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Getting the story on mental health services

Mental health services constitute a significant part of our health system. And yet there is still a great deal about mental illness—and how to improve mental health—that we don't understand.

CIHI is working with our partners to fill some of the gaps. In this issue, you'll read about our new mental health reporting system—built at Ontario's request. You'll also learn about how we are collaborating with Statistics Canada to study outcomes in the treatment of depression. New national indicators, developed in consultation with primary health care experts across the country, have the potential to provide the health system and Canadians with new tools for assessing the effectiveness of mental health services. As well, this issue includes new analysis on the mental health nursing workforce.

But that's not the whole story. To learn more, read on . . .

A man with schizophrenia at a shelter for the homeless. CP

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Canadian Institute for Health Information

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From the President

One in seven hospitalizations in Canada involve patients diagnosed with mental illness. In fact, mental illness is associated with a third of the total number of days patients spend in Canadian hospitals. And that doesn't even begin to tell the story of community-based mental health services.

Clearly, mental illness has a big impact on Canadians and their health system. And while we can't yet measure the full extent of that impact, our capacity for doing so is improving.

> We are committed to exploring ways to fill existing gaps in mental health information

When we opened our doors 12 years ago, CIHI could tell you how many people were entering Canadian hospitals with a mental illness and how long they stayed. By piecing together information from a variety of enhanced or new databases, we can now also tell you such things as how many nurses work in mental health and what percentage of time family doctors are dedicating to counselling. Through our new pharmaceutical database, we'll be able to start looking at drug utilization for mental illness.

As you will read in this issue, with the recent addition of the Ontario Mental Health Reporting System—which we built at Ontario's request—we can go much farther. This system not only provides the health system and Canadians with critical data on hospital stays relating to mental illness, but it includes tools that can be used in real time by clinicians to do such things as admissions assessments—useful in flagging patients at high risk for suicide and other problems. Ontario is already benefiting from having a fuller picture of mental health patients.

But sometimes the whole is worth more than the parts.

We'd like to furnish decision-makers and Canadians with a more comprehensive picture of mental health across Canada—not just for health services, but also from a population health perspective. Such information is critical for decision-makers as they consider the level and effectiveness of mental health services and addiction treatments offered by the provinces and territories, and by the country as a whole.

We are encouraged by the interest and prospects for more comparable interprovincial data on mental health. We are committed to exploring ways to fill existing gaps in mental health information.

And speaking of people with a strong interest in filling health information gaps, I wish to acknowledge the contributions of two departing members of CIHI's Board of Directors: Penny Ballem, former Deputy Health Minister in British Columbia, and Jocelyne Dagenais, former Assistant Deputy Minister of Strategic Planning, Evaluation and Information Management at Quebec's ministère de la Santé et des Services sociaux. But I'm very pleased to welcome new board member Roger Paquet, Deputy Minister, ministère de la Santé et des Services sociaux, Quebec.

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As of October 2006

Facts-at-a-glance

Mental health

- Percentage of Canadians who will personally experience a mental illness in their lifetime: **20**[1]
- Percentage of people living with a serious mental illness whose primary caregivers are family members: **almost 60**[2]
- Age range during which hospitalization is most likely to occur: **25 to 54 years**[3]
- Average length of stay related to mental illness in Canadian general hospitals in 2003–2004: **16.9 days**
- Average length of stay in psychiatric hospitals: **148.5 days**
- Total patient days in both general and psychiatric hospitals in 2003–2004: **6,678,292**[4]
- Total number of inpatient discharges and deaths in 2003–2004 in Canada related to mental illness: **192,562**
- Percentage from general hospitals: **86.5**
- Percentage from psychiatric hospitals: **13.54**[4]
- Number of nurses in Canada in 2005 practising in mental health: **21,243**
- Number of them that are male: **almost one in five**[5]
- Percentage of family physicians offering mental health care services in Canada in 2003: **84.2**[6]

