Taking Stock

A report on the quality of mental health and addictions services in Ontario

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A Report on the Quality of Mental Health and Addictions Services in Ontario

An HQO/ICES Report

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On the cover: Josée, standing near her home. See page 21 for her story. We thank Josée and the other people who share with us their experiences in Ontario's health system. (Cover photo by Roger Yip)

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About Us

Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by this single-minded purpose: **better health for all Ontarians.**

Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voices of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large-scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Institute for Clinical Evaluative Sciences

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization 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.

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Foreword


Dr. Joshua Tepper


Dr. Michael Schull

Mental illness and addictions affect every one of us. Even if you have not experienced a mental illness or addiction yourself, a family member, friend, colleague or neighbour almost certainly has. We don't talk about mental health as much as we should, and we hope this report will change that.

A collaboration between Health Quality Ontario (HQO) and the Institute for Clinical Evaluative Sciences (ICES), *Taking Stock* focuses on the quality of mental health and addictions care in Ontario. This report examines the quality of care and services Ontarians are receiving for mental illness and addictions, and aims to understand how timely, equitable, effective, efficient, and patient-centred that care is – which are many of the domains of quality highlighted in HQOs recently released vision for quality health care and services entitled Quality Matters.

Taking Stock also adds to what we know from the five mental health indicators in the Common Quality Agenda – a set of indicators developed by HQO, in partnership with ICES experts and others, to measure the long-term performance of the health system. These indicators were populated using ICES' health data and expertise, helping to make them relevant to Ontarians.

However, important gaps in information remain, highlighting the need for more – and better – data to gain a broader understanding of how Ontarians with mental illness and addictions are faring. For example, improved data could define what constitutes high-quality care and supports for mental illness and addictions, and capture all the supports and services that people access in the community.

Throughout the report, Ontarians generously share personal stories of their experiences with mental illness and addictions, ensuring that we never lose sight of the people behind the data that we present. Just as we need more data, we also need to hear more from the patients, families and caregivers who are affected by mental illness and addictions.

To improve the quality of the province's mental health and addictions system, the Government of Ontario has developed a mental health and addictions strategy, led by the Mental Health and Addictions Leadership Advisory Council. The Council provides direction on investments, promotes collaboration across sectors and reports annually on the strategy's progress. We hope that *Taking Stock* will inform their work.

Sincerely,

Dr. Joshua Tepper

President and CEO
Health Quality Ontario

Dr. Michael Schull

President and CEO
Institute for Clinical Evaluative Sciences

Executive Summary

While most Ontarians report being in good mental health, many of us live with, or are close to someone who lives with a mental illness or addiction, or both.

As a society, we recognize the burden these conditions put on individuals, families and communities. Every day, family members, friends and other informal caregivers provide support to people with a mental illness or addiction. In hundreds of community agencies, primary care clinics, and hospitals across Ontario, dedicated professionals are committed to improving access and services for people experiencing mental illness and addictions.

Through collective efforts, important progress has been made to reduce stigma and to improve services for people with mental illness and addictions. Still, access to services varies across the province, and the quality of services that are provided can be uneven.

We know that:

- About two million Ontarians are affected by a wide variety of mental illnesses and addictions each year.
- One-third of Ontarians who identified themselves as needing mental health or addiction services in a 2012 survey reported not getting help, or having their needs only partially met. Access barriers identified included a fear of social stigma, an inability to pay out-of-pocket for services, and not knowing where to find help.[1]
- One-third of emergency department visits for a mental illness or addiction are by people who have never been assessed and treated for these issues before by a physician.
- People in rural areas and those in the lowest income group are less likely to have a follow-up visit with a doctor within seven days of discharge from hospital for a mental illness or addiction. New Canadians are also more likely than non-immigrants to be assessed for a mental illness or addiction for the first time in an emergency department.
- Improvements have been made but we still have critical information gaps that are preventing us from pinpointing access and quality issues and resolving them.

It is important that we monitor the quality of the mental health and addictions care that so many Ontarians depend on for their well-being. We need systematic measurement in order to achieve a high-performing system. Work is underway in the province to develop better data: *The Mental Health of Children and Youth in Ontario: A Baseline Scorecard* by the Institute for Clinical Evaluative Sciences paved the way for better data in child and youth mental health, and the Mental Health and Addictions Leadership Advisory Council has recently set out strategies to improve not only performance measurement but also mental health and addictions care in Ontario.

Introduction

Photo by Roger Yip

April: A Helping Hand

April had been feeling depressed, on and off, for about a decade, but this time was much worse. She told her best friend, who then convinced April to see her family doctor. Her doctor was very understanding and walked April through the options for medications and counselling.

Although she was happy with the care she received from her family doctor, April didn't feel that it was enough. As a self-employed massage therapist, she had no medical or health benefits and couldn't afford medication or psychological therapy. Her doctor managed to get her medications through an assistance program. April also received referrals from her doctor to see a couple of psychologists whose services were covered by the Ontario Health Insurance Plan, but she had to wait three or four months for appointments at faraway offices, and was not satisfied with the results.

In the meantime, April says she was really struggling. "It's like being a in a dark hole," she says about her depression. "It's just overwhelming hopelessness. It feels like you have a huge weight on you all the time. Some days, I just lie in bed. I tell myself that I have work to do and I know I need to get up, but I just can't do it."

A competitive long-distance runner, April says exercise helped, but was certainly not a cure. Even when she was running through beautiful parks, she often thought about ways to end her life, looking at passing trees to find the best branch to hang herself from.

After starting medication, April began to improve and her lows were not as low. She is now sharing her experience on Facebook and encouraging others not to be scared to reach out for help from their family doctor, a help line or a friend.

"I think social media campaigns and people like [Olympian] Clara Hughes talking about mental illness has helped a lot," April says. "More people are telling people that they have depression and aren't trying to hide it as much as they used to." But April still worries that there are too many people like herself who don't have drug or health coverage and can't get access to the services they need when they need them.

> "**It's like being in a dark hole. It's just overwhelming hopelessness.** It feels like you have a huge weight on you all the time."

Mental illness and addictions affect one in five people worldwide over their lifetime. Depression, one of the most common mental illnesses, is predicted to become the illness that has the biggest impact on people's lives globally by 2030.[2]

The story is similar in Ontario. While most Ontarians report that their mental health is very good or excellent, at least one million people across the province are affected by a mental illness or addiction each year.[3]

Ranging in degree from mild to severe and in duration from temporary to chronic or recurrent, mental illnesses and addictions can develop at any point in life from childhood into old age. The onset of mental illness often happens at a young age: up to two-thirds of young adults with a mental illness indicated that they experienced symptoms before the age of 15, and up to half of those aged 45 to 64 years reported that their illness started before the age of 25.[4] These conditions can have profound effects on quality of life, affecting personal relationships, the ability to work or study, and the capacity to earn enough money for financial stability. They are also associated with a shortened lifespan, because people with certain mental illnesses are more likely to die from suicide compared to those with no mental illness, and also tend to have higher rates of physical illness.[4, 5]

Fortunately, there are effective treatments for mental illness and addictions. As with many other illnesses, people have the best outcomes when a mental illness or addiction is identified and treated early, which is why it is critical that people know how and where to get the help they need.

Ontario's mental health and addictions system is moving toward developing a clear set of evidence-based standards for the quality of mental health and addictions care that each Ontarian should receive, when and where they need it. By describing how Ontarians use mental health and addictions services in the community, in primary care and in specialty psychiatric settings, this report aims to inform potential strategies for improving the quality of Ontario's mental health and addictions system, by laying the foundation for routine public reporting on mental health and addictions services.

Ontarians' real-life stories lead off each chapter in the report, providing invaluable perspectives on how mental illness and addictions affect people's lives. The people who are experiencing mental illness and addictions are the reason this report exists.

Ontario's mental health and addictions system is moving toward developing a clear set of evidence-based standards for the quality of mental health and addictions care that each Ontarian should receive, when and where they need it.

Mental Illness and Addictions in Ontario

Photo by Roger Yip

Gord: Treating Others with Kindness

Gord couldn't help but smile when one of his clients recently said to him: "Gord, you're the nicest guy I've ever met." As a peer support specialist at a hospital in Toronto, Gord helps other people with mental illness and addictions understand their illness and find out where to get information for more help. A big part of his job is to get to know his clients - and to let them know that he can relate to a lot of their feelings and experiences.

Gord, 58, was diagnosed with schizoaffective disorder at the age of 17, and was hospitalized more than two dozen times for as long as a year. He heard voices, had delusions, such as perceiving that his mother was not his real mother, and was very detached from reality, at one point getting on a bus to Thunder Bay because he was convinced he had to live in the wilderness. Over time, with the right medication, Gord's condition improved, to the point where he began to work in mental health in the early 1990s. He has not been hospitalized in 10 years and now thrives by helping other people transition from hospital to the community.

"I try to help clients keep things in perspective," Gord says. "In my life, I've had a lot of bad times, but the place where it really reveals itself is in the negative sense of well-being. That's where the suffering is. If your sense of well-being is so low, you're not enjoying anything. If I'm in a rut or things are not good, I'll think long-term, things can change, and usually do change. As long as you try your best, things can get better."

In fact, the reason that peer support is possible is that there are more people who are making a good recovery, Gord says, and are able to do this type of professional work. "When peer support started, some people referred to it as a social experiment," Gord says, "but it's really proven to be beneficial. It's now considered a best practice."

Over the years, Gord has seen a lot of advances in how the public perceives mental illness and addictions. Years ago, a former girlfriend of Gord's became homeless and he lost track of her. One winter, while he was in hospital, someone brought Gord a newspaper with a story about his ex-girlfriend with the headline: "Bag lady freezes to death." The headline showed a lack of compassion and dehumanization of the woman by referring to her as a "bag lady." Since then, Gord has seen a reduction in the stigma associated with mental illness, including a greater recognition that recovery is possible.

"People are more aware now," Gord says. "We've acknowledged that years ago people were probably not treated as humanely as we would want, despite good intentions. Those are the roots of peer support, but pragmatically, it's now about providing that help in a way that will really improve somebody's life. Recovery is real."

> "People are more aware now. We've acknowledged that years ago people were probably not treated as humanely as we would want, despite good intentions... **It's now about providing that help in a way that will really improve somebody's life."**

Impact on Families and Caregivers

Family members and informal caregivers face their own challenges in their role of caring for those with a mental illness or addiction. It is very difficult to estimate the impact on caregivers' own health and well-being that results from caring for someone with a mental illness. When it comes to financial impact, one report on caregivers for people with bipolar affective disorder found that more than one-quarter of the caregivers lost income as a result of caring for a family member and nearly one-third incurred major financial costs.[15] In another survey, almost half of Canadians caregivers indicated paying out-of-pocket to care for their loved one, mostly for medication and transportation, with one in four of those spending more than $300 per month.

Mental Illness and Addictions in Ontario

A majority of Ontarians report that their mental health is very good or excellent, according to the 2012 Canadian Community Health Survey. However, close to 10% of Ontarians surveyed report that a mental illness or addiction affected them within the previous year.[3] This would represent about one million Ontarians. However, if we include all Ontarians that visit their doctor every year for a mental illness or addiction, this number goes up to two million. This means one Ontarian in five.

