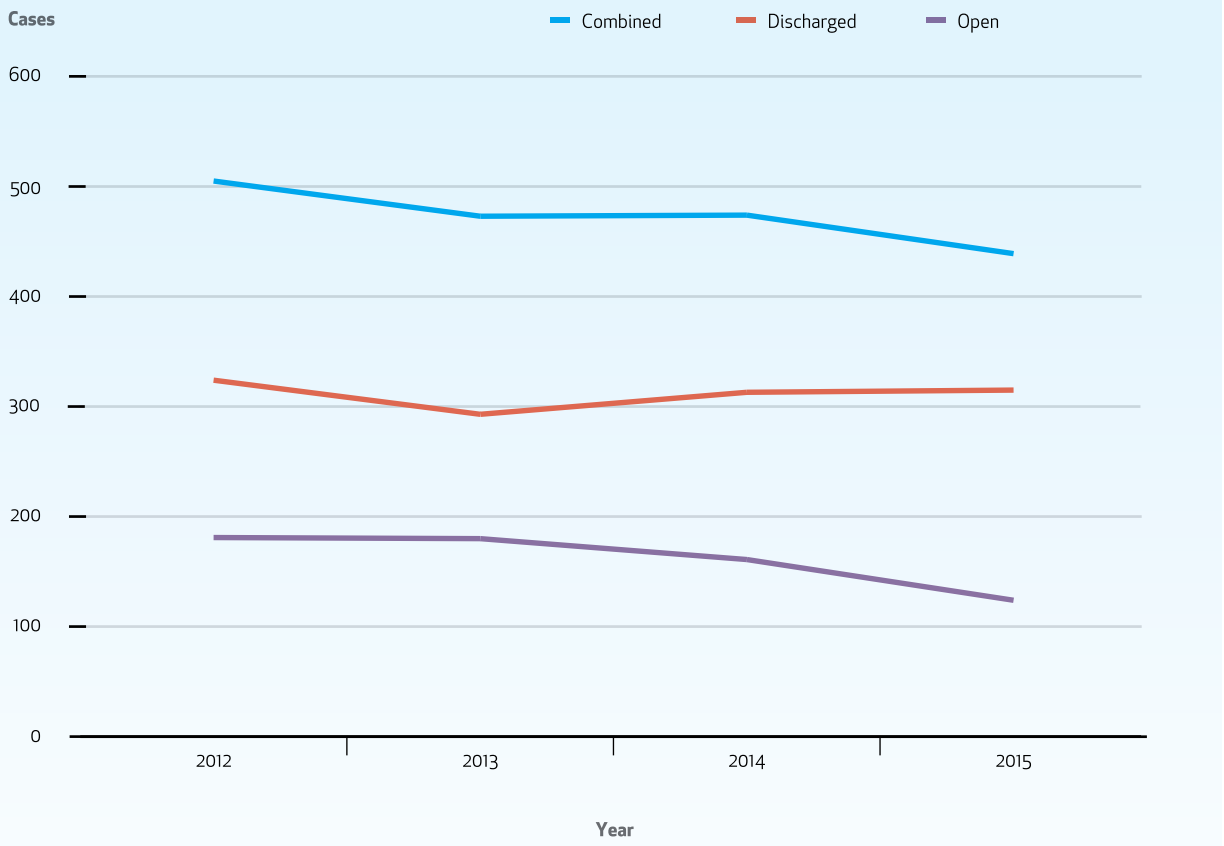


EXHIBIT 2.8.5 Volume and type of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, overall and by sex, in Ontario, 2012 to 2015

Key Finding

- Among cases designated ALC between 2012 and 2015, a higher volume were men. While the number of men who were ALC declined in that period, the number of women who were ALC remained stable.

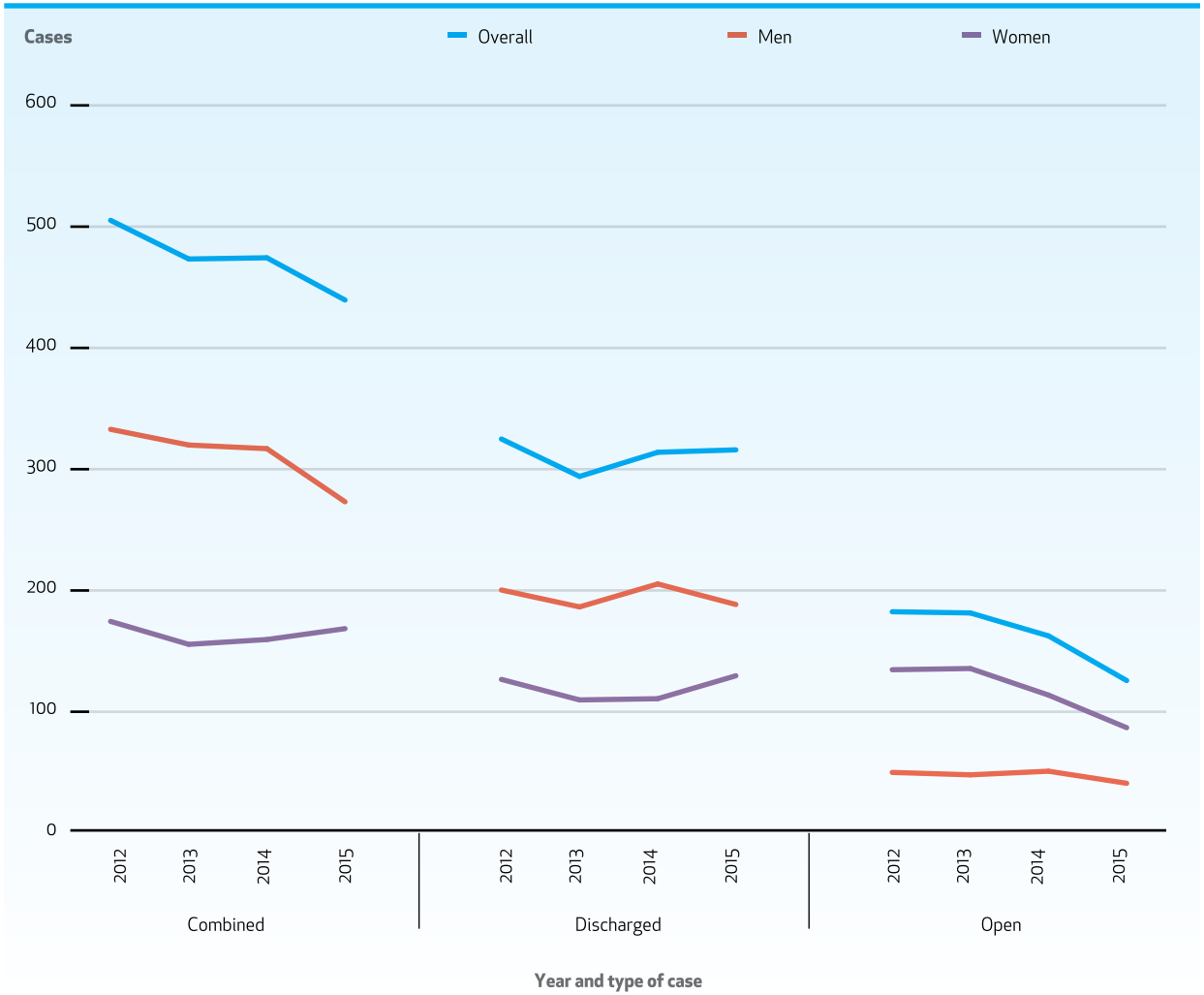


EXHIBIT 2.8.6 Volume and type of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, overall and by age group, in Ontario, 2012 to 2015

Key Finding

- The highest volume of cases designated ALC was among individuals aged 45 to 64; the volume of cases in this age group decreased over time.

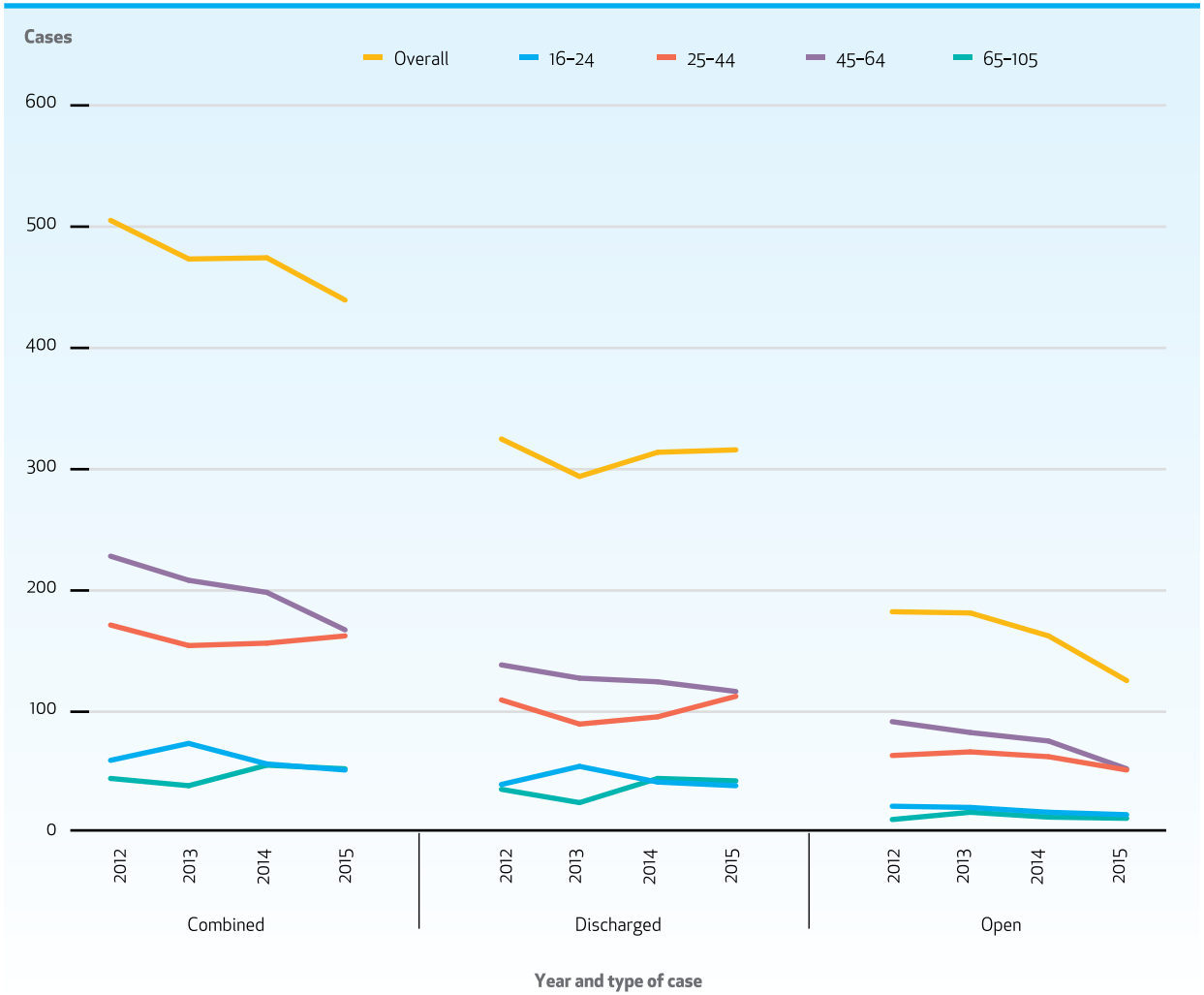


EXHIBIT 2.8.7 Volume and type of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, overall and by sex, in Ontario, three-year average for 2013 to 2015

Key Finding

- Between 2013 and 2015, the average volume of cases designated ALC for supportive housing was higher among men than women.

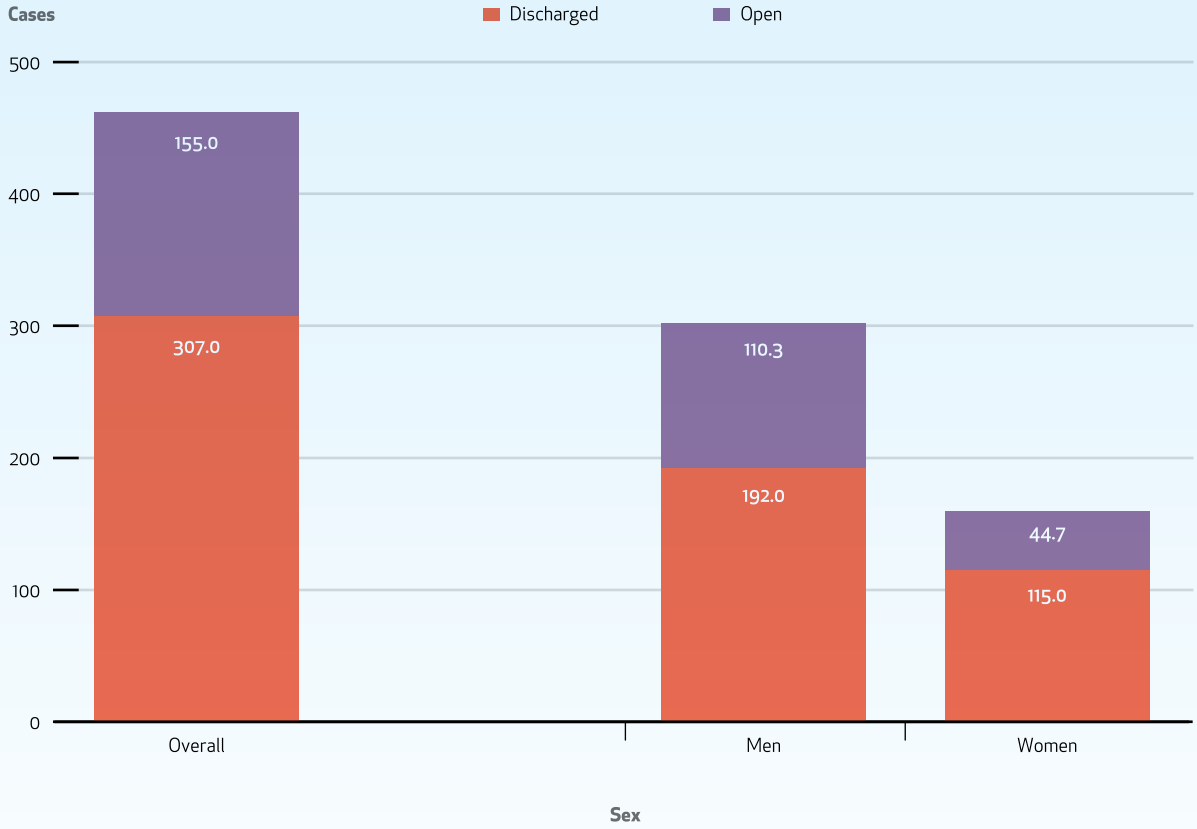


EXHIBIT 2.8.8 Volume and type of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, overall and by age group, in Ontario, three-year average for 2013 to 2015

Key Finding

- The average volume of cases designated ALC for supportive housing was highest among individuals aged 45 to 64 and lowest among those aged 65 to 105.

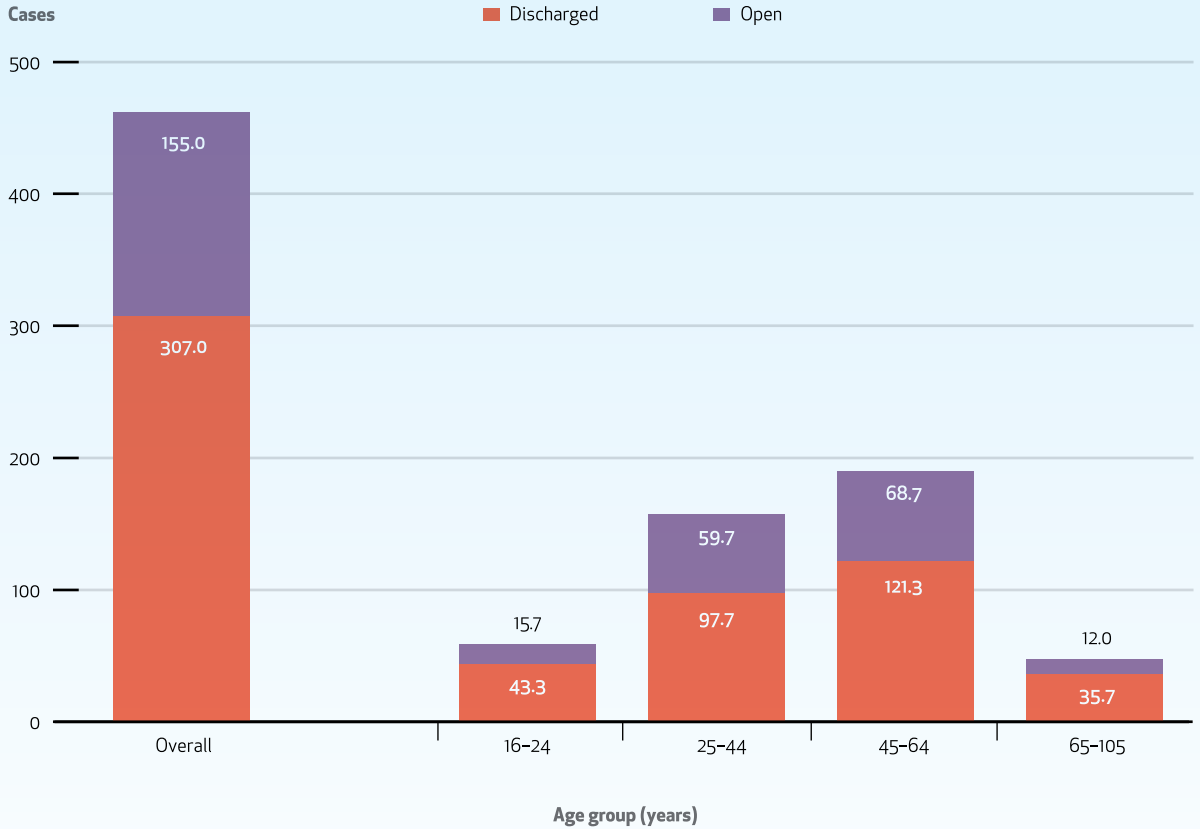
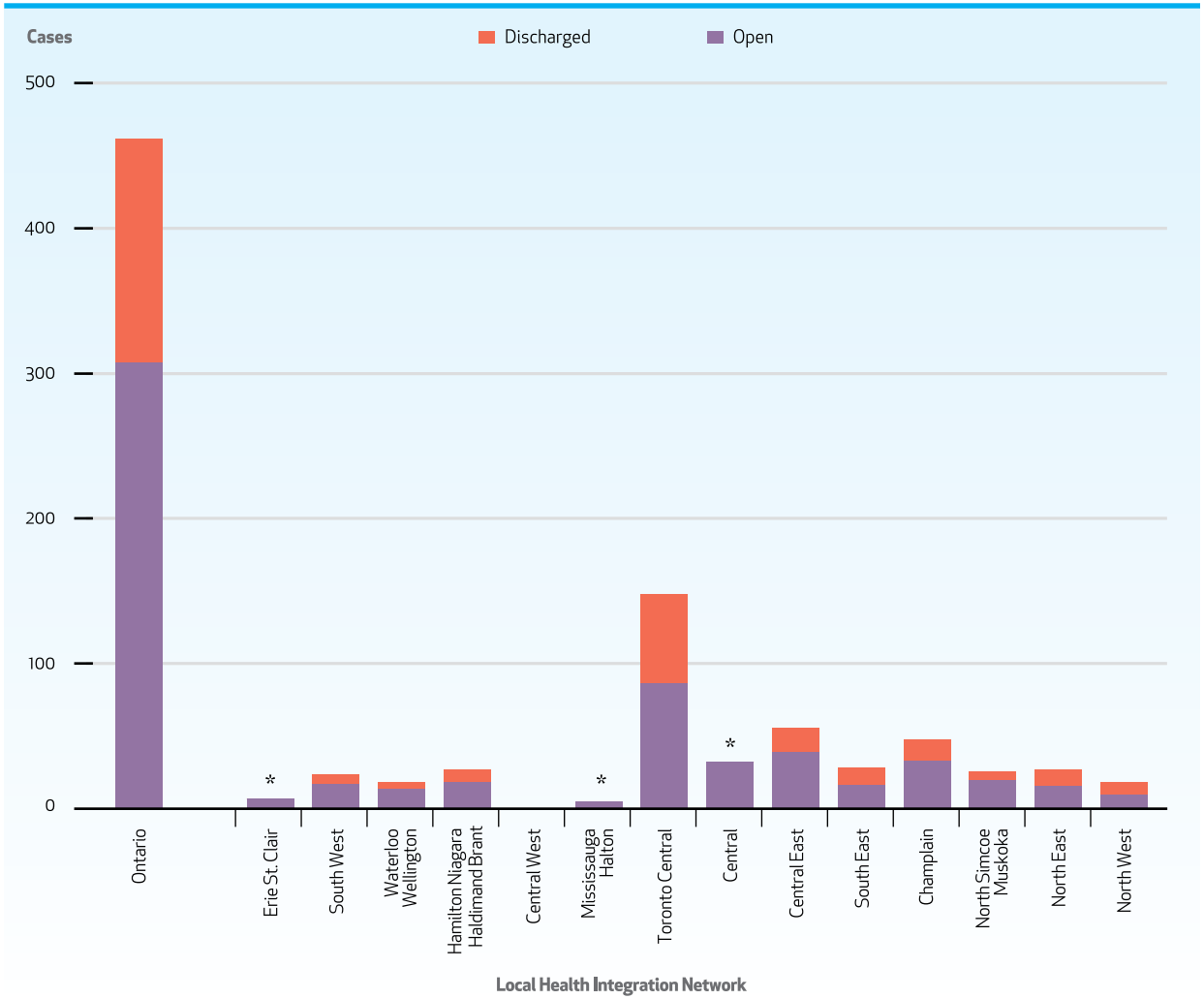


EXHIBIT 2.8.9 Volume and type of cases designated ALC for supportive housing/group homes/assisted living among patients aged 16 to 105 in mental health beds, by Local Health Integration Network, in Ontario, three-year average for 2013 to 2015

Key Finding

- The average volume of cases designated ALC for supportive housing was highest in the Toronto Central LHIN.



*No volume of open cases or volume less than 10 cases

EXHIBIT 2.8.10 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living by individuals aged 16 to 105, by type of case, in Ontario, 2012 to 2015

Key Finding

- The total number of days that patients spent in mental health beds designated ALC for supportive housing remained stable over time, except for a brief spike in 2015. The number of days that patients who were discharged spent in ALC, as a proportion of all ALC days, increased over time.

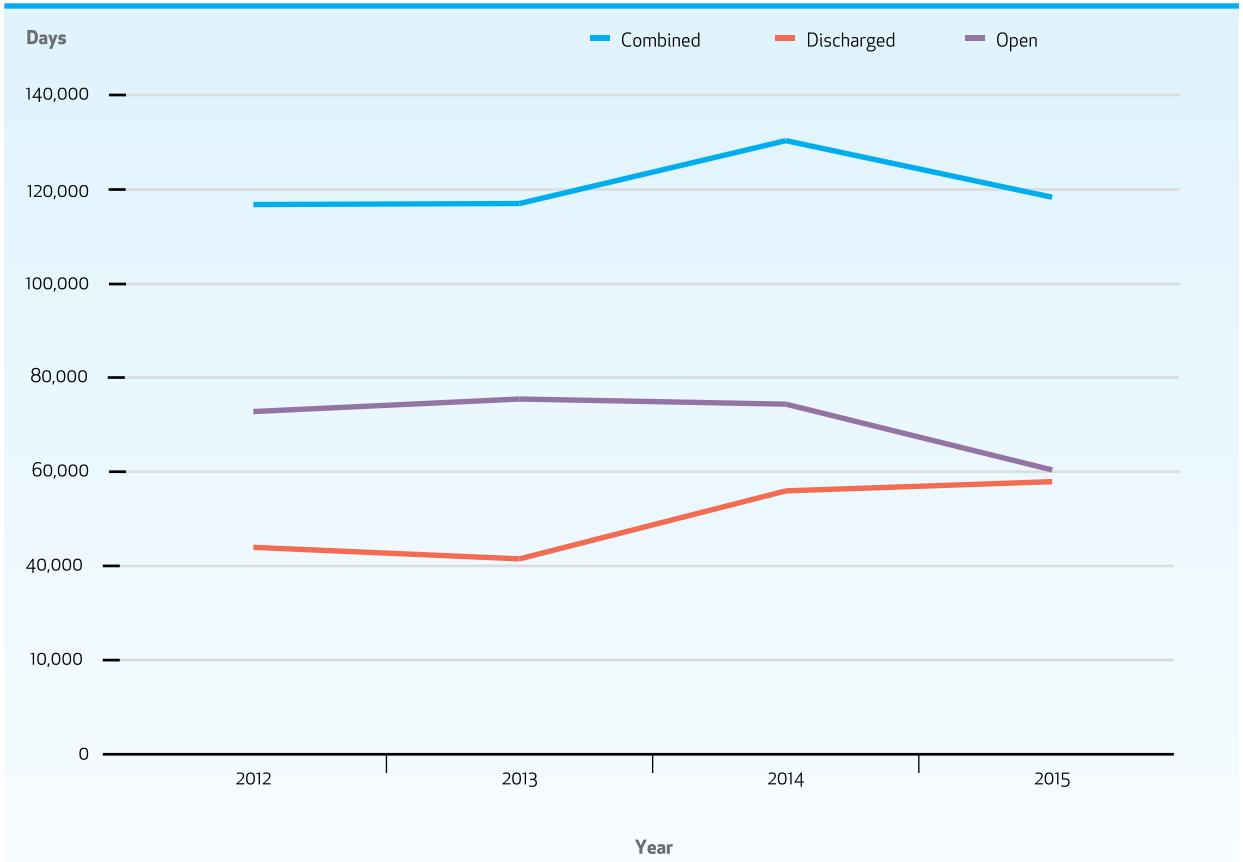


EXHIBIT 2.8.11 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living by individuals aged 16 to 105, overall and by sex, and type of case, in Ontario, 2012 to 2015

Key Finding

- Among patients in mental health beds designated ALC for supportive housing, men contributed more ALC days than women, and this was consistent over time.

EXHIBIT 2.8.12 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living among individuals aged 16 to 105, overall and by age group, and type of case, in Ontario, 2012 to 2015

Key Finding

- Among patients in mental health beds designated ALC for supportive housing, individuals aged 45 to 64 contributed the most ALC days. This was consistent over time with the exception of discharged cases in 2015, where 25- to 44-year-olds contributed more ALC days.

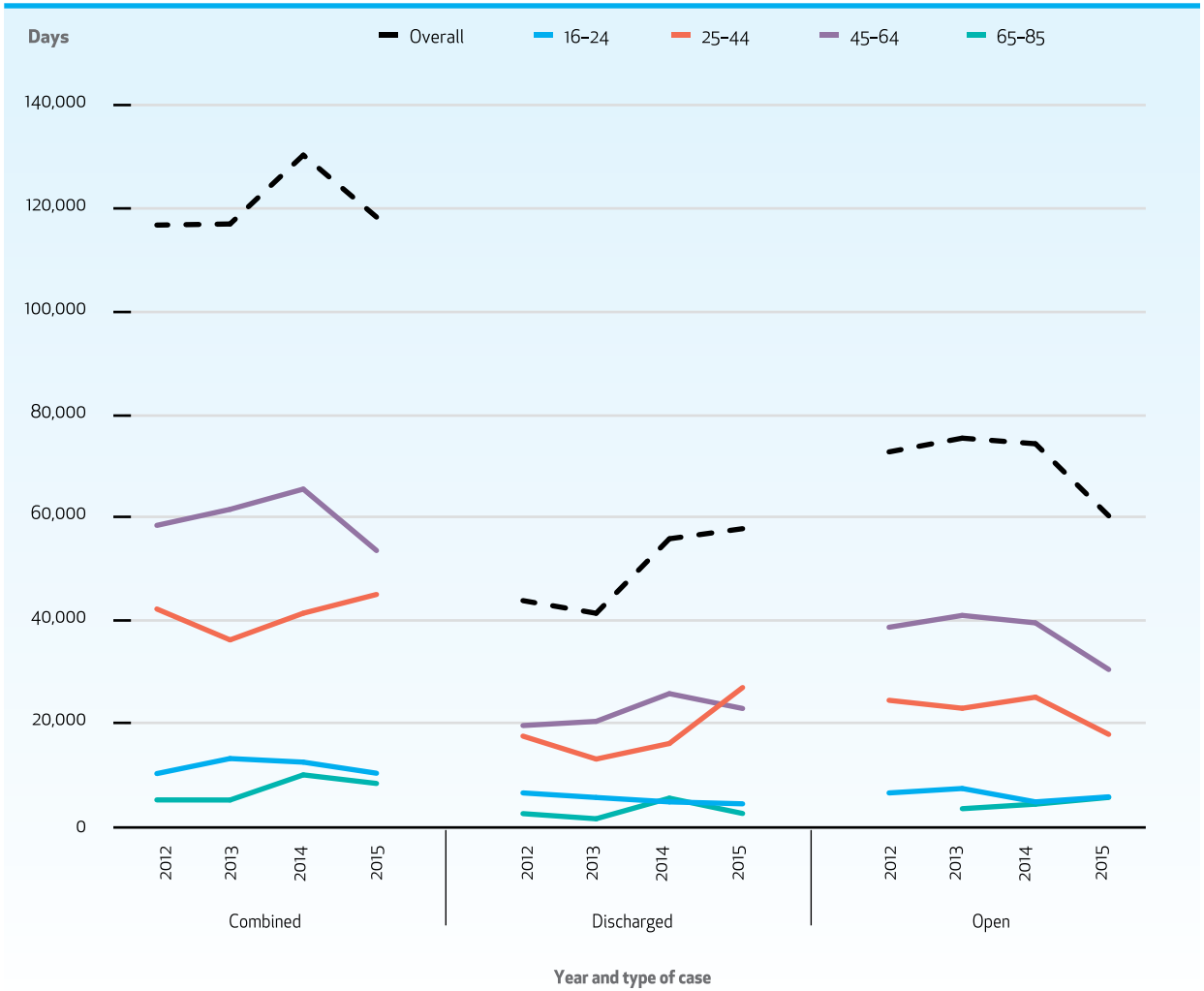


EXHIBIT 2.8.13 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living among individuals aged 16 to 105, by sex and type of case, in Ontario, three-year average for 2013 to 2015

Key Finding

- On average between 2013 and 2015, among patients in mental health beds designated ALC for supportive housing, men contributed more ALC days than women.

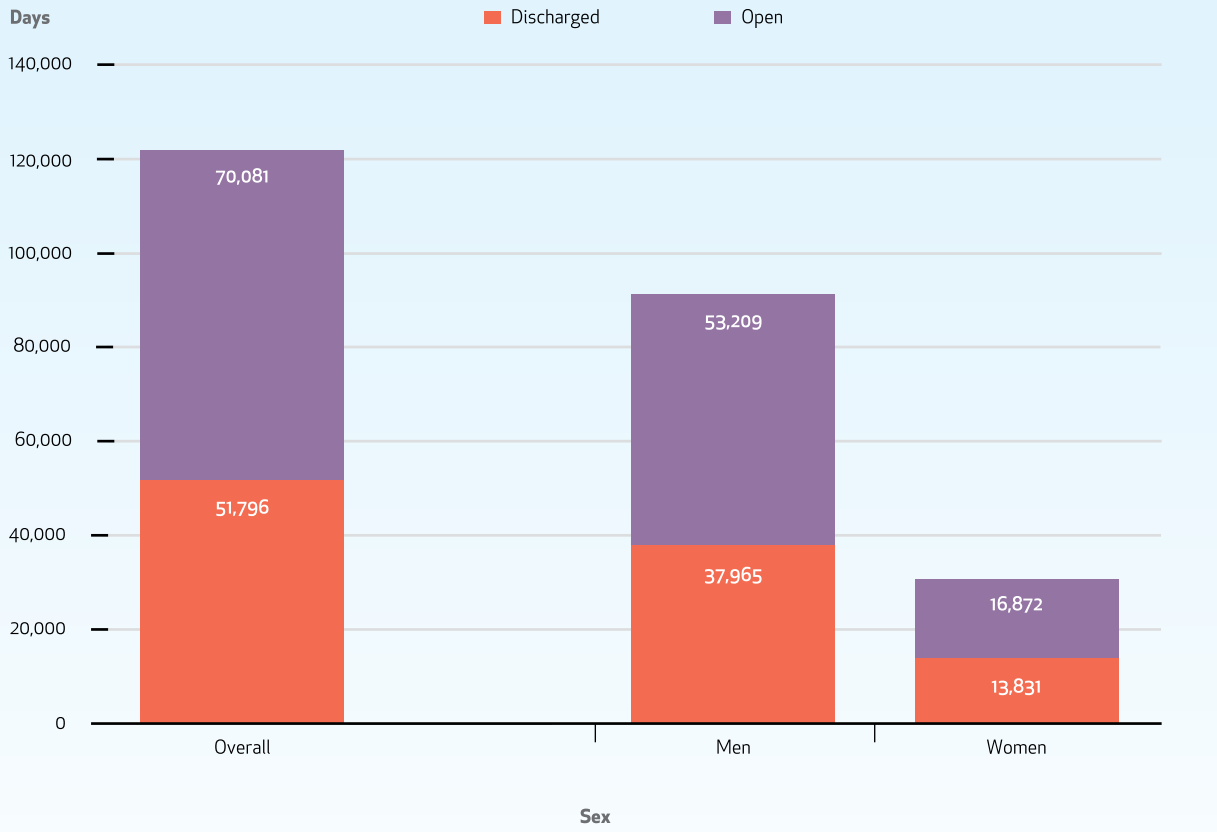


EXHIBIT 2.8.14 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living among individuals aged 16 to 105, by age group and type of case, in Ontario, three-year average for 2013 to 2015

Key Finding

- Among patients in mental health beds designated ALC for supportive housing, individuals aged 45 to 64 contributed half of all ALC days.

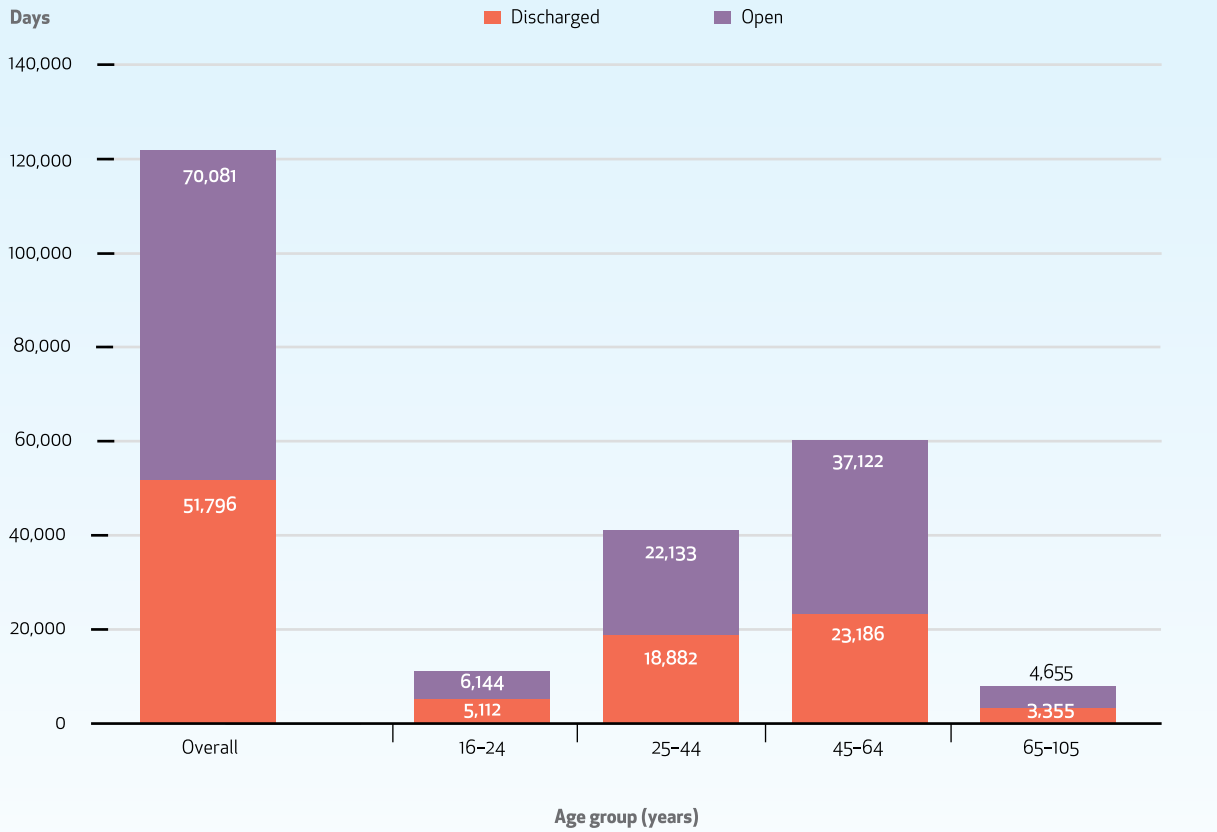
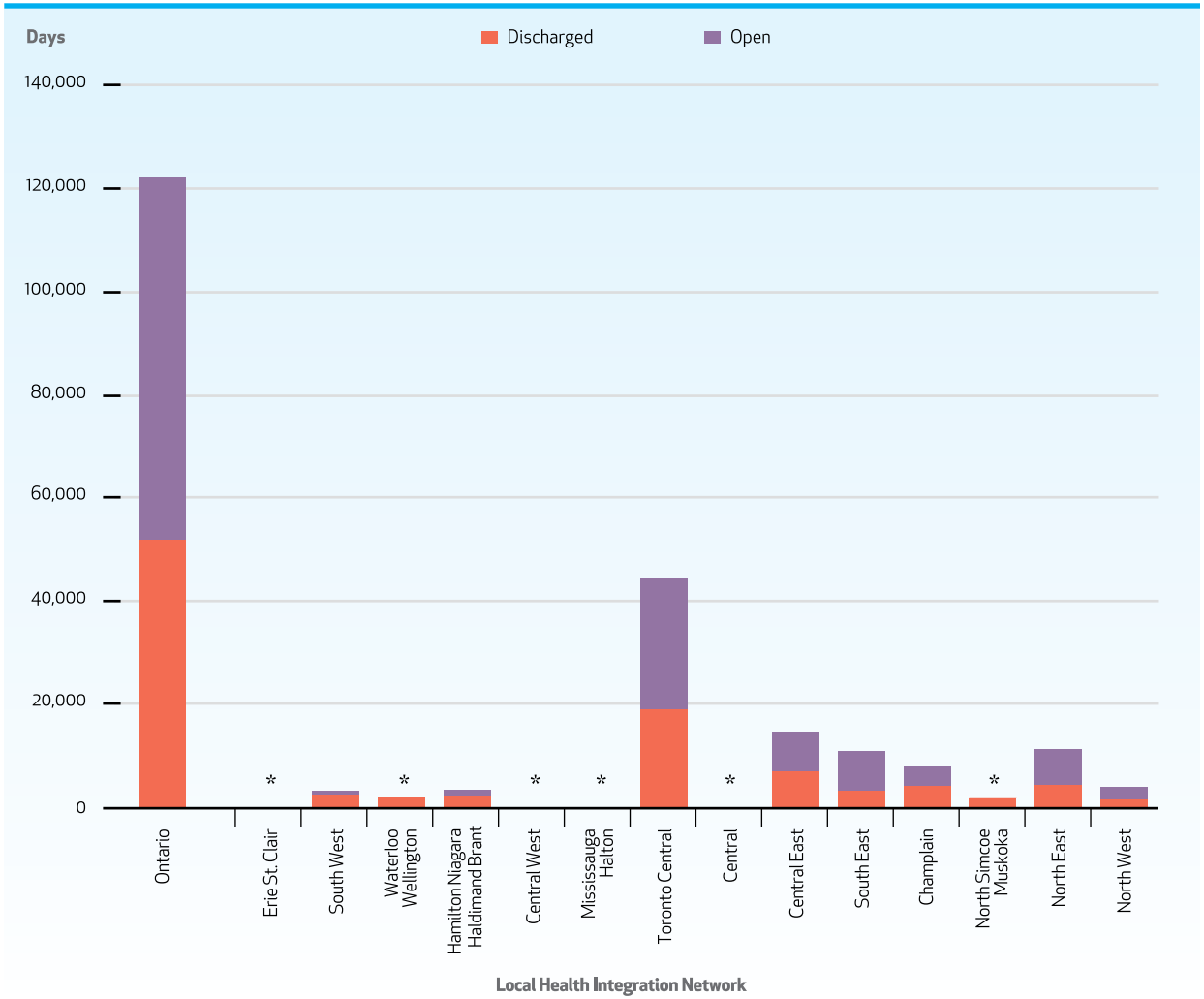


EXHIBIT 2.8.15 Number of days spent in mental health beds designated ALC for supportive housing/group homes/assisted living among individuals aged 16 to 105, by Local Health Integration Network and type of case, in Ontario, three-year average for 2013 to 2015

Key Finding

- Among patients in mental health beds designated ALC for supportive housing, those in the Toronto Central LHIN contributed the most ALC days.