1. Health Canada, *A Report on Mental Illnesses in Canada* (Ottawa: Health Canada, 2002).
2. The Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (commonly referred to as "The Kirby Report"), (Ottawa: Senate of Canada, 2006), originally from Toronto-Peel Mental Health Implementation Task Force, *The Time Has Come: Make It Happen. A Mental Health Action Plan for Toronto and Peel* (Toronto: Government of Ontario, 2002).
3. Canadian Institute for Health Information, *Hospital Mental Health Services in Canada, 2002–2003* (Ottawa: CIHI, 2005).
4. Canadian Institute for Health Information, *Availability of Hospital Mental Health Data, 2003–2004* (Analysis in Brief) (Ottawa: CIHI, 2006).
5. Canadian Regulated Nursing Professions Databases.
6. Canadian Institute for Health Information, *Evolving Role of Canada's Fee-for-Service Family Physicians, 1994 to 2003* (Ottawa: CIHI, 2006).

CIHI announces regional presence in Atlantic Canada

Steve O'Reilly

CIHI is pleased to welcome **Steve O'Reilly** to the newly created position of **Executive Director, Atlantic Canada.** Steve will work closely with health stakeholders in Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland and Labrador to better understand and meet their health information needs.

Steve brings more than 15 years of experience in this region's health sector. Most recently, Steve served as CEO of the Newfoundland and Labrador Centre for Health Information (NLCHI). Steve is an experienced researcher who has developed and implemented provincial and national health information systems and played a leadership role in introducing national data standards.

To contact Steve O'Reilly, email him at **soreilly@cihi.ca**.

Transitions

Indra Pulcins is CIHI's new **Director, Health Reports and Analysis**. Formerly Manager of Health Indicators, Indra has played a key role in working within and outside of CIHI to build a diverse set of comparable indicators for Canada's health regions. Indra holds a doctoral degree from the Department of Health Administration at University of Toronto.

Francine Anne Roy is the new **Director, Health Resources Information**. Francine Anne has extensive knowledge of CIHI's databases and health spending, health human resources and pharmaceuticals through her previous assignment as Manager, Health Human Resources. She comes to CIHI from the Ottawa Hospital and holds a master's in Project Management.

Caroline Heick is the **Director, Health Services Information**, in CIHI's Toronto office. Caroline is familiar with branch programs through her previous assignment as Director, Data Quality and Classifications. Prior to joining CIHI, Caroline worked with the PricewaterhouseCoopers health care consulting practice and holds a master's in Business Administration.

How CIHI gave Ontario a new way to report on mental health

Ontario's health ministry knew it needed a system to support mental health data submission and reporting. Having worked with the Ontario Hospital Association and other partners to develop a powerful new instrument for data collection, the ministry was planning to mandate its use in the province's 70 facilities with designated adult inpatient mental health beds. But it quickly realized that this tool alone could not monitor quality control and conduct data analysis.

So in 2004, the province turned to CIHI. The result is the Ontario Mental Health Reporting System (OMHRS)—the first system in Canada to contain demographic, clinical, administrative and resource information all specifically designed to support inpatient mental health services planning.

Using this new system, hospitals started their data collection and reporting for all mental health admissions on October 1, 2005.

The new mental health reporting system incorporates the Resident Assessment Instrument—Mental Health (RAI-MH)©, a unique standardized system with applications such as care planning and quality improvement. It is used to collect assessment data on a range of issues related to admission and discharge, including suicide risk, substance use, nutrition and medications. Hospitals can tailor the system to meet their own needs.

This new reporting system, intended to complement CIHI's Hospital Mental Health Database (which covers most of Canada), is already supporting Ontario facilities' service planning and management requirements and also informing the work of clinicians, researchers and policy-makers. Most importantly, however, it is helping to enhance the care received by Ontario residents hospitalized for mental illness.

For more information, please email **omhrs@cihi.ca**.