Mental illness and addictions are centred on abnormal thoughts, perceptions, emotions, behaviours and/or relationships with others,[6] all of which can lead to problems at school, at work, and within relationships. Common mental illnesses include anxiety disorders and mood disorders like depression. Other less common but serious mental illnesses include eating disorders, mood disorders such as bipolar disorder, and psychotic disorders such as schizophrenia. Common addictions include alcohol, prescription pain medications, heroin and cocaine, but addiction can involve anything that causes a craving, loss of control, compulsion and continued use regardless of the consequences.[7]

The severity of mental illness and addictions varies widely. For example, someone with mild depression might be fully functional at work, while someone with severe depression might be so disabled that he becomes unable to clean himself or sleep.[8] Often, the symptoms of mental illness and addictions fluctuate over time, with people experiencing periods of well-being and recovery followed by stages of decline. The severity of each person's mental illness or addiction can vary greatly during their lifetime, depending on their circumstances and whether they receive treatment.

What causes mental illness and addictions?

Mental illness and addictions develop and persist through a complex mix of biological, psychological and social factors.[9] A person with a family member who has a mental illness or addiction may be at an increased risk of developing one. Early stressful life events such as trauma and abuse can have a profound impact on later development of conditions such as depression, anxiety, post-traumatic stress disorder and addiction. Other stressful life events such as the death of a loved one, the loss of a job, a relationship break-up or a serious physical illness can trigger the onset or recurrence of a mental illness or addiction. However, sometimes a mental illness will develop without an obvious trigger.

Many social factors also influence people's mental health and can contribute to mental illness and addictions, including a person's life experiences, social life, family, workplace, and the economic conditions in which they live.

Here are a few of the ways in which these factors – known as the social determinants of health – play a key role in people's mental health:

- People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[10] including social stigma, discrimination, and a lack of access to education, employment, income and housing.

- People living in low-income neighbourhoods are more at risk of developing a mental illness such as depression than people living in high-income neighbourhoods.[11]
- People in marginalized groups are more likely to suffer from discrimination, violence, social exclusion and poverty, which can significantly impact their mental health.[10] For example,lesbian, gay, bisexual and transgendered youth face about four times the risk of suicide their heterosexual peers face.

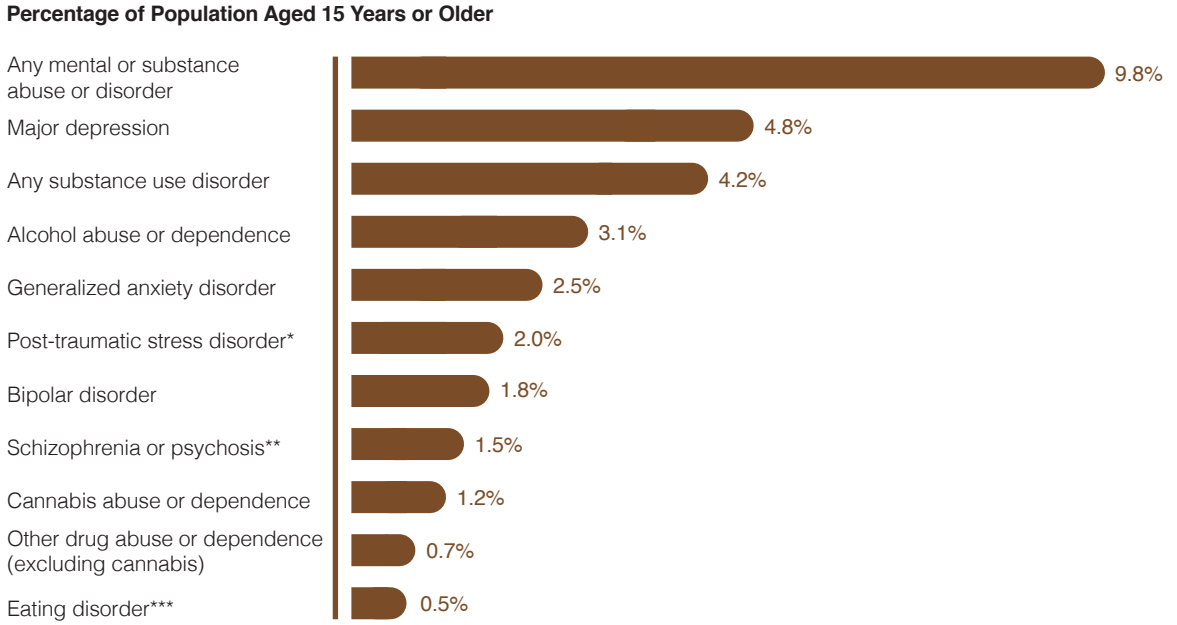
Ontarians can experience mental illness and addiction in many forms and at any point in their life. Major depression is the most common mental illness, with nearly 5% of Ontarians aged 15 and older reporting symptoms of a major depression in the past year. Addiction is also fairly common, with about 4% reporting symptoms of substance abuse or dependence. About 3% of all Ontarians report a diagnosis of a serious mental illness such as schizophrenia or bipolar disorder (Figure 2.1).

Mental illness and addiction often occur together. For example, 16% of Ontarians with alcohol use problems and 29% of those with illicit drug use problems also report symptoms of a mental illness. Similarly, people with a mental illness – especially those with schizophrenia, bipolar disorder and anxiety disorders – are up to twice as likely to have addictions compared to people without a mental illness.[12]

Men and women experience mental illness and addictions differently, as do different age groups (Figure 2.2).

FIGURE 2.1

Percentage of adults having experienced† selected types of mental illness or addiction in the previous year, in Ontario, 2012



Data source: Statistics Canada Table 105-1101 – Mental Health Profile, Canadian Community Health Survey – Mental Health (CCHS) 2012, provided by the Ministry of Health and Long-Term Care.

†Population aged 15 and over classified as meeting criteria for any of the measured disorders in the 12 months prior to the interview based on the Mental Health Survey, unless otherwise indicated.*Population aged 15 and over who reported that they have been diagnosed by a health professional as currently having post-traumatic stress disorder. **Population aged 15 and over who reported that they have ever been diagnosed by a health professional with schizophrenia or psychosis. ***Population aged 15 and over who reported that they have been diagnosed by a health professional as currently having an eating disorder.

FIGURE 2.2

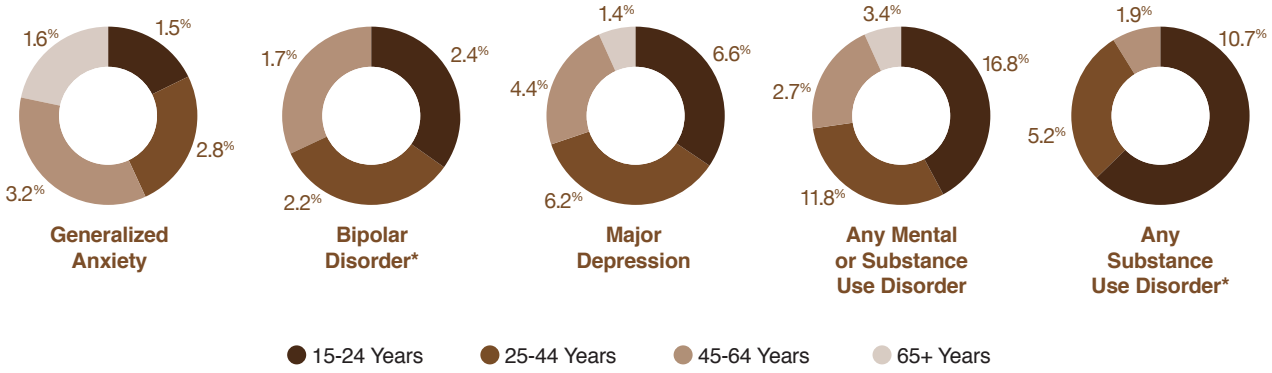
Mental illness and addictions in Ontario – a look by age, sex and condition

- Women are more likely to report having major depression compared with men (5.8% vs. 3.8%)
- Men are more likely to report substance use problems compared with women (6.2% vs. 2.3%)
- By age group, 15-to-24-year-olds report the highest rates of mental illness or addiction (16.8%)

One-year prevalence of mental illness and addictions by sex in Ontario 2012

Women appear to have **higher** one-year prevalence for affective and anxiety disorders.
Men appear to have **higher** rates of substance use disorders.

One-year prevalence of mental illness and addictions by age, in Ontario, 2012



15-24-year-olds report the **highest** levels of one-year prevalence of all but anxiety disorders.

Data sources: Data on prevalence by sex and age group are from Statistics Canada Table 105-1101 – Mental Health Profile, Canadian Community Health Survey – Mental Health (CCHS) 2012, provided by the Ministry of Health and Long-Term Care. * Estimates for population 65 years and older too unreliable to publish.

The cost of mental illness and addictions

Because they often develop at a young age and continue over a long period of time, mental illness and addictions cause major disruptions in people's ability to lead healthy lives. In fact, the combined loss of healthy years of life for nine common mental illnesses and addictions adds up to more than 600,000 years (including years of life lost due to premature death and years of poor health).[13]

The cost of mental illness and addictions can also be measured in economic terms through people's capacity to work, as well as costs for treatments and services. The World Health Organization estimates the cost of mental illness and addictions in developed countries to be between 3% and 4% of the economy (gross domestic product).[14] Direct public expenditures on mental health and addictions services and supports in Ontario amounted to approximately $3.5 billion in 2013-14. This represents an expenditure of $3.1 billion by the Ministry of Health and Long-Term Care and $440 million by the Ministry of Children and Youth Services, which funds Ontario's separate community child and youth mental health system. In addition, many other ministries fund programs and services for mental health and addiction.

In summary

Most Ontarians surveyed report having good or excellent mental health, yet one in five is affected by a mental health or addiction problem each year, which accounts for about two million people in Ontario. Nearly 5% of the Ontarians surveyed report having major depression and 4% report substance abuse or dependence. Often, people with mental illness develop an addiction, and vice-versa, and whether someone is experiencing mental illness, addiction, or both, there is a steep toll in quality of life, as well as in actual economic costs. These highlight the need for early detection and timely treatment.

Direct public expenditures on mental health and addictions services and supports in Ontario amounted to approximately $3.5 billion in 2013-14.

Access to Care for Ontarians with a Mental Illness or Addiction

Photo by Roger Yip

Josée: A Call for Help

"I'd known for a number of years that something wasn't quite right with me. But then everyone has their quirks. And everything was under control," Josée recalls. There was her fear of bridges, which had her making long detours to avoid them, and her burnout of 2006. More recently, during a trip to Labrador, she'd also suffered two panic attacks that had her partner in a state because he thought they were heart attacks. One more funny story to tell friends when they got home.

One February morning, everything changed dramatically. During a run-of-the-mill lovers' quarrel, Josée had a completely new impulse: "I so badly wanted to hit my partner!" She scared herself and started thinking back to her childhood, to the violence she'd experienced and to her father, who had a mental health problem.