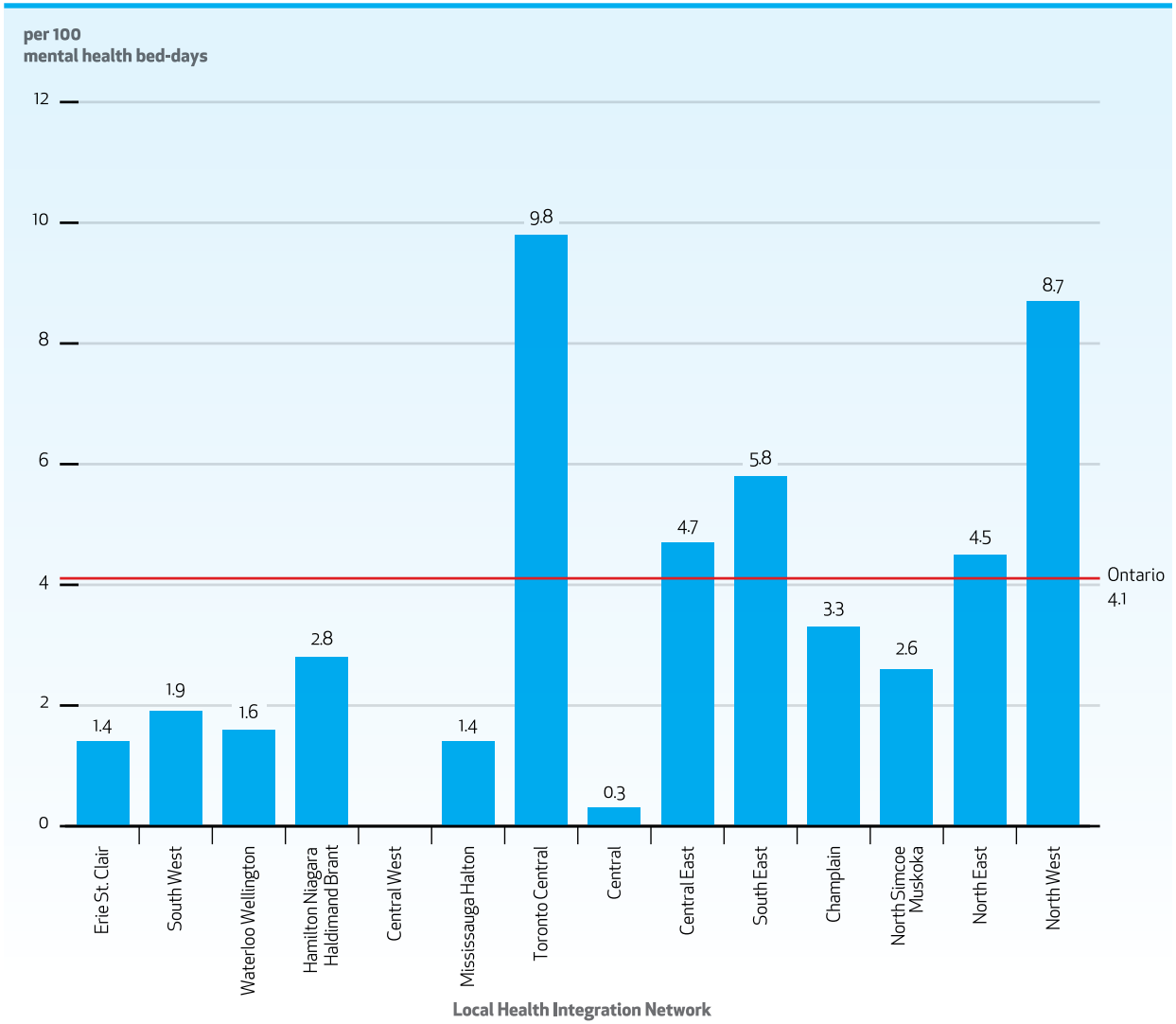


*No volume of open cases or volume less than 10 cases

EXHIBIT 2.8.16 Number of bed-days designated ALC for supportive housing/group homes/assisted living per 100 mental health bed-days, by Local Health Integration Network, in Ontario, 2015

Key Finding

- In 2015, patients designated ALC for supportive housing accounted for 4% of all mental health bed-days in the province; this varied widely by LHIN, with close to 10% of mental health bed-days dedicated to ALC for supportive housing in some regions. The highest rates in 2015 were found in the Toronto Central and North West LHINs.



3.0 Contextual Indicators for the Mental Health and Addictions System

Outpatient Care

3.1 Primary care physicians' full-time equivalent allocation to mental health and addictions care

3.2 Rate at which individuals were seen by a psychiatrist or a general practitioner/family physician for mental health and addictions care

3.3 Rate at which individuals received telepsychiatry consultations

3.4 Rate of mental health and addictions–related outpatient physician visits

Acute Care

3.5 Length of stay for psychiatric hospitalizations

3.6 Rate of hospitalizations for mental health and addictions care

3.7 Rate of emergency department visits for deliberate self-harm

3.8 Rate of mental health and addictions–related emergency department visits

3.1 Primary care physicians' full-time equivalent allocation to mental health and addictions care

Rationale

This indicator contributes to our knowledge of existing mental health and addictions service availability in Ontario by providing a more complete understanding of the existing capacity of the province's primary care physicians, consisting of general practitioners and family physicians, to provide MHA care. This indicator cannot be used in isolation to measure the adequacy of primary care provider resources, as adequacy also depends on the jurisdictional context, including local models of care, demand for care, and provider mix (i.e., non-physician providers of MHA services).

Results

GP/FPs' full-time equivalent (FTE) from 2010/11 to 2012/13 was annualized and adjusted for migration. For migration adjustment, a physician's FTE was assigned to the region where the physician's patients lived rather than where his or her practice was located. On average, about 10% of the GP/FPs' FTEs were allocated to MHA care provided to individuals aged 16 to 105 in outpatient settings. The proportion of GP/FPs' FTE allocated to MHA care was highest in the Toronto Central LHIN and lowest in the Central West LHIN.

Interpretation

Mental health and addictions care accounts for a substantial proportion of primary care activity. There appears to be greater mental health and addictions–related primary care activity in regions with large urban centres, such as the Toronto Central and Champlain LHINs.

EXHIBIT 3.1.1 Annualized migration-adjusted proportion of general practitioner/family physicians' full-time equivalent allocated to mental health and addictions–related outpatient services for adults aged 16 to 105, by Local Health Integration Network, in Ontario, three-year average for 2010/11 to 2012/13

Key Finding

- On average, between 2010/11 and 2012/13, the migration-adjusted proportion of GP/FPs' full-time equivalent (FTE) allocated to mental health and addictions–related outpatient care was highest in the Toronto Central LHIN and lowest in the Central West LHIN.

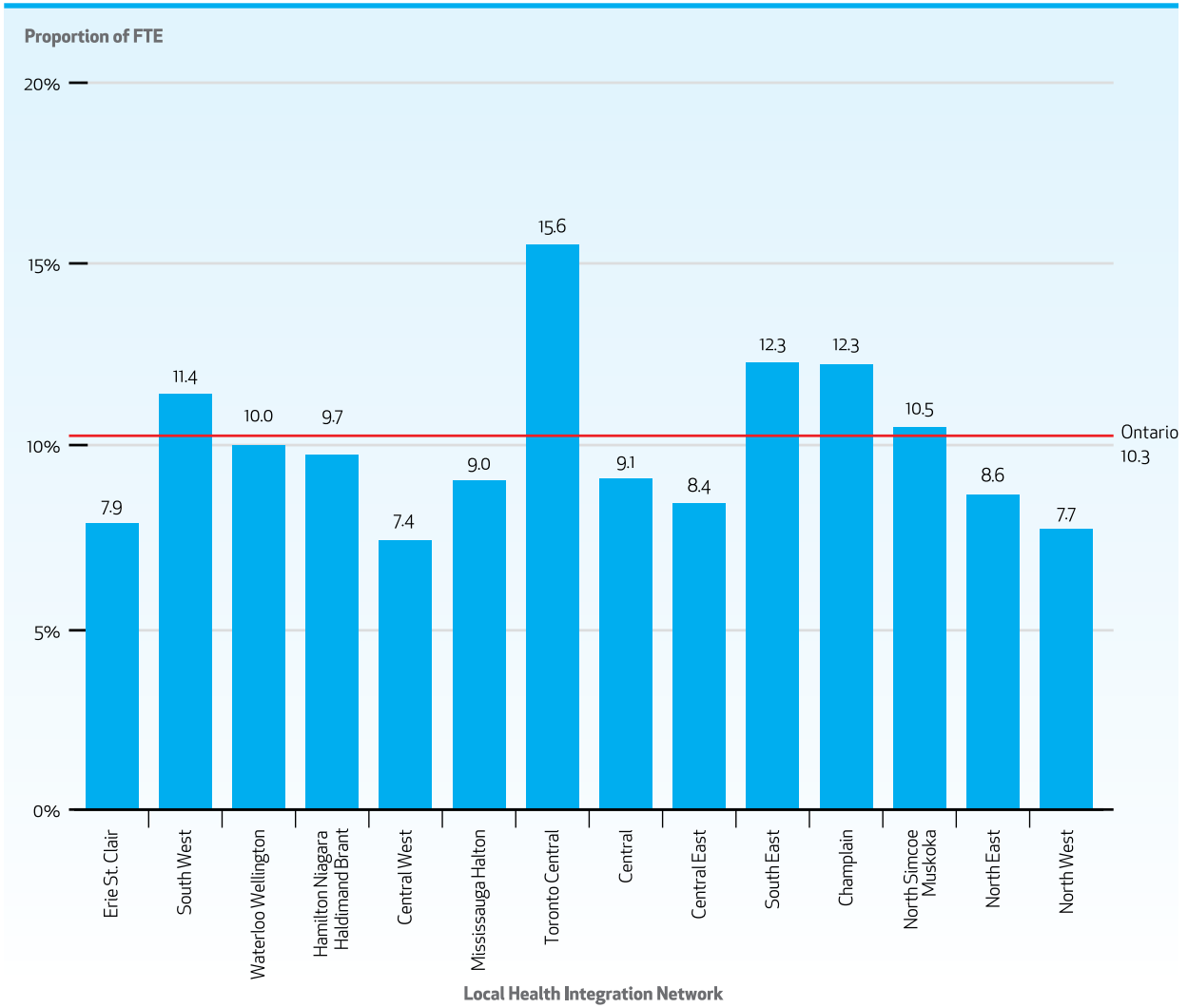
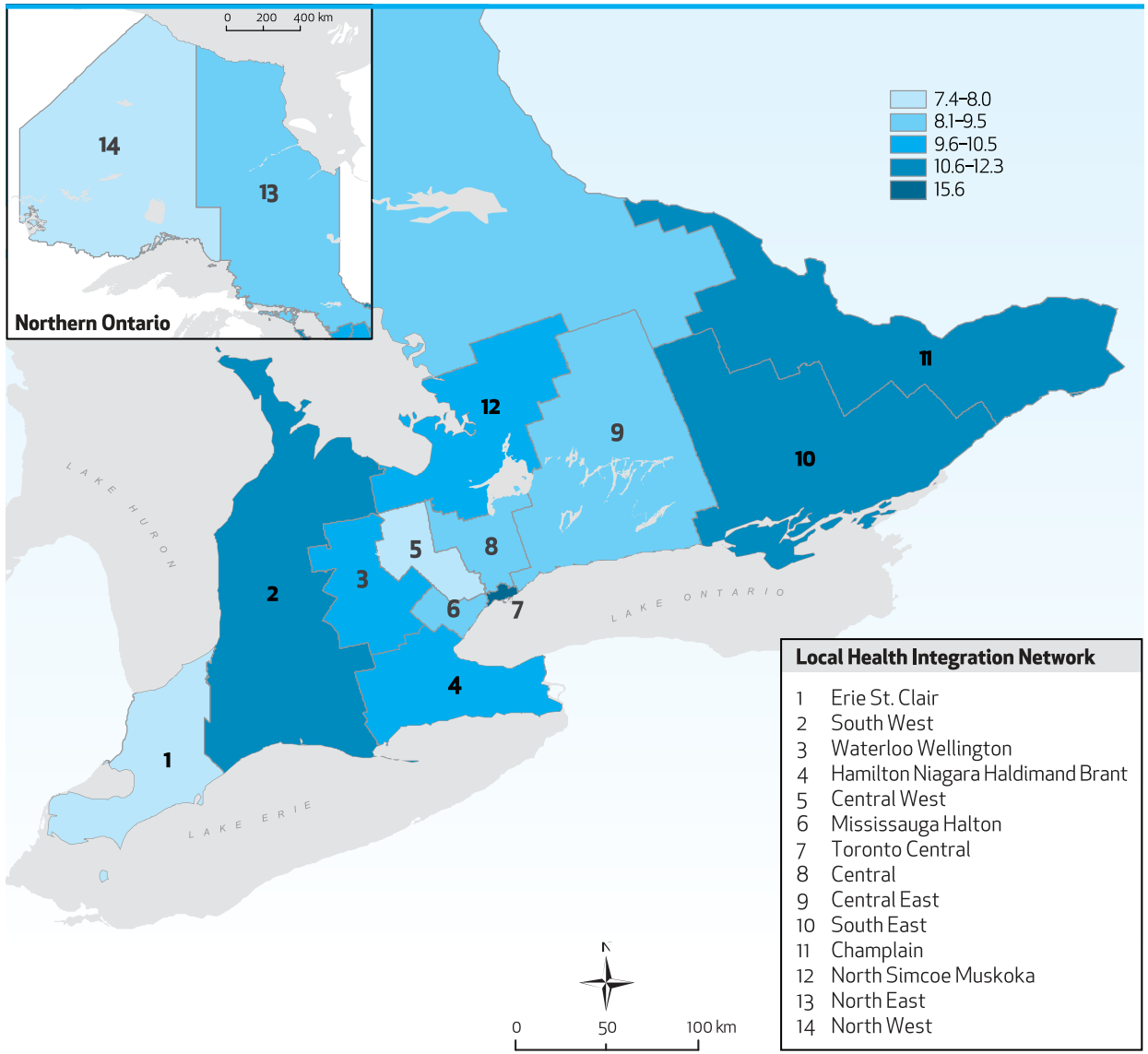


EXHIBIT 3.1.2 Annualized migration-adjusted proportion of general practitioner/family physicians' full-time equivalent allocated to mental health and addictions–related outpatient services for adults aged 16 to 105, by Local Health Integration Network, in Ontario, three-year average for 2010/11 to 2012/13

Key Finding

- On average, between 2010/11 and 2012/13, the migration-adjusted proportion of GP/FPs' full-time equivalent allocated to mental health and addictions–related outpatient care was highest in the Toronto Central LHIN and lowest in the Central West LHIN.



3.2 Rate at which individuals were seen by a psychiatrist or a general practitioner/family physician for mental health and addictions care

Rationale

Psychiatrists are physicians who specialize in mental health and addictions care. Their services are funded through the Ontario Health Insurance Plan (OHIP) and require a referral from another physician. Measuring the number of individuals who are seen by a psychiatrist is one measure of access to specialized care. Primary care providers, such as general practitioners and family physicians, provide variable amounts of MHA services in addition to general health care, depending on the case-mix of their practice. In addition to being a measure of access to MHA care, knowledge of the rate of and trends for visits to GP/FPs for MHA care can help with human resource planning.

Results

More adults living in Ontario receive MHA care from a GP/FP than from a psychiatrist. With the exception of individuals aged 16 to 24, between 2006 and 2014, a decline in the rates of individuals seen by a GP/FP for MHA care was observed. By contrast, during these same years a gradual increase in the rate at which individuals were seen by psychiatrists was observed. This was largely driven by a rapid increase in the number of 16- to 24-year-olds being seen by psychiatrists. In both physician specialties, the highest rate at which individuals were seen for MHA care was observed among adults aged 45 to 64. The rate at which women were seen by a physician of any specialty for MHA care was higher than for men. Similarly, the highest rates were observed among those living in the lowest income neighbourhood quintiles and among non-immigrants and refugees. Considerably more individuals saw a psychiatrist in the Toronto Central LHIN, while in the Erie St. Clair LHIN, more individuals received MHA care from a GP/FP. The age- and sex-standardized rate at which Ontario adults saw a GP/FP or a psychiatrist for MHA care was lowest in the Waterloo Wellington and North West LHINs, respectively.

Interpretation

The rate at which individuals were seen by a psychiatrist increased over time; this may reflect greater capacity, greater demand or an increase in awareness of MHA-related concerns coupled with de-stigmatization, particularly among younger adults. By contrast, the rate at which individuals were seen by a GP/FP for MHA care decreased over time, which may reflect access issues or referrals to non-physician care providers, who are not captured in the data. Higher rates observed in those residing in LHINs with large urban centres suggest that factors other than need are influencing access to specialist care.

EXHIBIT 3.2.1 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 population aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, the rate of individuals who saw a psychiatrist increased over time, while the rate of individuals who saw a GP/FP for MHA care decreased over time. The rate was higher among women for both physician specialties.

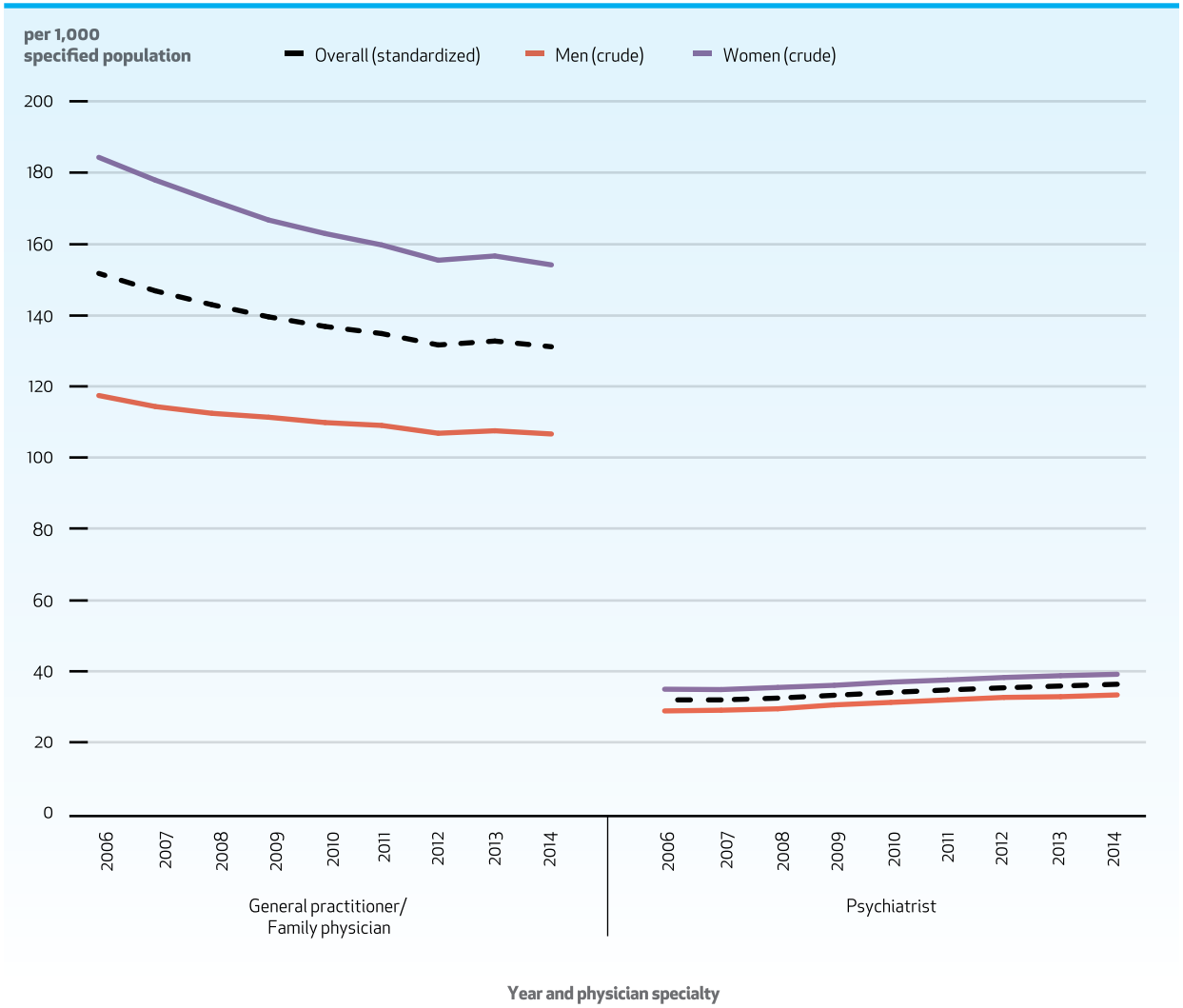


EXHIBIT 3.2.2 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 population aged 16 to 105 years, by age group, in Ontario, 2006 to 2014

Key Findings

- The rate of individuals who saw a GP/FP for MHA care was highest among individuals aged 45 to 64 and lowest among those aged 16 to 24. The rates decreased over time for all age groups, with the exception of those aged 16 to 24.
- The rate of individuals who saw a psychiatrist was highest among those aged 45 to 64. There was an increase over time in the rate of young adults aged 16 to 24 who saw a psychiatrist.

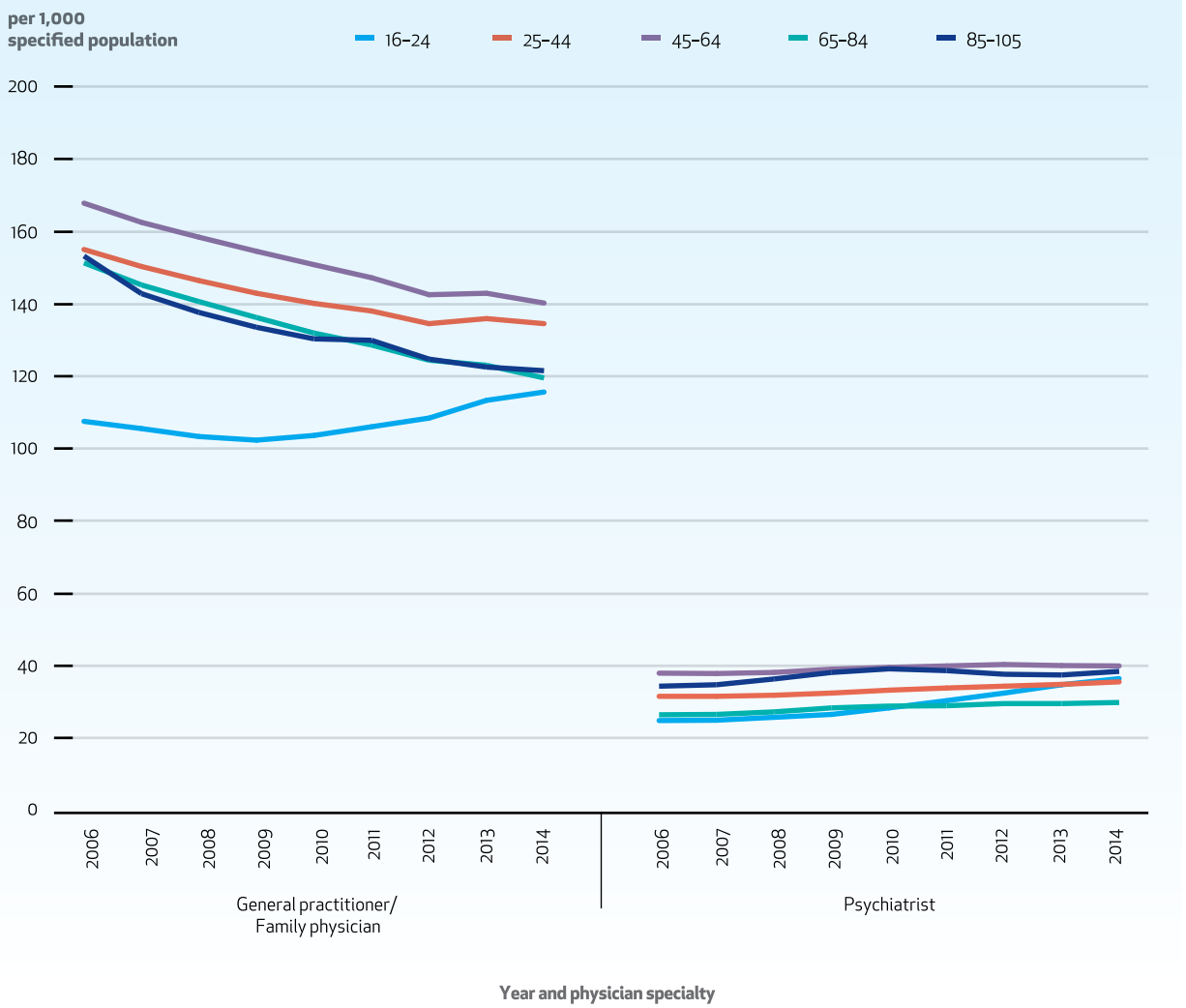


EXHIBIT 3.2.3 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate at which individuals saw a physician for MHA care was higher among women for both physician specialties.

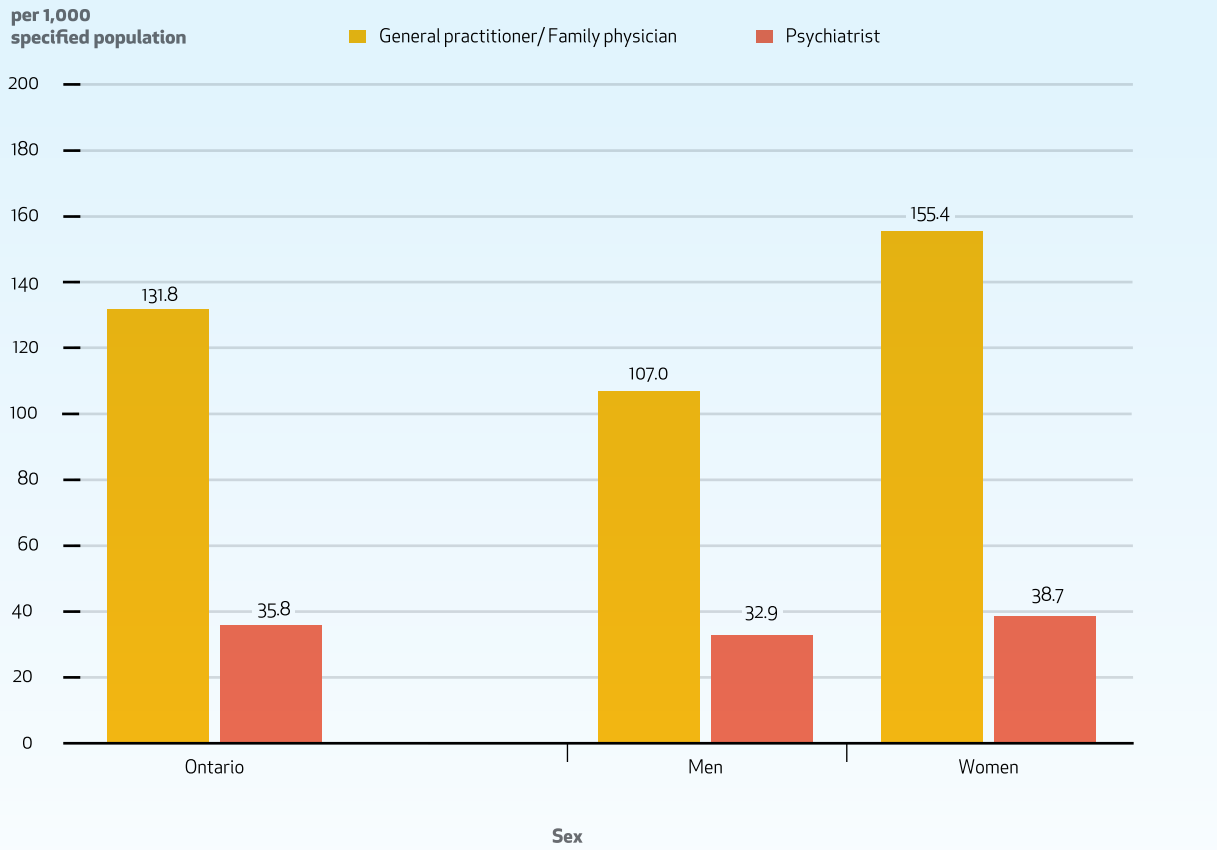


EXHIBIT 3.2.4 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the rate at which individuals were seen by either GP/FPs or psychiatrists for MHA care was highest among individuals aged 45 to 64.

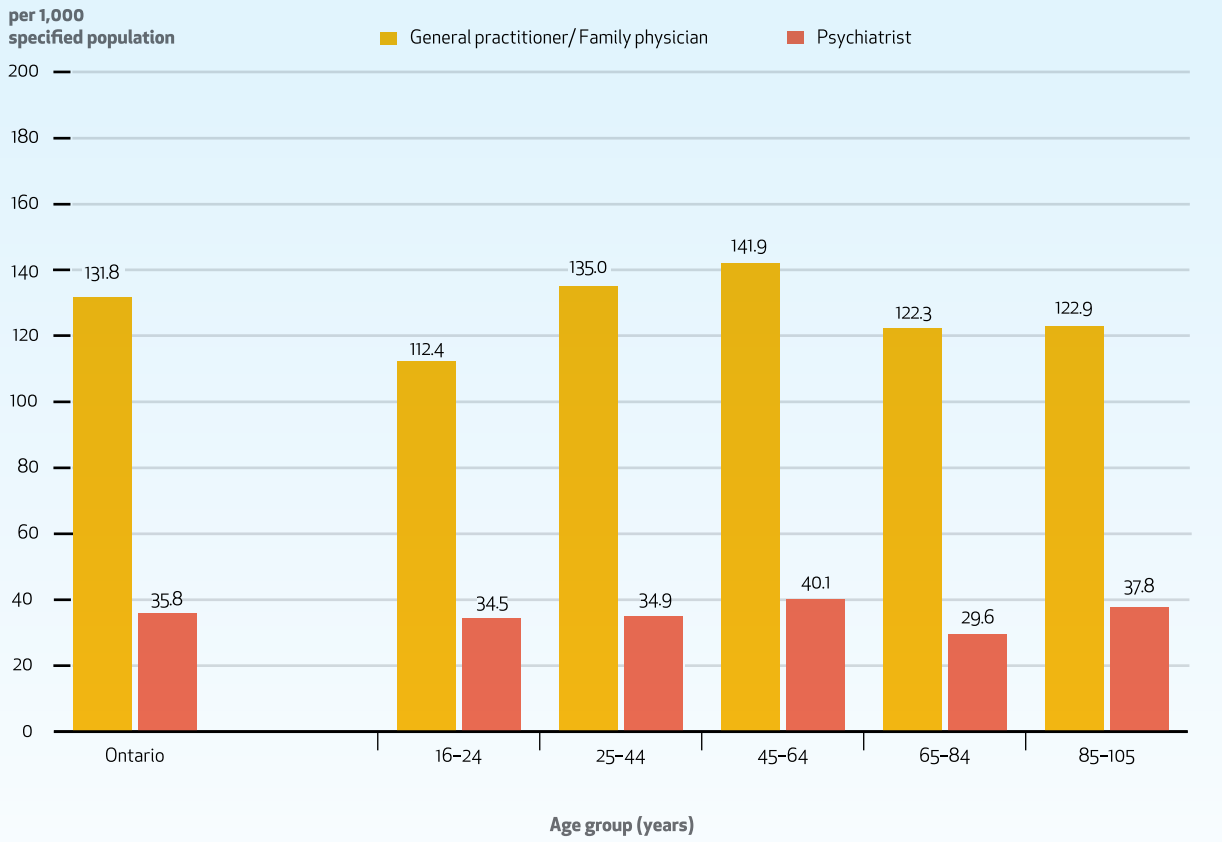


EXHIBIT 3.2.5 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of individuals seen by a physician for MHA care was highest among individuals in the poorest neighbourhoods.

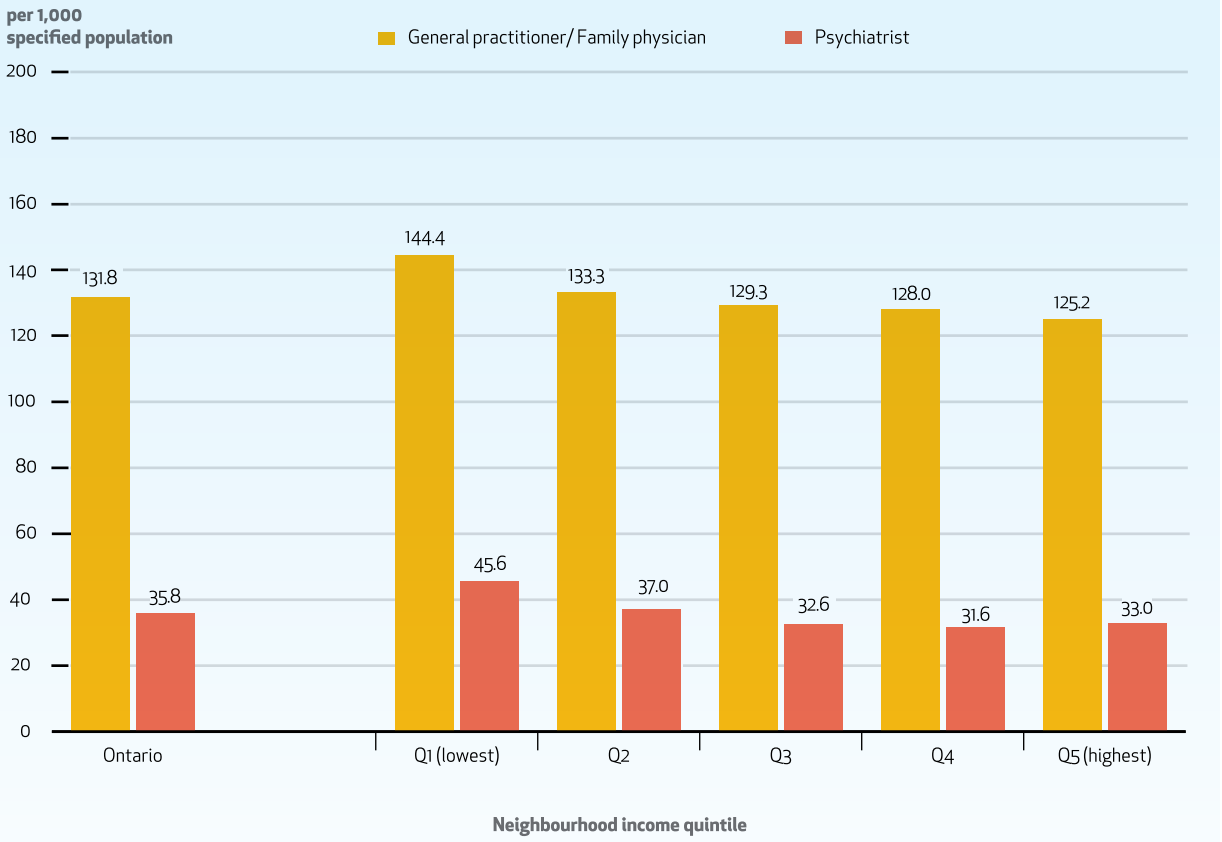


EXHIBIT 3.2.6 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average, between 2010 and 2012, the rate at which individuals were seen by a GP/FP for MHA care was higher among non-immigrants and refugees. The rate at which individuals were seen by a psychiatrist was highest among refugees and non-immigrants.

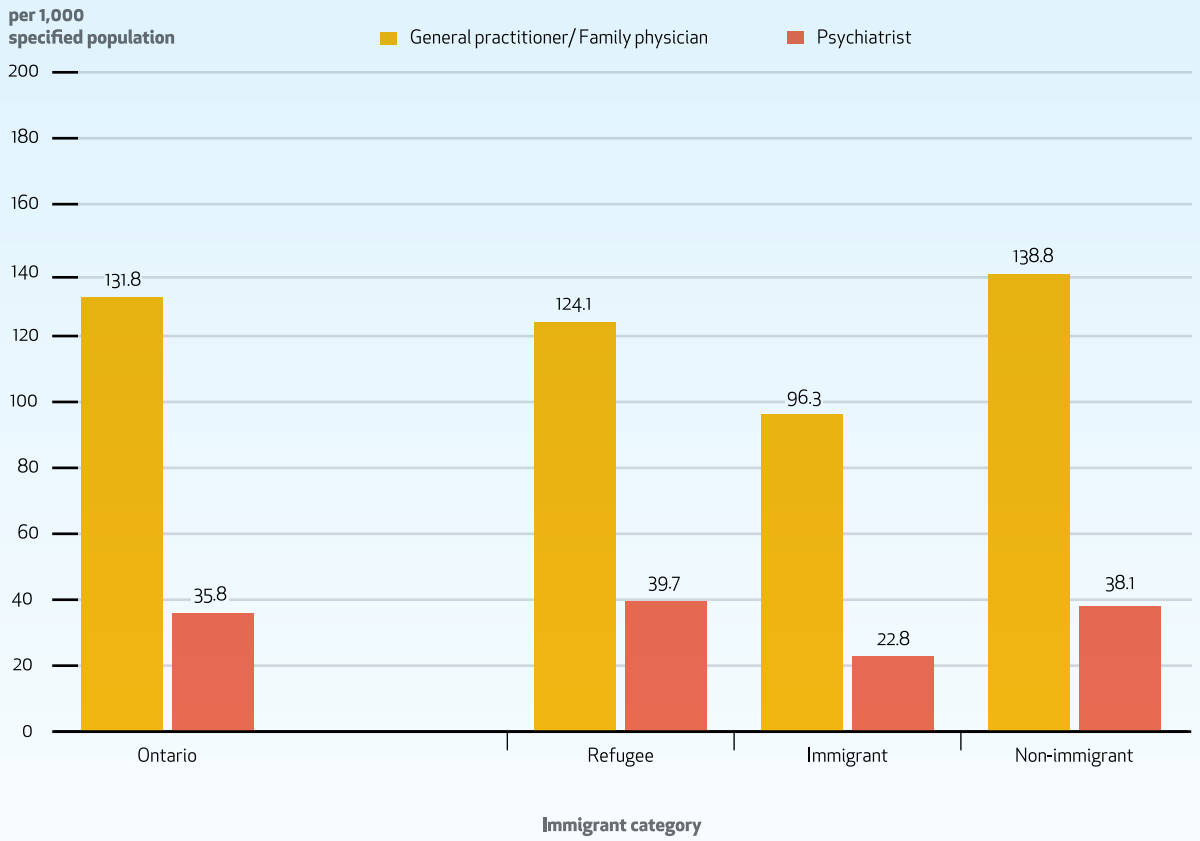


EXHIBIT 3.2.7 Number of individuals seen for mental health and addictions care by a general practitioner/family physician or psychiatrist per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Findings

- On average, between 2012 and 2014, the age- and sex-standardized rate at which individuals were seen for MHA care by a GP/FP was highest in the Erie St. Clair LHIN and lowest in the Waterloo Wellington LHIN.
- The age- and sex-standardized rate at which individuals were seen by a psychiatrist was highest in the Toronto Central LHIN and lowest in the North West LHIN.

