

Mental Health and Addictions System Performance in Ontario

2021 Scorecard

SUMMARY

February 2021



Ontario Health
Mental Health and Addictions
Centre of Excellence



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About This Scorecard

Since 2011, ICES (then known as the Institute for Clinical Evaluative Sciences) has been tasked by the Ontario Ministry of Health with monitoring and evaluating the province's mental health and addictions system.

ICES released a **baseline scorecard** on child and youth mental health in 2015, followed by an **updated scorecard** in 2017. Reporting was expanded to include adult mental health and addictions in a **2018 scorecard**. Together, these three reports provide a comprehensive, system-wide view of mental health and addiction trends in Ontario.

The 2021 scorecard adopts an across-the-lifespan approach. It covers the period from 2009 to 2017 and includes 13 indicators grouped into three domains: (1) quality of care indicators – safety, effectiveness, timeliness and efficiency – identified by the Institute of Medicine in 2001 and adopted by Health Quality Ontario (now Ontario Health Quality), (2) descriptive indicators of health service use to provide context to the other indicators and (3) an indicator on opioid prescription use during pregnancy and associated infant outcomes.

ICES works closely with the Ontario Ministry of Health and the Mental Health and Addictions Centre of Excellence to develop a performance measurement framework that monitors and evaluates mental health and addiction system performance across the lifespan, facilitates improved monitoring of shifting mental illness and addiction trends in the province, helps target research areas of interest, and provides more up-to-date research evidence to knowledge users in the mental health and addictions sector.

The infographics presented in this summary highlight selected indicators. Complete results and methods can be found in the 2021 chart pack and technical appendix, both available at www.ices.on.ca.

Performance indicators for Ontario’s mental health and addictions system

Quality of care indicators

Safe	Effective	Timely
<ul style="list-style-type: none"> • Use of physical restraints during psychiatric hospitalizations 	<ul style="list-style-type: none"> • Rates of emergency department visits for deliberate self-harm • Rates of death by suicide 	<ul style="list-style-type: none"> • Rates of emergency department visits as first point of contact for mental health and addictions-related care
Efficient		
<ul style="list-style-type: none"> • Rates of outpatient visits within 7 days following a mental health and addictions-related hospital discharge 	<ul style="list-style-type: none"> • Rates of 30-day hospital readmission following a mental health and addictions-related hospital discharge 	<ul style="list-style-type: none"> • Rates of 30-day emergency department re-visits following an MHA-related emergency department visit

Health service use indicators

- Rates of mental health and addictions-related outpatient visits
- Rates at which individuals were seen by a psychiatrist, general practitioner/ family physician or paediatrician
- Rates of mental health and addictions-related emergency department visits
- Rates of mental health and addictions-related hospitalizations
- Length of stay for psychiatric hospitalizations

Opioid-related indicator

- Rates of prenatal opioid exposure and neonatal abstinence syndrome

Outpatient visits



↑ 9% Between 2009 and 2017, the rate of **outpatient visits** for mental health and addictions care increased from **52.6 to 57.2 visits per 100 people**.

Age groups with the largest increase:

14-17 years:

↑ 58%

18-21 years:

↑ 47%

Age group with the largest decrease:

85-105 years:

↓ 17%

2 IN 3 outpatient visits for mental health and addictions care were to a primary care physician.



Higher rates of outpatient care may reflect greater need, a greater likelihood to seek help, or both.

Emergency department visits



↑ 47% Between 2009 and 2017, the rate of **emergency department visits** for mental health and addictions care increased from **13.5 to 19.7 visits per 1,000 people**.

Age groups with the largest increase:

10-21 years:

↑ >90%

22-24 years:

↑ 75%

25-44 years:

↑ 50%

Conditions with the largest increase:

Substance-related disorders:

↑ 50%

Anxiety disorders:

↑ 39%



The very large increase in emergency department visits compared to the more modest increase in outpatient visits may suggest barriers to accessing outpatient services.

Hospitalizations



↑ 23% Between 2009 and 2017, the **hospitalization** rate for mental health and addictions care increased from **4.5** to **5.5 hospitalizations per 1,000 people**.