"I'd figured out that I needed to do something, but who could I turn to? Luckily, as a former researcher, I was used to digging up information," Josée explains. So she made a list of all the organizations in her area that offered mental health services in French. "It would have been impossible for me to understand and to discuss what was happening to me in a language other than my mother tongue."

That February afternoon, Josée frantically got on the phone to send out an S.O.S., and her calls for help worked. Hawkesbury's Centre Royal-Comtois Center, a community mental health and addictions services agency, was offering a brand-new quick assessment and stabilization program, in French, that seemed designed to help her.

With the support of a team of professionals - including a psychotherapist, an occupational therapist and a psychiatrist - and with some private but mostly group sessions, Josée developed the tools she needed to improve her situation. Accepting the diagnosis was part of the journey. "I had to admit that I was suffering from chronic anxiety, that it was part of my personality and that I'd have to live with it for the rest of my life. The hardest part was overcoming my resistance to taking medication."

Today, Josée is making the most of her retirement. When she and her partner hit the road with their camper, her old worries no longer come along for the ride. "I'm at peace now," she says.

> "**I had to admit that I was suffering from chronic anxiety,** that it was part of my personality and that I'd have to live with it for the rest of my life."

Access to Care for Ontarians with a Mental Illness or Addiction

Ontario's mental health and addictions system has the resources and expertise to deliver a variety of high-quality treatment options. In this report, we distinguish between services delivered in three main settings: the community, primary care and specialty physicians' offices, and hospitals. While there is significant overlap within these categories (for example, physicians often work with community-based programs, and hospitals can run community-based services), they nevertheless provide a useful general description of where and how mental health and addictions services are available in Ontario.

Regardless of the setting, people with a mental illness or addiction should be able to access the help that they need, when and where they need it, and avoid any barriers to getting help. Here, we look at issues related to access to services, including whether Ontarians perceive that they have access to timely care from primary care providers and psychiatrists, and how many Ontarians have their first contact with the mental health and addictions system in the emergency department instead of a physician office setting, which would be preferable. We also examine whether there is equitable access to services, by exploring differences in access by age group, sex, immigration status and by where people live within the province.

What Ontarians say about access to and timeliness of mental health

Not all Ontarians feel that they are able to access the treatment they need. According to the 2012 Canadian Community Health Survey, about 17% of Ontarians aged 15 and older (close to 1.9 million people) reported a need for mental health and addictions services (although not necessarily having a mental disorder) within the last year. More than one-third of these people (almost 700,000) reported that their need was either unmet or only partially met.[3] This group identified a number of barriers that kept them from accessing care for a mental illness or addiction (Figure 3.1).

FIGURE 3.1

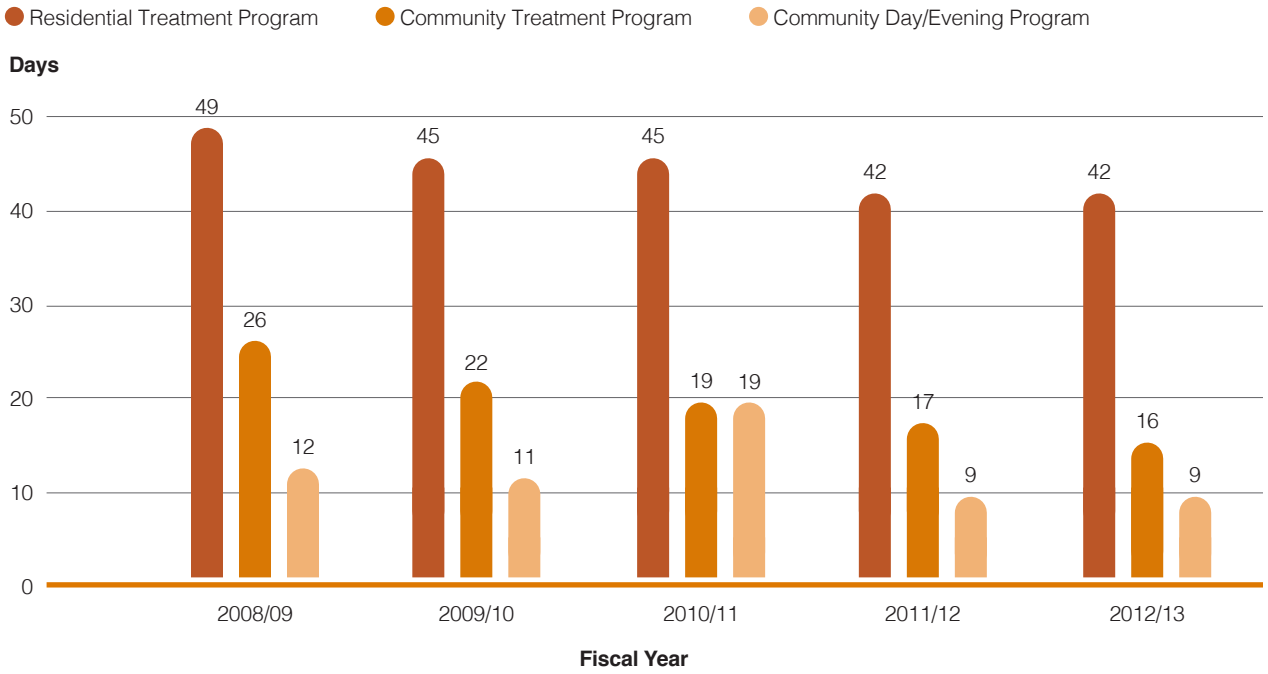
Perceived barriers to receipt of mental health and addictions care services reported by respondents with unmet or partially met needs, by type of need, in Ontario, 2012

Data source: Ontario sample of the 2012 Canadian Community Health Survey Mental Health, provided by the Institute for Clinical Evaluative Sciences.

Another type of barrier is the inability to access services in a timely manner. For the best chance of recovery, people with a mental illness or addiction must have access to services when they need them. Efforts to improve access have led to some noticeable improvements in recent years. Ontarians do not wait as long as they used to for addiction treatment programs. The average wait time for community addiction treatment programs in the province improved to 16 days in 2012/13 from 26 days in 2008/09, and to 42 days for residential addiction treatment programs in 2012/13 from 49 days in 2008/09 (Figure 3.2).

FIGURE 3.2

Wait times for addiction treatment programs in Ontario, 2008/09 to 2012/13

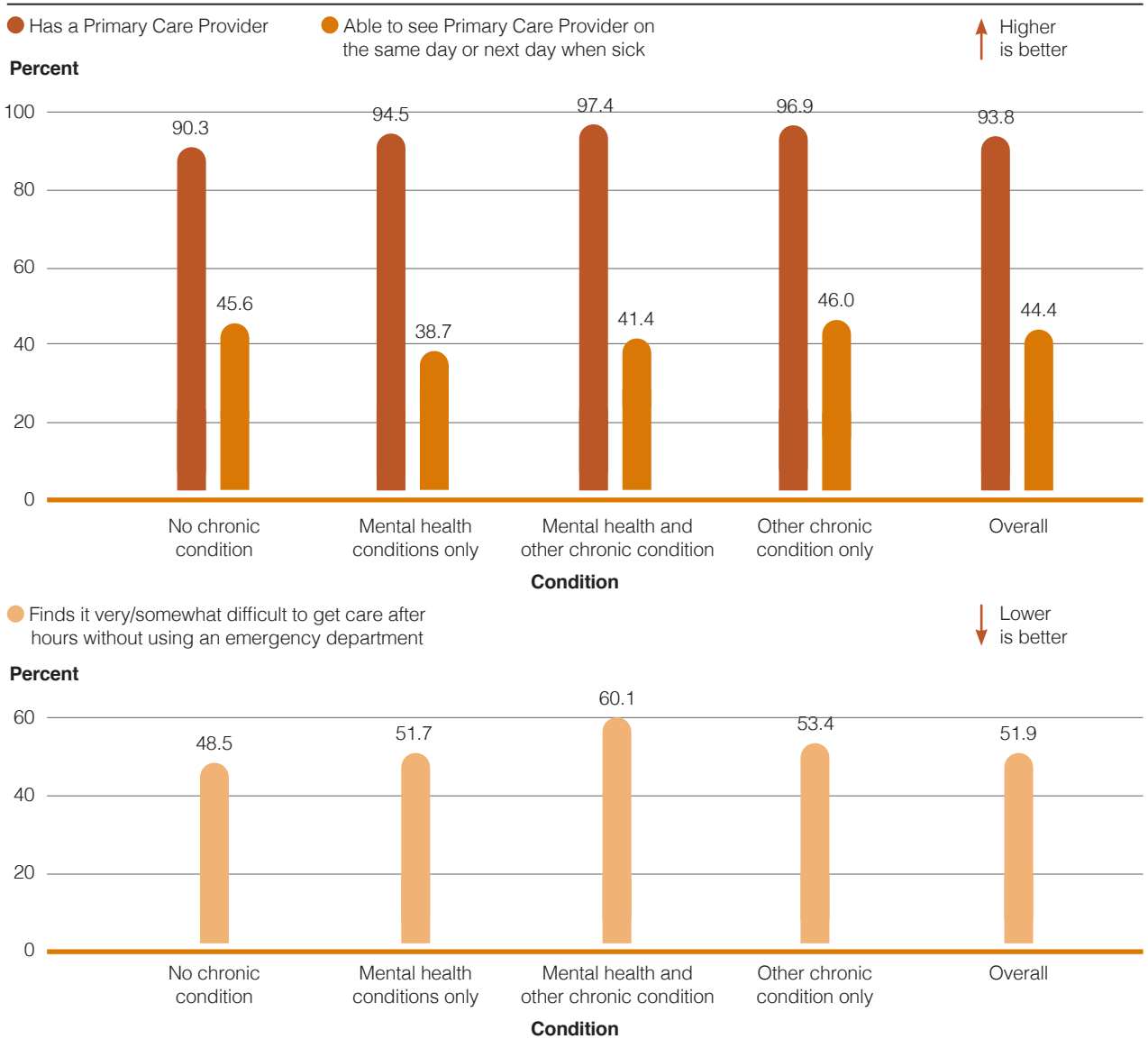


Data source: ConnexOntario, in Choi S. Availability, Utilization, and Related Costs for Addiction Treatment Programs in Ontario: A Report. Collaborative Health Service and Policy Program, Institute of Health Management, Policy and Evaluation, University of Toronto, 2013, provided by the Ministry of Health and Long-Term Care. Note: Wait times data were not available for residential withdrawal programs

However, in other areas, Ontarians are still facing challenges. Timely access to primary care providers remains a concern for people with mental illness (as it is for Ontarians overall). Although most people with a mental illness (94.5%) have a regular primary care provider, only 40% feel that they can see their primary care provider on the same day or next day when they are sick, and about half report that they can see their physician in the evenings or on weekends (Figure 3.3). These figures are comparable for Ontarians without mental illness, but not for people with a mental illness and at least one other chronic condition, among whom a higher proportion than in any other group find it very or somewhat difficult to get care after hours without going to the emergency department.

FIGURE 3.3

Proportion of Ontarians with a primary care provider, able to see their provider in a timely manner and who find it difficult get after-hours care without going to the emergency department, by condition, in Ontario, October 2013 to September 2014



Data source: Health Care Experience Survey, provided by the Ministry of Health and Long-Term Care.