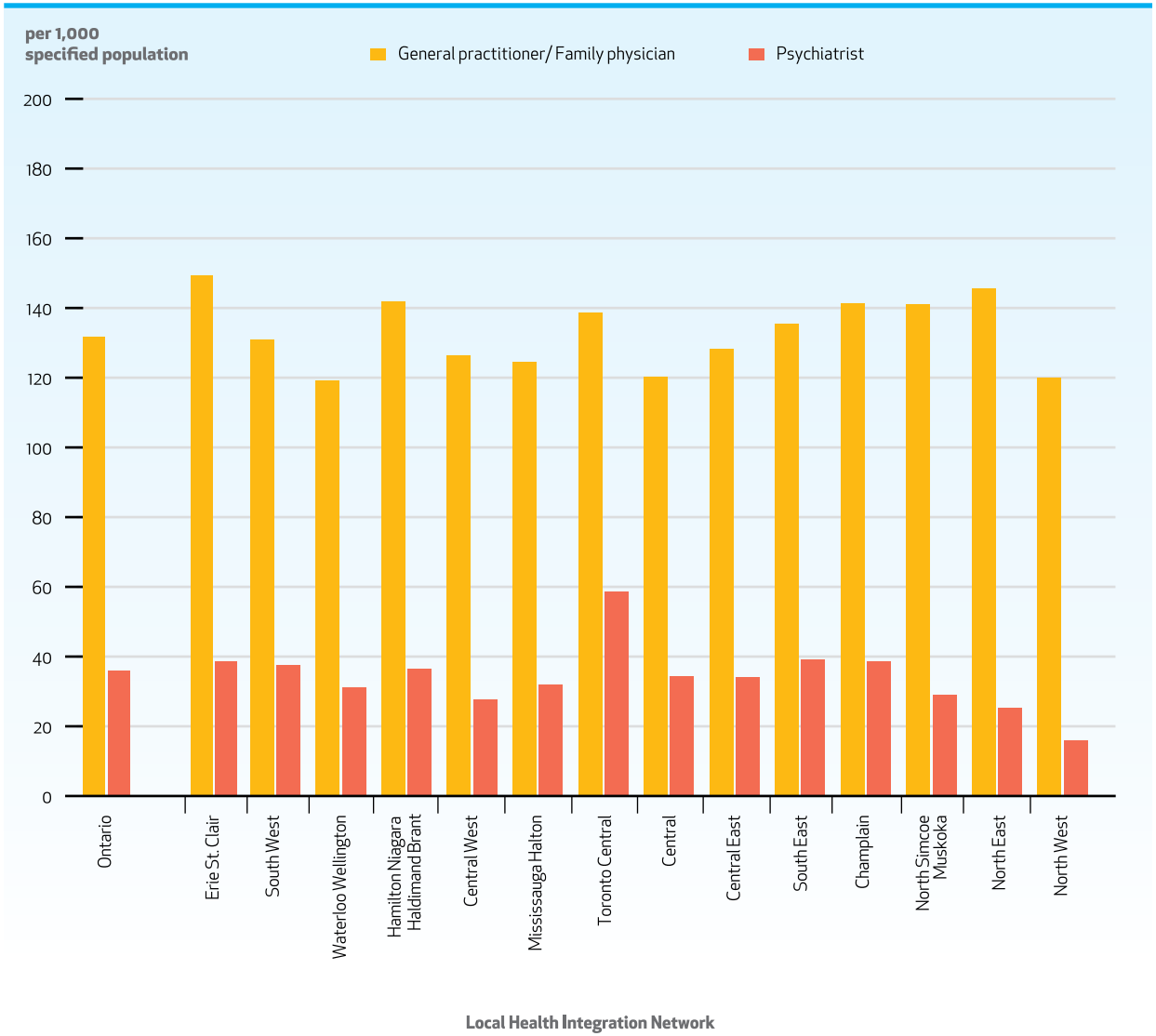


EXHIBIT 3.2.8 Number of individuals seen for mental health and addictions care by a general practitioner/family physician per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate at which individuals were seen for MHA care by a GP/FP was highest in the Erie St. Clair LHIN and lowest in the Waterloo Wellington LHIN.

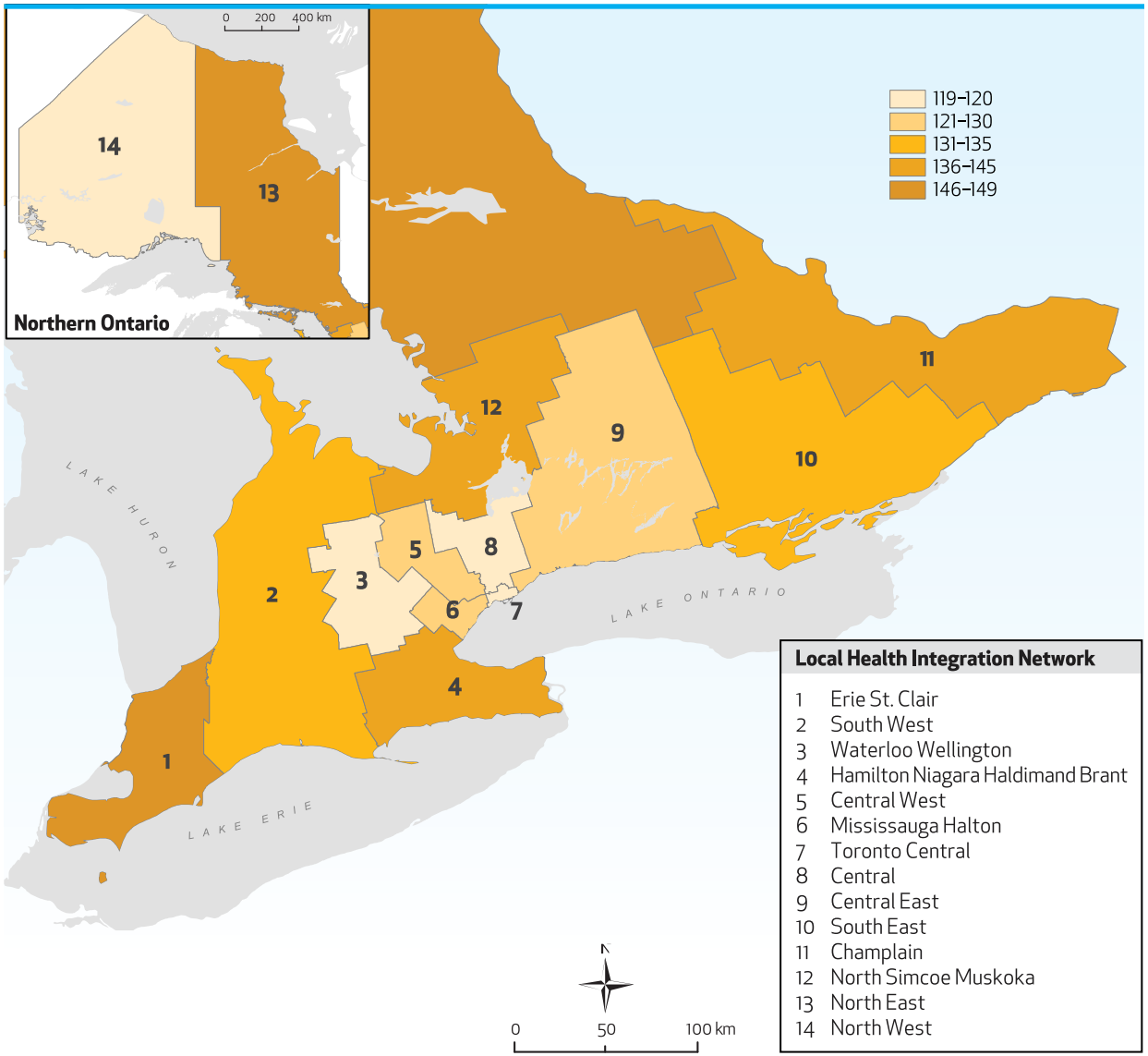
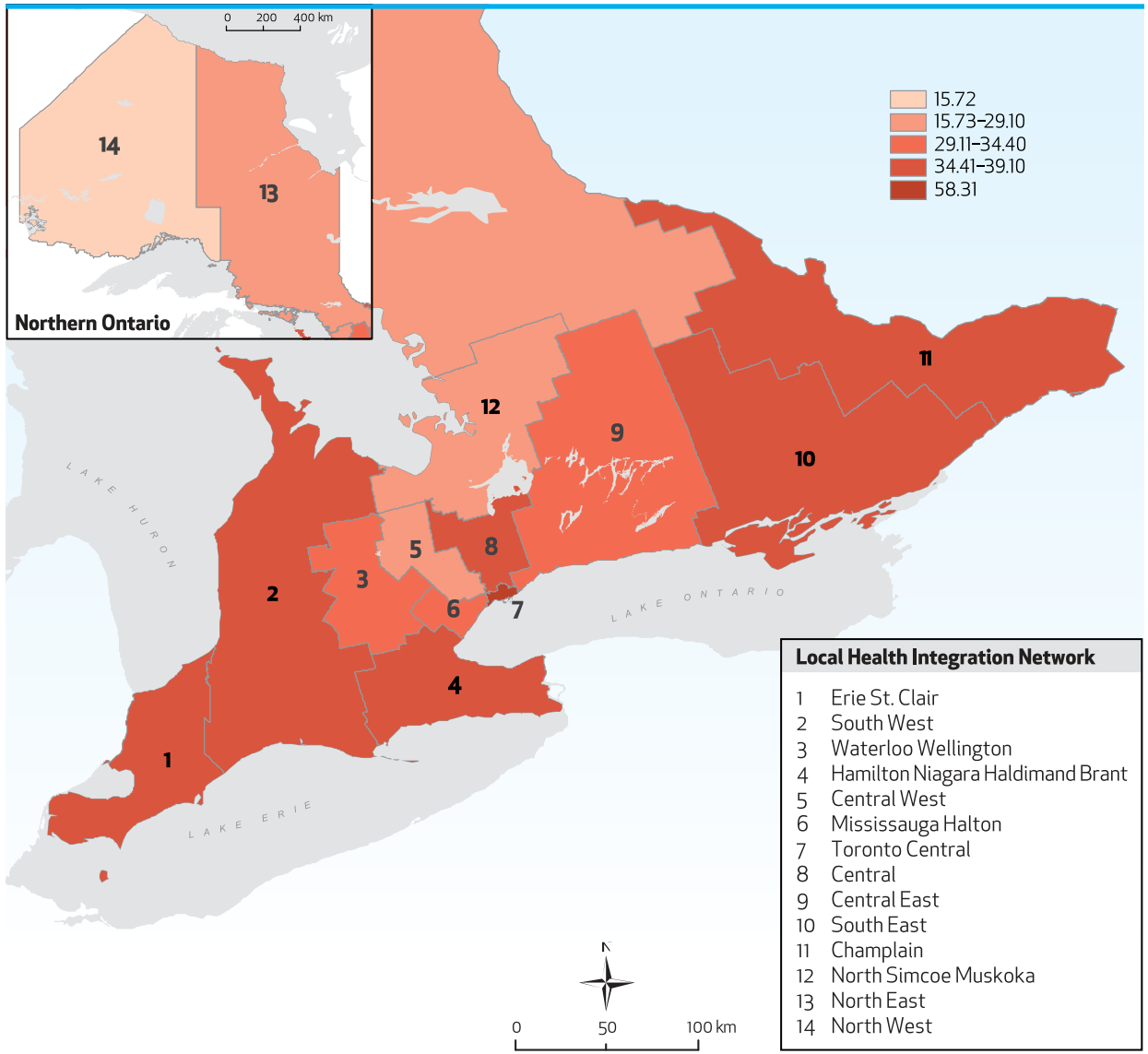


EXHIBIT 3.2.9 Number of individuals seen by a psychiatrist per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate at which individuals were seen by a psychiatrist was highest in the Toronto Central LHIN and lowest in the North West LHIN.



3.3 Rate at which individuals received telepsychiatry consultations

Rationale

Telepsychiatry, a mode of care provided via secure, real-time videoconferencing, can be an effective way to improve access to mental health and addictions care in regions with few or no psychiatrists. Telepsychiatry consultations usually take place in health care settings such as hospitals, physician clinics and community-based mental health and addictions agencies.

Results

Between 2008 and 2014, telepsychiatry use increased dramatically across all age groups. Rates of use were higher among women, individuals living in lower-income neighbourhoods, non-immigrants and those residing in the northern LHINs. Less than one percent of individuals who saw a psychiatrist did so via telepsychiatry.

Interpretation

Telepsychiatry use was higher in rural and remote areas than in urban areas. Although the increasing rate of telepsychiatry use likely had an impact on access to specialist services in rural and remote areas, it is still considerably low overall.

EXHIBIT 3.3.1 Number of individuals who received telepsychiatry consultations per 10,000 population aged 16 to 105 years, overall and by sex, in Ontario, 2008 to 2014

Key Finding

- The rate at which individuals received telepsychiatry consultations increased over time, and particularly after 2010. The rate was slightly higher for women.

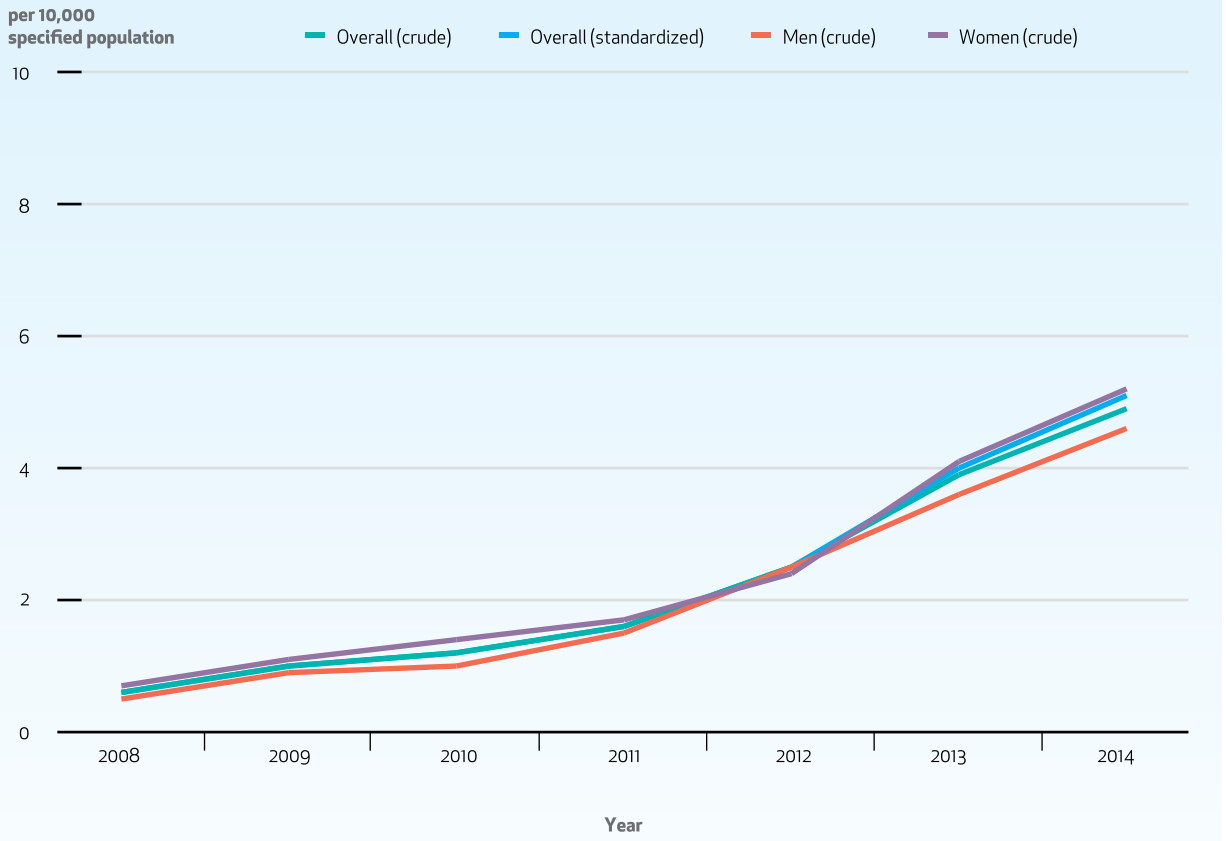


EXHIBIT 3.3.2 Number of individuals who received telepsychiatry consultations per 10,000 crude population aged 16 to 105 years, by age group, in Ontario, 2008 to 2014

Key Finding

- The largest increase in the rate of telepsychiatry consultations was observed in the younger age groups. In 2014, individuals aged 16 to 24 had the highest rate of telepsychiatry consultations.

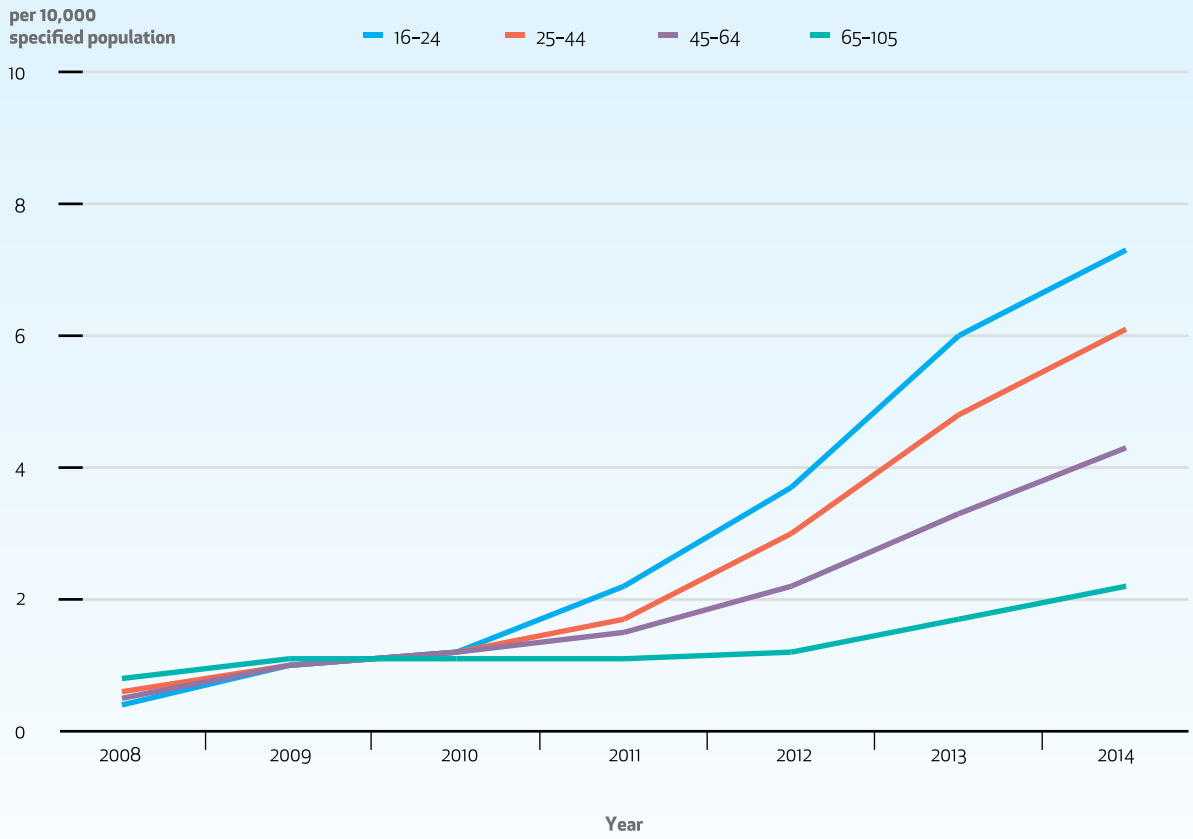


EXHIBIT 3.3.3 Number of individuals who received telepsychiatry consultations per 10,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average between 2012 and 2014, the rate at which individuals received telepsychiatry consultations was slightly higher for women.

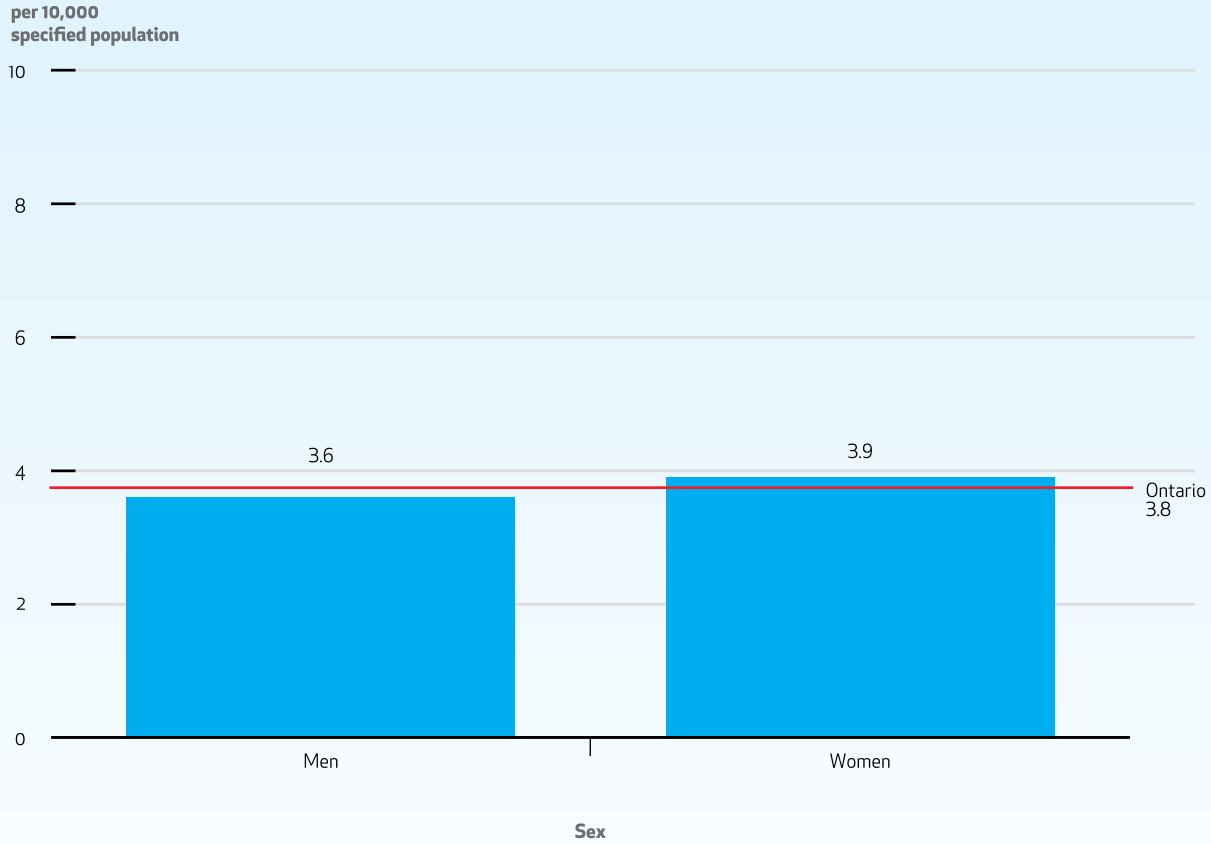


EXHIBIT 3.3.4 Number of individuals who received telepsychiatry consultations per 10,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of telepsychiatry consultations was highest among individuals aged 16 to 24 years and decreased with age.

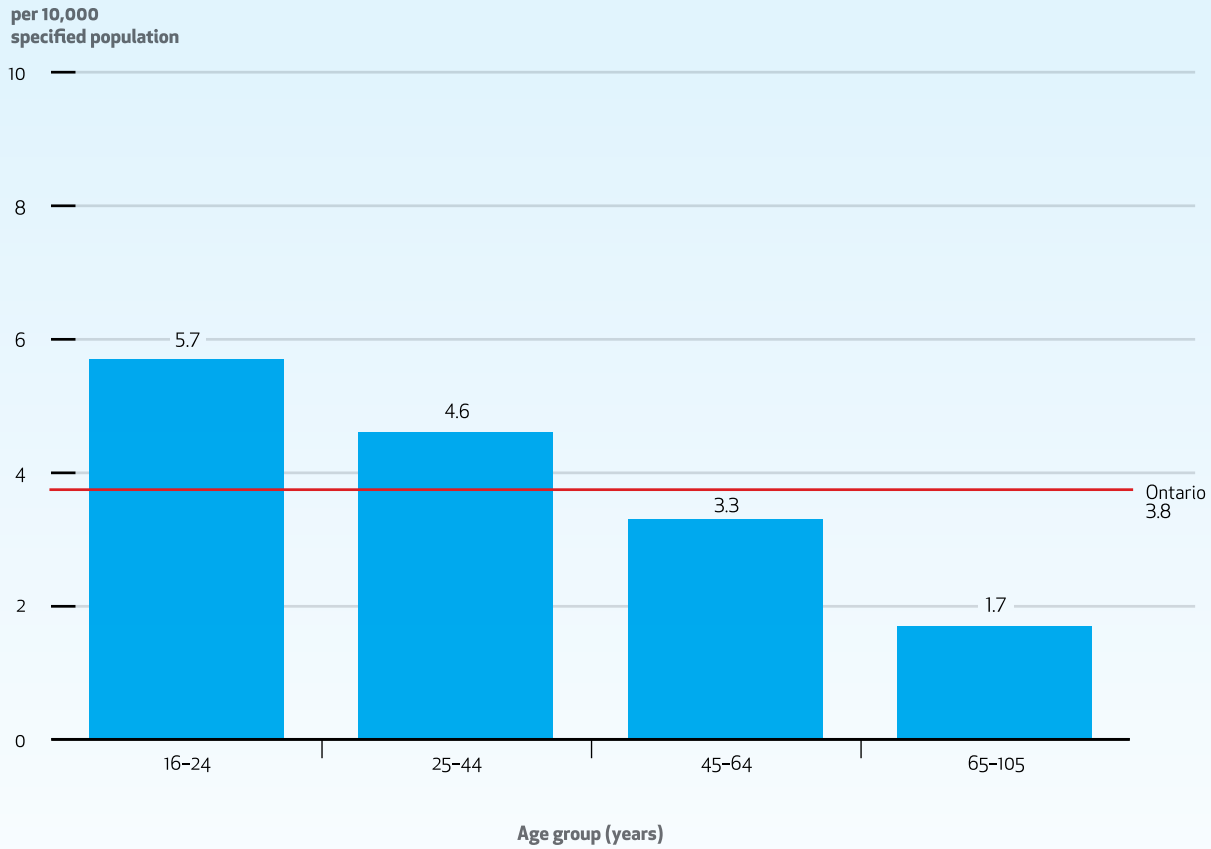


EXHIBIT 3.3.5 Number of individuals who received telepsychiatry consultations per 10,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of telepsychiatry consultations was higher among individuals in poorer neighbourhoods; the rate decreased as neighbourhood income level increased.

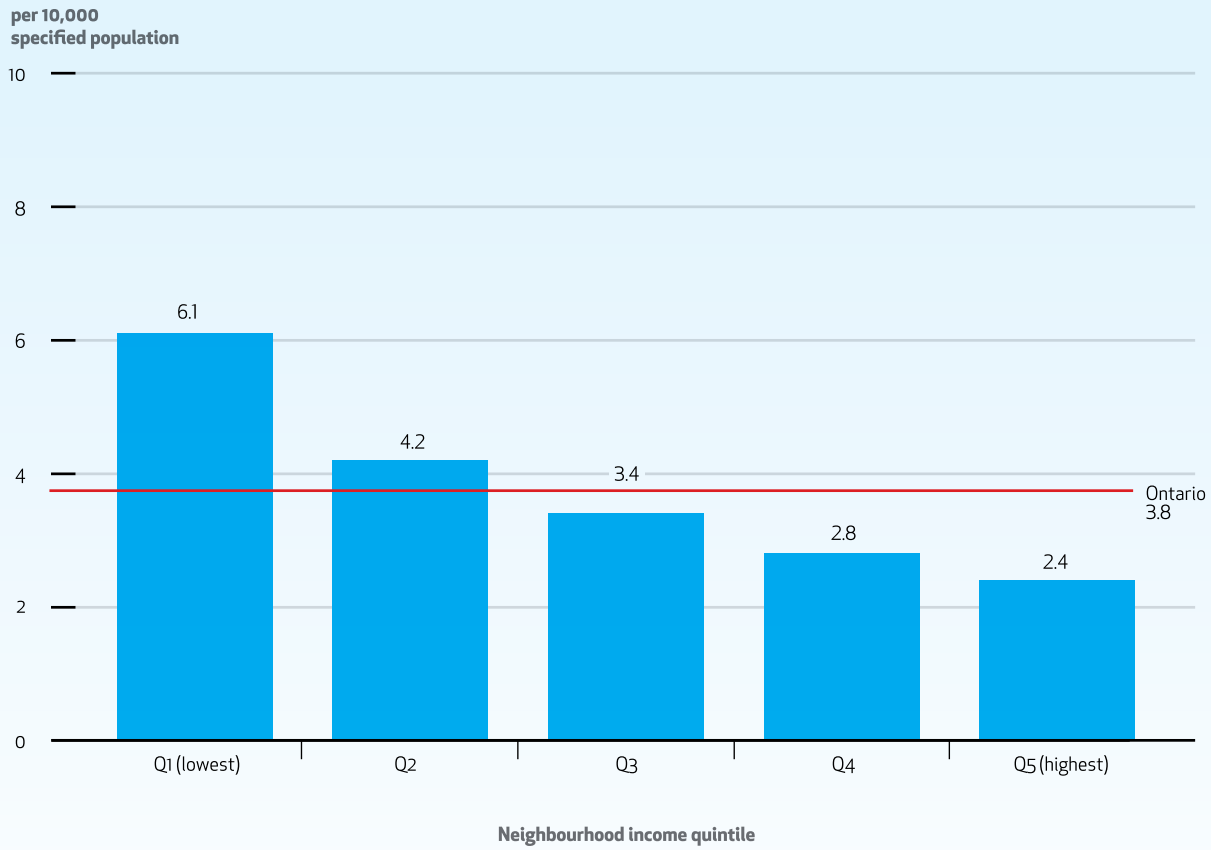


EXHIBIT 3.3.6 Number of individuals who received telepsychiatry consultations per 10,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average between 2010 and 2012, the rate of telepsychiatry consultations was highest among non-immigrants.

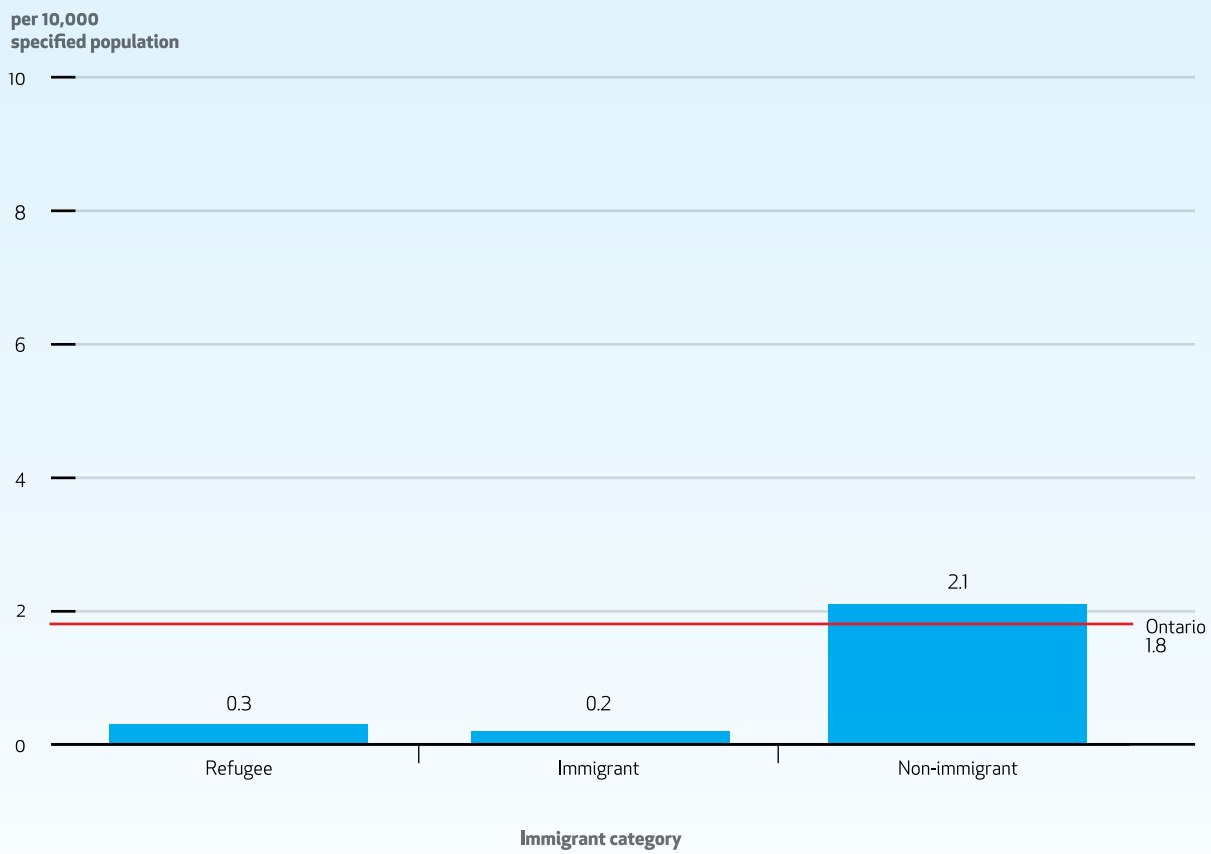


EXHIBIT 3.3.7 Number of individuals who received telepsychiatry consultations per 10,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the age- and sex-standardized rates at which Ontario adults received telepsychiatry consultations were highest among individuals living in the in the North West, North East, and North Simcoe Muskoka LHINs.

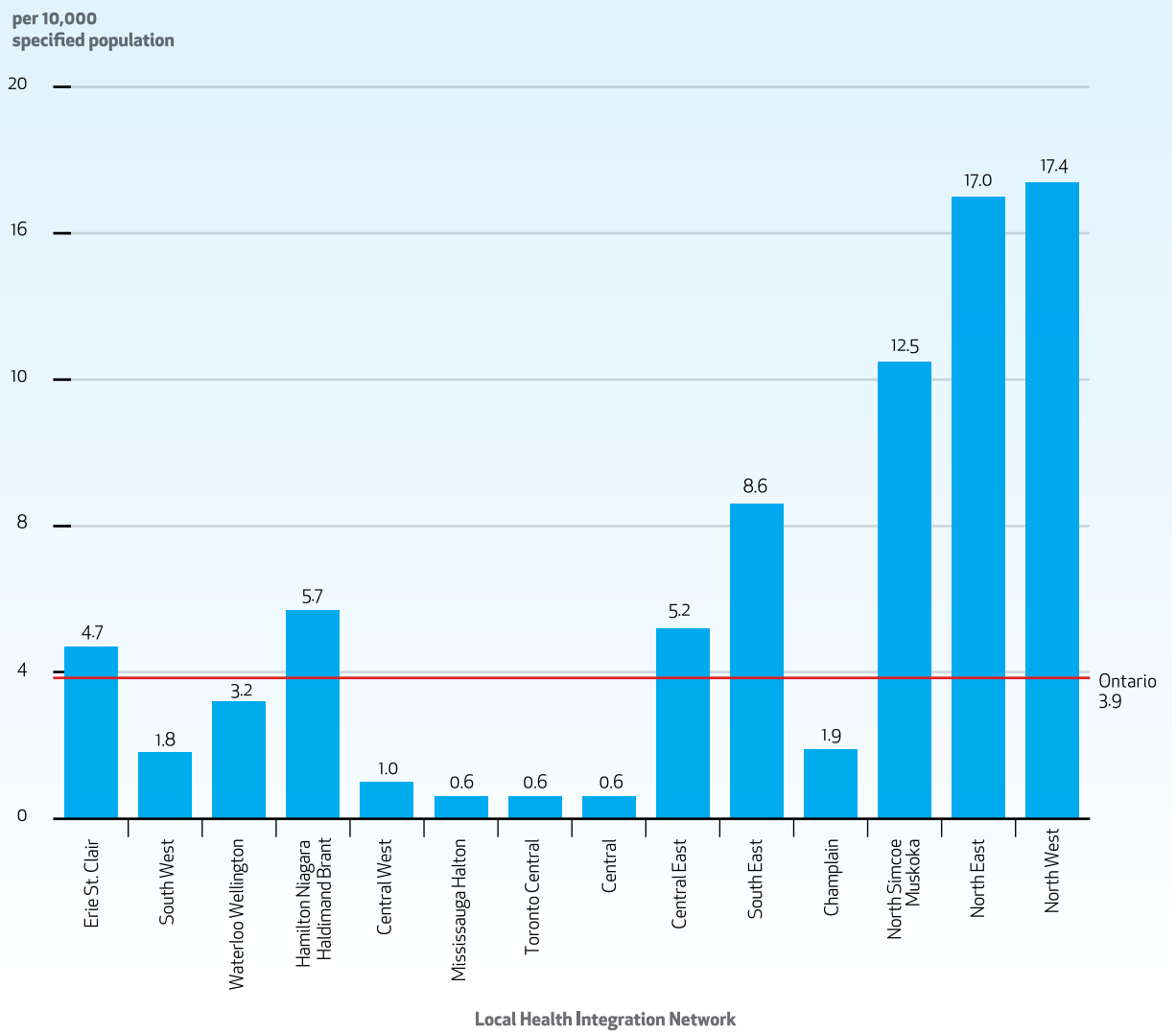


EXHIBIT 3.3.8 Number of individuals who received telepsychiatry consultations per 10,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the age- and sex-standardized rates at which Ontario adults received telepsychiatry consultations were highest among individuals living in the in the North West, North East, and North Simcoe Muskoka LHINs.