Age groups with the largest increase:

10-13 years:

↑ 115%

14-17 years

↑ 136%

Age group with the largest decrease:

85-105 years:

↓ 13%

Conditions with the largest increase:

Anxiety disorders:

↑ 49%

Substance-related disorders:

↑ 25%

The median length of stay in hospital decreased from 8 DAYS TO 6 DAYS.



Results suggest an increased burden of mental illness severe enough to require hospitalization among children and youth.

Emergency department as first point of contact



↓ Between 2009 and 2017, the percentage of **emergency department visits** that were the first point of contact for mental health and addictions care decreased from **33%** to **29%**.

Despite improvements over time, in 2017,

>1 IN 3 **people under 25 and**

>1 IN 4 **people aged 25+**

used the emergency department as their first point of contact.



A high rate of people using the emergency department as a first point of contact suggests barriers to accessing outpatient mental health and addictions care.

Self-harm and suicide



↑ 24% Between 2009 and 2017, the rate of **emergency department visits for self-harm** increased from 15.7 to 19.4 visits per 10,000 people.

Age groups with the largest increases in self-harm:

10-13 years:

14-17 years:

18-21 years:

↑ 128%

↑ 108%

↑ 72%

Between 2009 and 2015, the suicide rate remained unchanged for all age groups:

10 DEATHS PER 10,000 PEOPLE



Despite significant investments in mental health care, preventing suicides and self-harm events remains a challenge.

Conclusion

Overall, there has been an increase in outpatient health service use for mental illness and addictions in Ontario, particularly among young people. There has also been a large increase in the rate of emergency department visits for mental illness and addictions, with the highest rate being among young people aged 14 to 24. Furthermore, self-harm presentations to the emergency department have increased, again particularly among the young, and the rate of suicide has not declined over time.

Taken together these findings suggest that outpatient mental health and addictions services are insufficient to prevent crises that require emergency services or hospitalization.

These findings have important service delivery implications. Clear clinical pathways to triage and coordinated care are critical across the lifespan. Many mental health problems can be treated by primary care providers or by community mental health organizations, with psychiatrist support in collaborative care models. Specialized psychiatric services can then be reserved for individuals who do not achieve remission through such models and individuals with more severe mental illness who require ongoing specialized care.

Limitation

A major limitation of this report is the lack of data on mental health and addictions services provided by nonphysicians, particularly allied health professionals. This information would help us form a more complete picture of mental health service use in Ontario and describe how care is coordinated across different sectors.

About ICES

ICES is an independent, nonprofit research institute that uses population-based health information to produce knowledge on a broad range of health care issues. ICES' unbiased evidence helps measure health system performance, provides a clearer understanding of the shifting health care needs of Ontarians, and creates discussion of practical solutions for using scarce resources. ICES' knowledge is highly regarded in Canada and abroad, and is widely used by governments, hospitals, planners and practitioners to make decisions about care delivery and develop policy.

About the Mental Health and Addictions Centre of Excellence

The **Mental Health and Addictions Centre of Excellence** will support Ontario in building a comprehensive and connected mental health and addictions system.

The Centre has been embedded in Ontario Health, the government agency created to oversee health care delivery in Ontario, so that it can take what has worked to improve quality of care for other conditions and apply the same approaches to mental health and addictions in Ontario.

The Centre is working with partners across the health care system to develop programs and resources to support people who need care and their families.

Ontario Structured Psychotherapy Program

Ontario is increasing access to treatment for depression, anxiety and anxiety-related disorders – the most common mental health conditions. **Ontario Structured Psychotherapy**, a program modelled on the success of the Increasing Access to Psychological Therapies program in England, offers a number of free services, including one-on-one cognitive behavioural therapy, group sessions and online courses. The program is delivered within a measurement-based care framework, with the data used to monitor quality and facilitate quality improvement. The program is being piloted in four regions of Ontario and will be expanded to other parts of the province.

Statement on Indigenous Mental Health Data

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. 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.

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