Dr. Shelley Turner: It Could Happen to Anybody

One of Dr. Shelley Turner's first patients at an addictions centre in Thunder Bay was a 17-year-old girl who had gone blind in one eye from injecting liquid cocaine into her neck. "She was very, very addicted," says Dr. Turner, a physician of Aboriginal heritage. The girl regained her eyesight after receiving treatment in hospital and Dr. Turner prescribed methadone to stabilize her addiction. Six months later, the girl, who had returned to school, proudly showed Dr. Turner her grades. She had the highest English mark in her school. Two years later, she was still sober.

These are the kinds of stories that people don't hear, says Dr. Turner, who works mainly with people of Aboriginal heritage. "I have a lot of those good stories where you see people being able to pay the rent, feed the kids, put clothes on their backs, and a big smile on their face because they're so proud of themselves," she says. "That's awesome."

As a physician who cares for a large number of patients with addiction, Dr. Turner says one of her main roles is ensuring her patients have the right medication, but a key part of her work also involves listening to patients and getting to know them. She is at times a cheerleader, a shoulder to cry on, and a navigator.

She is at times a cheerleader, a shoulder to cry on, and a navigator.

First contact in the emergency department

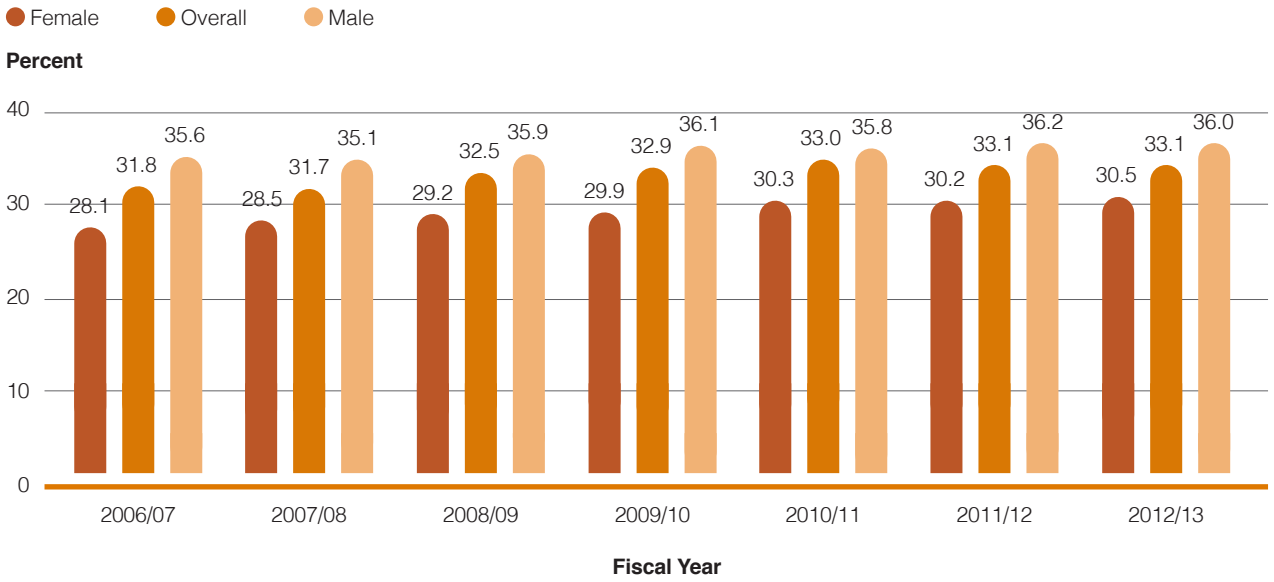
Another way of looking at Ontarians' ability to access mental health and addictions services is to look at the percentage of people who arrive at hospital emergency departments without having previously accessed mental health or addictions services from a physician. When someone has their first contact in the emergency department, it could signal missed opportunities to prevent a mental health crisis through readily accessible services in community settings, although this cannot be confirmed since we only capture data at this point in time on prior contact with a physician. Data on the use of other resources such as psychologists, counsellors, social workers and other community services are not captured.

One-third of Ontarians who go to an emergency department for a mental illness or addiction have had no prior documented outpatient contact with a physician for mental health or addiction care, and this has remained stable over time (Figure 3.4). About 35% of people with anxiety disorders or addictions have their first mental health or addictions contact in the emergency department, compared to 13% of those with schizophrenia (Figure 3.5). Men are more likely than women (36% vs. 30.5%) to have first contact with the mental health and addictions system in the emergency department.

The rate of first contact in the emergency department for a mental illness or addiction is lower among children and youth in Ontario (up to age 24), varying by condition, from less than 2% (16.0 per 1,000 people) for schizophrenia and other psychotic disorders to just under 25% (233.4 per 1,000 people) for anxiety disorders (Figure 3.6).

FIGURE 3.4

First contact in the emergency department for a mental illness or addiction per 100 population aged 16 years and older among those with a visit related to a mental illness or addiction, by sex, in Ontario, 2006/07 to 2012/13



Data sources: National Ambulatory Care Reporting System, Discharge Abstract Database, Ontario Health Insurance Plan Claims Pleas History Database, Ontario Mental Health Reporting System and Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences.

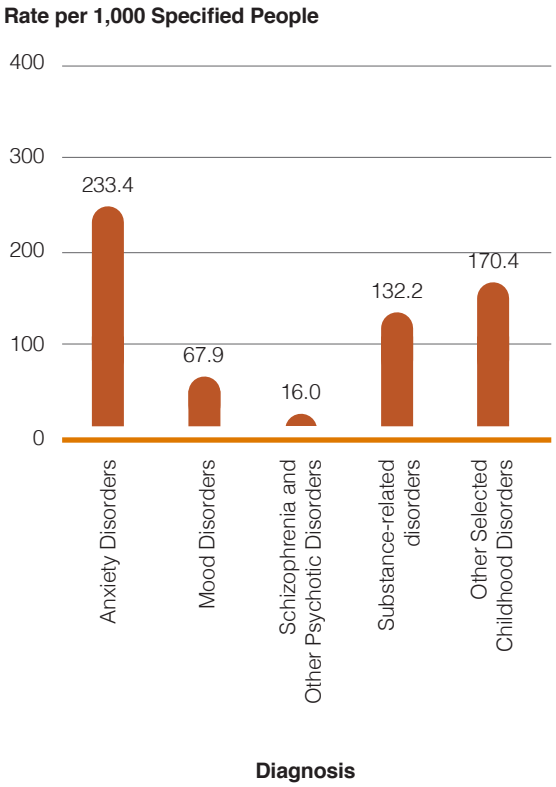
FIGURE 3.5

First contact in the emergency department for a mental illness or addiction per 100 population aged 16 years and older among those with a visit related to a mental illness or addiction, by diagnosis, in Ontario, 2012/2013

Data sources: National Ambulatory Care Reporting System, Discharge Abstract Database, Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System and Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences.

FIGURE 3.6

First contact in the emergency department for a mental illness or addiction per 1,000 population aged 0 to 24 years among those with a visit related to a mental illness or addiction, by diagnosis, in Ontario, 2011/2012



Data sources: National Ambulatory Care Reporting System, Discharge Abstract Database, Ontario Health Insurance Plan Claims History Database, Ontario Mental Health Reporting System and Registered Persons Database, provided by the Institute for Clinical Evaluative Sciences.

Transitions after a hospital stay

After a hospital stay, the transition back to the community can be challenging for many people. There is evidence that interventions designed to help with a smooth transition can prevent problems, such as a return to hospital.[17] In Ontario, less than one-third of patients hospitalized for a mental illness or addiction have a follow-up visit with a doctor within seven days of leaving hospital. In contrast, 44% of patients hospitalized for heart failure will see a doctor within seven days of leaving hospital.[18] This could signal problems with the transition from the acute care setting in hospital to the community. By type of mental illness or addiction, the lowest rate of follow-up visit within seven days is among people who have been hospitalized for schizophrenia or psychosis (Figure 3.7).

FIGURE 3.7

Rate of follow-up with a doctor within seven days of leaving hospital after admission for mental illness or addiction, by diagnosis, in Ontario, 2012/13

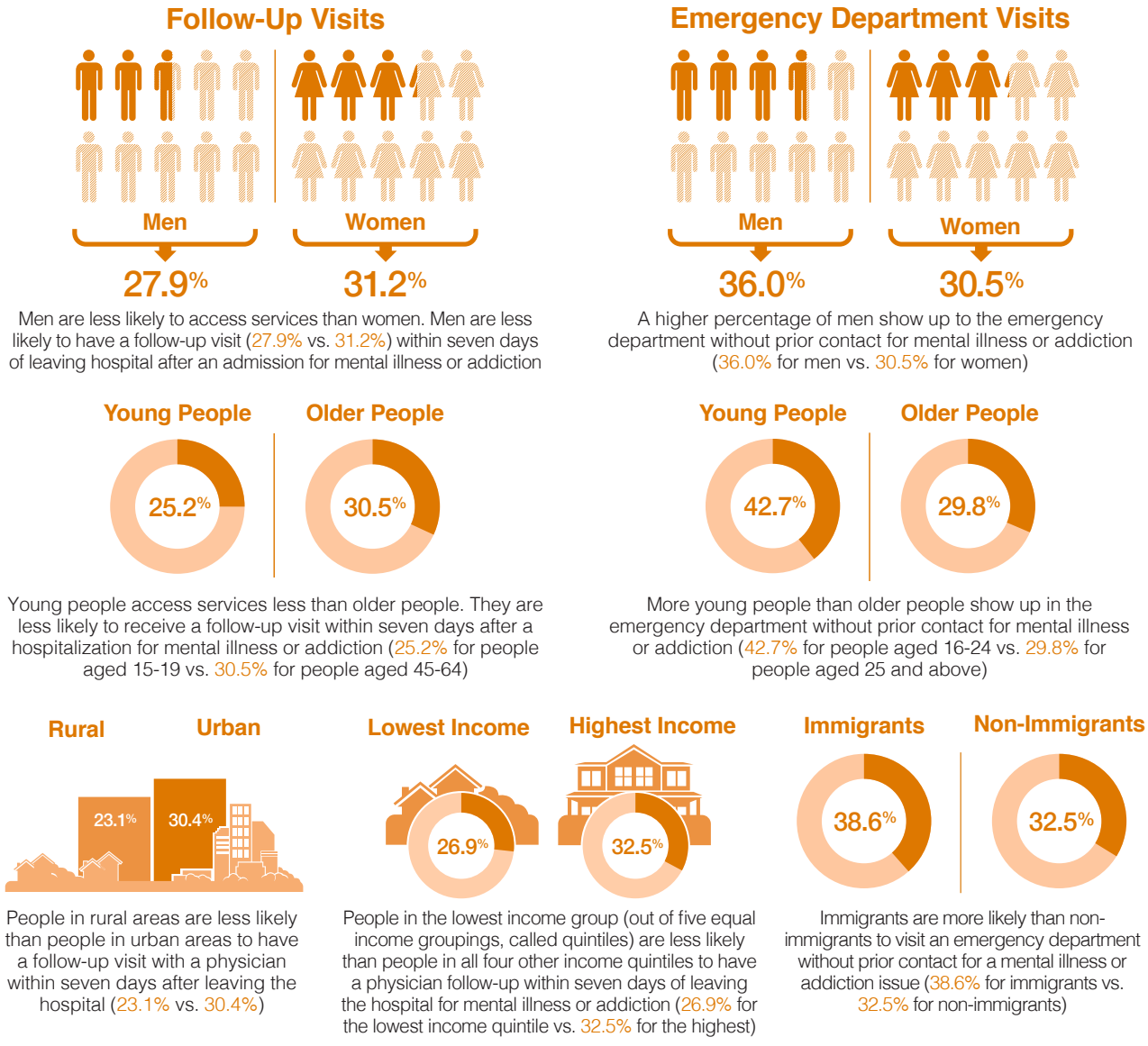
Data sources: Discharge Abstract Database and Ontario Health Insurance Plan Claims History Database, provided by the Institute for Clinical Evaluative Sciences.