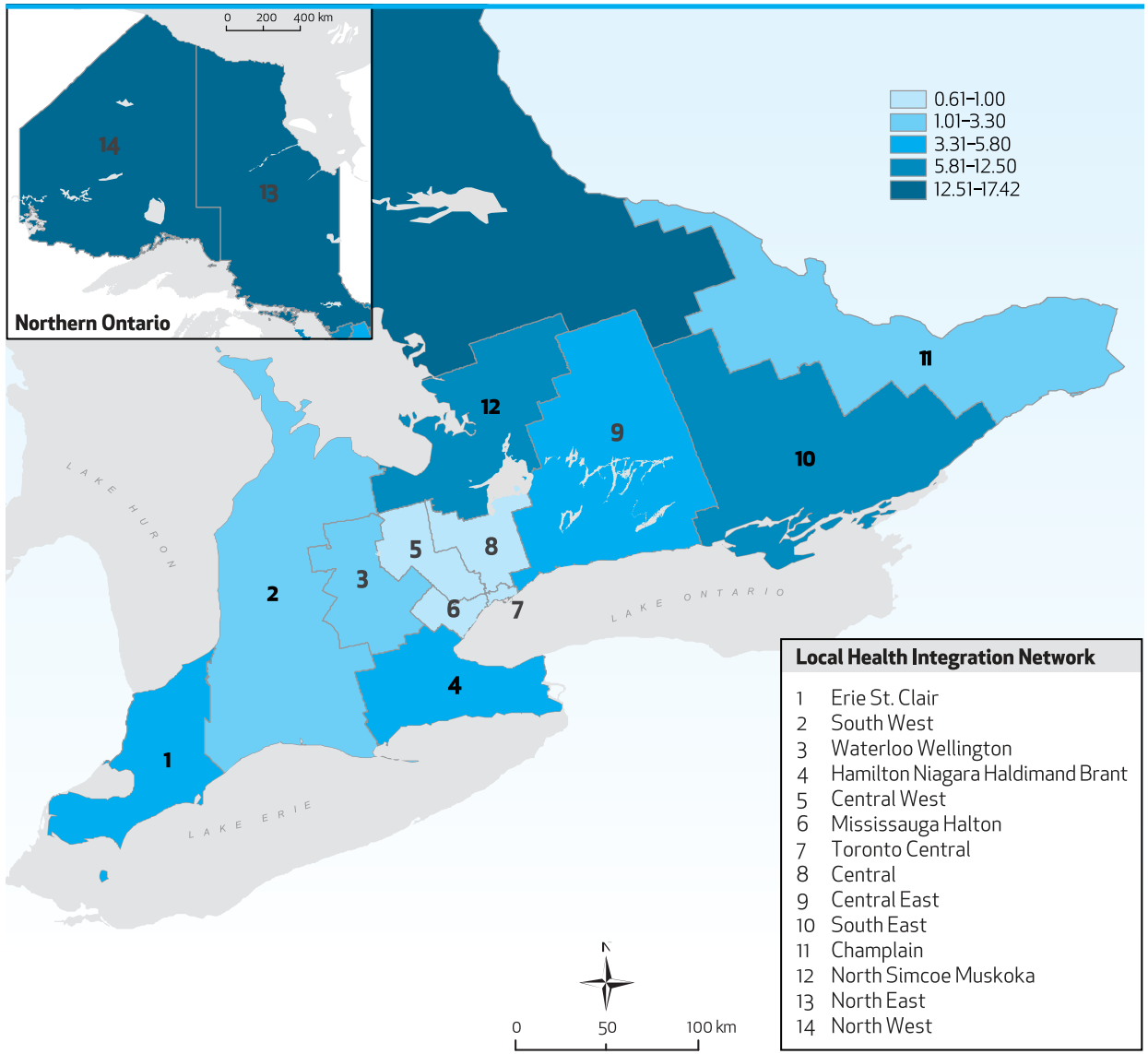
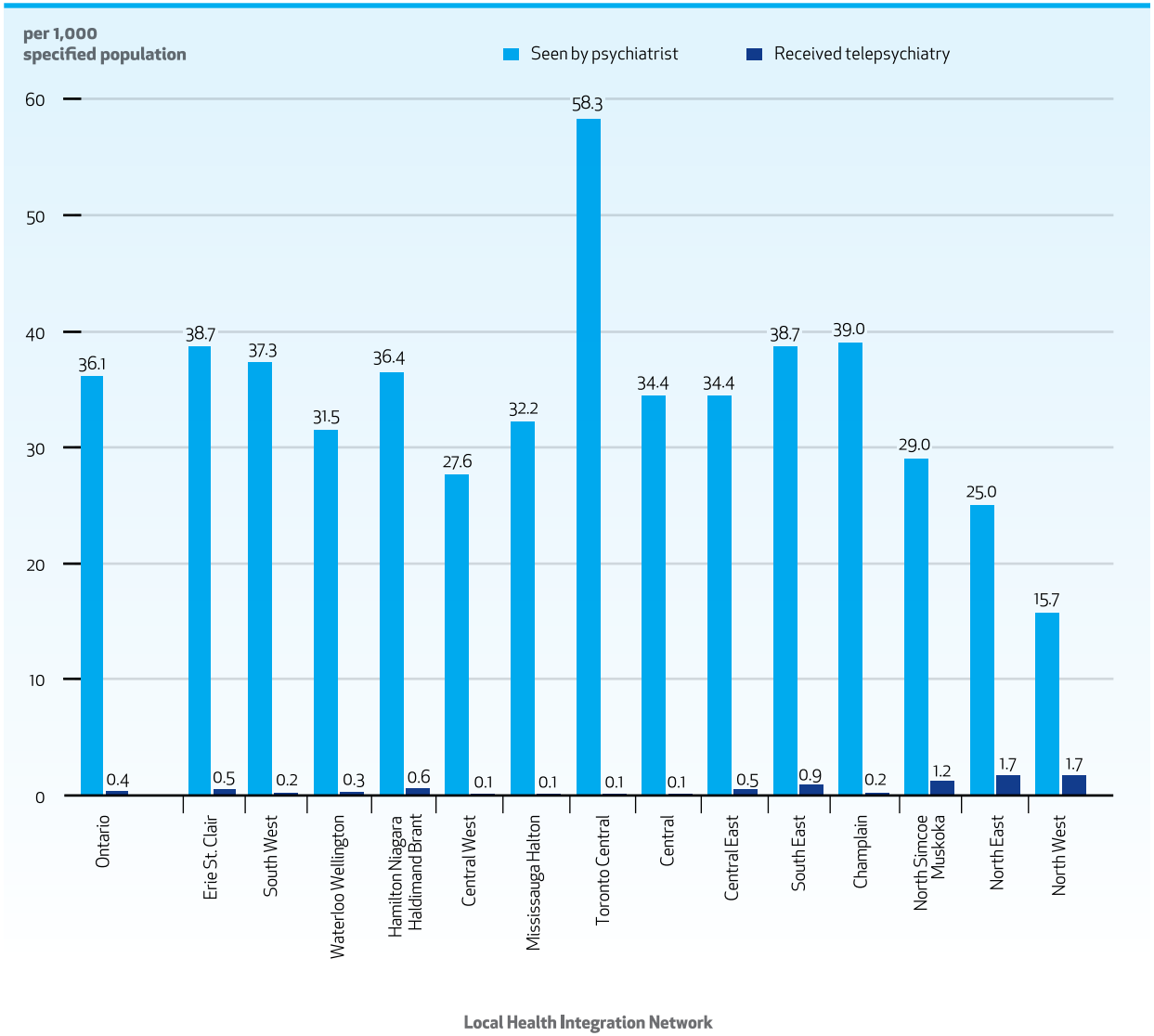


EXHIBIT 3.3.9 Number of individuals who were seen by a psychiatrist or received telepsychiatry consultations per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Findings

- Approximately one percent of Ontario adults being seen by a psychiatrist used a telepsychiatry service.
- On average between 2012 and 2014, the rate at which individuals were seen by a psychiatrist was highest in the Toronto Central LHIN and lowest in the North West LHIN. By contrast, the rate at which Ontario adults received telepsychiatry consultations was highest in the North West, North East and North Simcoe Muskoka LHINs and lowest in the Mississauga Halton, Toronto Central and Central LHINs.



3.4 Rate of mental health and addictions–related outpatient physician visits

Rationale

The use of physician services for mental health and addictions problems (currently the only outpatient service for which data are available) provides a measure of service needs. Knowledge of the rate of and trends for outpatient visits according to physician type may help in human resource planning.

Results

There was a slight decrease over time in the rate of MHA-related outpatient physician visits. The highest rates of outpatient visits were observed among women, non-immigrants and those living in lower-income neighbourhoods. Individuals aged 25 to 64 had the highest rate of outpatient physician visits for MHA care. The lowest rate of physician visits was observed among young adults aged 16 to 24, but this rate increased rapidly, particularly for visits to GP/FPs. Outpatient visits to GP/FPs for MHA care decreased among individuals aged 45 and over. The use of outpatient physician services for MHA care was highest in the Toronto Central LHIN, where GP/FP and psychiatrist visit rates were roughly equivalent. In all other LHINs, the GP/FP visit rate was higher. The lowest rate of GP/FP visits was observed in the Waterloo Wellington LHIN, and the lowest rate of psychiatrist visits was observed in the North West LHIN.

Interpretation

With the bulk of mental health and addictions care in outpatient physician settings being delivered by primary care providers, geographic variation suggests that the rate of outpatient visits was driven by physician availability rather than degree of need.

EXHIBIT 3.4.1 Number of outpatient physician visits for mental health and addictions care per 100 standard population aged 16 to 105 years, by physician specialty, in Ontario, 2006 to 2014

Key Finding

- Between 2006 and 2014, the rate of MHA-related physician visits decreased slightly; this was related to a decrease in the rate of visits to GP/FPs between 2006 and 2008.

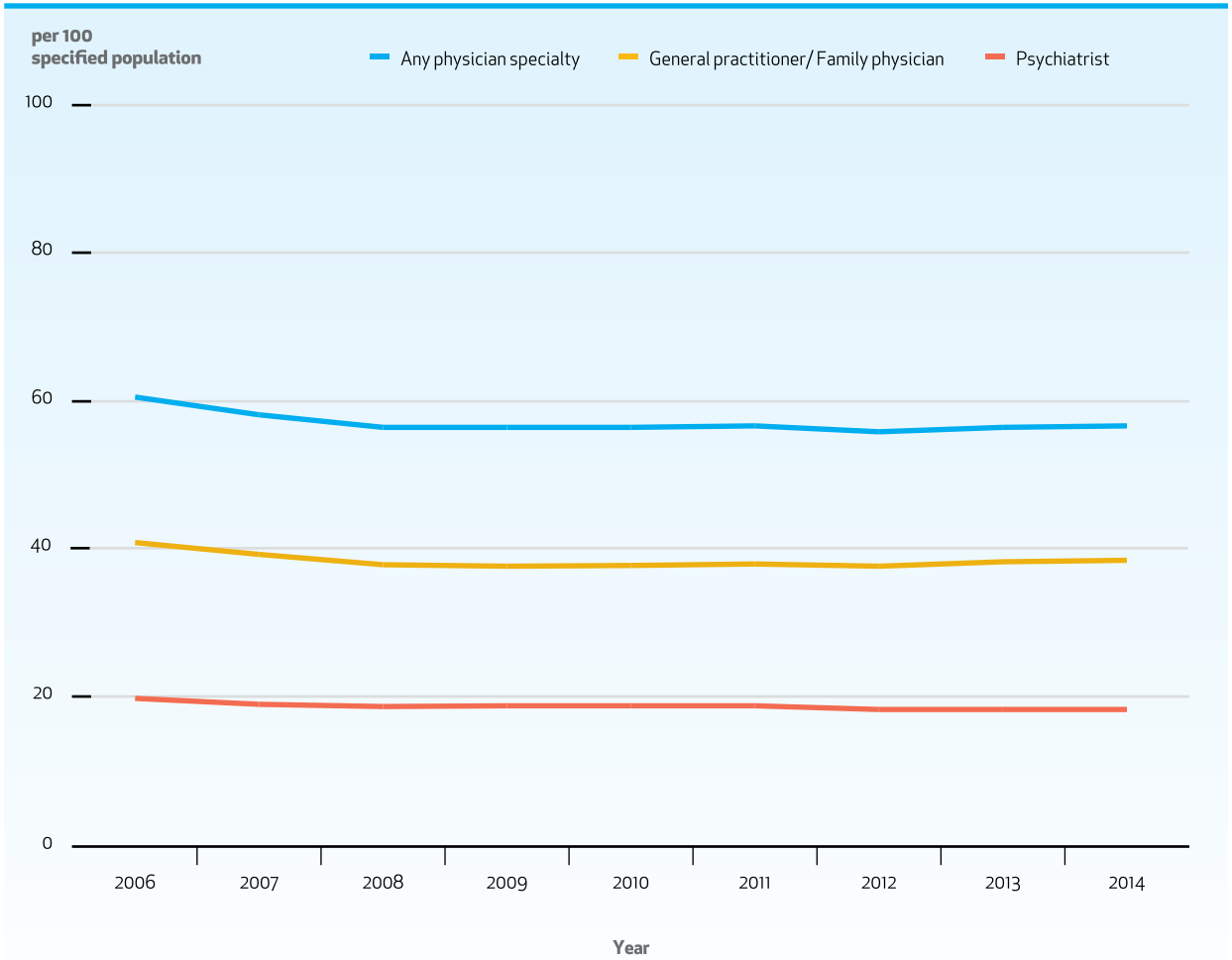


EXHIBIT 3.4.2 Number of outpatient physician visits for mental health and addictions care per 100 population aged 16 to 105 years, overall and by sex and physician specialty, in Ontario, 2006 to 2014

Key Finding

- The rate of MHA-related physician visits decreased slightly over time for all specialties. The decrease was mostly due to a drop in the rate of visits to GP/FPs by women. The rate of visits to psychiatrists was stable, both overall and for men and women.

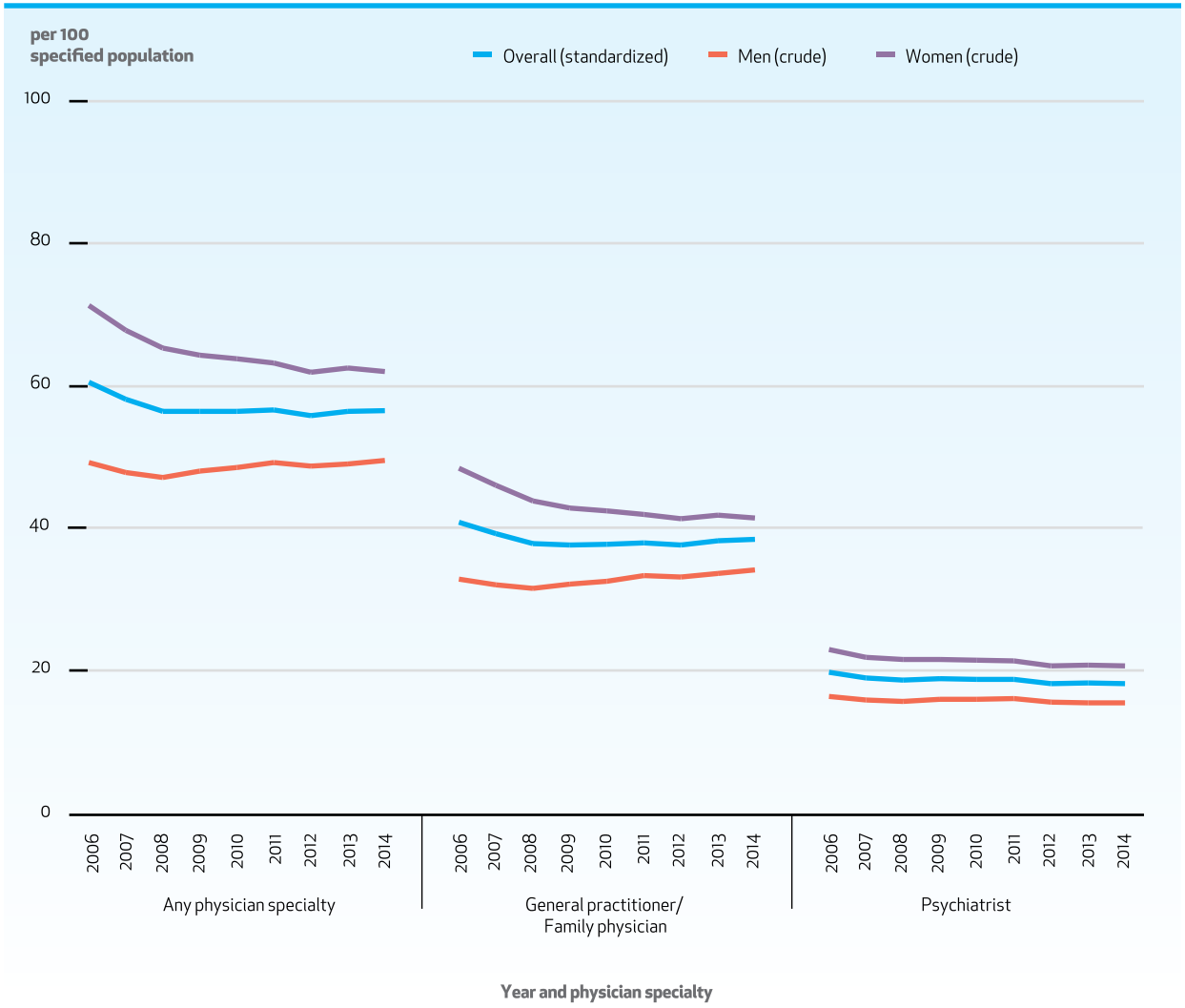


EXHIBIT 3.4.3 Number of outpatient physician visits for mental health and addictions care per 100 crude population aged 16 to 105 years, by age group and physician specialty, in Ontario, 2006 to 2014

Key Findings

- The rate of MHA-related visits to GP/FPs was higher among individuals aged 25 to 64. The rate decreased over time for most age groups, with the exception of individuals aged 16 to 44.
- The rate of visits to psychiatrists was highest among individuals aged 25 to 64, and this rate decreased over time. A trend was observed in the increased rate of psychiatrist visits among individuals aged 16 to 24.

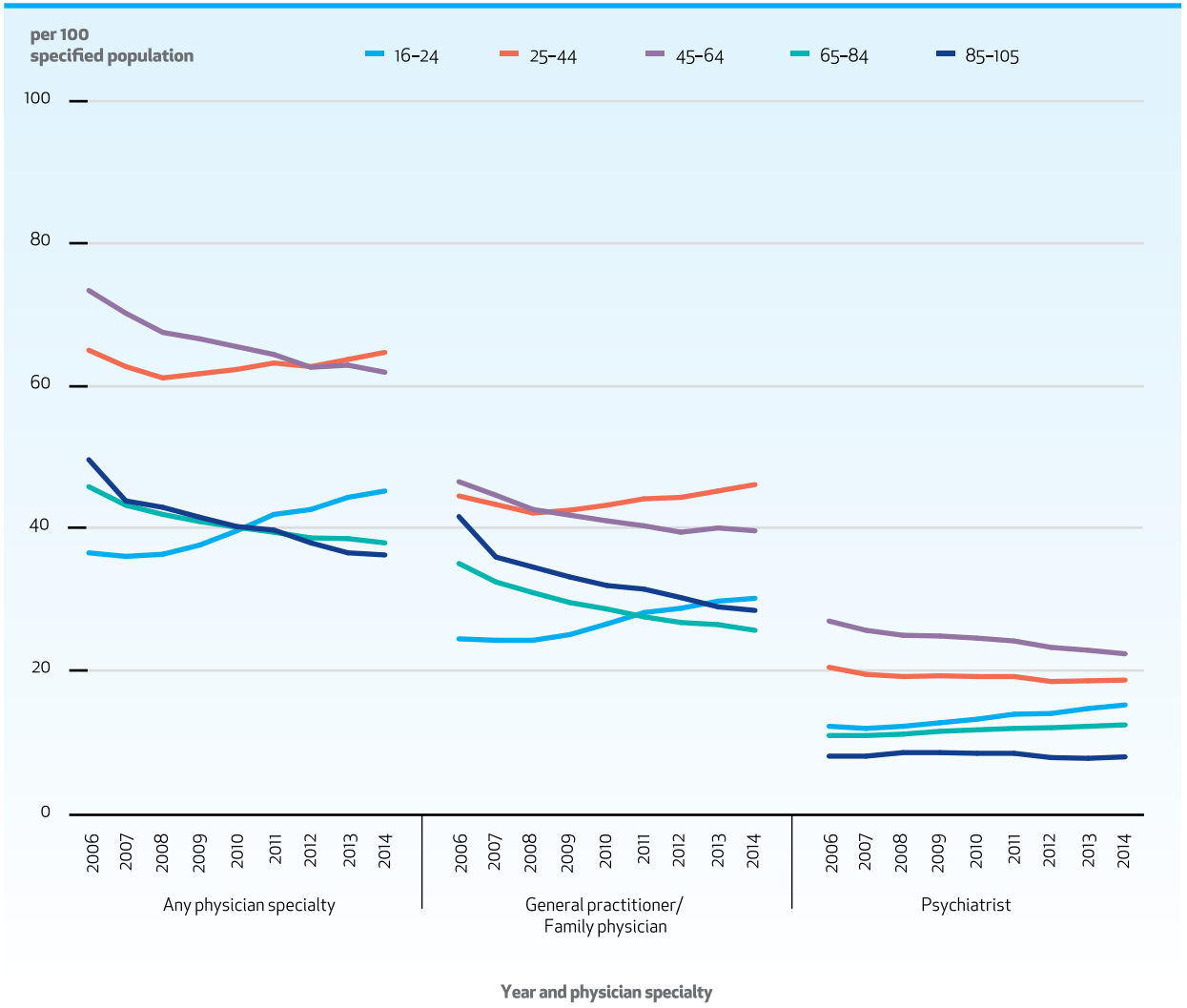


EXHIBIT 3.4.4 Number of outpatient physician visits for mental health and addictions care per 100 crude population aged 16 to 105 years, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average between 2012 and 2014, the rate of MHA-related outpatient visits for all physician specialties was higher among women.

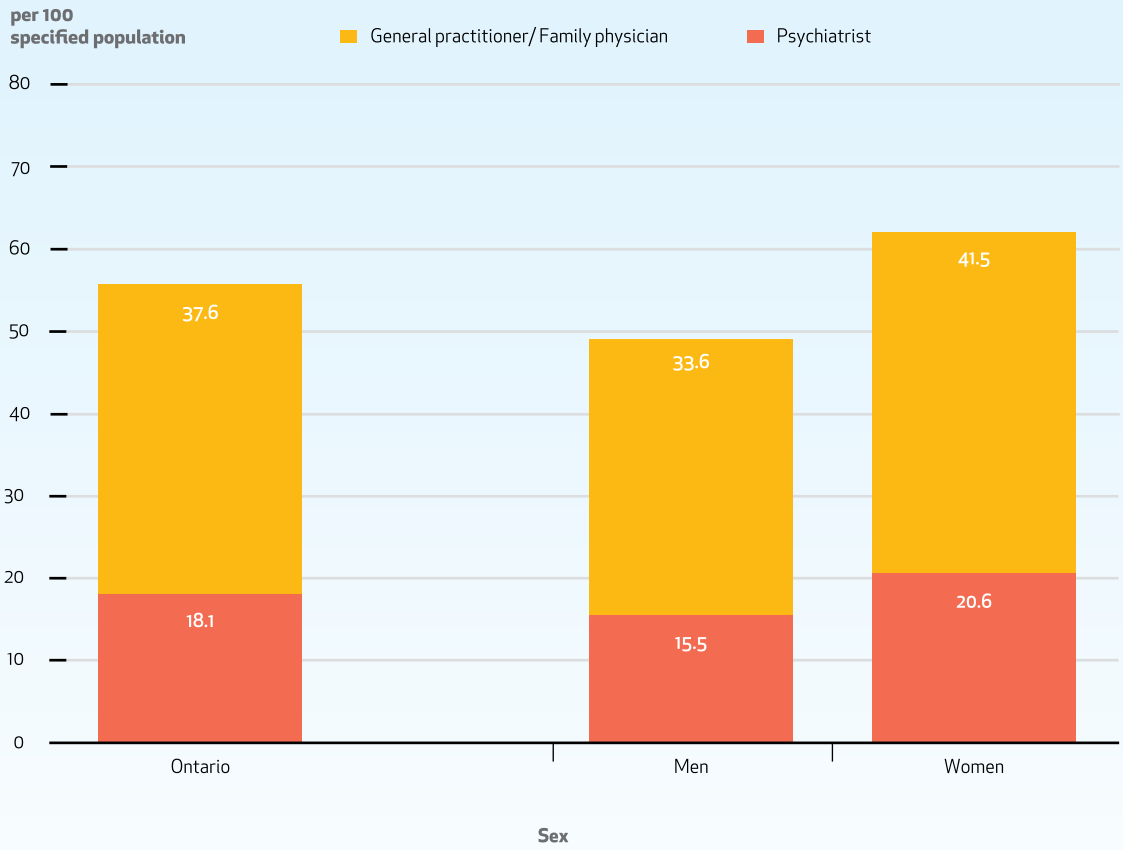


EXHIBIT 3.4.5 Number of outpatient physician visits for mental health and addictions care per 100 crude population aged 16 to 105 years, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Findings

- The rate of MHA-related outpatient visits to any physician specialty was highest among individuals aged 25 to 64.
- The rate of visits to GP/FPs was highest among individuals aged 25 to 44. The rate of visits to psychiatrists was highest among individuals aged 45 to 64.

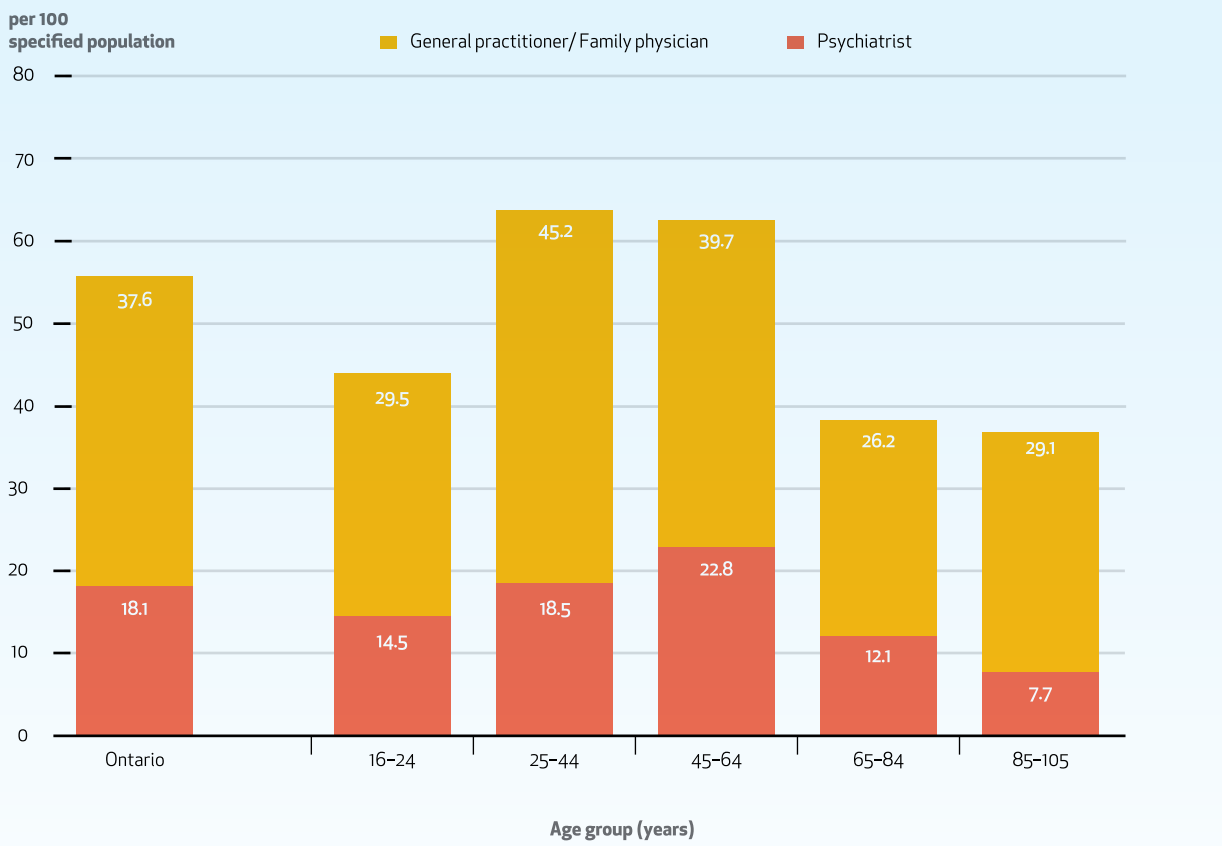


EXHIBIT 3.4.6 Number of outpatient physician visits for mental health and addictions care per 100 crude population aged 16 to 105 years, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of MHA-related outpatient visits to any physician specialty was highest among individuals living in the poorest neighbourhoods.

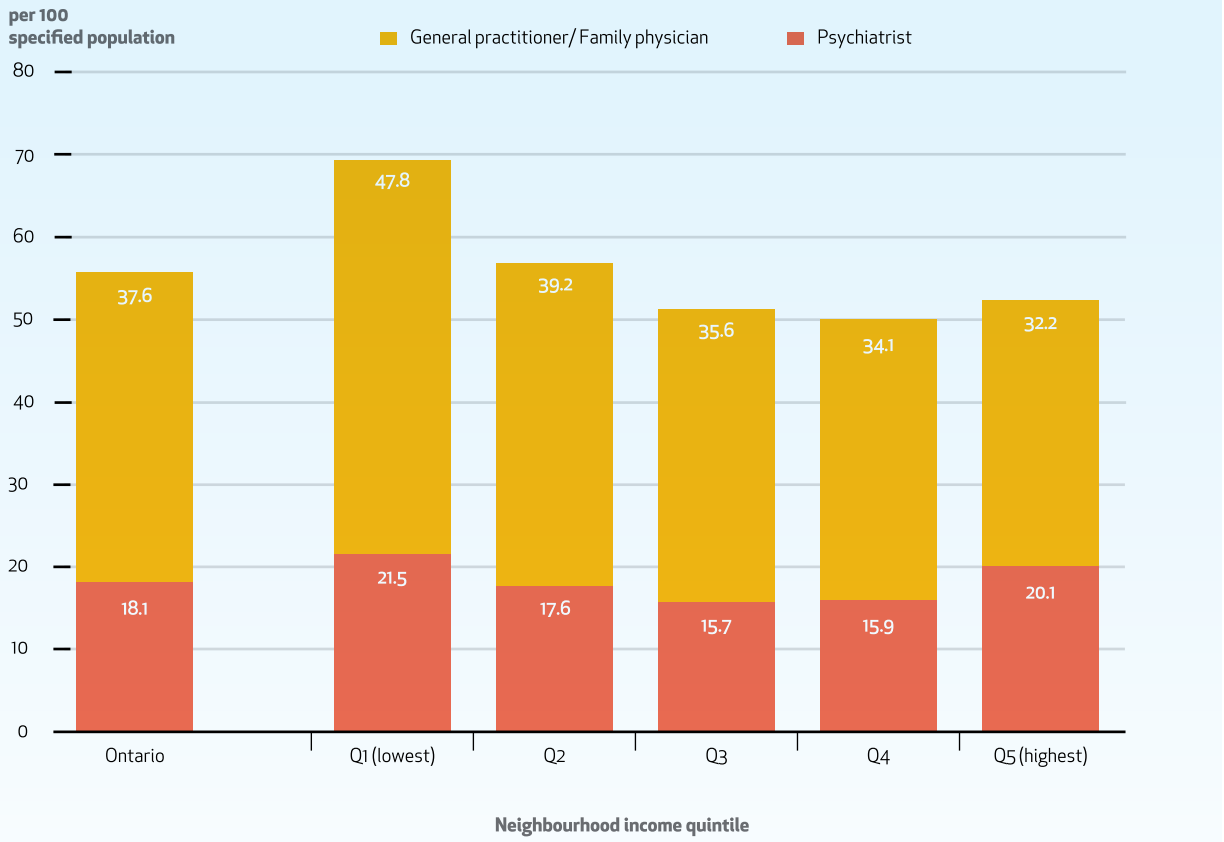


EXHIBIT 3.4.7 Number of outpatient physician visits for mental health and addictions care per 100 crude population aged 16 to 105 years, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

Key Finding

- On average between 2010 and 2012, the rate of MHA-related outpatient visits to any physician specialty was highest among non-immigrants and refugees.

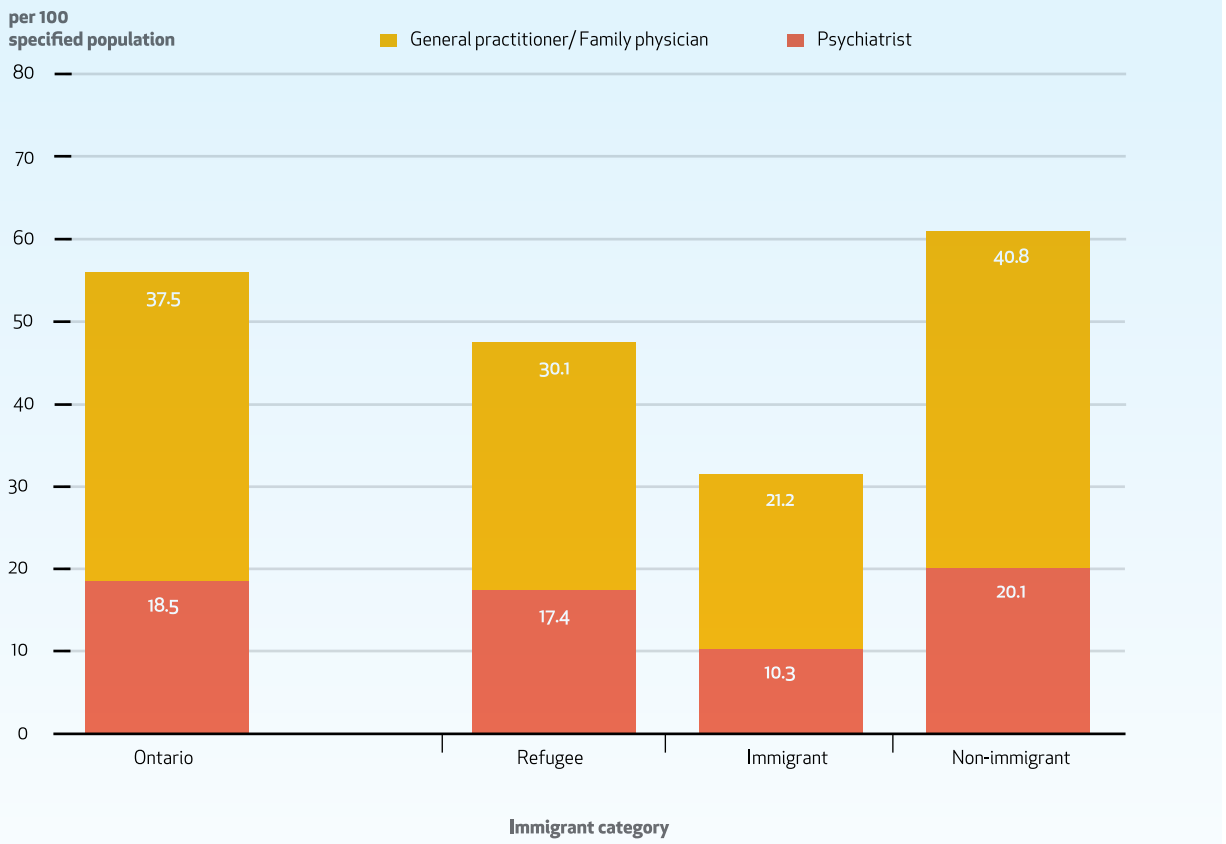


EXHIBIT 3.4.8 Number of outpatient physician visits for mental health and addictions care per 100 standard population aged 16 to 105 years, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, the age- and sex-standardized rate of MHA-related outpatient physician visits was highest in the Toronto Central LHIN, where rates of visits to GP/FPs and psychiatrists were roughly equivalent. In all other LHINs, the rate of visits to GP/FPs was higher. The lowest rate of GP/FP visits was in the Waterloo Wellington LHIN, and the lowest rate of psychiatrist visits was in the North West LHIN.

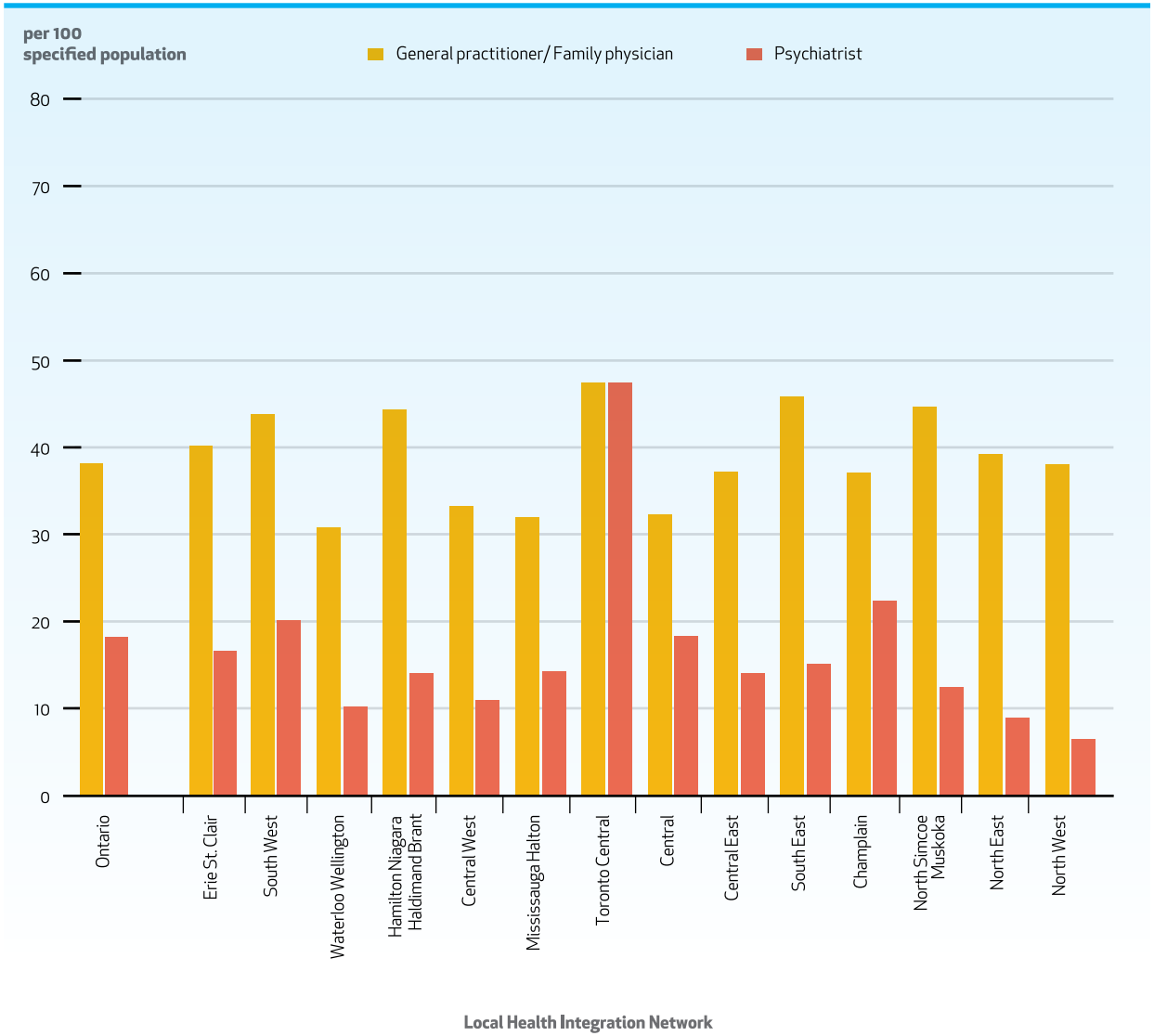


EXHIBIT 3.4.9 Number of outpatient visits to any physician specialty for mental health and addictions care per 100 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of MHA-related outpatient visits to any physician specialty was highest in the Toronto Central LHIN and lowest in the Waterloo Wellington LHIN.