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Measuring primary health care—
an important part of the mental health picture

For most Canadians, the first point of contact for health services—including mental health care—is a primary health care (PHC) provider, such as a family doctor or a nurse practitioner. But information on this critical entry point into the health system is limited.

"We can't manage what we can't measure," says Judith MacPhail, a consultant for the PHC Indicator Development Project at CIHI. "Currently, we know little about how PHC services are delivered and the results of these services. We need more comparable information about how the system is evolving in Canada so regions can learn from one another."

Early last year, CIHI launched the first-ever consensus-building process aimed at selecting and developing a list of pan-Canadian PHC indicators, some of which deal with mental health care.

The first phase—which included consultations with health ministries, researchers, health providers and professional associations from across the country—resulted in a list of 105 indicators that can be used to compare and measure PHC. An abridged list of 30 indicators is now the potential starting point for measuring primary health care in a consistent way and across regions. CIHI is looking into options for collecting PHC data.

"When used within the right context, a well-developed indicator can provide decision-makers with important information on the performance of the health care system or on the health of a population," says MacPhail.

Groups interested in measuring PHC and mental health services can benefit from these indicators by agreeing to capture similar data so they can learn from each other.

Spotlight on the mental health nursing workforce in Canada

Supply

The mental health nursing workforce increased 3.6% between 2003 and 2005, from 20,495 in 2003 to 21,243 in 2005.

- The 2005 total includes 12,809 registered nurses (RNs) and 3,470 licensed practical nurses (LPNs) who identified "psychiatry/mental health" as their primary area of practice, along with the entire registered psychiatric nurses (RPN) workforce of 4,964.

Age

In 2005, the average age of mental health nurses was 46.8 years. This compares to average ages of 44.5 for others working in direct patient care and 44.7 for all regulated nurses.

Gender

Almost one-fifth (17.9%) of the mental health nursing workforce is male, even though only 6.1% of the entire nursing workforce is male.

- In 2005, 14.6% of mental health RNs were male, and 23.4% of mental health LPNs were male. More than one-fifth (22.6%) of the RPN workforce is male.

Full-time employment

Rates of full-time employment are higher for those working in mental health than for those working in other areas of direct patient care. In 2005, almost two-thirds (64.6%) of the mental health nursing workforce was employed full-time, compared to slightly more than half (53.2%) for other areas of direct patient care.

- In 2005, 25.5% of mental health regulated nurses worked part-time; 34.3% of regulated nurses working in other areas of direct patient care worked part-time.
- In 2005, 10.0% of mental health regulated nurses worked on a casual basis; 12.5% of regulated nurses working in other areas of direct patient care worked on a casual basis.

Place of work

Of the 21,243 nurses employed in mental health in 2005, three-quarters (75.3%) worked in the hospital sector and one-quarter (23.2%) worked outside of the hospital sector (1.5% did not state their place of work).

CIHI and Statistics Canada look at diabetes and depression

CIHI and Statistics Canada are collaborating on a unique initiative that uses two diseases prevalent in our society—diabetes and depression—as case studies for health outcomes analysis and reporting.

"Serving patients as well and as efficiently as possible is the ultimate goal of the health care system," says Greg Webster, Director of Research and Indicator Development with CIHI. "This initiative will provide decision-makers and policy-makers at multiple levels—including health regions—with useful information to improve patient outcomes."

Depression, if untreated, can lead to disability, dependency and potentially suicide. Health outcomes for diabetics can include complications such as cardiovascular problems, blindness and renal failure.

The project will consider factors such as the number of individuals who regularly see a medical doctor, the survival rates of patients with and without diabetes undergoing kidney dialysis and readmission rates for patients.

"Health outcomes research allows us to understand the end results of particular health care practices and interventions," says Shamali Gupta, Senior Analyst, Health Services Research at CIHI. "Linking the care that people receive to the outcomes they experience will help us improve the effectiveness of our system."