Equity and access

In an equitable health system, everyone would have an opportunity to access quality health services based on their need, regardless of factors such as their gender, age, income, immigration status, or whether they live in a rural or urban area. But this is not always the case. In Ontario, there are some groups of people who are less likely to access mental health and addictions services (Figure 3.8).

If we can identify and address the barriers to access in the province's services for mental health and addictions, it could lead to more equitable access and better mental health for Ontarians, particularly those who are marginalized. Services such as self-serve, interactive online programs could help youth access more services. For newcomers to Ontario, community leaders could help reach out to immigrants and break through language and cultural barriers. Each population presents different challenges and offers opportunities for targeted services.

FIGURE 3.8
Variation in access



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database, Ontario Health Insurance Plan Claims History Database, Citizenship and Immigration Canada Database and Yearly Ontario intercensal and postcensal population estimates and projection, provided by the Institute for Clinical Evaluative Sciences.

In summary

Ontarians with a mental illness or addiction need to be able to access the right services in the right place at the right time, but data suggest that this is often not the case. One in three Ontarians who have a perceived need for mental health and addictions services say their needs are only partly met or not met at all. A similar proportion (one-third) of people who go to the emergency department for a mental illness or addiction have had no prior outpatient contact with a physician for a mental illness or addiction in the previous two years. And, access to mental health and addictions services is not equitable across all groups among Ontario's population.

But there are gaps in our information. We don't know the extent to which people are able to access community-based services, and the impacts of these services on people's ability to get the care they need. Moving forward, we need to improve our capacity to measure the entire span of mental health and addictions services so we can identify critical inefficiencies and inequities in how services are delivered. Strategies to improve service delivery can then be developed so that all Ontarians have access to the mental health and addictions services they need, when they need them.

If we can identify and address the barriers to access in the province's services for mental health and addictions, it could lead to more equitable access and better mental health for all Ontarians.

Services for Mental Illness and Addictions

Photo by Roger Yip

Raymond: A Home at Last

Raymond sums up his experience living on the street in Ottawa in one word: hard. The 58-year-old would regularly drink enough alcohol to black out and would then wake up in a hospital, thinking, "How the heck did I get here?"

One day, Raymond was at a drop-in centre and the manager asked if he would like to join the "wet program" – where he would get a limited supply of alcohol throughout a day – at another centre that also provided housing. Raymond said yes, knowing that if he stayed on the street drinking the way he was, he might soon be dead.

At the centre, he has access to a bed, food and laundry facilities. "I don't have to peel my socks off anymore – that's how gross it gets," Raymond says. "You've been out there for a week and even the flies don't want to go near you. I make a joke of it, but it's true. It's not the life I want anymore. I want to have a better life now, and this is pretty well a start."

Raymond, who began drinking at age 16 and was an alcoholic within a year, says the centre's wet program is helping him manage his addiction. The program provides a small drink of alcohol every hour. "It's not enough to get loaded, but it keeps you stable," he says. "It feels better to be stable than to be right out of it."

At the centre, they do crafts, play games, and also take day trips to go fishing, go to the theatre, have barbeques and play pool – all things that Raymond never had a chance to do while living on the street.

Since joining the centre, Raymond has also benefitted from other services, including seeing a mental health nurse, with whom he discussed his feelings about being down about himself and never knowing where he was going to sleep or what he would eat. He is now taking antidepressant medication.

"A lot of times I'd wake up and get lucky and have enough to go and buy myself a bottle and then after I got that bottle, all my cares just weren't there anymore," Raymond says. "When I was drunk, I was past the point of caring and I would just keep going. It's something I don't want to do again."

Raymond is hopeful for his future, although he doesn't want to jump too far ahead with his plans. He's happy to have found a girlfriend at the centre and is grateful for the care he receives. "If it wasn't for the health system and all of this stuff here, where would we be?" he says.

> "**When I was drunk, I was past the point of caring.** It's something I don't want to do again."

Services for Mental Illness & Addictions

In Ontario, treatment for mental illness and addictions is delivered by various types of providers and services across different settings such as the community, primary care and specialty physicians' offices, and hospitals. While many initiatives are in development to systematically collect information on the impact and the quality of the care in each setting as well as overall across settings, the measures currently available are still limited and not evenly available across settings. Still, we are able to present information about the perception of community mental health and addictions services and support, the utilization of primary and acute care services for mental illness and addictions, as well as some measures of the quality of care.

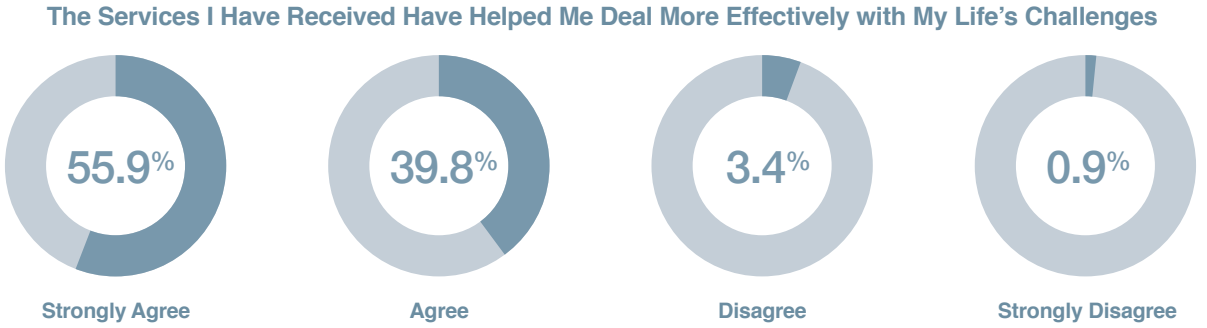
Community mental health and addictions services

Services provided by community mental health and addictions agencies have made a big difference in the lives of people like Raymond. Although we do not systematically collect information on the effectiveness of these services and supports, a pilot study involving 1,753 respondents across 23 diverse sites in Ontario found that the majority of people surveyed after receiving care from community mental health and addictions services said the care they received helped them deal with their life's challenges (Figure 4.1).

The same survey also showed that people felt that they received the services they needed in community mental health and addictions programs, that they found the environments welcoming, inclusive and comfortable and that they felt safe at all times (Figure 4.2).

FIGURE 4.1

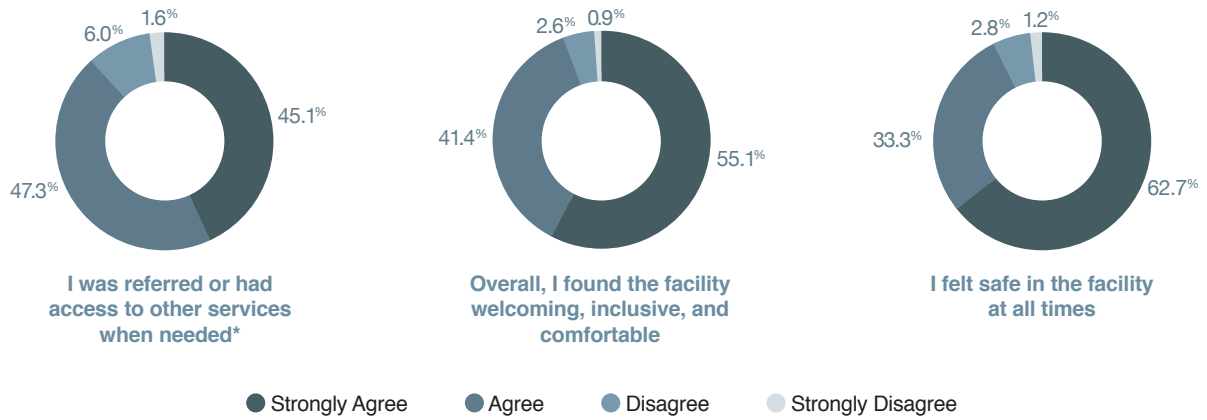
Perceived effectiveness of the community mental health and addictions services received, in Ontario, 2012



Data source: Results from the Ontario Perception of Care for Mental Health and Addictions (OPOC-MHA) Tool Pilot Study, from Health Canada's Drug Treatment Funding Program (DTFP), led by Brian Rush, Scientist Emeritus, Social and Epidemiological Research Department, Centre for Addiction and Mental Health.

FIGURE 4.2

Perceptions of usefulness and comfort with community mental health and addictions services received, in Ontario, 2012



Data source: Results from the Ontario Perception of Care for Mental Health and Addictions (OPOC-MHA) Tool Pilot Study, from Health Canada's Drug Treatment Funding Program (DTFP), led by Brian Rush, Scientist Emeritus, Social and Epidemiological Research Department, Centre for Addiction and Mental Health. *Including alternative approaches in addition to the programme or service enrolled in and that is being assessed.

Primary care

Each year, at least two million Ontarians go to a family doctor or psychiatrist with a mental health or addiction concern. The people who make these visits represent 15% of Ontario's population, or roughly one out of every seven people (Figure 4.3).

Ontario primary care providers, including family doctors and nurse practitioners, play an important role in mental illness and addictions within the broader system of community, hospital and specialized services. Ideally, people with a mental illness or addiction would turn to their primary care provider to get assessed and receive any treatment, advice and referrals to other care providers, depending on the type and severity of their illness. Those with more complex needs would be referred to psychiatrists or other specialist services.

Other mental health and addictions services providers, such as psychologists, social workers and psychiatric nurses, provide psychotherapy services, but they are not always part of Ontario's publicly funded health system. No-cost access to these providers in the province is generally only available through outpatient hospital services, and sometimes through Family Health Teams or other primary care models. These services are usually covered – at least in part – by an extended health insurance plan through the workplace, but many Ontarians do not have access to these plans, or the plans may not cover enough to meet their needs.