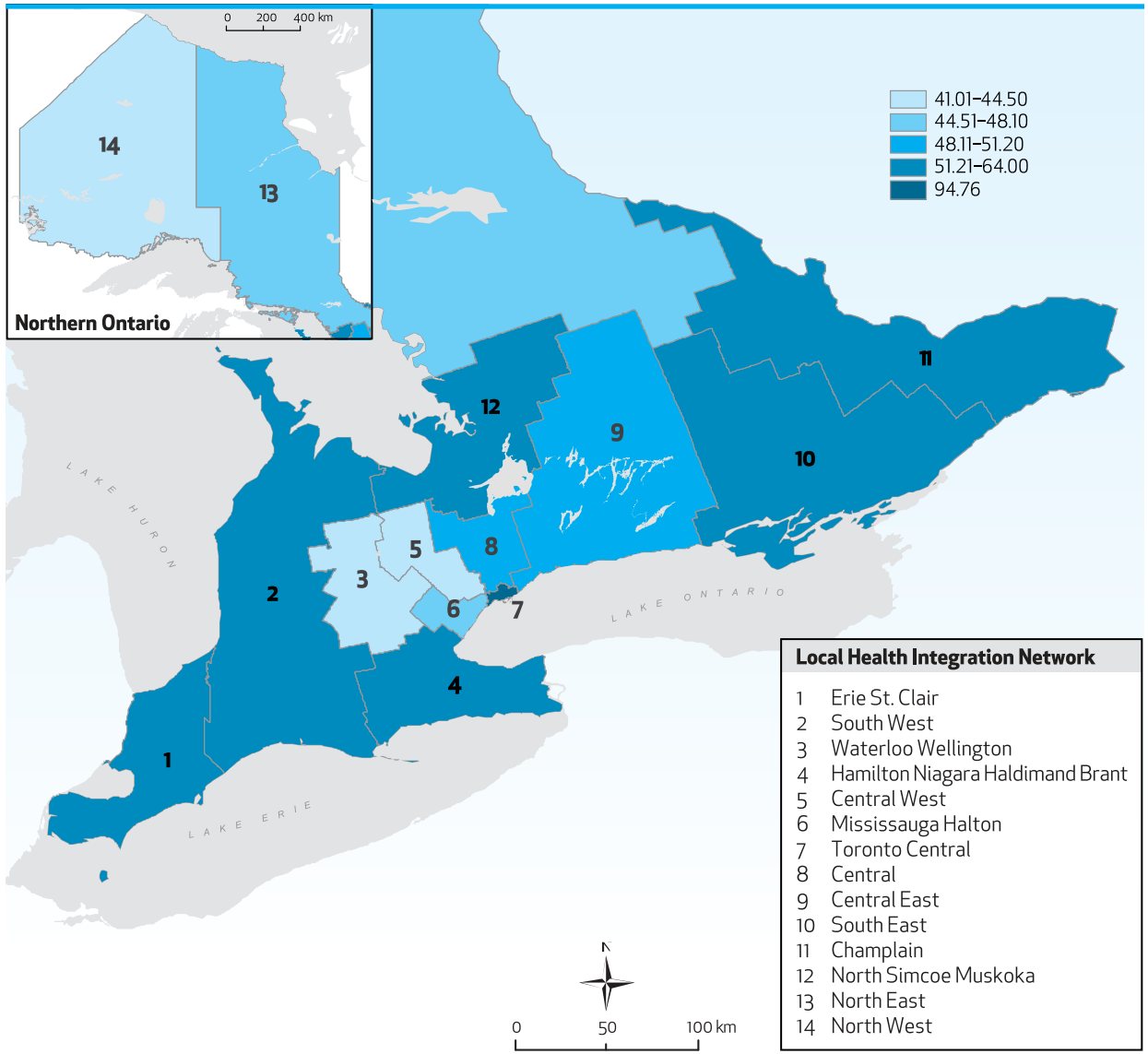


EXHIBIT 3.4.10 Number of outpatient visits to a general practitioner/family physician for mental health and addictions care per 100 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of MHA-related outpatient visits to GP/FPs was highest in the Toronto Central LHIN and lowest in the Waterloo Wellington LHIN.

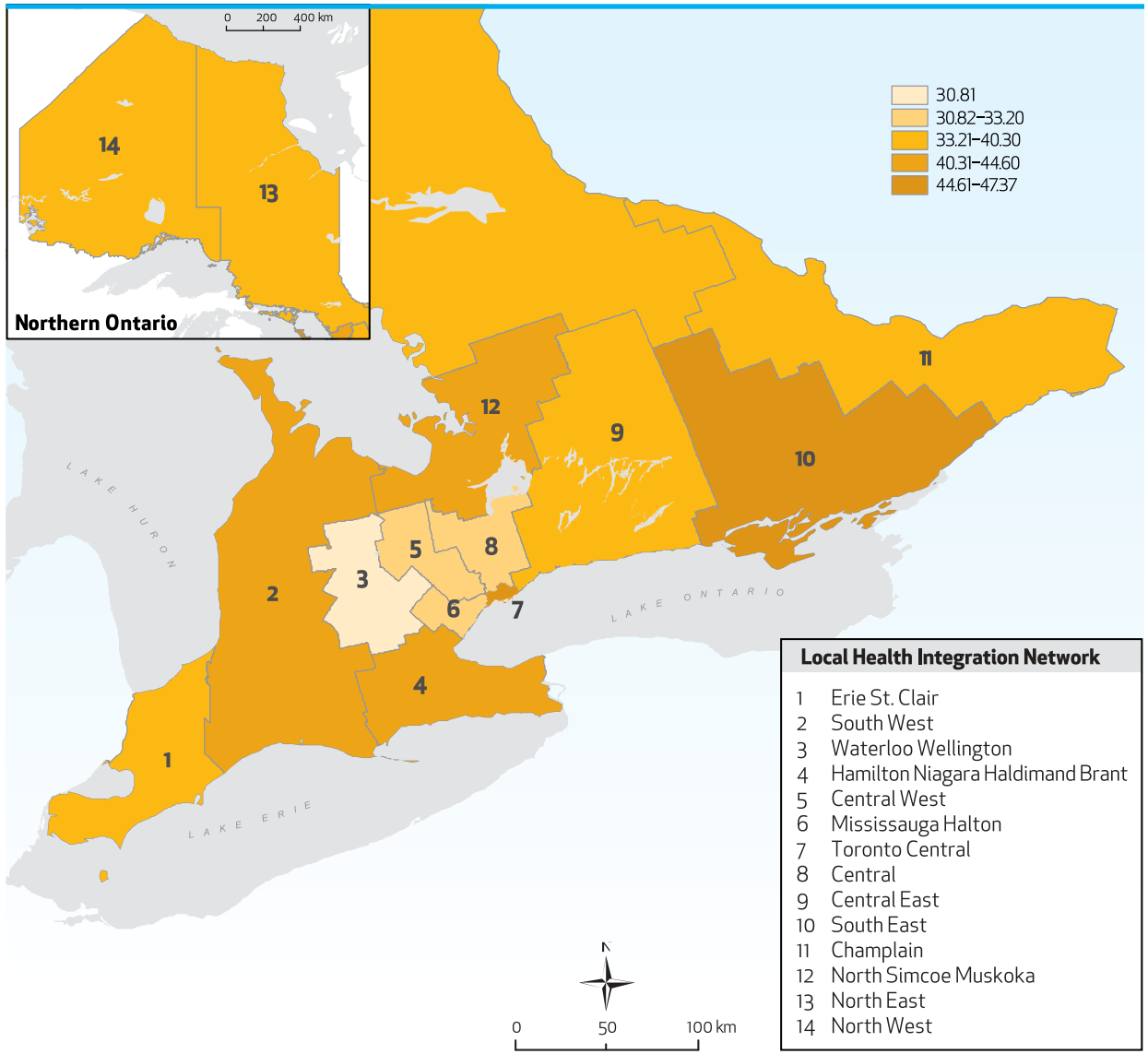
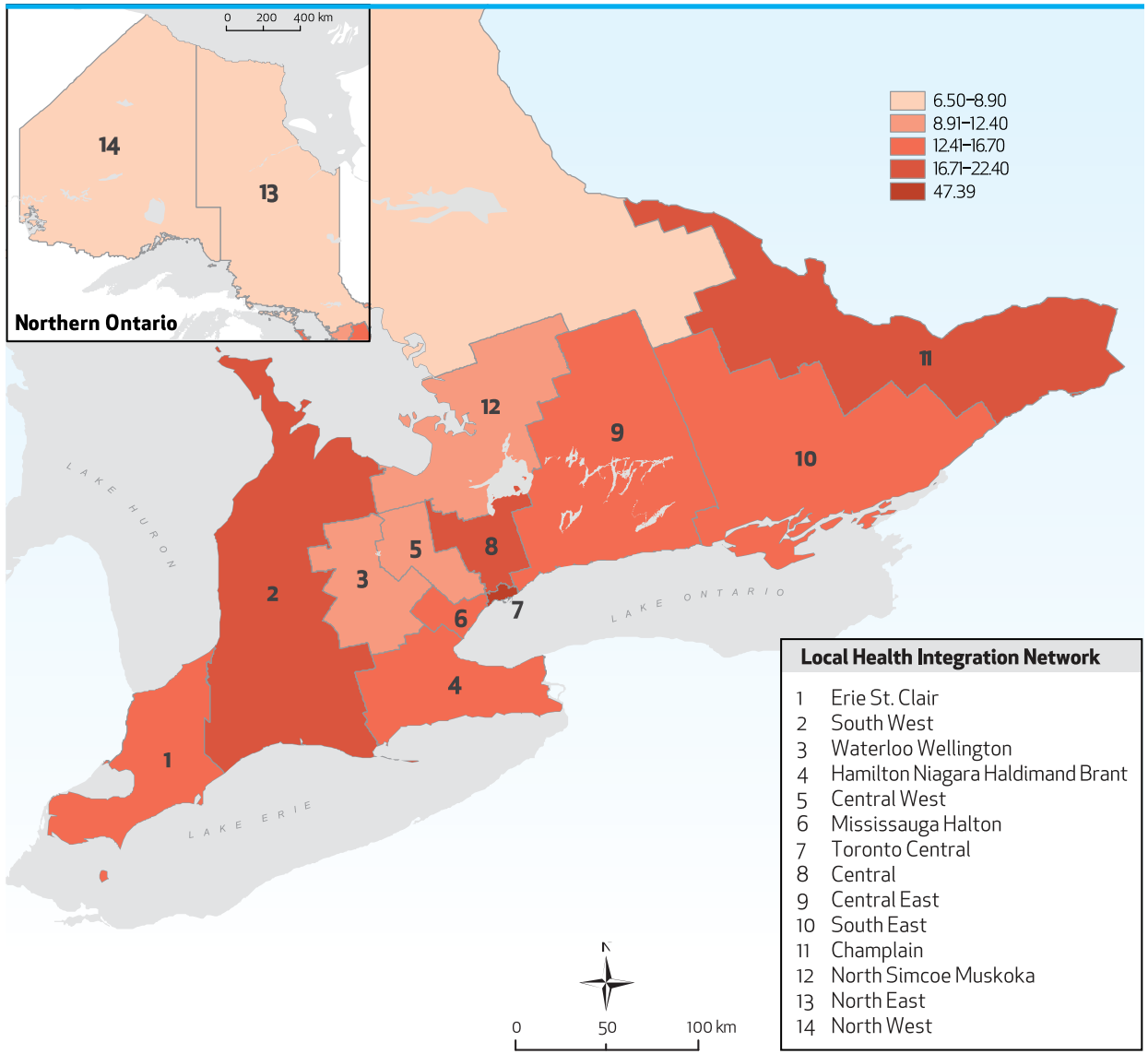


EXHIBIT 3.4.11 Number of outpatient visits to a psychiatrist per 100 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The age- and sex-standardized rate of MHA-related outpatient visits to psychiatrists was highest in the Toronto Central LHIN and lowest in the North West LHIN.



3.5 Length of stay for psychiatric hospitalizations

Rationale

The length of psychiatric hospitalizations can be affected by illness severity at admission, discharge planning and other care processes at the hospital, and by the availability of resources to support discharge in the community. Along with patterns of hospitalization prevalence, trends in lengths of stay could reflect the efficiency of the mental health and addictions care system.

Results

The median length of stay for psychiatric hospitalizations among all adults remained stable at approximately eight days from 2006 to 2014 but was longest among those aged 65 years and older. Across the major mental health and addictions diagnostic groups, median hospital lengths of stay ranged from 2 days for deliberate self-harm without a psychiatric diagnosis to 14 days for schizophrenia. Furthermore, a slight decline in hospital length of stay was seen for schizophrenia, mood disorders, anxiety disorders, and substance-related disorders, where the median length of stay decreased by about 2 to 3 days.

Median length of stay did not vary by neighbourhood income or by immigrant category. However, geographic variation was seen, with the longest stays observed in the Erie St. Clair LHIN and the shortest in the North West LHIN.

Interpretation

The median number of days in hospital for mental health and addictions care has remained stable over time among adults in Ontario. However, it appears that the length of stay related to some conditions, such as schizophrenia, may be decreasing. Long lengths of stay in older adults may be related to their more complex health needs or the availability of appropriate community resources to support discharge. Geographically, the shortest lengths of stay were found in the North East and North West LHINs, which had the highest overall hospitalization rates.

EXHIBIT 3.5.1 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- From 2006 to 2014, the median length of stay for a psychiatric hospitalization remained relatively stable at about 8 days, with no difference observed between men and women.

EXHIBIT 3.5.2 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by age group, in Ontario, 2006 to 2014

Key Finding

- The median length of stay for psychiatric hospitalizations was highest among adults aged 65 and older, and this decreased over time. For the other age groups, the median length of stay remained stable.

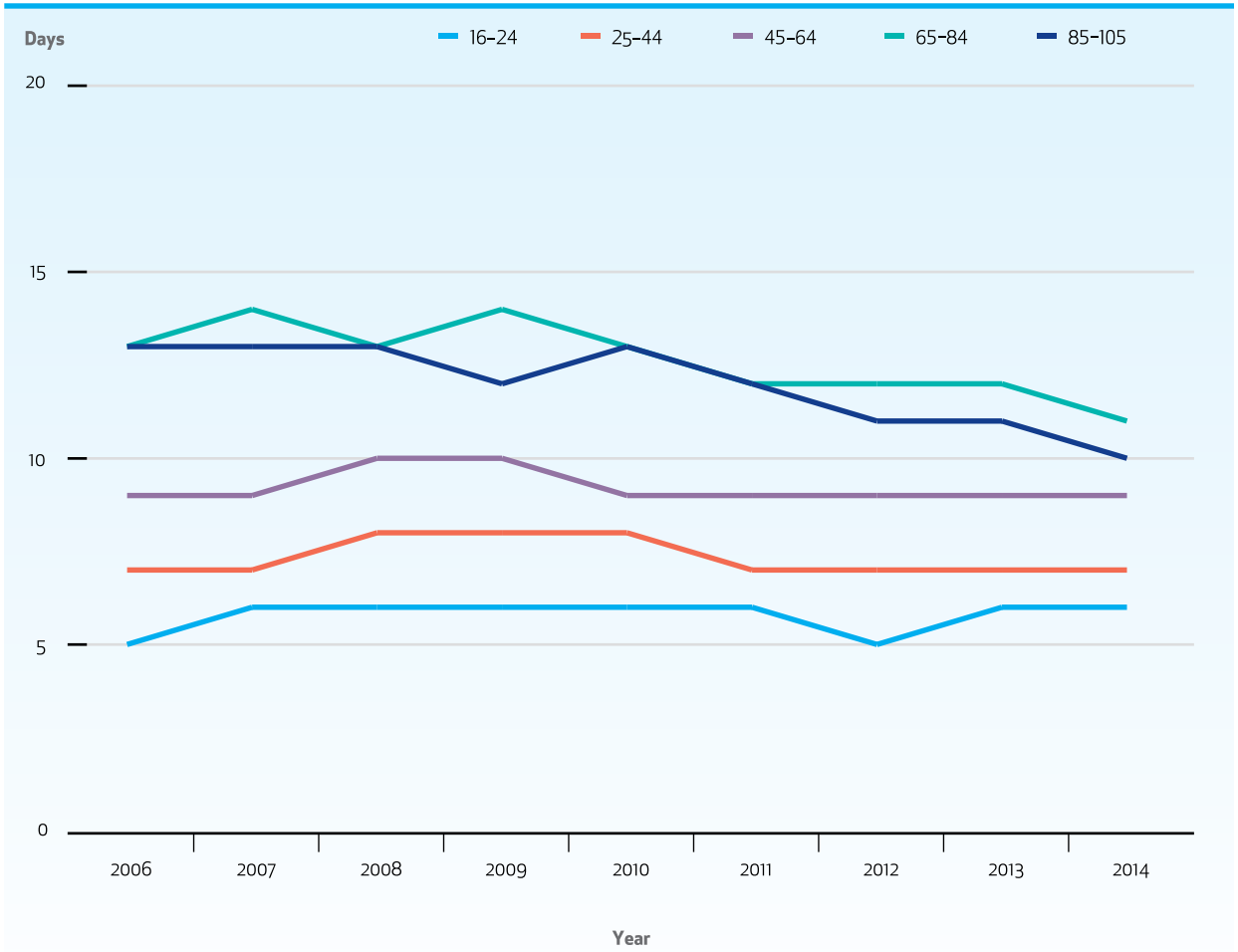


EXHIBIT 3.5.3 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by type of disorder, in Ontario, 2006 to 2014

Key Finding

- The longest lengths of stay for psychiatric hospitalizations were found among those with schizophrenia and mood disorders. In general, there was a decrease in the median number of days in hospital for most diagnostic groups.

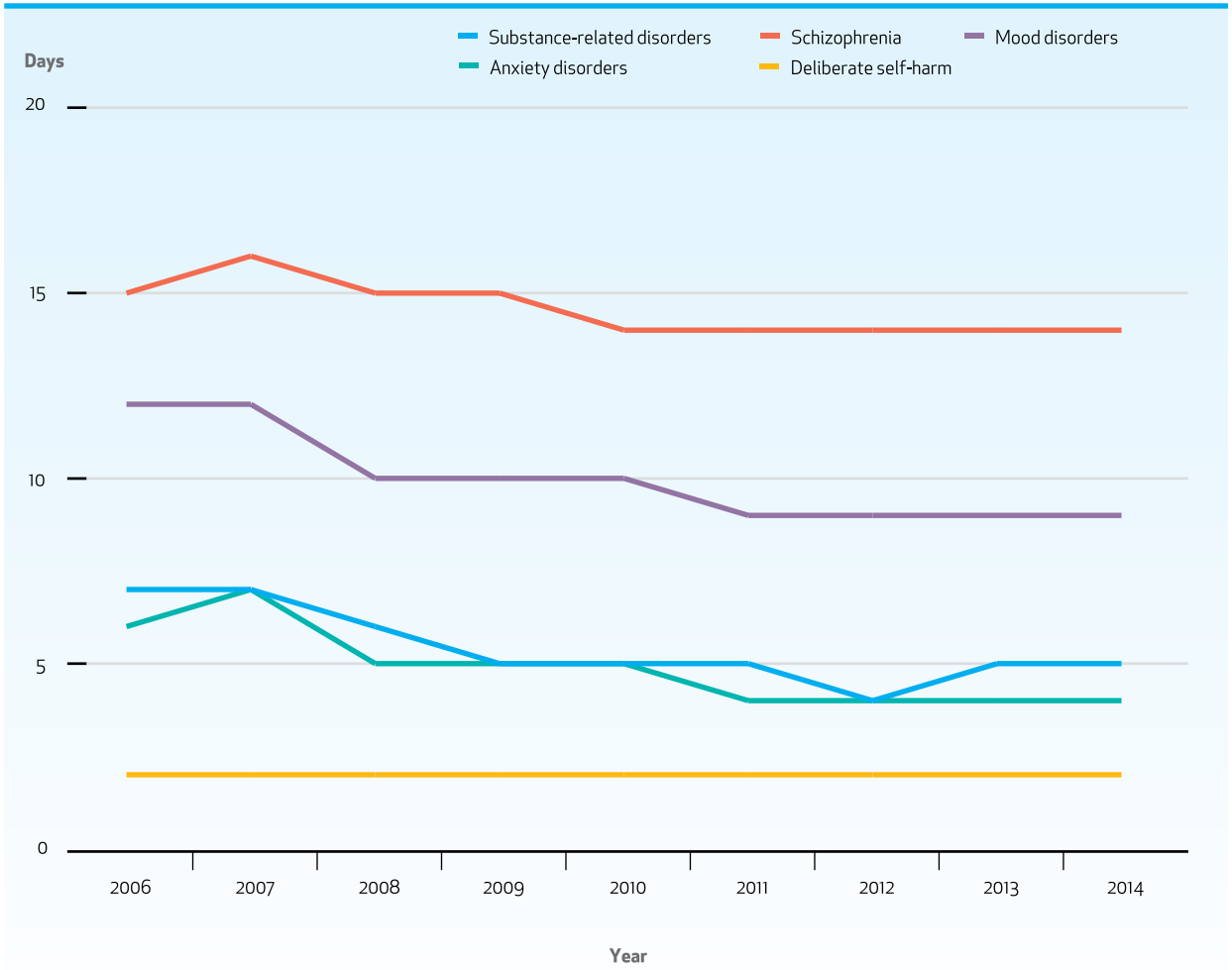


EXHIBIT 3.5.4 Length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by 25th, 50th and 75th percentile, in Ontario, 2006 to 2014

Key Finding

- The length of stay for psychiatric hospitalizations ranged from 3 days (25th percentile) to approximately 20 days (75th percentile), with a median length of stay of 8 days.

EXHIBIT 3.5.5 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average, between 2012 and 2014, there was no difference between men and women in the median number of days they were hospitalized for mental health and addictions care.

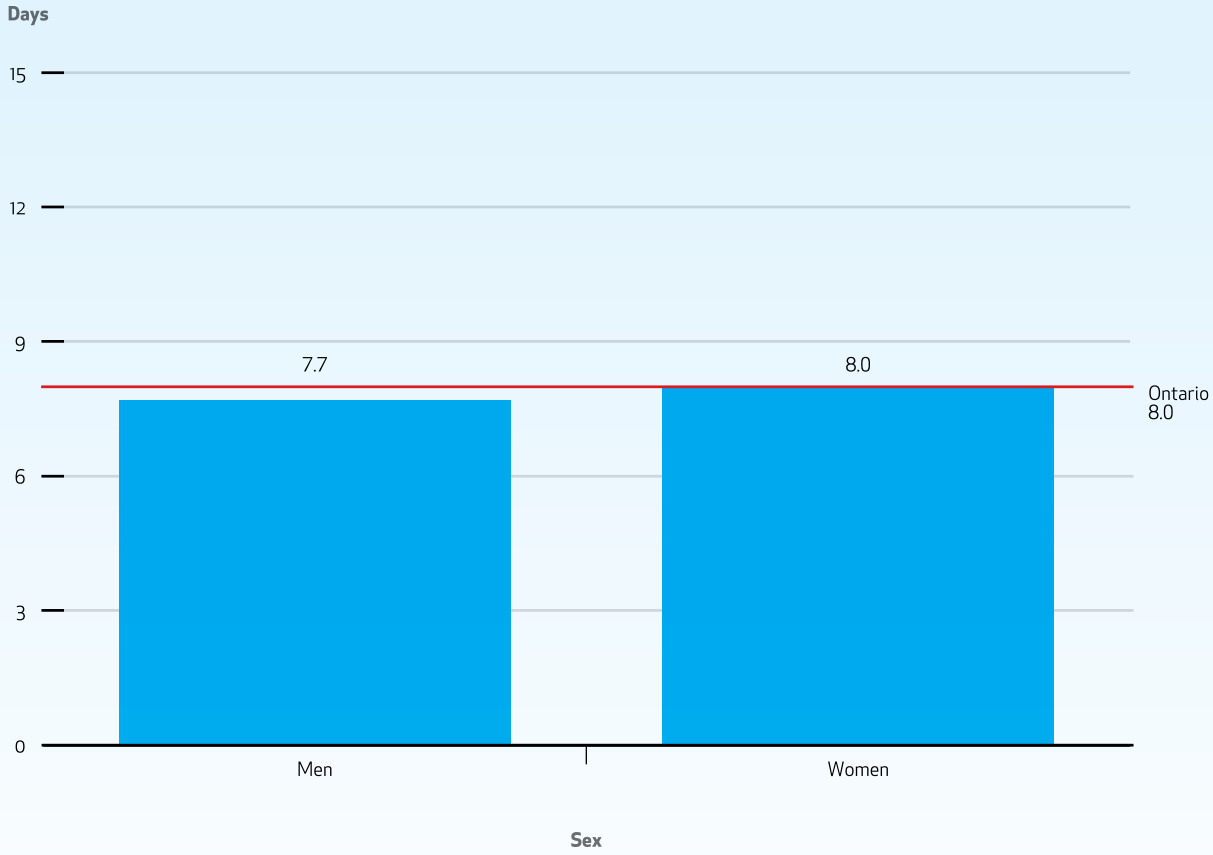


EXHIBIT 3.5.6 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The median length of stay for psychiatric hospitalizations was longest for older adults, specifically those aged 65 to 84, and shortest for individuals aged 16 to 24.

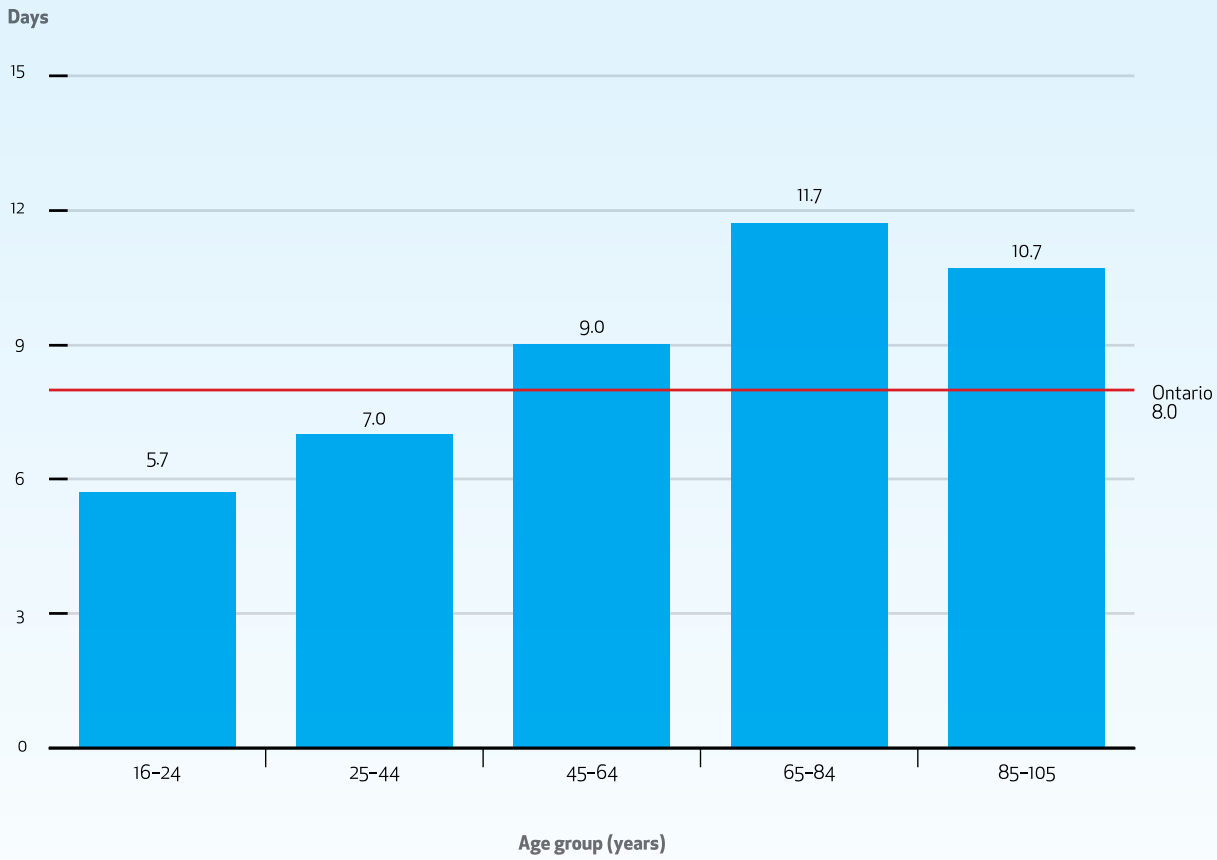


EXHIBIT 3.5.7 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

Key Finding

- The longest median length of stay for psychiatric hospitalizations was observed among individuals with schizophrenia. They exhibited a median length of stay that was between 5 and 12 days longer than hospitalizations for other diagnostic groups.

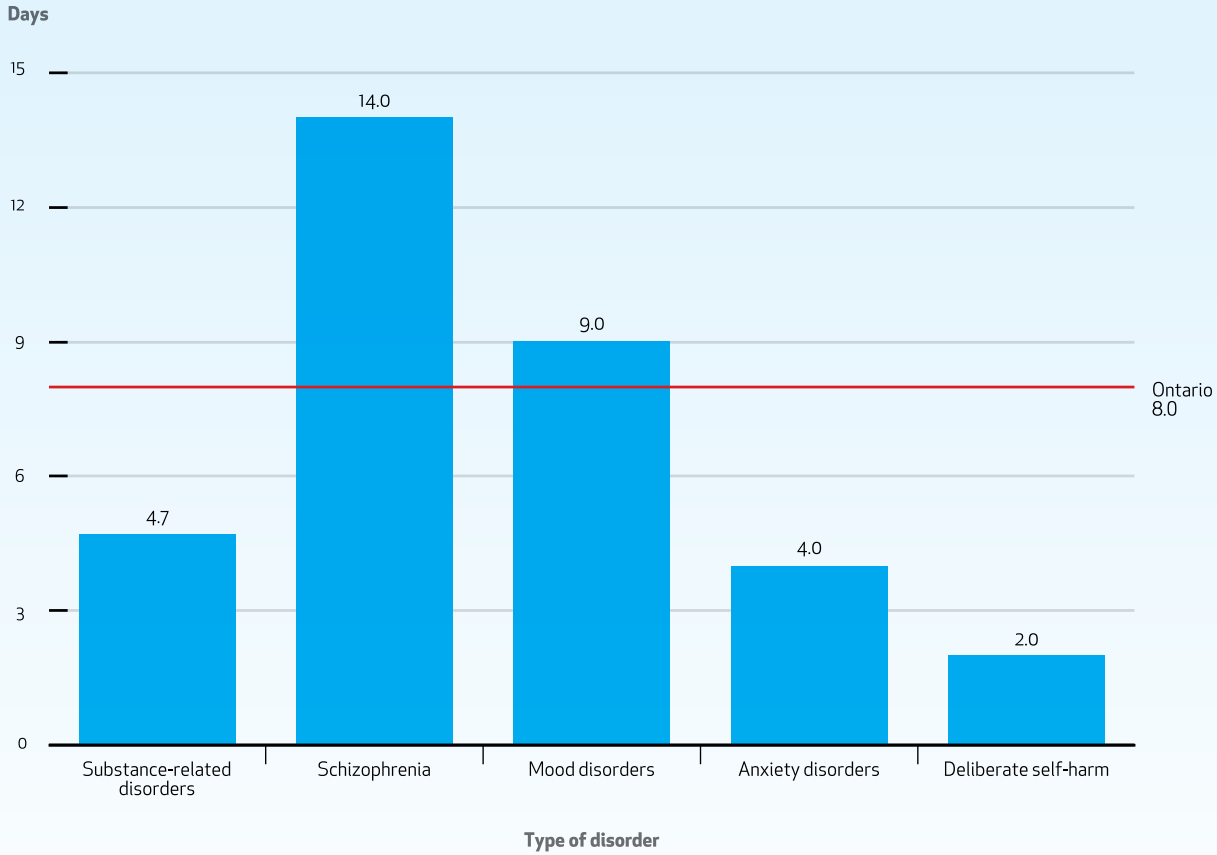


EXHIBIT 3.5.8 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The median length of stay in hospital for a psychiatric disorder did not vary by the neighbourhood income level of the patient.

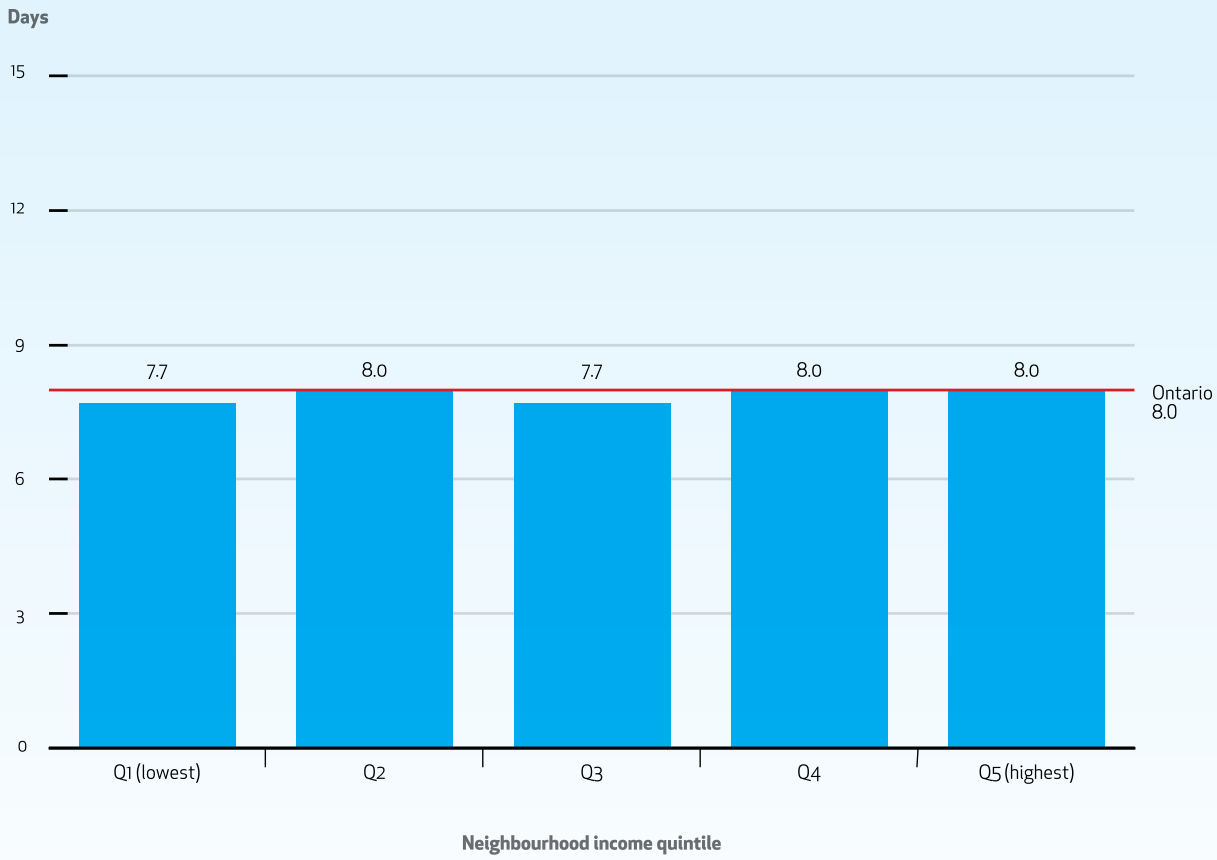


EXHIBIT 3.5.9 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- There was no difference among immigrant categories in the median number of days spent in hospital for a psychiatric condition.

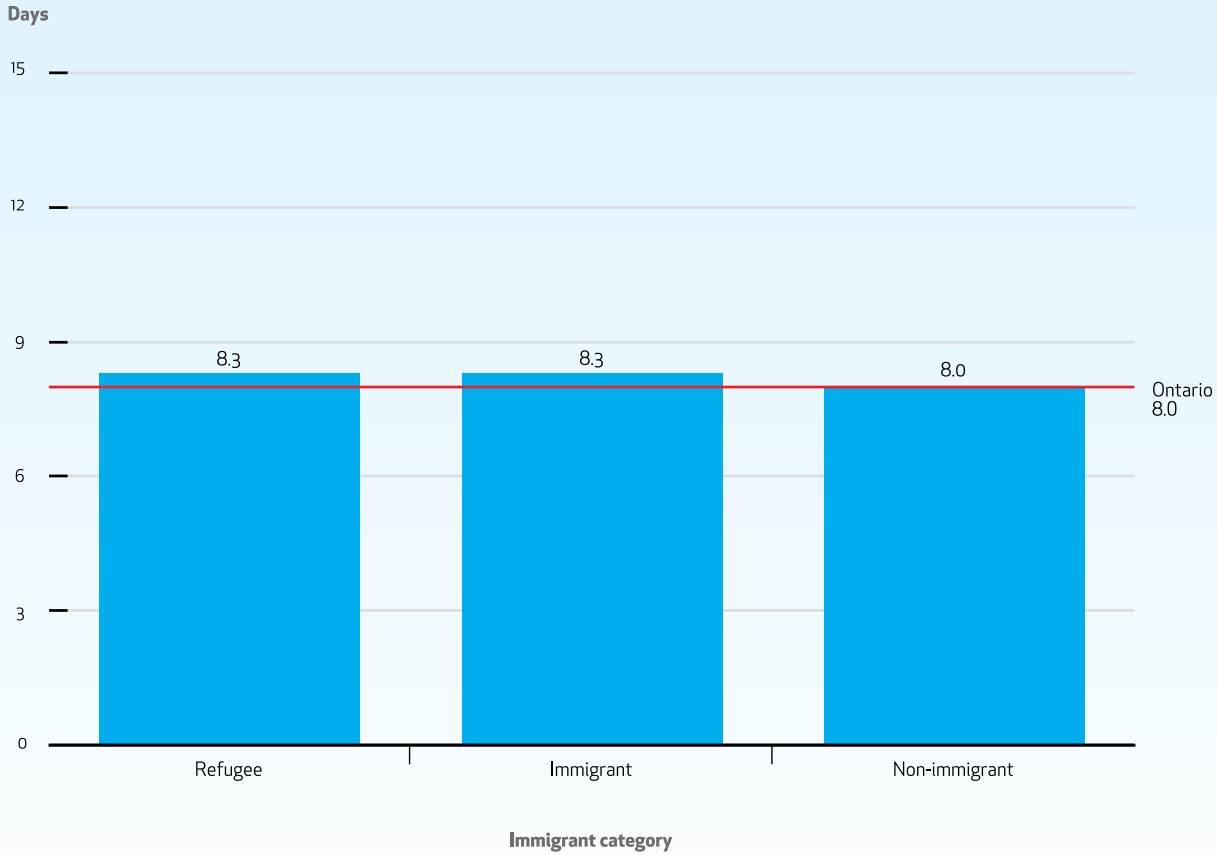


EXHIBIT 3.5.10 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The median length of stay for psychiatric hospitalizations varied across LHINs, with the longest stay reported in the Erie St. Clair LHIN and the shortest in the northern LHINs, particularly the North West LHIN.