The Diabetes and Depression Outcomes Project is currently in the analysis stage, with a report on its findings expected in the fall of 2007.

More data needed on mental health

There is a significant amount of hospital-based data on mental health. But Canada has a long way to go.

"If you're going to improve the physical and mental health of Canadians, we need to track the performance of health care services," says Senator Michael Kirby, who chaired a Senate committee that looked at mental health, mental illness and addiction services. "Otherwise, we don't know if we are doing better or worse," he says.

One-fifth of the population of Canada will experience mental illness in their lifetime, according to the Standing Senate Social Affairs, Science and Technology Committee report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, released in May. Yet the report noted that Canada "currently has no national picture of the status of mental health."

Canada "currently has no national picture of the status of mental health."

Most mental illness treated in the community

Most mental illness, except extreme cases, gets treated at the community level or within the primary health care system. In fact, mental health experts estimate that only about 1 in 10 people with mental illness receive treatment in hospitals.

"There is a need for more data and databases purposely for mental health issues," says Nawaf Madi, Program Lead for Mental Health and Addictions at CIHI. "Some community information is available at the regional and provincial level, but there are inconsistencies—so painting a national picture at this point is challenging."

Existing data

CIHI holds administrative inpatient hospital data (the Discharge Abstract Database, the Hospital Mental Health Database and the Ontario Mental Health Reporting System); cross-sectional survey data pertaining to mental health exists at Statistics Canada. CIHI's health human resource data provide information on health professionals working in mental health, and its pharmaceutical database (still in development) will offer data on drug utilization for mental illness.

Information on mental health fragmented or incomplete

The deputy chair of the Senate Committee, Dr. Wilbert Keon, says the lack of information makes it difficult to take stock of existing services and to determine what is still needed.

"At the present time, information is fragmented and incomplete. One really can't plan for comprehensive programs," he says.

"Tremendous efforts and progress are being made through CIHI, the Canadian Institutes of Health Research and Canada Infoway," he says. "There are additional pools of data in mental health institutions and in some of the primary care centres, but no one has put these data together in a comprehensive and useful way."

"We desperately need to have a clear picture of what services are being provided to whom, for what," says the President of the Canadian Psychiatric Association of Canada, Dr. Don Milliken.

Need for population-specific data

The Senate committee report identifies some key health information gaps. For example, Canada does not currently collect data on an ongoing basis on the prevalence of mental illness and addiction among specific populations—such as Aboriginal Peoples—some of which are at higher risk for mental disorders than the general population.

But collecting these data is crucial if existing services are going to be improved, says Karen McGrath, CEO of the Canadian Mental Health Association.

"We know how many people are admitted to hospital. But that doesn't tell us what kind of service someone needs in the community. We need data to get a handle on the numbers, on the different types of illness and what services are needed."

"Tremendous efforts and progress are being made through CIHI, the Canadian Institutes of Health Research and Canada Infoway."

October 2006

3–4 Health Data Conference 2006, Building Capacity to Inform, Regina (held in conjunction with Saskatchewan Health and Health Quality Council)

23–27 Journées annuelles de santé publique (annual public health days), Montréal

25–27 Ontario Public Health Association 2006 Conference, Cornwall

November 2006

2–4 2006 Family Medicine Forum, Quebec

6–8 Ontario Hospital Association Health Achieve 2006, Toronto

December 2006

10 6th Annual Canadian Home Care Association Conference, Toronto

Putting the data to use

Limiting use of restraints in continuing care facilities

CIHI offers hundreds of education sessions to hospitals and health facilities across Canada. Education sessions focused on teaching the standardized assessment component of CIHI's Continuing Care Reporting System, which is based on the inter*RAI* Resident Assessment Instrument—Minimum Data Set 2.0 (RAI MDS 2.0)©, are helping improve the quality of care to residents of continuing care facilities.