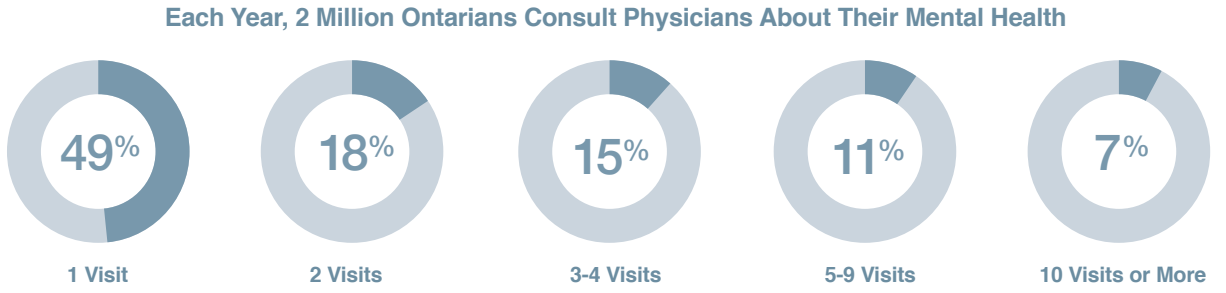
Among the people who visit a family doctor or psychiatrist for mental illness or addiction, more than half make multiple visits per year and almost one in five make at least five visits per year (Figure 4.3). Compared with other age groups, a slightly higher proportion of Ontarians aged 35 to 64 visit physicians for a mental illness or addiction. Adults aged 19 to 54 account for the highest use of physicians' services for mental health and addictions care.[19]

In total, there are roughly seven million visits to physicians' offices in Ontario each year for a mental illness or addiction, accounting for about 10% of all visits to physicians in the province.[19] Primary care offices receive the majority (two-thirds) of these visits, with the other one-third going to psychiatrists.

For children and youths (up to 24 years old), the rate of outpatient visits is highest in the transition years, that is, among 15-to19-year-olds and 20-to-24-year-olds, with most of the visits being to psychiatrists. While the rates of outpatient visits for the overall population in recent years have been fairly stable, the rates have increased for children and youth, and especially for 15-to-19-year olds, who in 2002/03 saw a psychiatrist at the rate of 24.6 per 1,000 youths, which rose to 33.8 in 2011/12.[20]

FIGURE 4.3

Percentage of patients by number of visits to a family doctor or psychiatrist for a mental illness or addiction, in Ontario, 2013/14



Data source: Ontario Health Insurance Plan Claims History Database, provided by the Ministry of Health and Long-Term Care. Note: Visits for mental health and addictions conditions excluding dementia and developmental disabilities.

Odette: Good Work

Odette says getting a job at her local mental health community program in North Simcoe was the best thing that happened to her. She started at the community program looking for help for herself, but was soon working there and helping others, Before that, Odette's depression led her to isolate herself from everyone and everything. She was withdrawn, confused and always tired.

"I felt like I couldn't fit in to places or jobs," Odette says, "but when I started here, they said 'Work within your strengths. What you can do, do, and we'll try to work around it.' And they did." Performing a variety of tasks, including coordinating guest speakers at the program's social club, doing dishes for club dinners, and tending to the garden, Odette gradually reconnected with parts of her life that she had lost, and also discovered new interests, including fundraising. "It is a grounding, stabilizing force in my life, and means very much to me," Odette says about her job. "I can't say enough about the positive reinforcement. When you're not sure of yourself, people say, 'You can do it. You're doing a great job.'"

Odette has seen a lot of changes in the people who come to the program, and in others like herself who work there. "I've become more open. I've been able to see growth in myself and growth in other people, too," she says; "I've had blinders on for a long time. They seem to be letting down and I'm opening up more."

People with mental illness or addiction are marginalized socially, financially and in so many other ways, Odette says, and having a job helps in every way, but especially in gaining self-confidence. When they first asked her to list her strengths, Odette didn't know and didn't think it was anybody's business. "Slowly but surely I got my trust back in people and learned that it was safe and it was OK," she says. "I really started to grow and to share my inner feelings."

> " **Slowly but surely I got my trust back in people** and learned that it was safe and it was OK."

Photo by Roger Vo

Specialist care

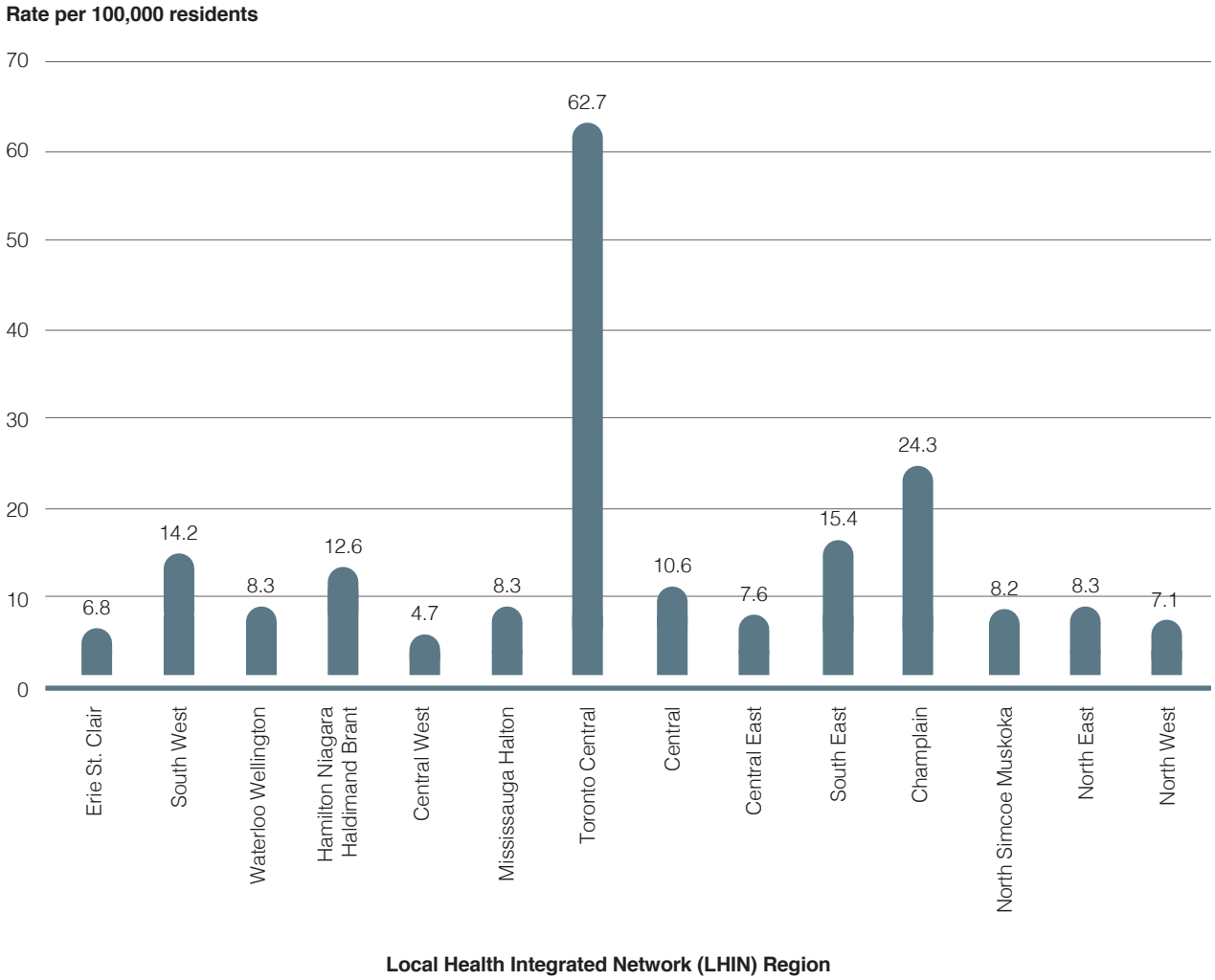
People who need to see a mental illness and addictions specialist, such as a psychiatrist, face challenges with accessing them at the right place and time. The number of psychiatrists per 100,000 residents in Ontario (15.7) varies widely across the province's 14 Local Health Integration Network regions, from a low of 4.7 per 100,000 in the Central West LHIN region to a high of 62.7 per 100,000 in the Toronto Central LHIN region (Figure 4.4).

In areas where there are more psychiatrists (high-supply areas), each psychiatrist, on average, sees fewer patients more often. For example, psychiatrists in the Toronto Central LHIN region see half as many patients as psychiatrists from low-supply areas like the Central West LHIN region. However, psychiatrists in the Toronto Central LHIN region see 8.3% of their patients more than 16 times per year, while psychiatrists in low-supply LHIN regions see just 0.3% of their patients more than 16 times per year.[21]

The patients who visited a psychiatrist more often were wealthier and less likely to have been admitted to a hospital for a mental illness or an addiction than the ones who visited a psychiatrist less often. It is not clear whether seeing a psychiatrist more often results in improved mental health for patients, but this pattern of care across the province does mean that accessing a psychiatrist in a region with a high supply can be just as challenging as it is in regions with a low supply.[21]

FIGURE 4.4

Supply of full-time psychiatrists per 100,000 residents, in Ontario, by LHIN region, 2009



Sources: The Institute for Clinical Evaluative Sciences Physician Database, and Statistics Canada 2001 census estimates, provided by the Institute for Clinical Evaluative Sciences.
Note: Visits for mental health and addictions conditions excluding dementia and developmental disabilities.

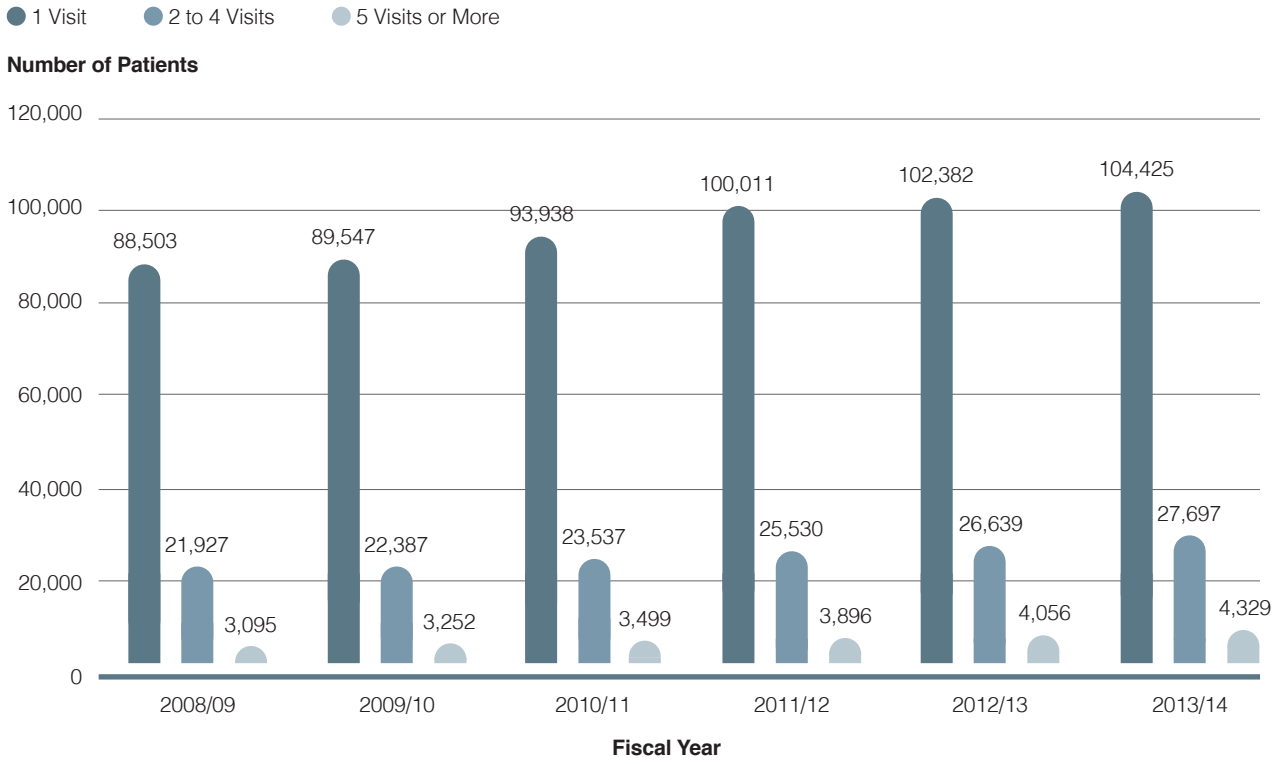
Hospital care

While crisis intervention services are often available in the community, emergency departments are critical for people when they are experiencing a mental illness or addiction crisis. People may also end up in emergency departments if they have challenges accessing mental health and addictions services outside the hospital, particularly if they face delays in accessing services, and could end up being admitted to hospital for treatment.