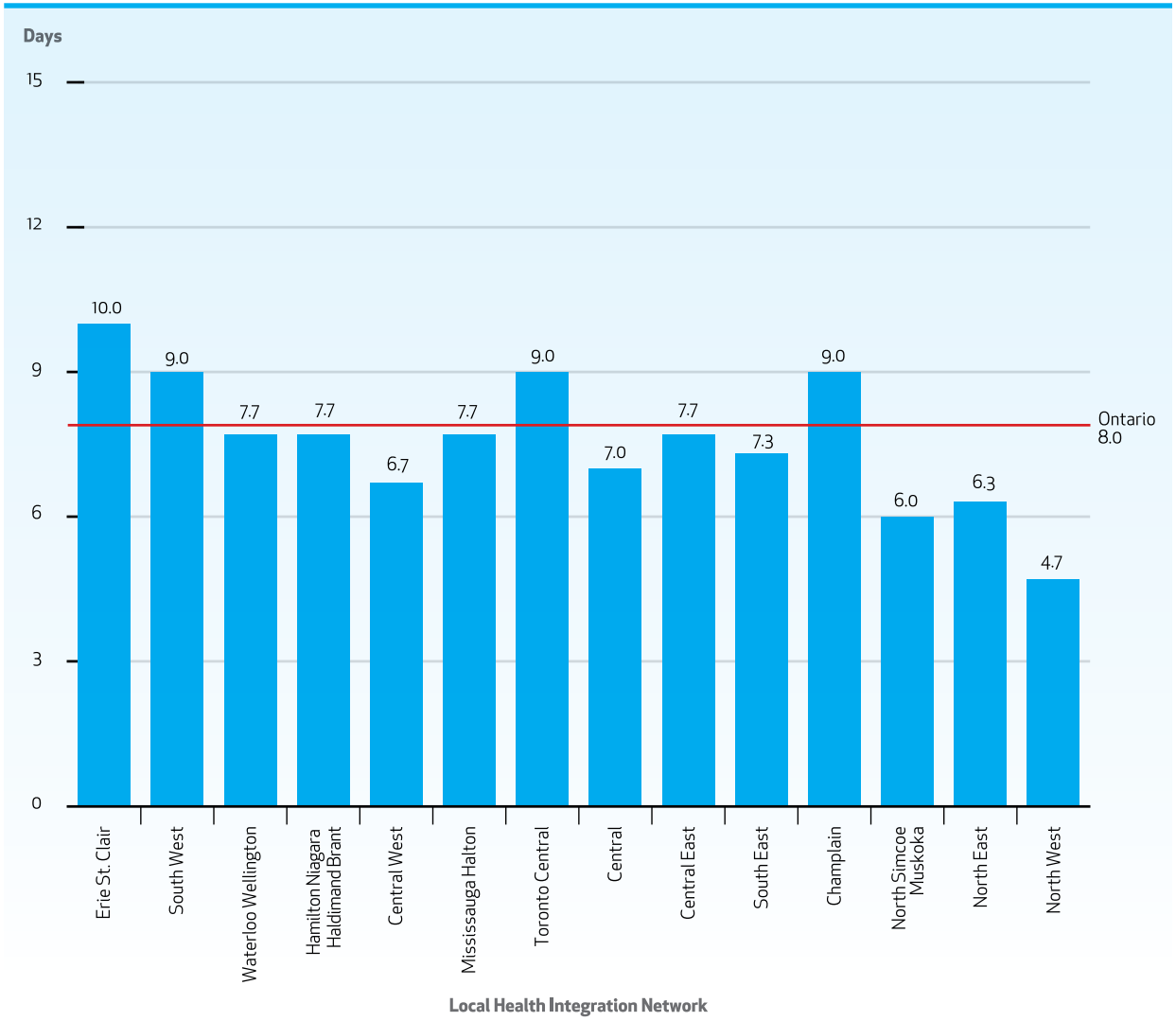
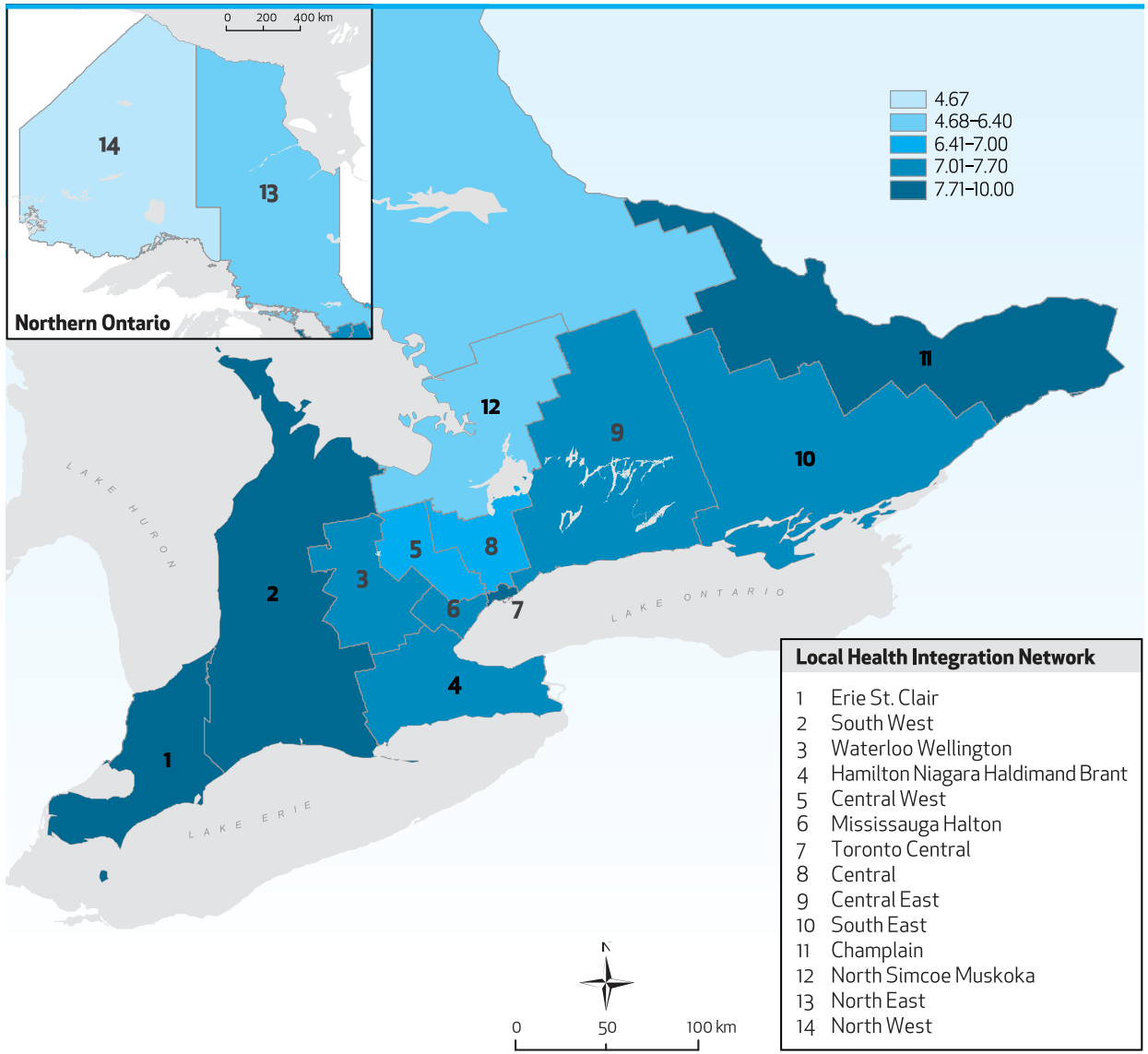


EXHIBIT 3.5.11 Median length of stay for psychiatric hospitalizations among individuals aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The median length of stay for psychiatric hospitalizations varied across LHINs, with the longest stay reported in the Erie St. Clair LHIN and the shortest in the northern LHINs, particularly the North West LHIN.



3.6 Rate of hospitalizations for mental health and addictions care

Rationale

The rate of hospitalizations for mental health and addictions care is an aggregate measure of a number of processes, including population-based illness burden requiring psychiatric hospitalization, regional availability of hospital beds, adequacy of community resources to provide timely access to care, and other factors.

Results

From 2006 to 2014, MHA-related hospitalizations remained stable and were similar for men and women. Rates of hospitalizations were stable across most age groups with the exception of individuals aged 16 to 24 and 85 to 105, where rates were the highest and increased over time. The most common reason for an MHA-related hospitalization was mood disorders, while the least common was deliberate self-harm without a psychiatric diagnosis.

The rate of MHA-related hospitalizations was higher for lower-income individuals and for refugees and non-immigrants. The rate was highest in the North West and North East LHINs and lowest in the Mississauga Halton LHIN.

Interpretation

The rate of MHA-related hospitalizations was low from 2006 to 2014, with about 5 hospitalizations per 1,000 individuals, and remained stable during that time. However, further examination indicates that some subpopulations were at greater risk for MHA-related hospitalizations, including younger adults aged 16 to 24 and older adults aged 85 to 105, and individuals living in lower-income neighbourhoods and in the northern LHINs. With higher rates of hospitalization observed among these groups, improving access to and management of care via community-based services may help to reduce burden.

EXHIBIT 3.6.1 Number of mental health and addictions–related hospitalizations per 1,000 population aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- From 2006 to 2014, the rate of MHA-related hospitalizations remained stable and was similar for men and women.

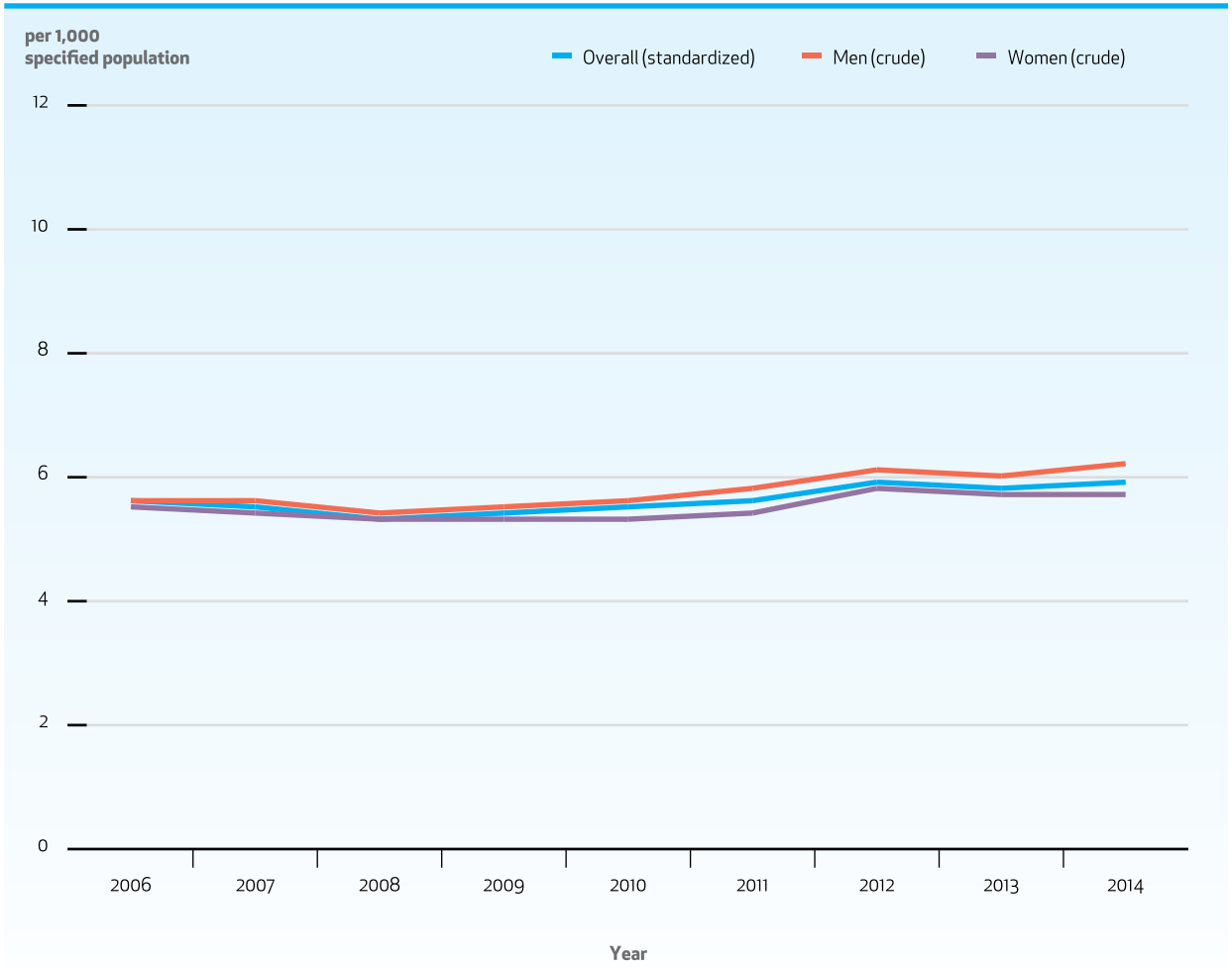


EXHIBIT 3.6.2 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by age group, in Ontario, 2006 to 2014

Key Finding

- The rate of MHA-related hospitalizations was stable over time for most age groups, except for individuals aged 16 to 24 and 85 to 105, where rates were highest and increased over time.

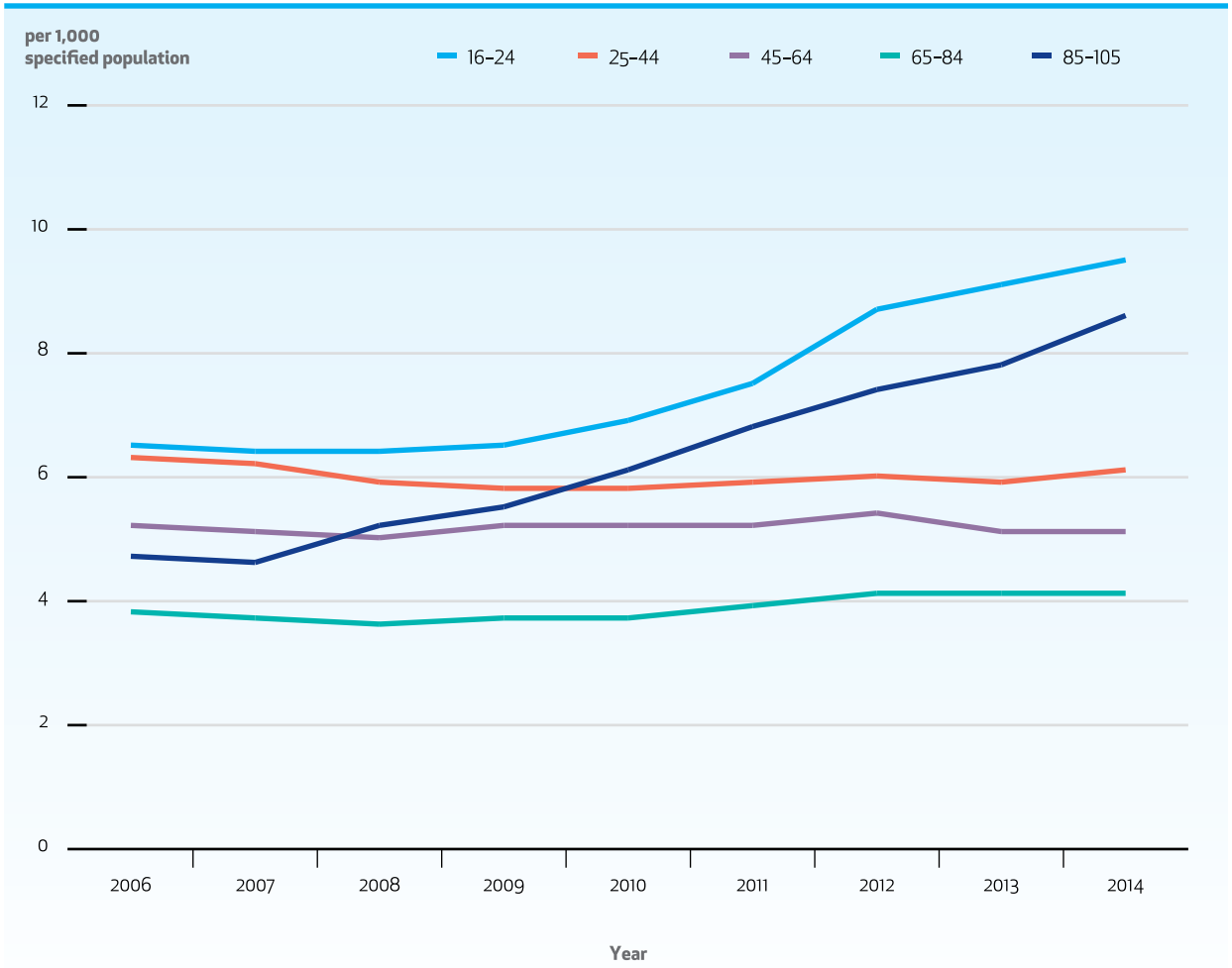
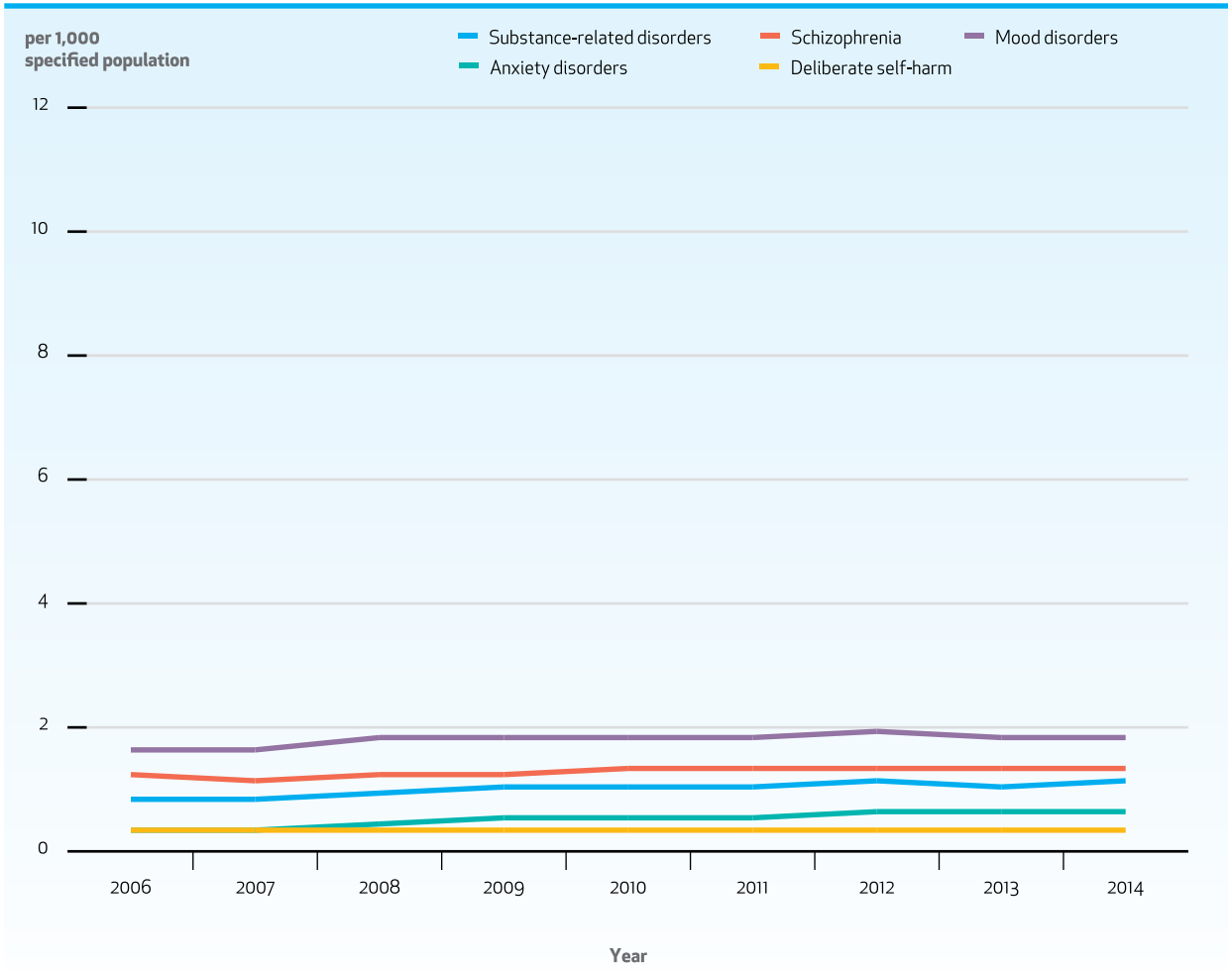


EXHIBIT 3.6.3 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by type of disorder, in Ontario, 2006 to 2014*

Key Finding

- The most common reason for an MHA-related hospitalization was mood disorders, and the least common reason was deliberate self-harm without a psychiatric diagnosis. Rates across all diagnostic groups were consistent over time.



*Hospitalizations by diagnosis are denominated over the entire Ontario population aged 16 to 105 years, resulting in rates that appear to be lower than rates for other exhibits in this indicator series.

EXHIBIT 3.6.4 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- On average between 2012 and 2014, the rate of MHA-related hospitalizations was similar for men and women.

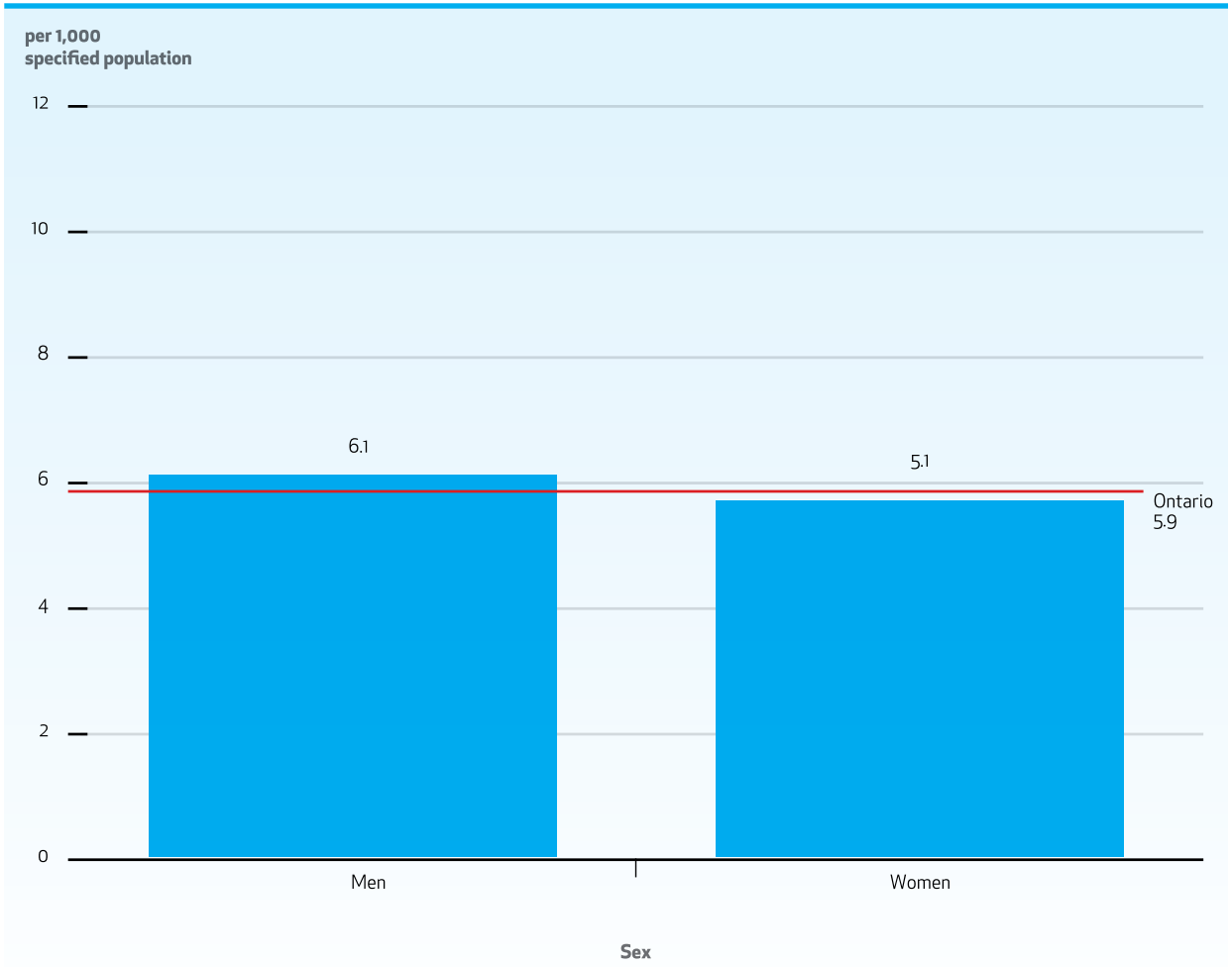


EXHIBIT 3.6.5 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of MHA-related hospitalizations was highest among individuals aged 16 to 24 and 85 to 105.

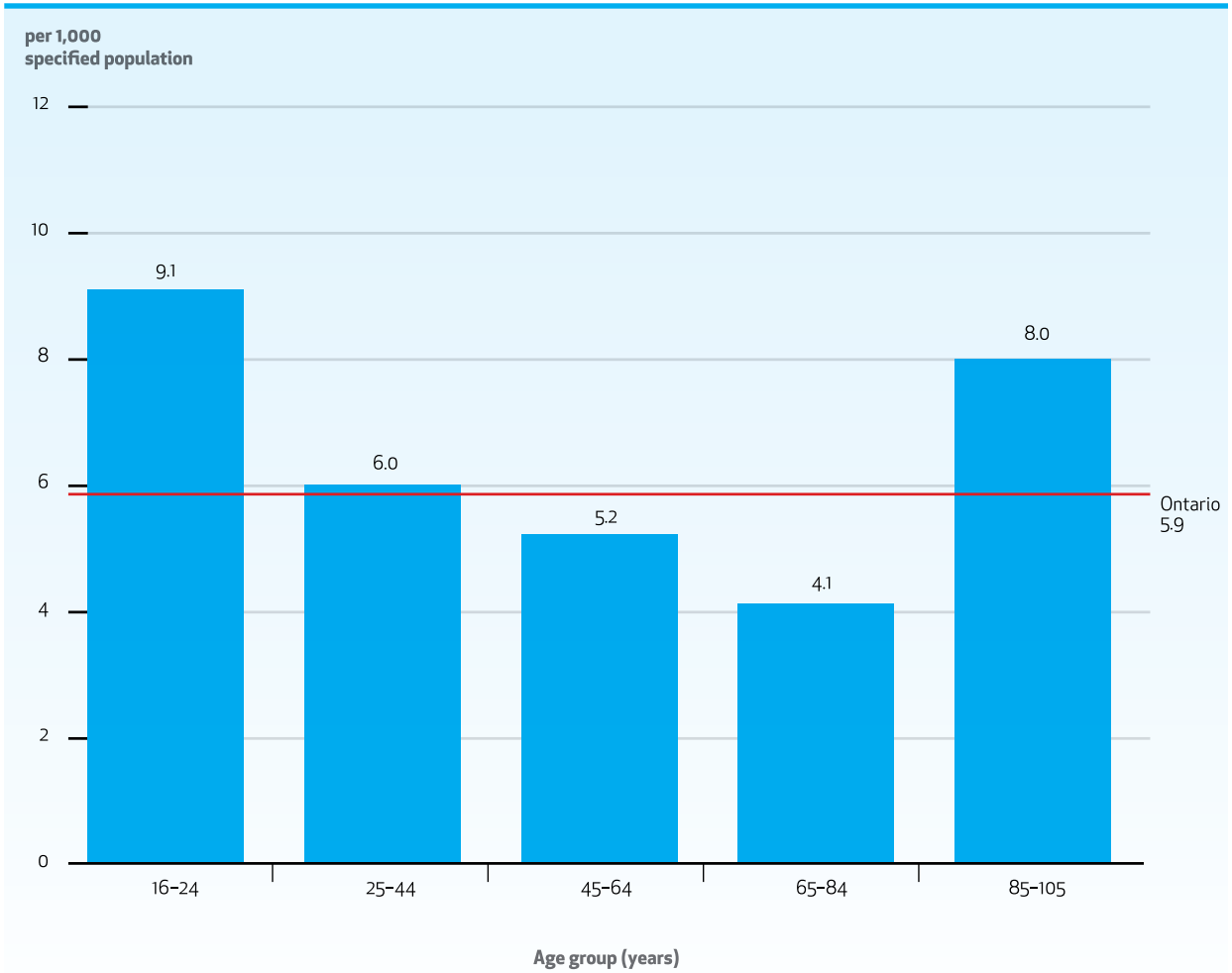
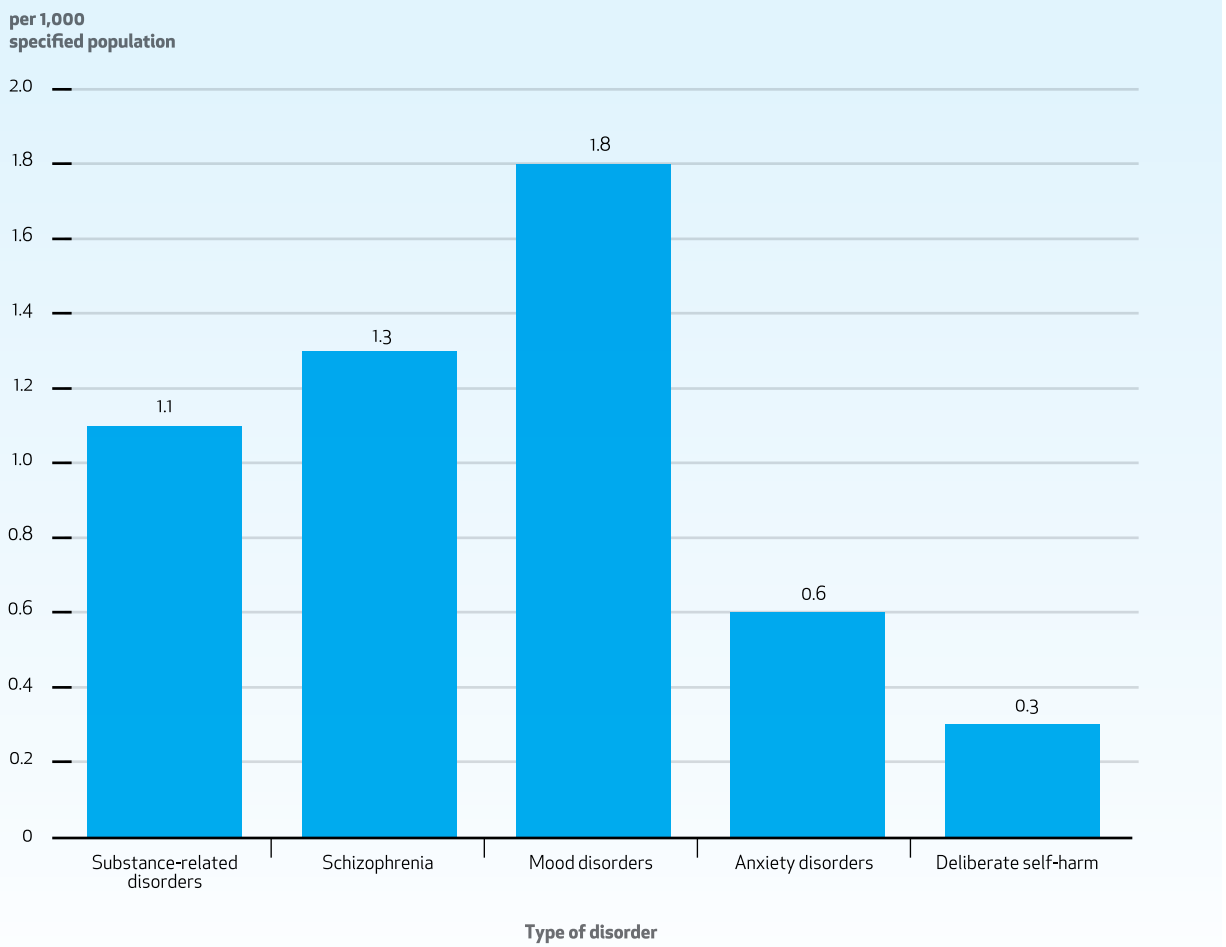


EXHIBIT 3.6.6 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by type of disorder, in Ontario, three-year average for 2012 to 2014*

Key Finding

- Mood disorders were the most common reason for MHA-related hospitalizations, followed by schizophrenia and substance-related disorders.



*Hospitalizations by diagnosis are denominated over the entire Ontario population aged 16 to 105 years, resulting in rates that appear to be lower than rates for other exhibits in this indicator series.

EXHIBIT 3.6.7 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of MHA-related hospitalizations was higher among individuals living in lower-income neighbourhoods. As neighbourhood income increased, the rate of hospitalizations decreased.

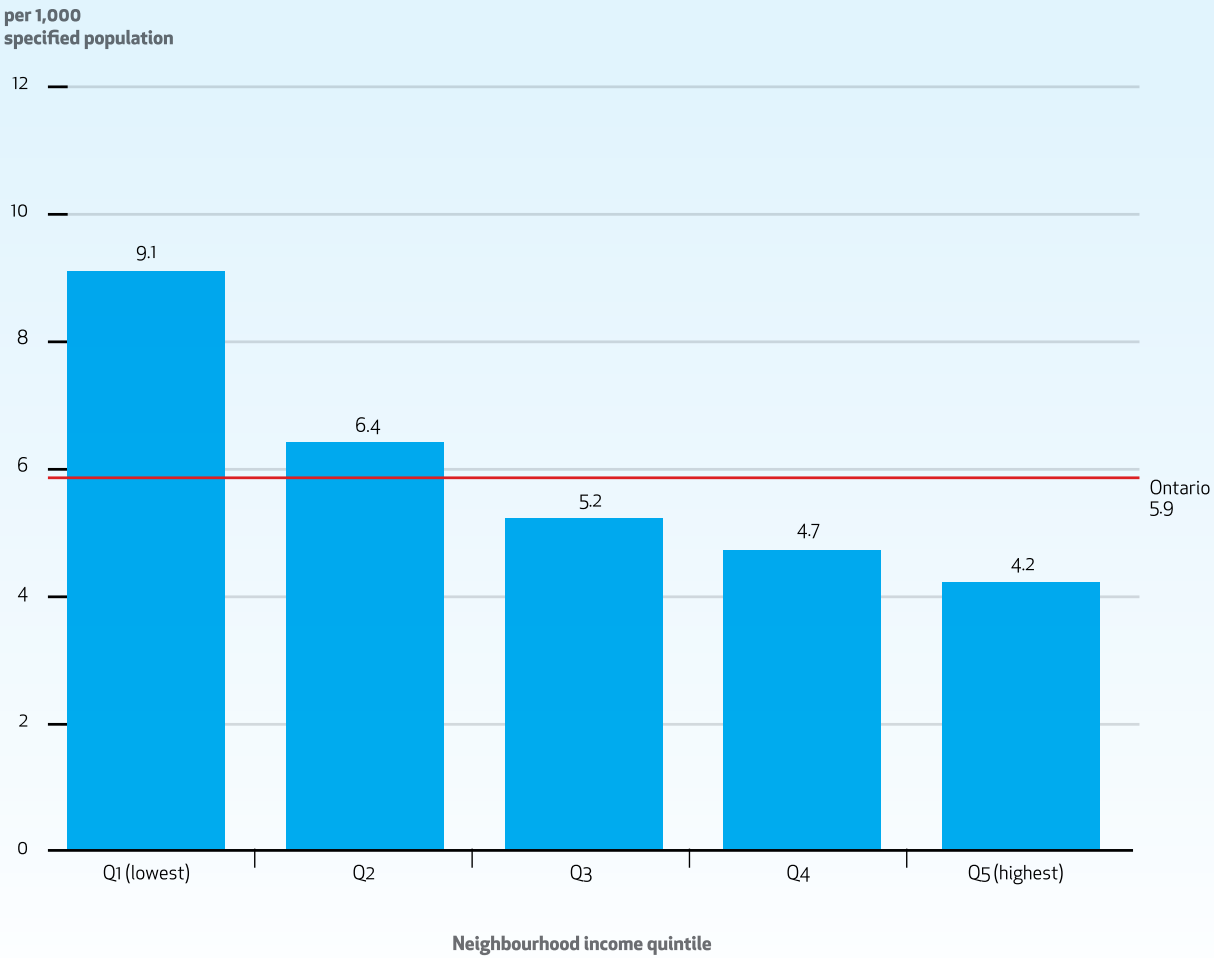


EXHIBIT 3.6.8 Number of mental health and addictions–related hospitalizations per 1,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- The highest rate of MHA-related hospitalizations was among non-immigrants, and the lowest rate was among immigrants.