The Chinook Health Region in Alberta is using CIHI's education sessions and data to help it generate quality indicator reports, and has identified the high use of restraints in continuing care facilities as an area for improvement. With this information, the health region has established benchmarks for restraint use and has moved quickly to implement a "least restraint" policy. The Chinook Health Region now reports an observed decrease in daily restraint use and better quality of life for residents in regional facilities.

As the new system is adopted across Alberta and beyond, CIHI's clinical educators will support regions across the country in using comparative quality indicator reports to improve the quality of care in nursing homes and long-term care facilities across Canada.

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Did you know?

Nearly one-tenth of Canada's total health expenditure is on non-hospital institutions, such as nursing homes and other residential care facilities. In 2003, these institutions accounted for 9.3% ($11.4 billion) of total health expenditures. Their share of expenditures is estimated to have been the same in 2004 and 2005.

Source: National Health Expenditure Database.

Call for submissions: ICD-10-CA modifications

Members of the public and representatives of relevant agencies are invited to submit their suggestions for modifications to the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Canada (ICD-10-CA), and the Canadian Classification of Health Interventions (CCI).

CIHI has opened the public submission process to offer users of the classifications and the health data they provide an opportunity to provide input into the maintenance and enhancement cycle.

For more information, or to download a submission form, please visit **www.cihi.ca**.

Researchers looking at youth suicide in B.C. and Manitoba First Nations communities

Why some First Nations communities experience much higher rates of youth suicide rates than others is the focus of a long-term study funded by CIHI's Canadian Population Health Initiative.

In previous research with 200 First Nations communities in British Columbia, Dr. Michael Chandler at the University of British Columbia and Dr. Christopher Lalonde at the University of Victoria developed six markers of "cultural continuity" that reflected steps taken by communities to preserve and promote their cultural heritage—and retain control over such services as health care and law enforcement.

Here's what they found: youth suicide is almost non-existent in communities that have retained strong ties to their culture and have more control over local services.

The team's latest research is investigating how cultural continuity may influence suicide rates and other health outcomes—such as rates of death due to injuries, violence and alcohol and substance use. And they've expanded their investigation to include First Nations communities in both Manitoba and B.C.

For more information contact Dr. Chris Lalonde at **lalonde@uvic.ca**.

Did you know?

In Canada, the overall suicide rate was 5 deaths per 100,000 people aged 5 to 19. In parts of rural Canada with no commuters to urban areas, boys aged 5 to 19 are four times and girls the same ages are six times more likely to commit suicide than their urban counterparts.

Source: How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants.

Credits

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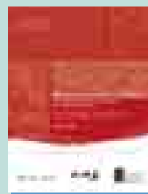
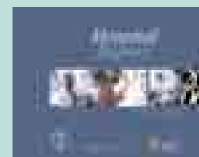
Recently Published Reports

How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants



This report, funded by CIHI's Canadian Population Health Initiative, describes health differences between urban and rural Canadians.

Hospital Report 2006: Acute Care



A joint initiative of the Ontario Hospital Association and the Government of Ontario, this report was produced by CIHI to help people in Ontario better understand and assess the performance of the province's hospitals.

Health Indicators 2006

This report is a compilation of selected indicators measuring health status, non-medical determinants of health, health-system performance and community and health-system characteristics.

The Evolving Role of Canada's Fee-for-Service Family Physicians, 1994 to 2003

Based on CIHI's National Physician Database, this report looks at how family doctors' billing practices have changed over 10 years. It looks at a variety of physicians' health care services, including office and hospital visits, mental health care and basic and advanced procedures.

Workforce Trends of Regulated Nurses in Canada, 2005

For the first time, this year's collection of reports on registered, licensed practical and registered psychiatric nurses includes *Highlights From the Regulated Nursing Workforce in Canada, 2005.*

Hip and Knee Replacements in Canada

This annual report provides information on hip- and knee-joint replacements performed in Canada. It includes surgery-specific information and demographic, provincial and outcome analysis.