The number of patients visiting an emergency department for a mental illness or addiction has increased since 2008/09. While most patients with a mental illness or addiction visit the emergency department only once during a year, some will make two to four visits, and a small number will visit five times or more (Figure 4.5).

FIGURE 4.5

Number of patients visiting an emergency department for a mental illness or addiction, by frequency of visits, in Ontario, 2008/09 to 2013/14



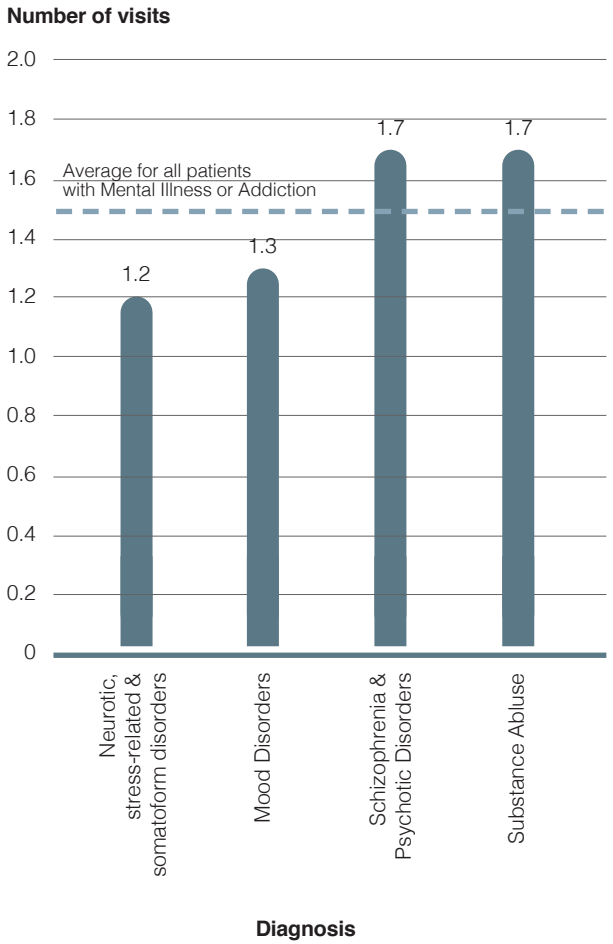
Data source: National Ambulatory Care Reporting System, provided by the Ministry Health and Long-Term Care.
Note: Visits for mental health and addictions conditions excluding dementia and developmental disorders.

Overall, the average number of emergency department visits for a mental illness or addiction is 1.5 per patient. Patients with a substance abuse problem or a psychotic disorder use the emergency department more frequently, on average (Figure 4.6).

Visits for a mental illness or addiction made by children and youths to emergency departments over a three-year period reveal that 15-to-19-year-olds have the highest rate of visits, at 18 per 1,000 people, followed closely by 20-to-24-year-olds, with just over 16 per 1,000 people (Figure 4.7).

FIGURE 4.6

Average number of emergency department visits per patient related to a mental illness or addiction, by selected diagnosis, in Ontario, 2013/14



Data source: National Ambulatory Care Reporting System, provided by the Ministry Health and Long-Term Care. Note: Visits for mental health and addictions conditions, excluding dementia and developmental disorders.

FIGURE 4.7

Rate of emergency department visits related to a mental illness or addiction per 1,000 population aged 0 to 24 years, by age group, in Ontario, three-year average for 2009/10 to 2011/12

Data sources: National Ambulatory Care Reporting System, Registered Persons Database and Citizenship and Immigration Canada Database, provided by the Institute for Clinical Evaluative Sciences.

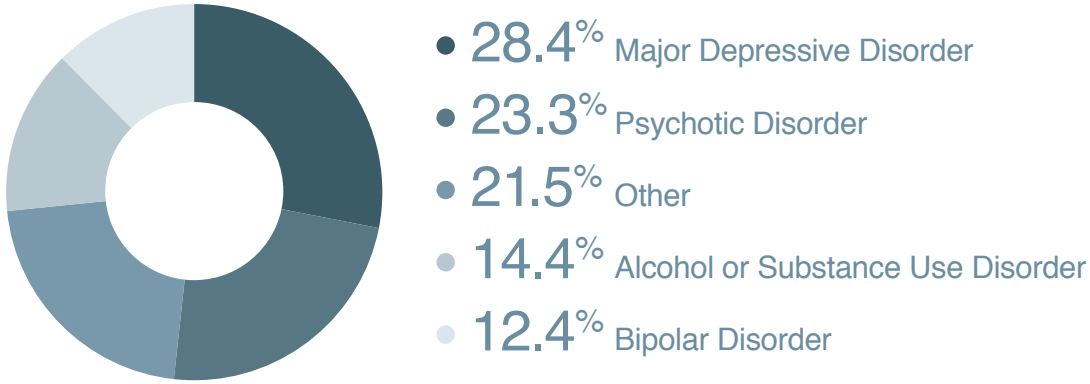
Inpatient hospital care

Ontario hospitals offer a range of services for people with a mental illness or addiction, some of which require hospitalization. Overall, about five people per 1,000 Ontarians are hospitalized for a mental illness or addiction in a year. This rate has been relatively stable over the last six years.[22]

Looking at the main diagnoses of the people admitted for the first time to a designated mental health bed in Ontario over a five-year period, major depression and psychotic disorders account for more than half of all first admissions, with 28.4% for major depression and 23.3% for a psychotic disorder (Figure 4.8).

FIGURE 4.8

Percentage of all first hospital admissions for a mental illness or addiction, by diagnosis, in Ontario, between 2008 and 2013



Data source: Ontario Mental Health Reporting System, provided by the Institute for Clinical Evaluative Sciences. Note: Based on main discharge diagnosis on the first admission for 95,055 unique individuals admitted to a designated mental health bed in Ontario between 2008 and 2013.

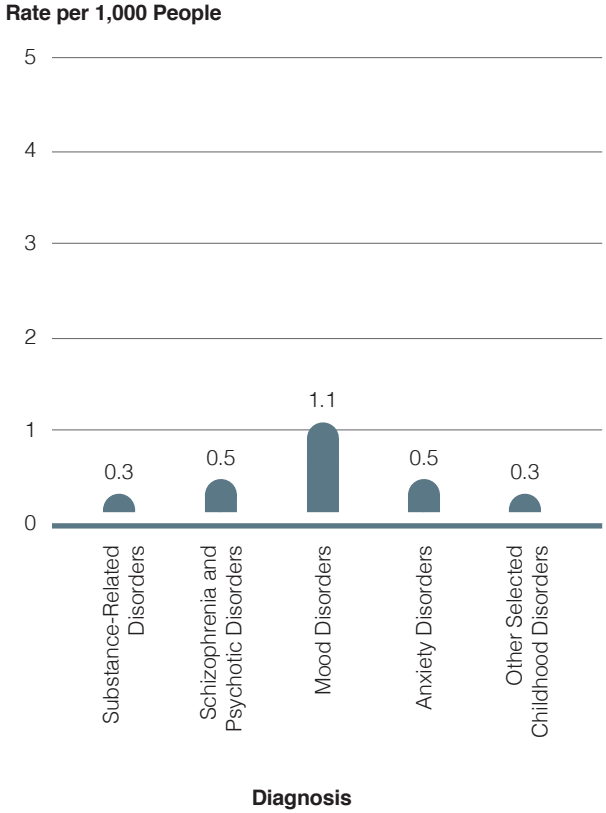
Hospitalization for a mental illness or addiction can happen at a young age. The highest rate of hospitalization among children and youths (up to 24 years old) is for mood disorders, with just over 1 hospitalizations per 1,000, about twice the rate for anxiety disorders (Figure 4.9). These rates have been increasing over time.[23]

If people do not have access to needed supports and care in the community after being hospitalized, they could end up being readmitted to hospital. Overall, just over 12% of people admitted to hospital for a mental illness or addiction get readmitted within 30 days.[23] The readmission rates for people admitted to hospital for a mental illness or addiction is slightly higher than for patients admitted for surgical treatment (7%) and slightly lower than for patients admitted for medical treatment (14%).[18] Patients with schizophrenia or another psychosis have the highest rate (12.5%) of readmission within 30 days after leaving the hospital (Figure 4.10). It is important to note that a readmission may also reflect the worsening of a patient's condition unrelated to the quality of care.

In the case of children and youths, we look at hospital revisits, which include readmissions as well as visits to an emergency department after a previous visit or admission for a mental illness or an addiction. The revisit rate for a mental illness or addiction among children and youths is under 20 per 1,000, except for schizophrenia and other psychotic disorders, where it is 73 per 1,000 (Figure 4.11).