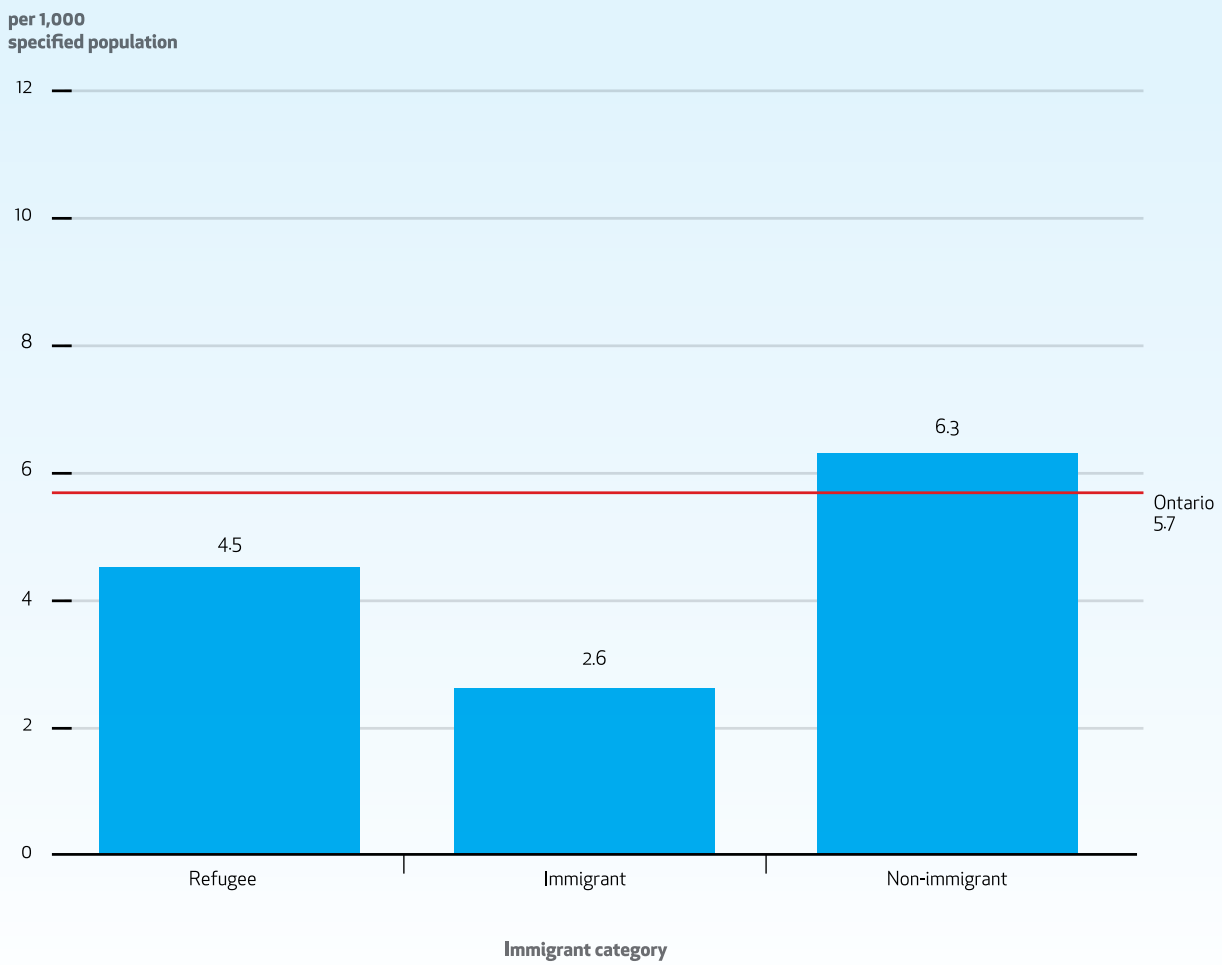
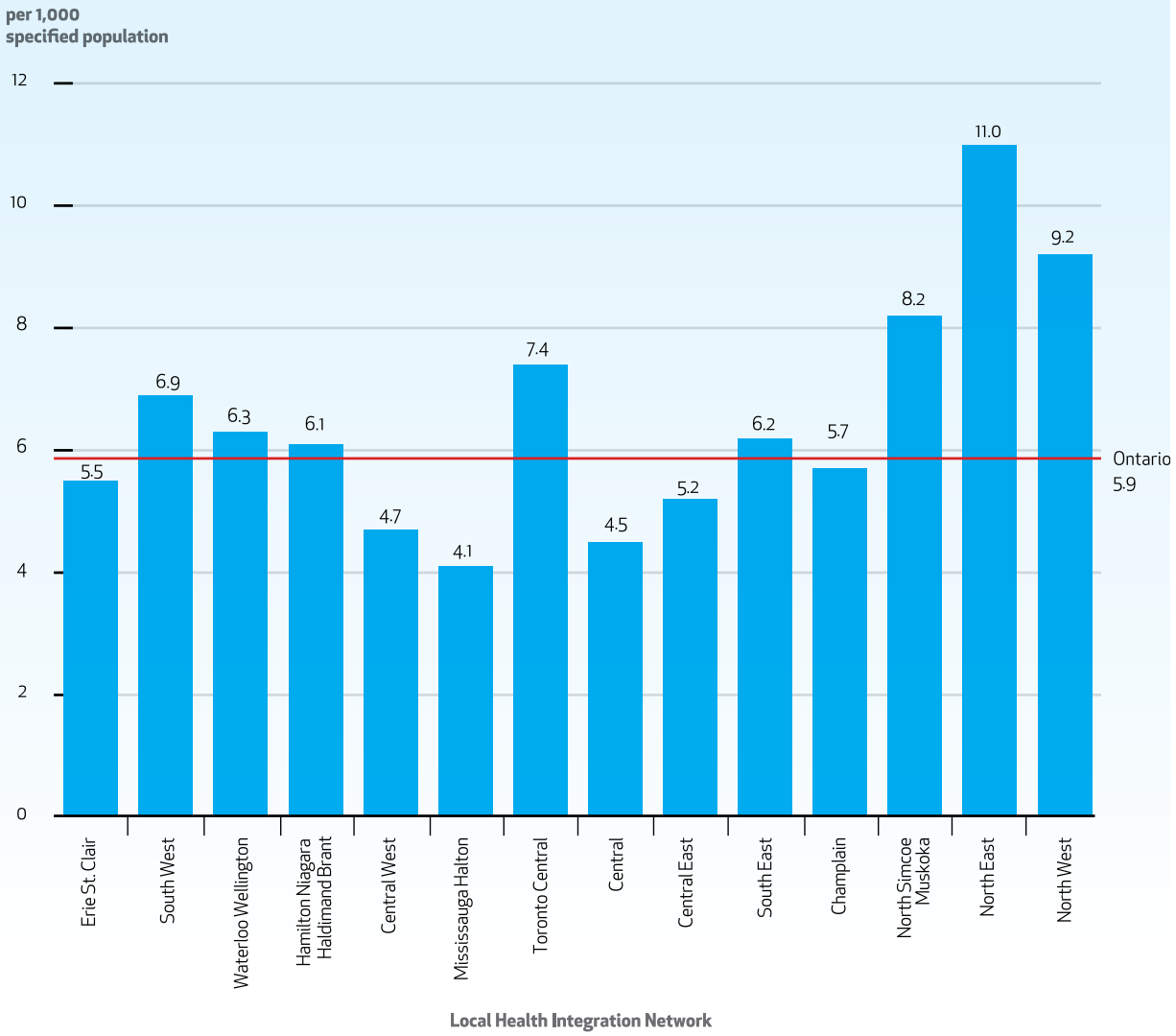


EXHIBIT 3.6.9 Number of mental health and addictions–related hospitalizations per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- MHA-related hospitalizations were more common in the North West, North East, and North Simcoe Muskoka LHINs.

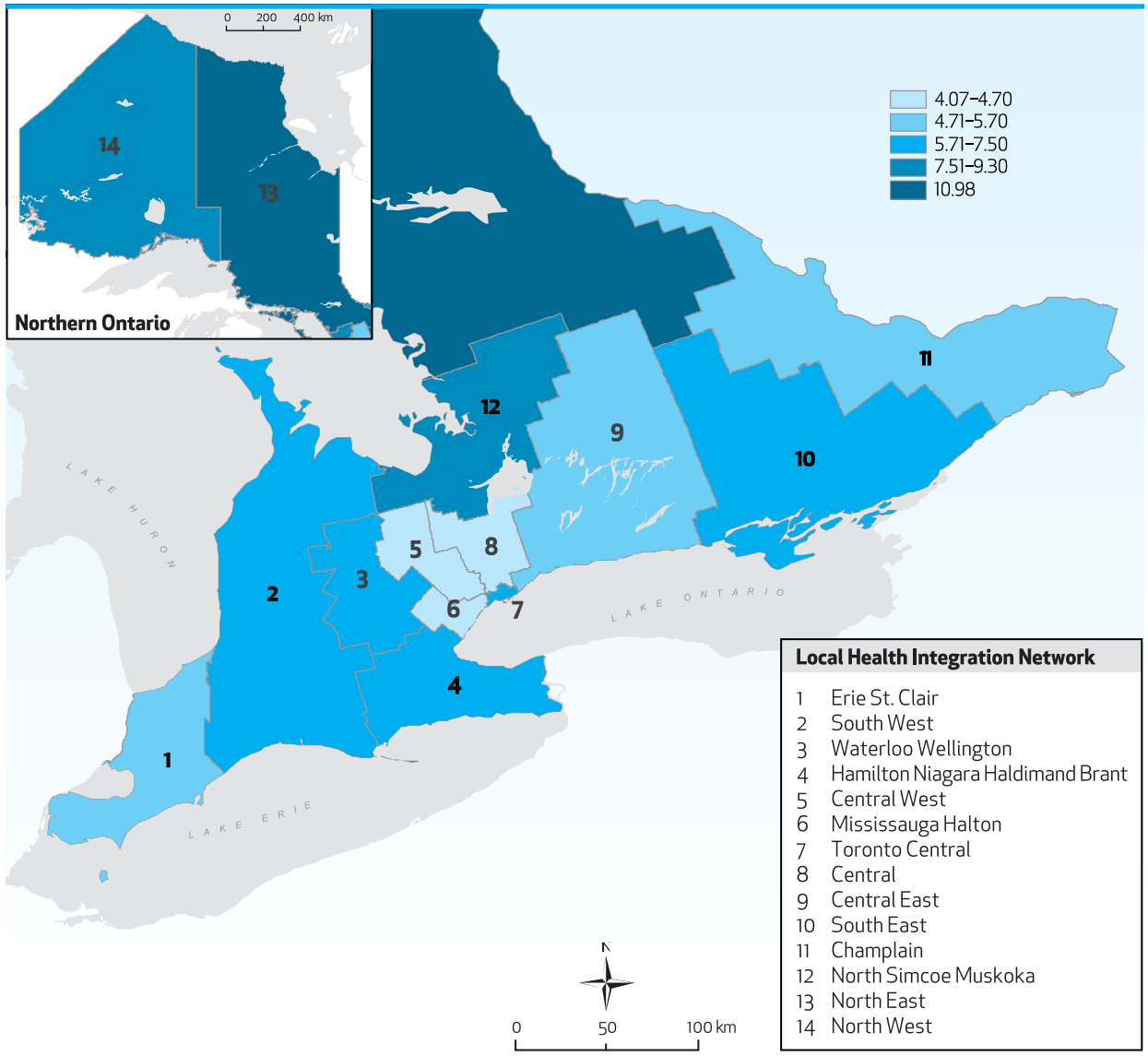


*Age- and sex-adjusted.

EXHIBIT 3.6.10 Number of mental health and addictions–related hospitalizations per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- MHA-related hospitalizations were more common in the North West, North East, and North Simcoe Muskoka LHINs.



3.7 Rate of emergency department visits for deliberate self-harm

Rationale

Deliberate self-harm refers to non-fatal self-poisoning or self-injury and encompasses a wide range of behaviours, from non-suicidal acts to attempted suicide (carried out with at least some intent to end one's life). These behaviours are important markers of mental health and may reflect a lack of access to primary care and community-based mental health services. This indicator takes into account all visits for deliberate self-harm regardless of whether a mental illness or addiction diagnosis is present.

Results

Emergency department visits for deliberate self-harm decreased slightly between 2006 and 2014. ED visits for deliberate self-harm occurred at a higher rate among women than men and occurred among 16- to-24-year-olds at a rate twice that of other age groups. Individuals living in lower-income neighbourhoods had a higher rate of ED visits for deliberate self-harm compared to those living in higher-income neighbourhoods. Across immigrant categories, non-immigrants had a higher rate of ED visits compared to refugees and immigrants. Geographically, adults living in the North West LHIN had the highest rate of ED visits for deliberate self-harm compared to other LHINs.

Interpretation

The rate of ED visits for deliberate self-harm is trending downward. The high rate of ED visits for deliberate self-harm among young adults aged 16 to 24 is consistent with previous evidence indicating that while deliberate self-harm behaviours occur across the lifespan, young adults have disproportionately higher rates.[6] The geographic differences, particularly the high rates in the North West LHIN, highlight a subpopulation in need of enhanced mental health supports that offer timely access to high quality mental health care.

[6] Catledge CB, Scharer K, Fuller S. Assessment and identification of deliberate self-harm in adolescents and young adults. *J Nurse Pract*. 2012; 8(4):299–305.

EXHIBIT 3.7.1 Number of emergency department visits for deliberate self-harm per 10,000 population aged 16 to 105 years, overall and by sex, in Ontario, 2006 to 2014

Key Finding

- From 2006 to 2014, the rate of ED visits for deliberate self-harm decreased slightly, a trend observed for both men and women.

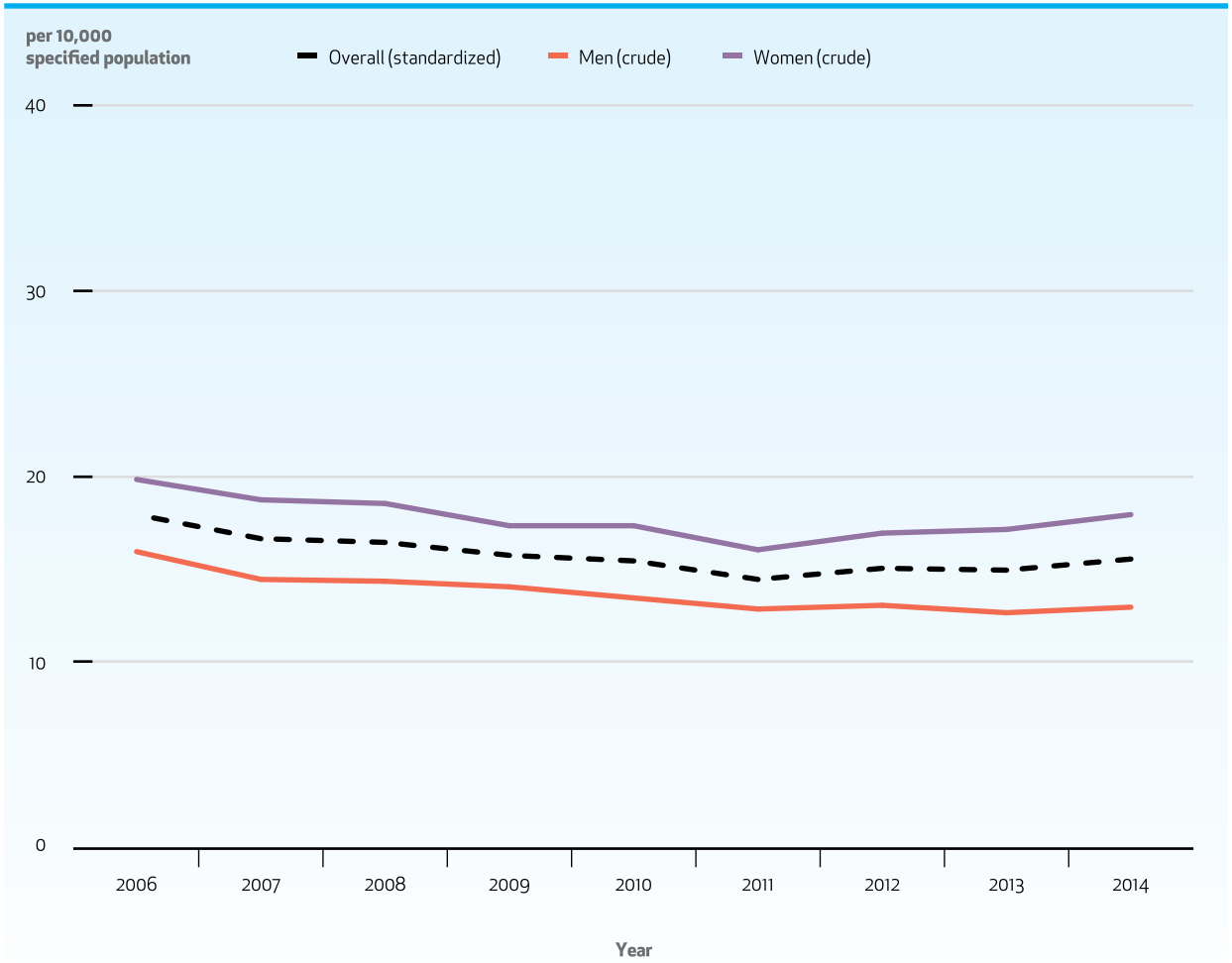


EXHIBIT 3.7.2 Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 16 to 105 years, by age group, in Ontario, 2006 to 2014

Key Finding

- The rate of ED visits for deliberate self-harm was highest among those aged 16 to 24 with the rate first decreasing and then rising to a higher level by 2014. Rates declined over time among adults aged 25 to 44 but remained stable among those aged 45 and older.

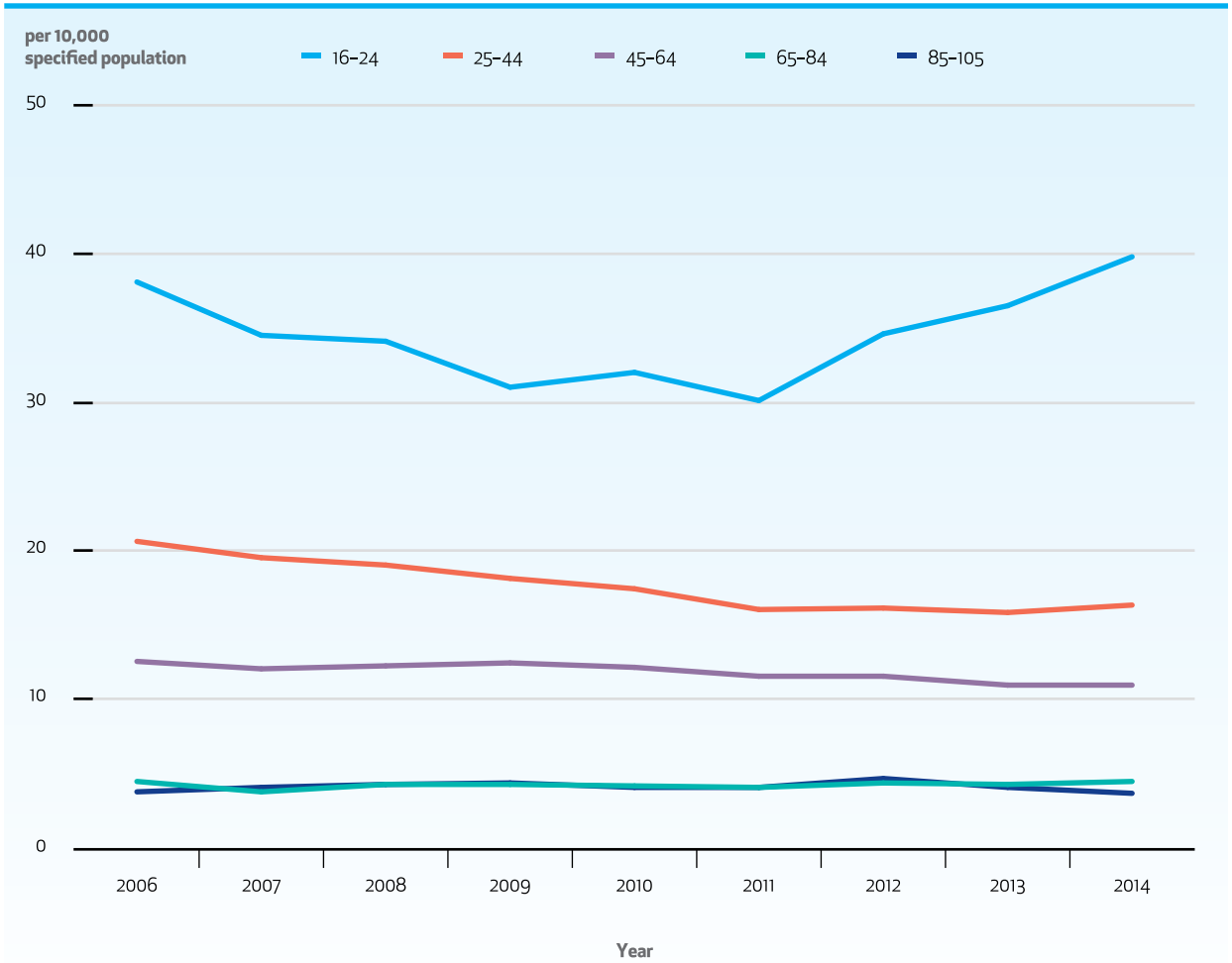


EXHIBIT 3.7.3 Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- From 2012 to 2014, the three-year average rate of ED visits for deliberate self-harm was higher for women than for men.

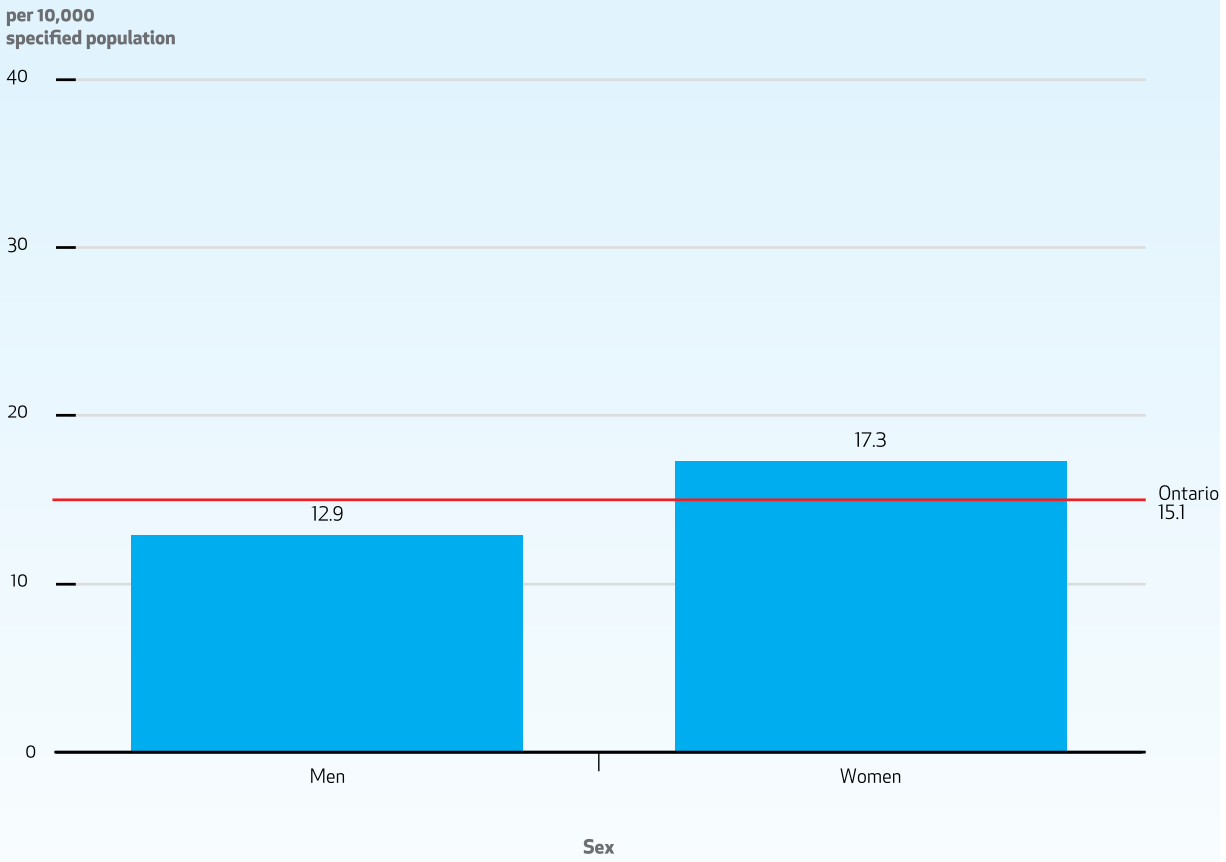


EXHIBIT 3.7.4 Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of ED visits for deliberate self-harm was characterized by a steep age gradient whereby the youngest age group had the highest rate and the oldest age group had the lowest. The average rate of ED visits between 2012 and 2014 was nearly nine times higher among individuals aged 16 to 24 than among those aged 65 and older.

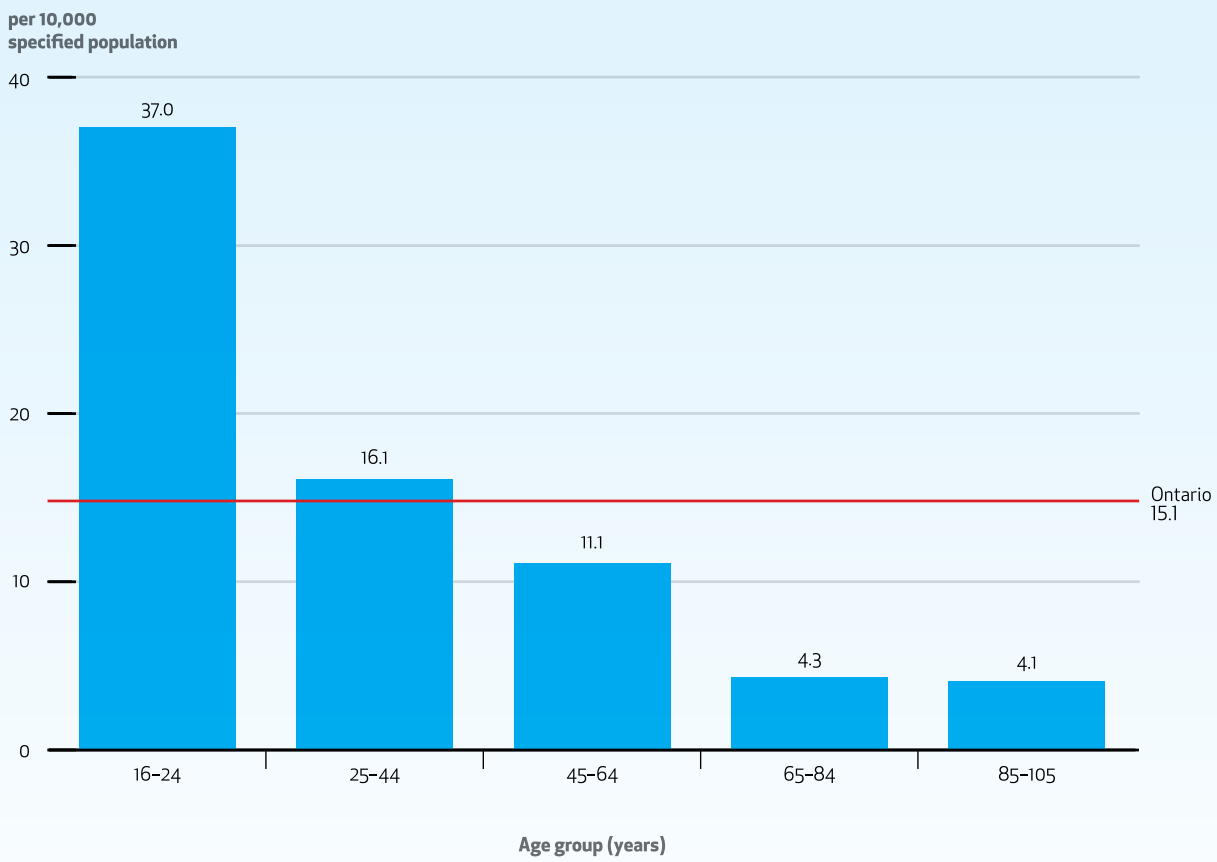


EXHIBIT 3.7.5 Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- Adults living in poorer neighbourhoods had higher rates of ED visits for deliberate self-harm than those living in wealthier neighbourhoods. The rate of ED visits at the lowest income level was more than twice that of the highest level.

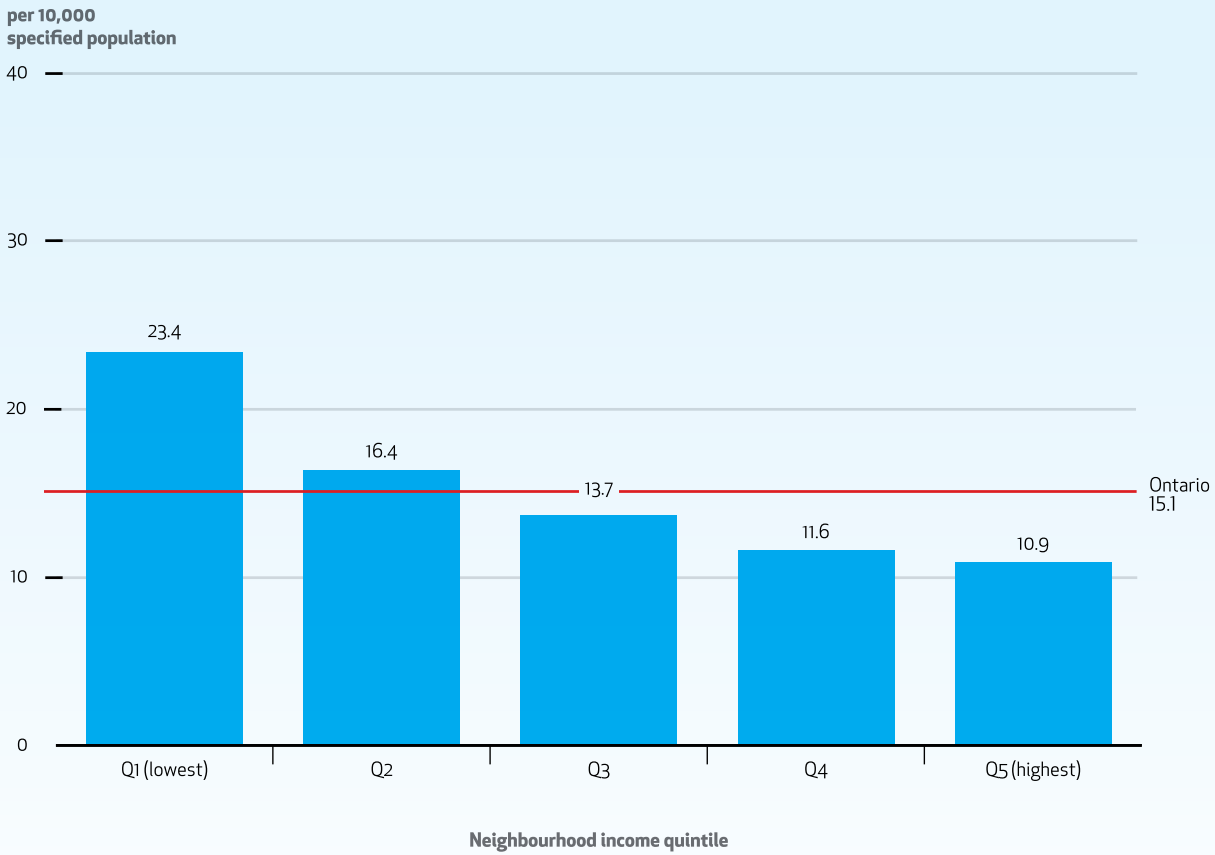


EXHIBIT 3.7.6 Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- The average rate of ED visits for deliberate self-harm was highest among non-immigrants.

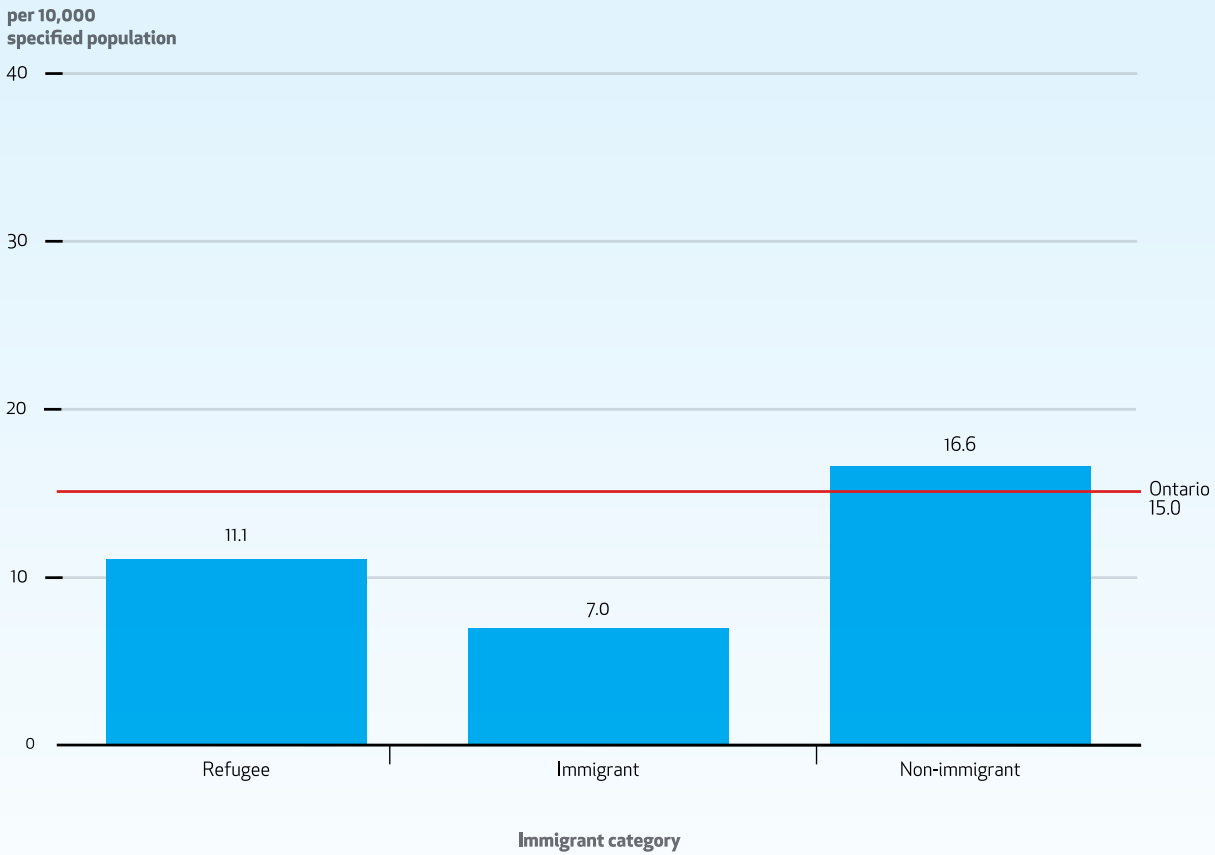


EXHIBIT 3.7.7 Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 16 to 105 years, by Local Integration Health Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of ED visits for deliberate self-harm varied geographically, with the highest rate reported in the North West LHIN and the lowest in the Central LHIN.

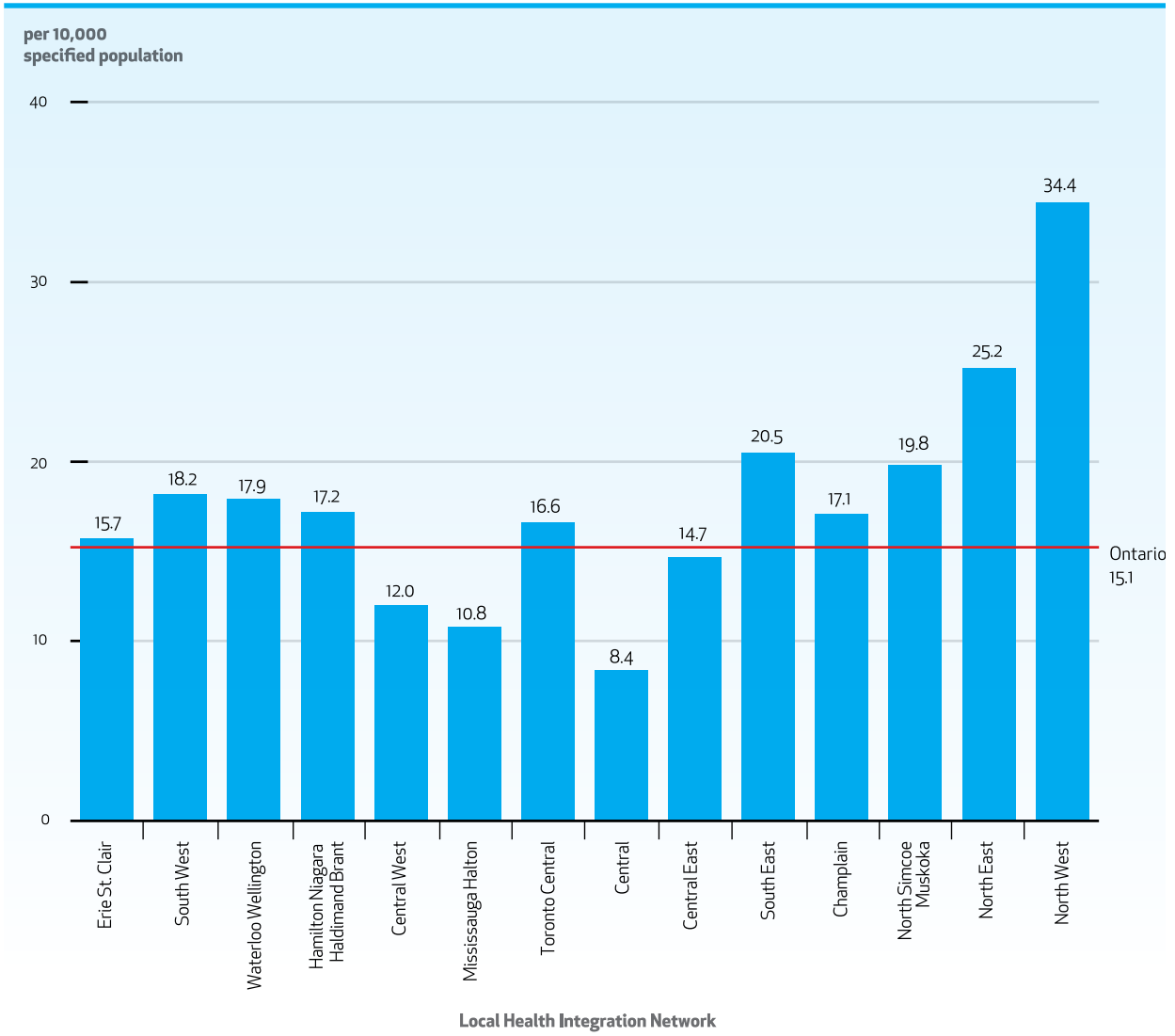
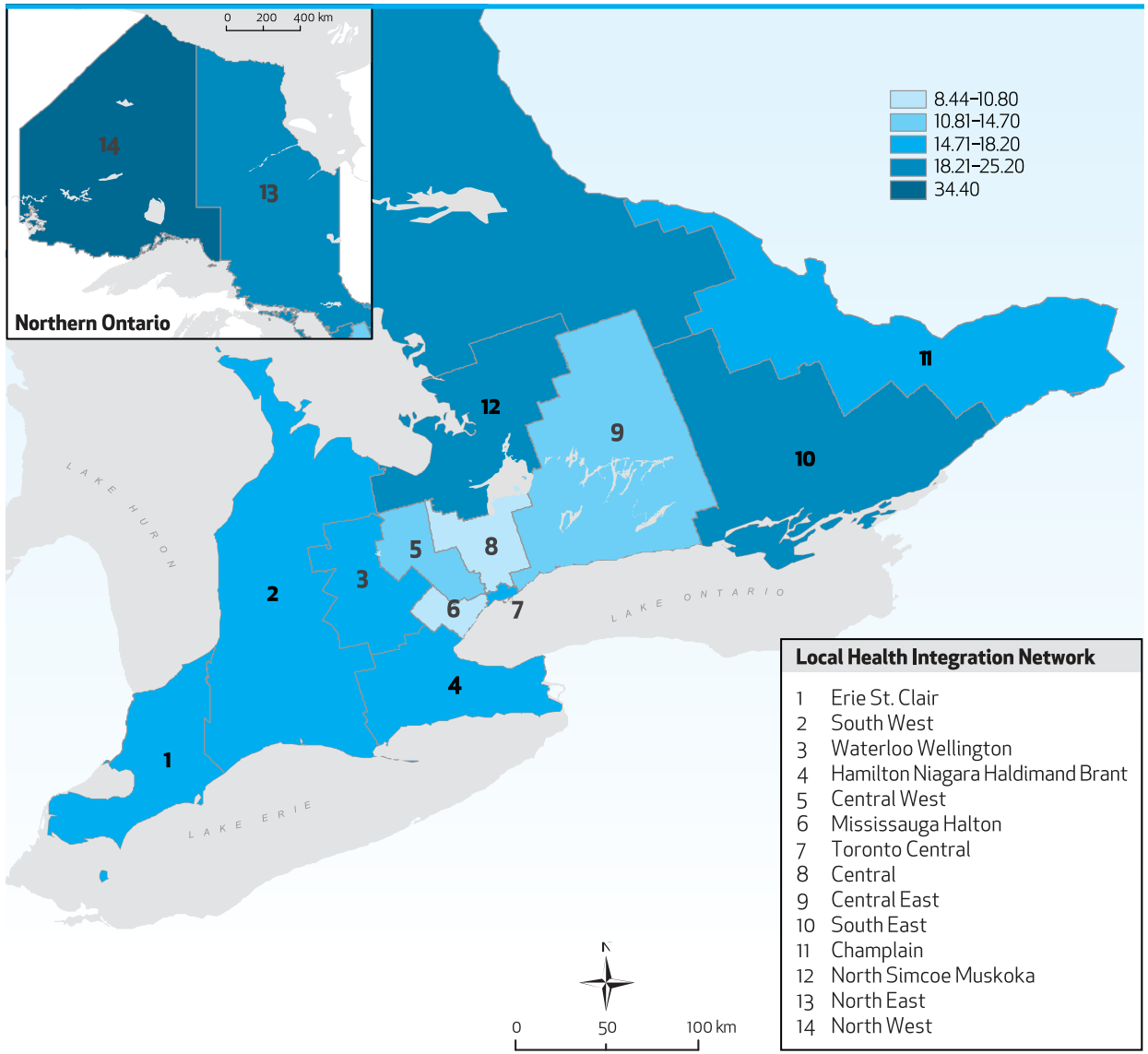


EXHIBIT 3.7.8 Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 16 to 105 years, by Local Integration Health Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The rate of ED visits for deliberate self-harm varied geographically, with the highest rate reported in the North West LHIN and the lowest in the Central LHIN.