FIGURE 4.9

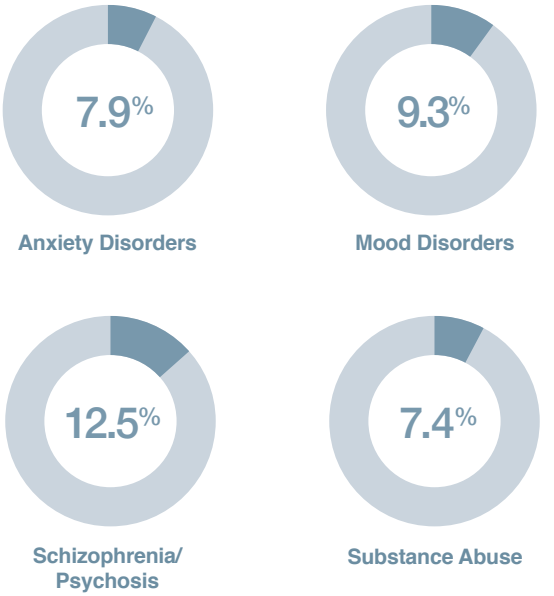
Rate of hospital admissions related to a mental illness or addiction per 1,000 population aged 0 to 24 years, by diagnosis, in Ontario, 2011/12



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Registered Persons Database and Citizenship and Immigration Canada Database, provided by the Institute for Clinical Evaluative Sciences. Rates were standardized by age and sex to the 2002 Ontario population

FIGURE 4.10

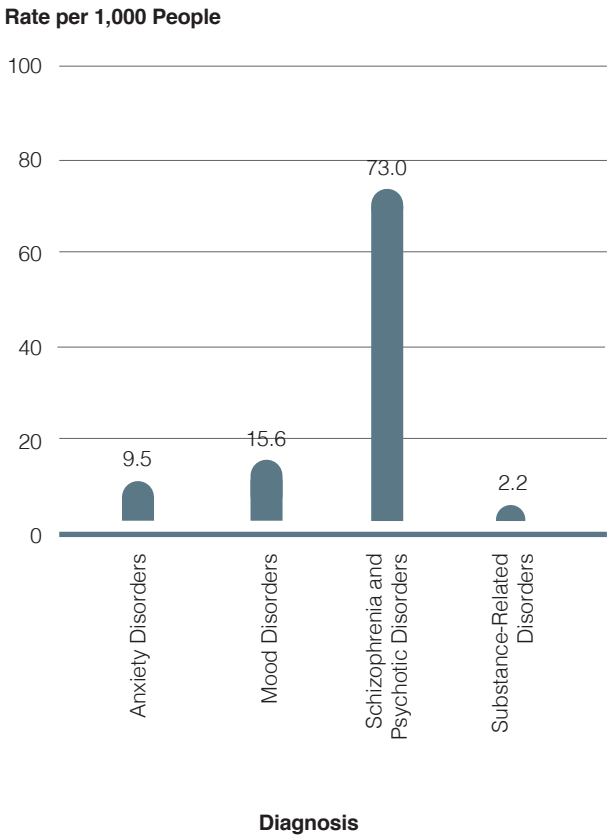
Hospital readmission rate within 30 days for a mental illness or addiction per 100 population aged 16 years and older, by diagnosis, in Ontario, 2012/13



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, National Ambulatory Care Reporting System, Registered Persons Database and Citizenship and Immigration Canada Database, provided by the Institute for Clinical Evaluative Sciences.

FIGURE 4.11

Rate of hospital revisits (emergency department visit or admission to hospital) within 30 days of an emergency department visit related to mental health and addictions per 1,000 population aged 0 to 24 years, by diagnosis, in Ontario, 2011/12



Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, National Ambulatory Care Reporting System, Registered Persons Database and Citizenship and Immigration Canada Database, provided by the Institute for Clinical Evaluative Sciences.

In summary

Ontarians can access mental health and addictions services through various types of providers in the community, in the primary care setting and in hospitals. A wide range of services are provided in the community, but data are not systematically collected on the effectiveness of these services and supports. We have more information about services in primary care. At least two million Ontarians go to the doctor with a mental health or addiction concern each year, more than half of whom make multiple visits per year. Each year in Ontario, two-thirds of the mental health or addiction visits are to primary care physicians and visits to psychiatrists account for the other third.

Hospital emergency departments play an important role in critical care for people with a mental illness or addiction, and the number of patients visiting an emergency department for a mental illness or addiction in Ontario is on the rise. About five people per 1,000 Ontarians are hospitalized for a mental illness or addiction in a year, a rate that has remained relatively stable in recent years, and more than 12% of people admitted to hospital for mental illness or addiction get readmitted within 30 days.

People may also end up in emergency departments if they have challenges accessing mental health and addictions services outside the hospital, particularly if they face delays in accessing services, and could end up being admitted to hospital for treatment.

The Road Ahead

Photo by Roger Yip

This report takes stock of the current state of mental health and addiction care in Ontario, so that we can define a clear path forward to improve services – through evidence – for Ontarians with a mental illness or addiction.

We now know that while most Ontarians report being in good mental health, a substantial number are living with a mental illness or addiction, and in many cases, both. People across Ontario are working to provide services and supports to help people achieve and sustain recovery, and yet, despite our best efforts, many Ontarians are not getting the mental health and addictions services they need. Pathways of care are often fragmented across different sectors of the mental health and addictions system, causing problems for some people when they transition from one provider to another.

Many people with a mental illness or addiction are having their first mental health assessment in an emergency department, which could mean that people are having problems accessing physician services. Access to treatment, services and supports is inconsistent, with people who live in rural or remote communities being less likely to receive timely, high-quality care. Younger people do not always appear to have equitable access to mental health and addictions services compared to older people, and new Canadians and lower-income earners are less likely to access quality services in Ontario.

So how do we make things better? To focus improvement in mental health and addictions care in the areas where quality gaps are most apparent, we first need to measure how the system is performing. Those performance measures will be a key piece of the Ontario government's strategy, *Open Minds, Healthy Minds,* which launched in 2011. The strategy began with a first phase focusing on child and youth mental health, along with a scorecard developed by the Institute for Clinical Evaluative Sciences. This report supports Phase 2 of the ministry's strategy, as it bridges the gap between child and youth services and adult services.

There is a lot of other work underway to find new and better ways of measuring the quality of our mental health and addictions system.

Some of those activities include:

- Health Quality Ontario reports on key indicators related to mental health and addictions as part of the Common Quality Agenda, a set of focused indicators covering the province's broader health system. These indicators of quality will continue to evolve.
- Health Quality Ontario is also working toward developing quality standards for the treatment of some mental illnesses, including depression, schizophrenia and dementia.
- The Institute for Clinical Evaluative Sciences will again develop a scorecard for quality of care for Phase 2 of the ministry's strategy, helping to improve the capacity to monitor and report on the quality of care for mental illnesses and addictions in Ontario.
- Ontario's Mental Health and Addictions Leadership Advisory Council will help advance the work for the *Open Minds, Healthy Minds* strategy.
- The Ontario division of the Canadian Mental Health Association and Addictions and Mental Health Ontario is working to support a culture of continuous improvement in the community-based mental health and addictions sectors.
- At the national level, the Mental Health Commission of Canada continues to provide leadership to improve the mental health system across the country.
- Internationally, the World Health Organization and the International Initiative for Mental Health Leadership are driving improvements in measurement, quality of care and overall understanding of how to improve mental health. Many of Ontario's mental health and addictions leaders are part of this national and international work.

The access and quality issues highlighted in *Taking Stock* are often the result of the many parts of the system not working together as they should, despite best efforts locally across Ontario to improve service coordination. This report is a first step toward monitoring and reporting on the mental health and addiction system in Ontario to help us assess how we are doing as we go forward. For the sake of April, Gord, Josée, Raymond, Odette and all of the other Ontarians who are experiencing a mental illness or addiction, we need to make sure this work continues.

Methods Notes

The Methods Notes provide a brief description of the methods used in this report. For more details, please see the Data Sources and Indicators Description on HQO's website.

Indicator selection

The report expands on the five mental health indicators in the Common Quality Agenda – a set of indicators developed by HQO, in partnership with ICES experts and others, to measure the long-term performance of the health system. By adding indicators, it is possible to look more closely at the quality of care and services Ontarians receive for mental illness and addictions.

This report also builds on the Evaluation Framework and Scorecard developed for each of Phase 1 and Phase 2 of *Open Minds, Healthy Minds*, Ontario's comprehensive mental health and addictions strategy. HQO and ICES, in collaboration with the Ministry of Health and Long-Term Care and Ontario's Mental Health and Addictions Leadership Advisory Council, selected Phase 1 and Phase 2 Evaluation Framework and Scorecard indicators and also added some contextual indicators.

Data sources

The data presented in this report were supplied by a variety of data providers, including ICES and the Ontario Ministry of Health and Long-Term Care (MOHLTC).

Survey, clinical, administrative and pilot project data were used for the analysis. Below are the data sources used:

- Citizenship and Immigration Canada Database (CIC)
- ConnexOntario
- Discharge Abstract Database (DAD)
- Health Care Experience Survey (HCES)
- National Ambulatory Care Reporting System (NACRS)
- Ontario Health Insurance Plan Claims History Database (OHIP claims)
- Ontario Mental Health Reporting System (OMHRS)
- Ontario sample of the 2012 Canadian Community Health Survey Mental Health (CCHS-MH)
- Registered Persons Database (RPDB)
- Ontario Perception of Care for Mental Health and Addictions (OPOC-MHA) Tool Pilot Study results from Health Canada's Drug Treatment Funding Program (DTFP)
- The Institute for Clinical Evaluative Sciences Physician Database (IPDB)
- Yearly Ontario intercensal and postcensal population estimates and projection

For a full list of data sources as they relate to each indicator, please refer to Data Sources and Indicators Description on HQO's website.

Diagnosis groups

For the purpose of this report, mental health conditions include addictions but exclude dementia and developmental disabilities.

Where relevant and possible, the results are reported by the most common categories of mental health disorders, which are:

- Substance abuse or substance-related disorders including alcohol and other substance use
- Anxiety disorders such as panic disorder, obsessive-compulsive disorder, phobias and generalized anxiety disorder
- Mood disorders such as depression and bipolar disorder
- Schizophrenia and other psychotic disorders

Limitations

There are certain limitations to take into consideration when interpreting the results.

- The prevalence of mental illness and addictions reported are estimates based on responses to a survey and not on actual diagnoses. While the method used to assess mental health disorders on the basis of a questionnaire is similar to the World Health Organization Composite International Diagnostic Interview (WHO-CIDI) and provides very good estimates, it is not as precise as basing prevalence rates on actual diagnoses.
- In some instances, the indicators reported do not cover the whole population. That is the case, for example, for the Canadian Community Health Survey - Mental Health, a survey that excludes persons living on reserves and other aboriginal settlements, full-time members of the Canadian Forces, and the institutionalized population. It is also the case for some of the patient experience indicators that are based on a pilot project that includes a diverse and representative sample of Ontario's addiction and mental health agencies, but not all agencies. While the data still cover a significant and representative portion of the population, it is possible that the non-inclusion of some sub-populations introduces some biases.
- The unavailability of data for privately provided services such as consultations with psychologists or social workers makes it impossible to assess the full range of services people may access.
- Similarly, the impossibility of linking data in many instances precludes drawing a complete picture of the pathways and transitions between services and support used in different settings, such as the community, primary care and specialty physicians' offices and hospitals.

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Health Quality Ontario's Performance Monitoring and Public Reporting

Since 2006, Health Quality Ontario has been creating a better health system by reporting on its performance

Our public reporting not only gives Ontarians the information they need to understand about their health system, it can also lead to direct improvements. Our public reporting products include:

Measuring Up, our yearly report on the health system's performance, theme reports that delve into focused topics and online reporting of health system indicators.

The Common Quality Agenda

The Common Quality Agenda is the name for a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting. Health Quality Ontario uses the Common Quality Agenda to focus improvement efforts to track long-term progress in meeting health system goals to make the health system more transparent and accountable. The indicators promote integrated, patient-centred care and form the foundation of our yearly report, Measuring Up. As we grow our public reporting on health system performance, the Common Quality Agenda will evolve and serve as a cornerstone for all of our public reporting products.

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