3.8 Rate of mental health and addictions–related emergency department visits

Rationale

The use of the emergency department for mental health and addictions care may signal a lack of early identification of mental illnesses and addictions, as well as gaps in service provided by the primary care, specialty service and community sectors.

Results

Between 2006 and 2014, the rate of MHA-related ED visits increased for both men and women and across most age groups. Rates of visits were higher among men and those aged 16 to 24 years compared with women and older age groups, respectively. Anxiety and substance-related disorders were the most common reasons for an ED visit, and rates steadily increased for both conditions. No change was observed in the rate of visits for mood disorders, schizophrenia, and deliberate self-harm without a psychiatric diagnosis.

Adults living in lower-income neighbourhoods had higher rates of MHA-related ED visits compared to those living in higher income neighbourhoods. Rates of visits were higher among non-immigrants and refugees compared to immigrants. Geographically, the highest rates of MHA-related visits were in the North West and North East LHINs, and the lowest rate was in the Central LHIN.

Interpretation

Explanations for the rise in MHA-related ED visits among Ontario adults between 2006 and 2014 include (1) the burden of mental illnesses and addictions may have increased during this time; (2) identification of those suffering from mental illnesses and addictions may have improved; and (3) the willingness to seek help for mental illnesses and addictions may have increased. A more comprehensive understanding of these trends is warranted.

EXHIBIT 3.8.1 Number of mental health and addictions–related emergency department visits per 1,000 population aged 16 to 105 years, overall and by sex, 2006 to 2014

Key Finding

- From 2006 to 2014, the overall rate of MHA-related emergency department visits increased and was slightly higher among men than women.

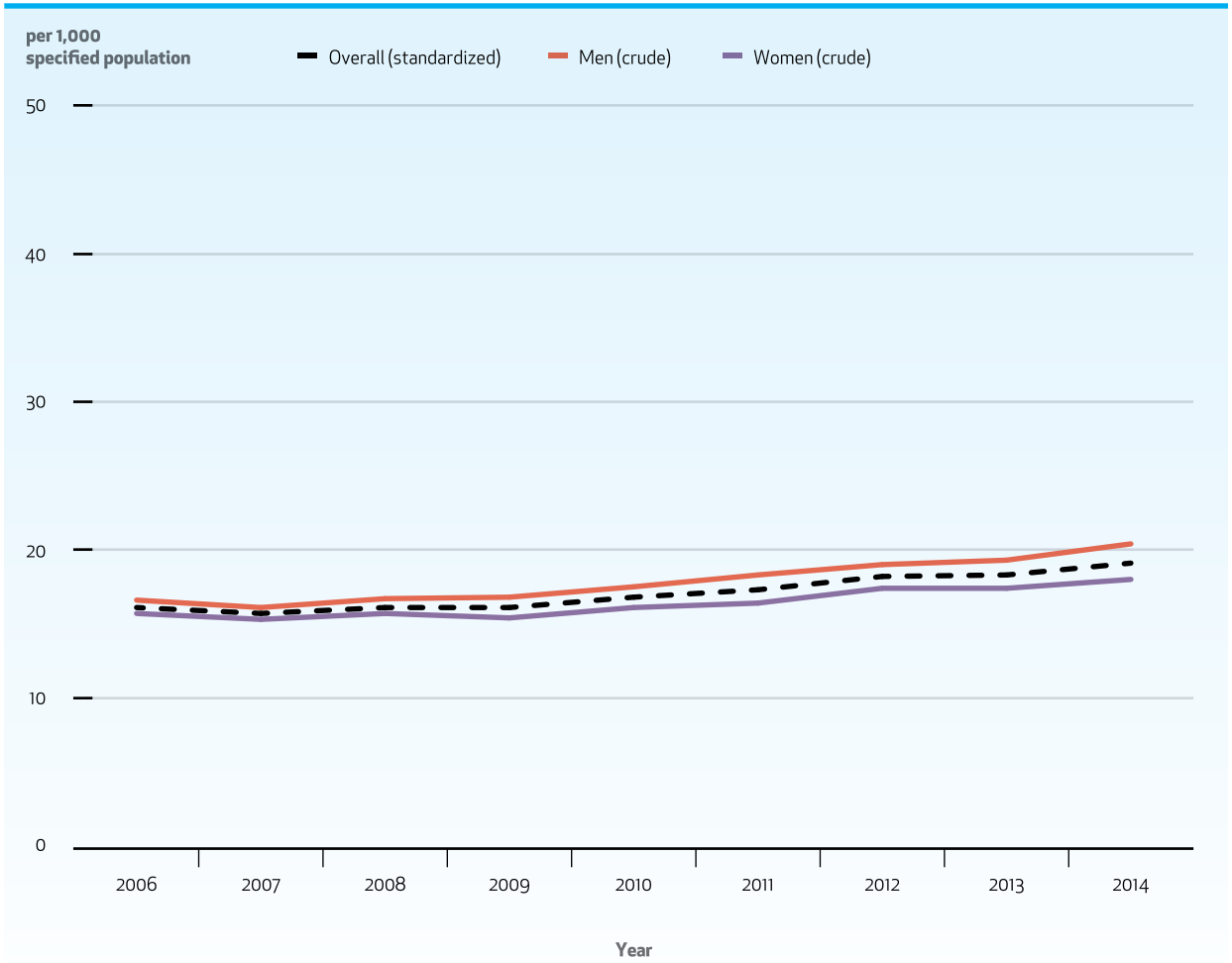


EXHIBIT 3.8.2 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by age group, 2006 to 2014

Key Finding

- The rate of MHA-related emergency department visits increased for most age groups, particularly those aged 16 to 24 years for whom the rate of visits was higher and increased faster compared to all other age groups.

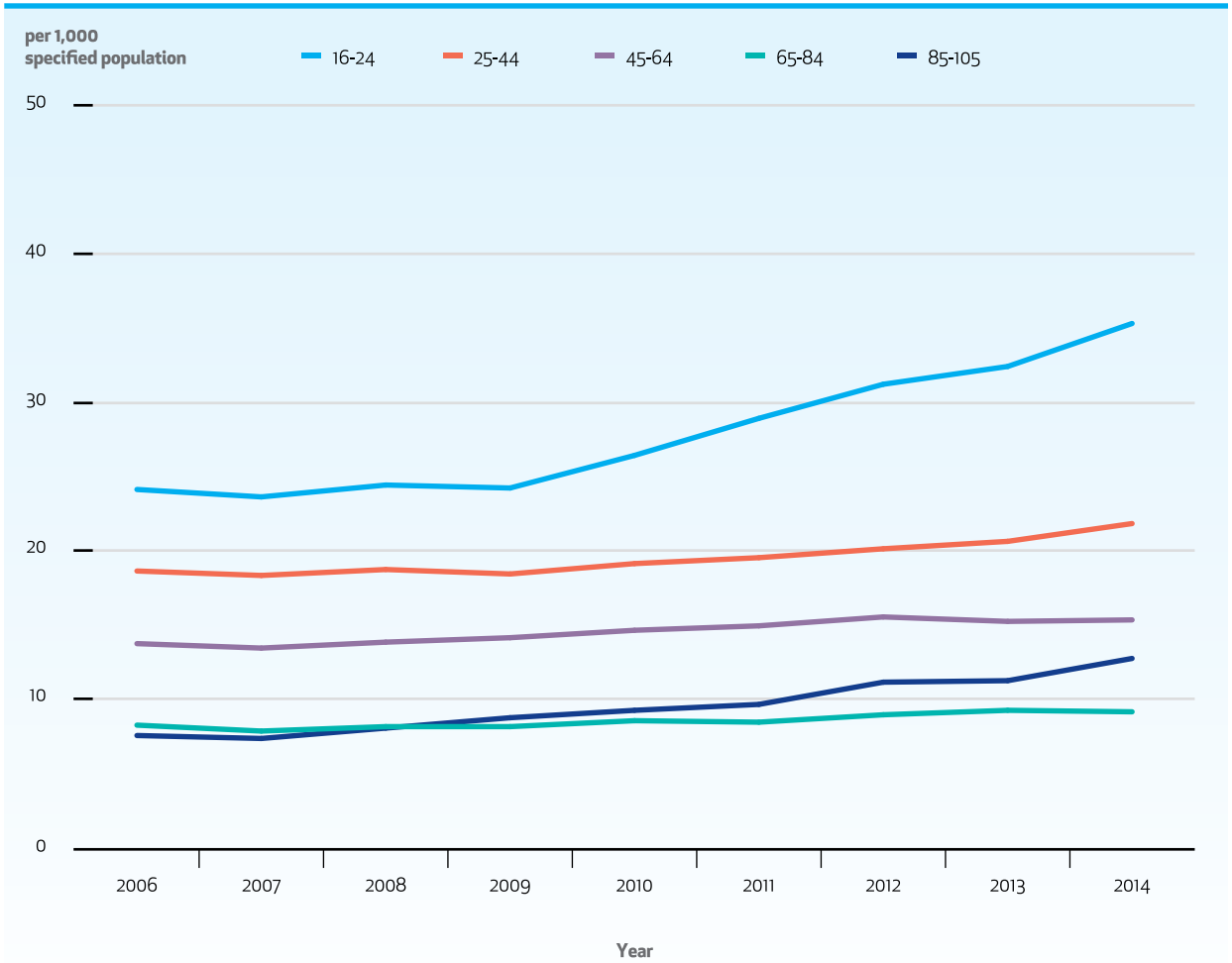
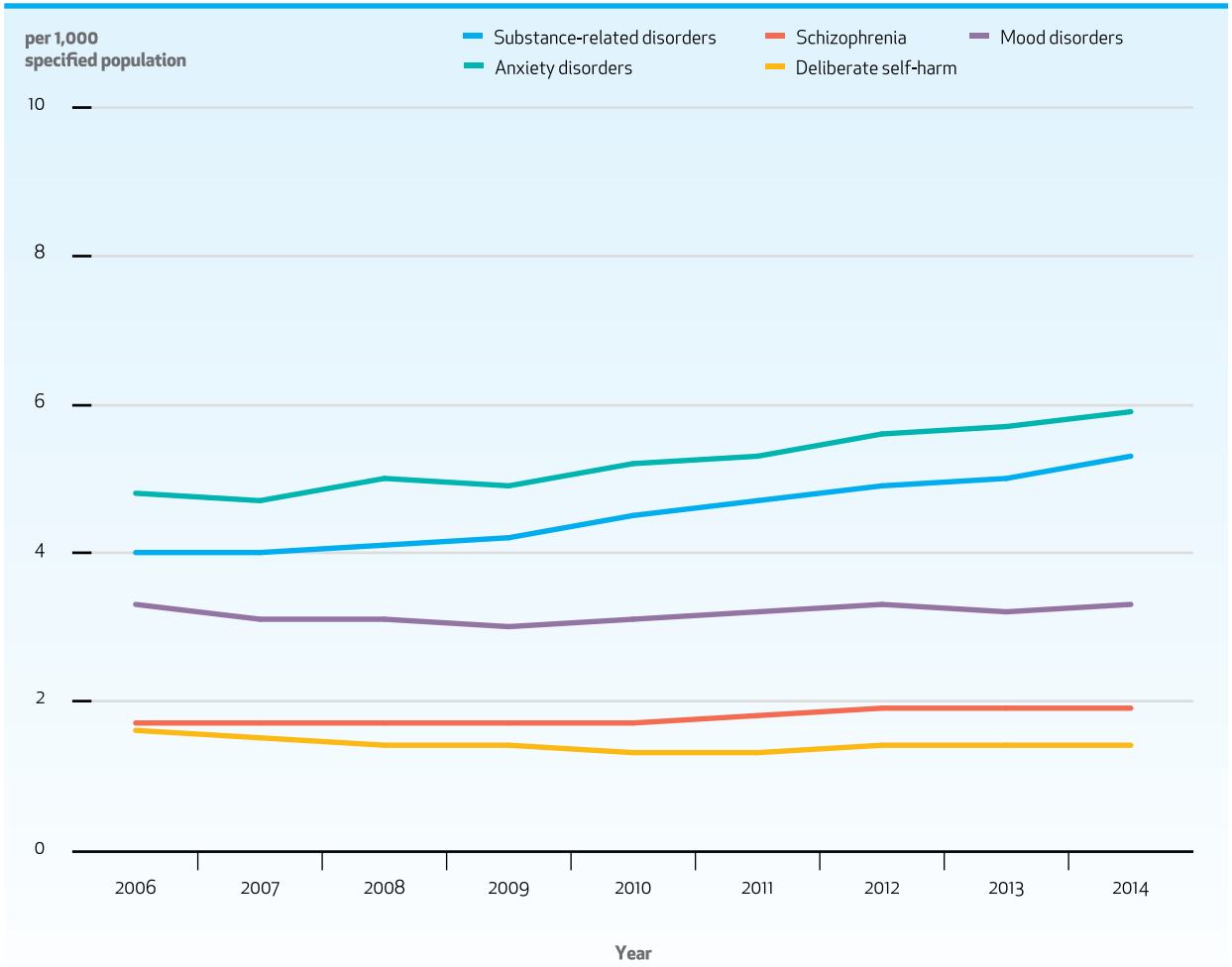


EXHIBIT 3.8.3 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by type of disorder, 2006 to 2014*

Key Finding

- Anxiety and substance-related disorders were the most common reasons for an MHA-related emergency department visit. Visit rates increased over time for both of these disorders while remaining stable for mood disorders, schizophrenia and deliberate self-harm without a psychiatric diagnosis.



*Emergency department visits by diagnosis are denominated over the entire Ontario population aged 16 to 105 years, resulting in rates that appear to be lower than rates for other exhibits in this indicator series.

EXHIBIT 3.8.4 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by sex, in Ontario, three-year average for 2012 to 2014

Key Finding

- Between 2012 and 2014, the three-year average rate of MHA-related emergency department visits was higher for men than women.

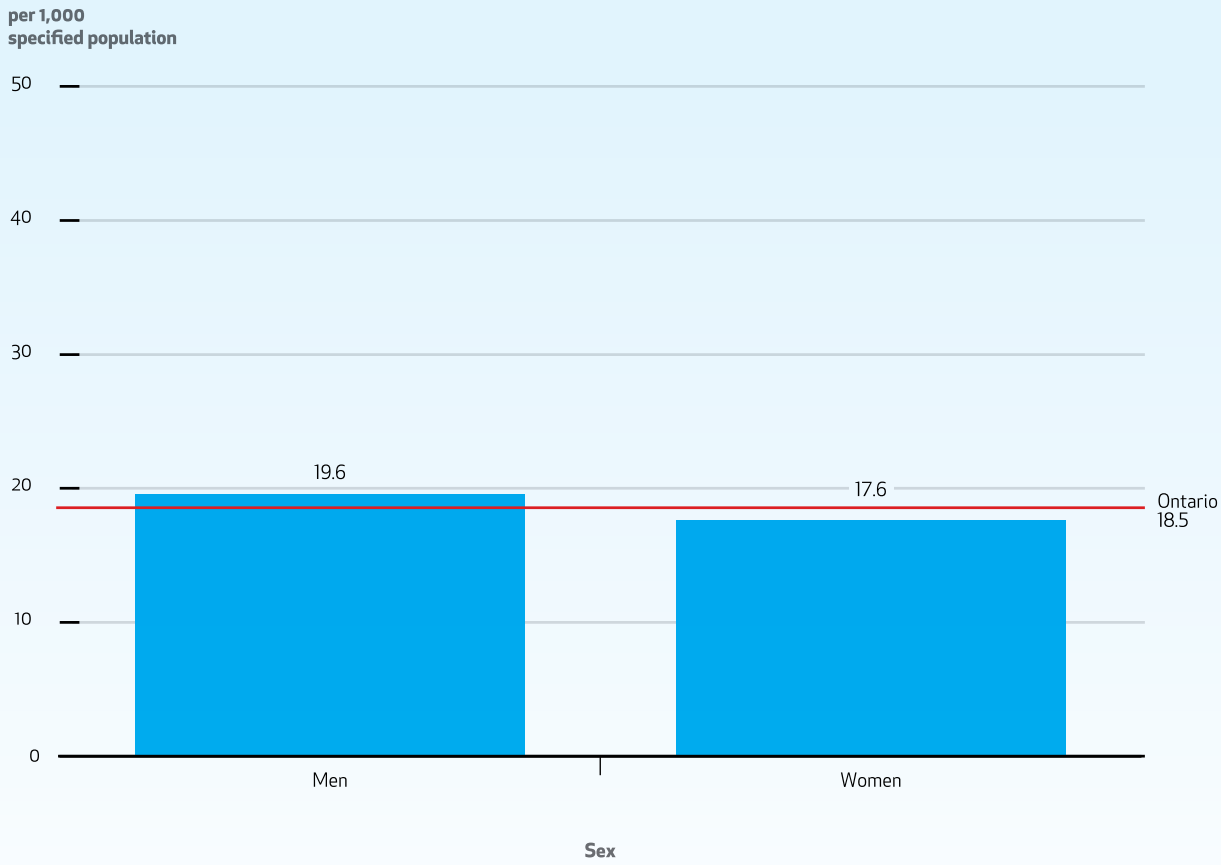


EXHIBIT 3.8.5 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by age group, in Ontario, three-year average for 2012 to 2014

Key Finding

- Between 2012 and 2014, the average rate of MHA-related emergency department visits was higher among younger adults, particularly those aged 16 to 24 years.

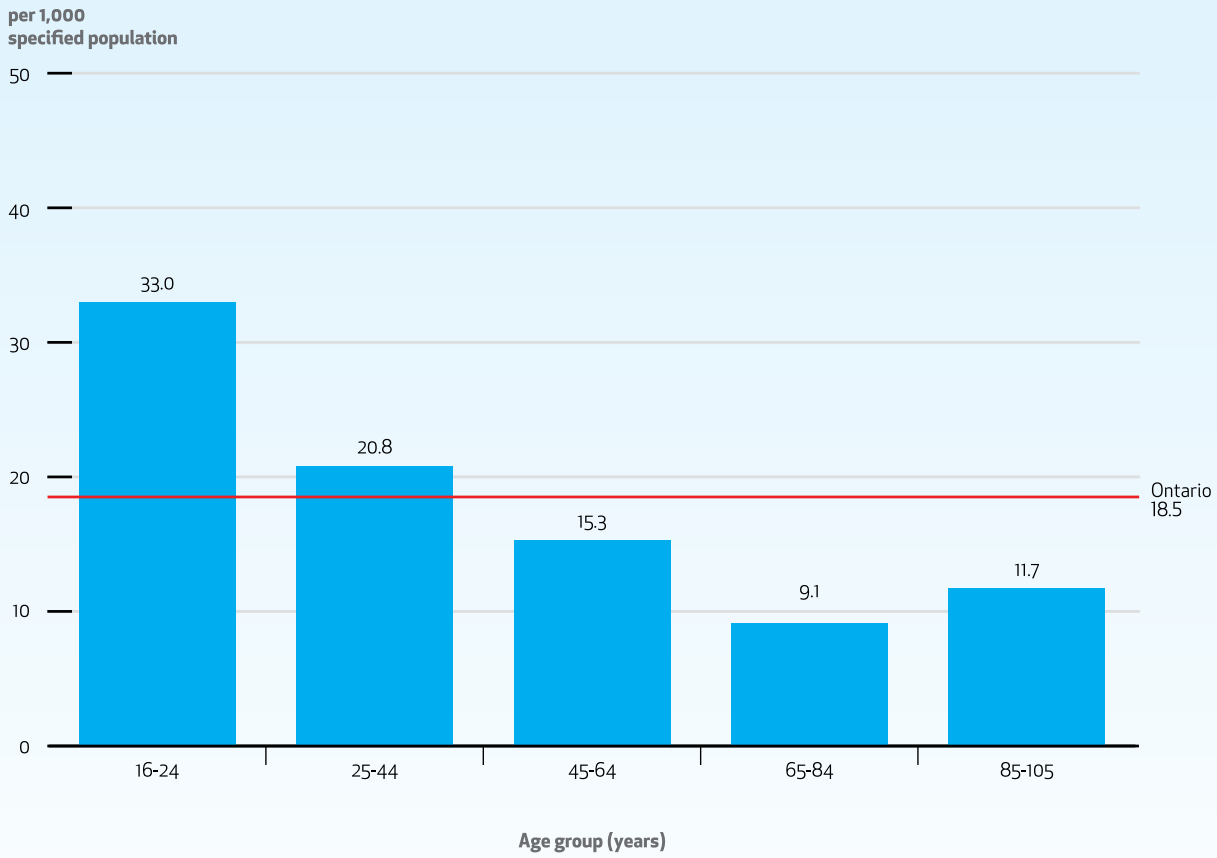
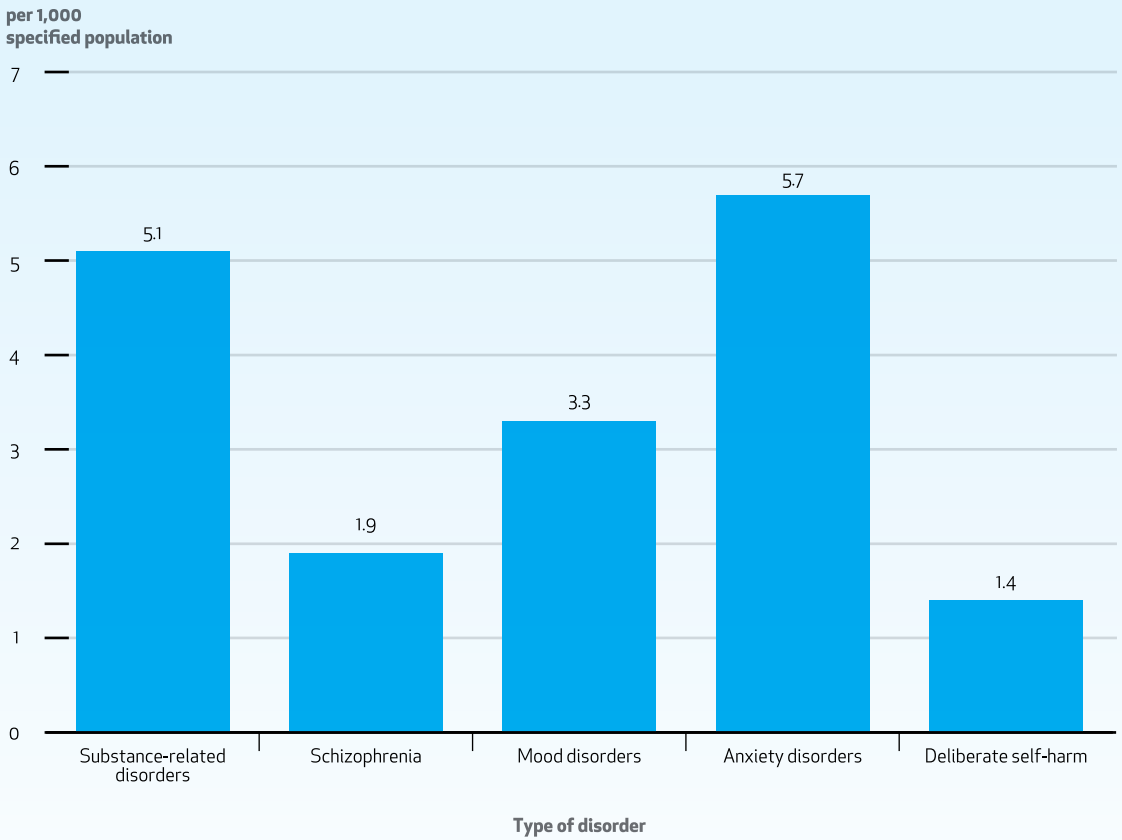


EXHIBIT 3.8.6 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by type of disorder, in Ontario, three-year average for 2012 to 2014*

Key Finding

- Anxiety and substance-related disorders were the most common reasons for an emergency department visit; schizophrenia and deliberate self-harm without a psychiatric diagnosis were the least common reasons.



*Emergency department visits by diagnosis are denominated over the entire Ontario population aged 16 to 105 years, resulting in rates that appear to be lower than rates for other exhibits in this indicator series.

EXHIBIT 3.8.7 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

Key Finding

- An income gradient was observed for MHA-related emergency department visits, such that adults in the poorest neighbourhoods had almost three times the number of visits than adults in the wealthiest neighbourhoods.

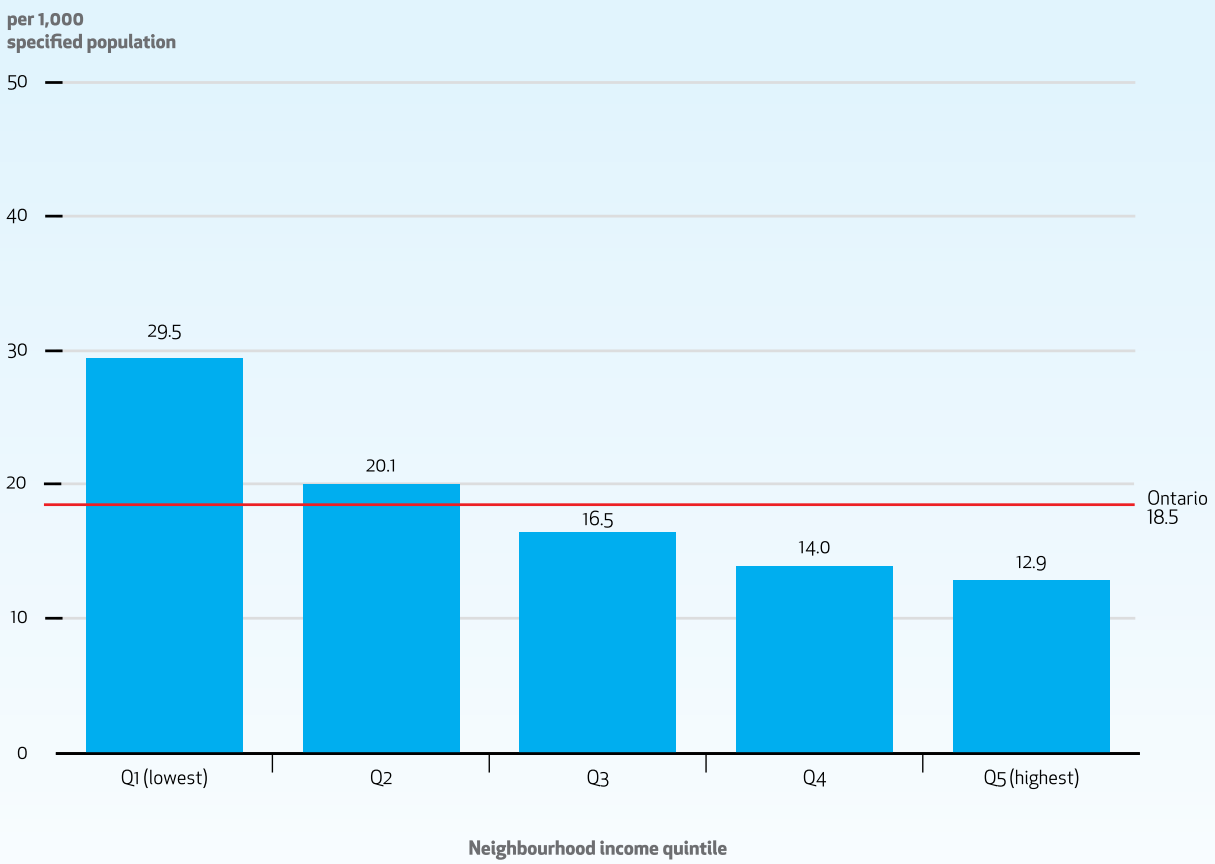


EXHIBIT 3.8.8 Number of mental health and addictions–related emergency department visits per 1,000 crude population aged 16 to 105 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

Key Finding

- Non-immigrants and refugees had the highest rates of MHA-related emergency department visits, and immigrants had the lowest rate.

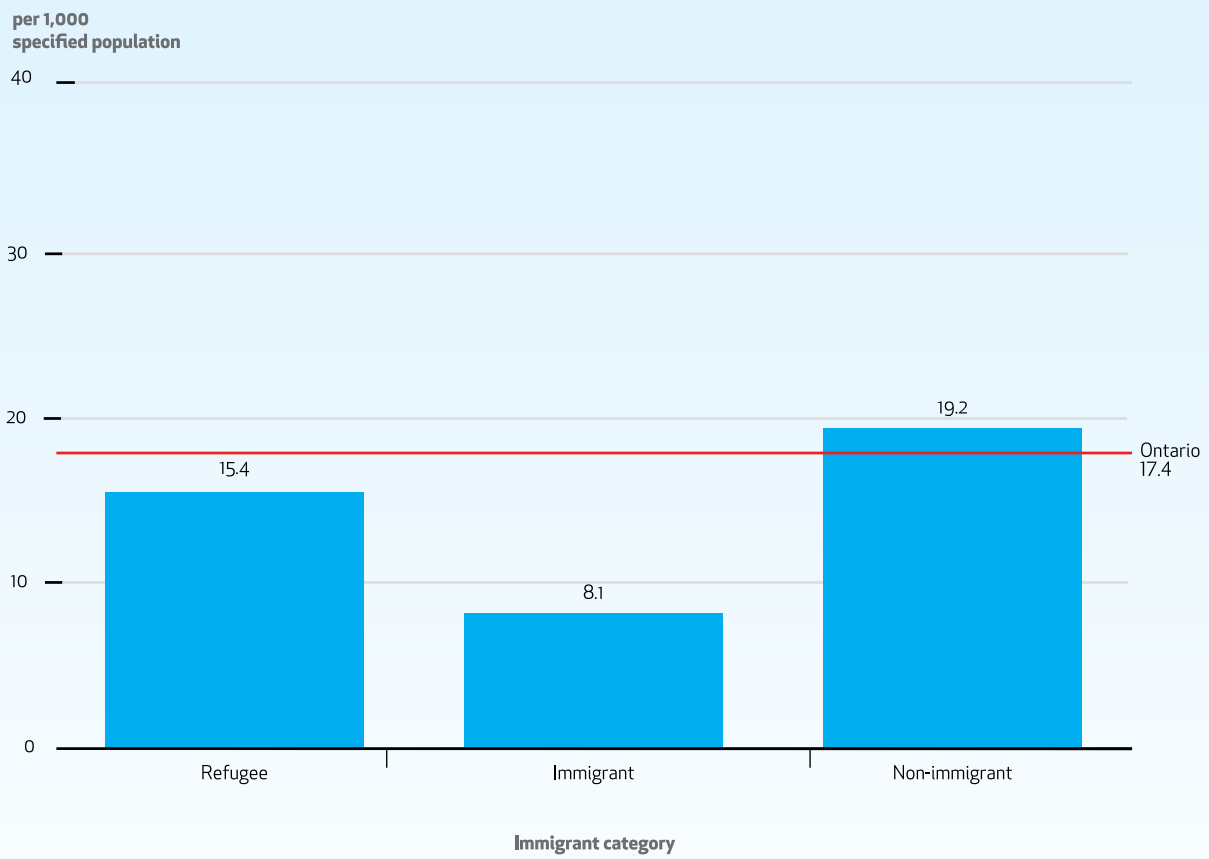


EXHIBIT 3.8.9 Number of mental health and addictions–related emergency department visits per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The highest rates of MHA-related emergency department visits were found in the northern LHINs, where rates in the North East and North West LHINs were about 1.5 to two times higher than the provincial average. The lowest rate of visits was observed in the Central LHIN.

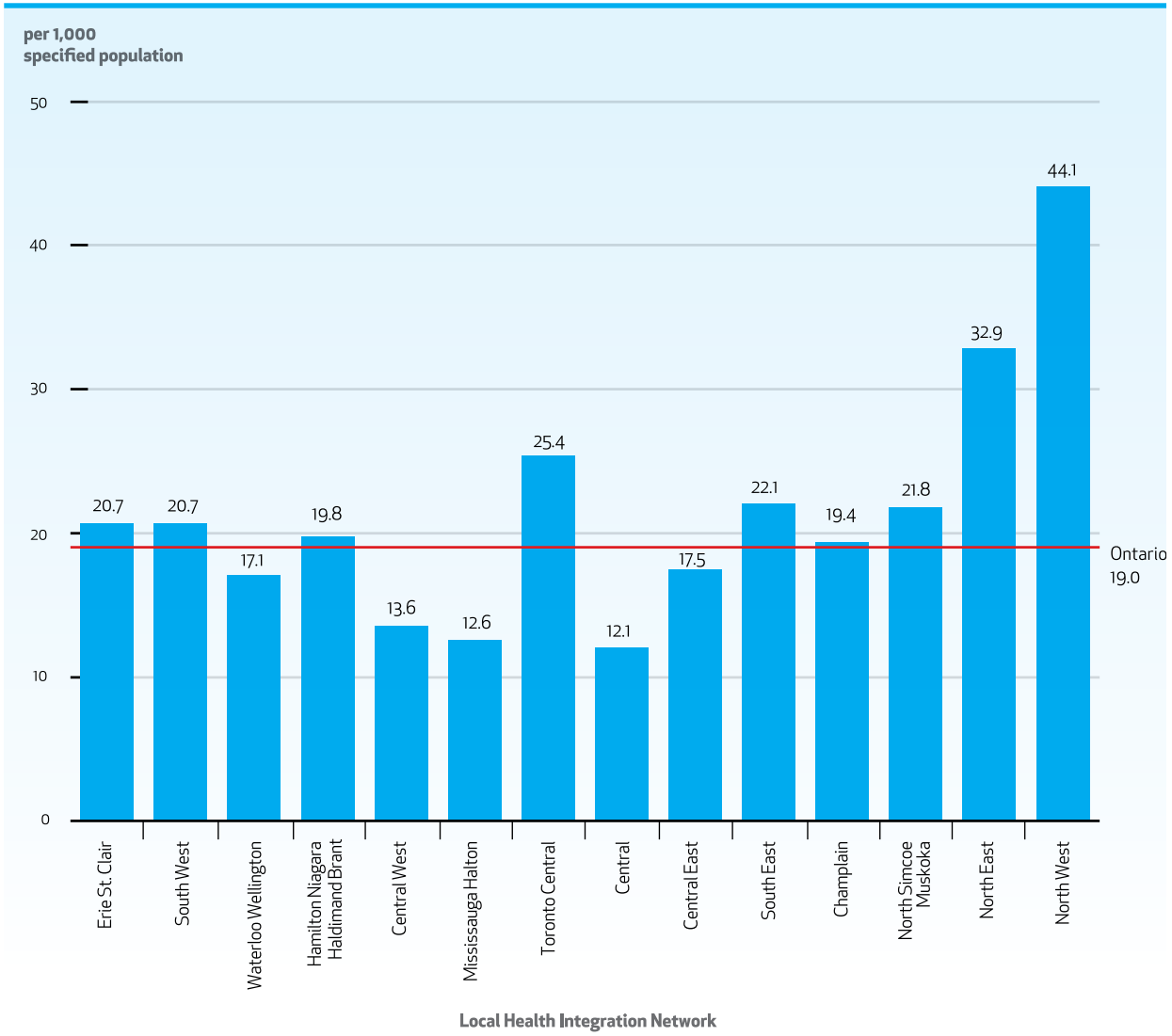
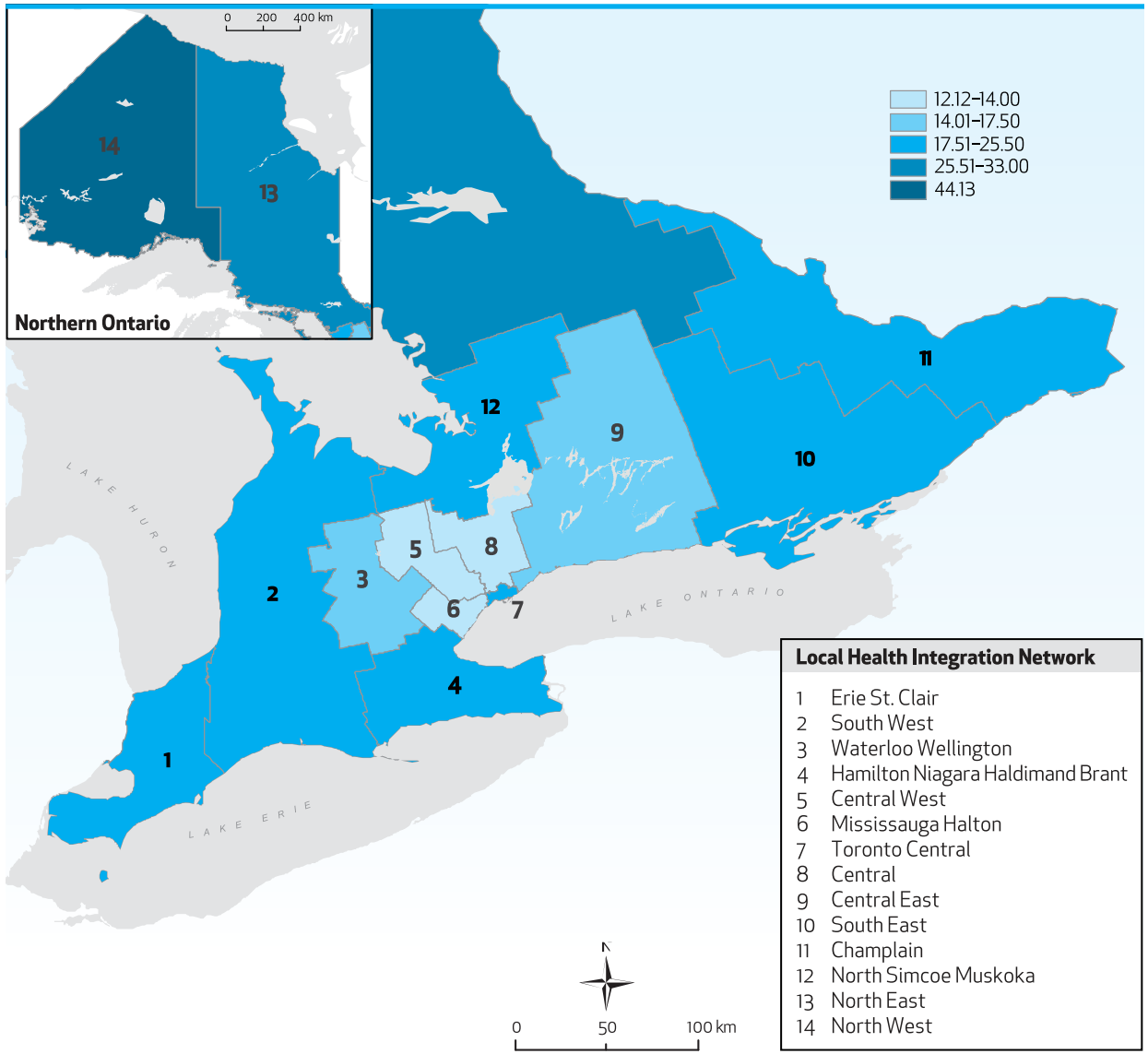


EXHIBIT 3.8.10 Number of mental health and addictions–related emergency department visits per 1,000 standard population aged 16 to 105 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Key Finding

- The highest rates of MHA-related emergency department visits were found in the northern LHINs, where rates in the North East and North West LHINs were about 1.5 to two times higher than the provincial average. The lowest rate of visits was observed in the Central LHIN.



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