Mental Health and Addictions System Performance in Ontario First Nations (2009-2019)

CHIEFS OF ONTARIO

Executive Summary

This summary presents the combined results of the Mental Health and Addictions Systems Performance First Nations in Ontario (2009-2019) Interim Report, October 2021, and the Final Report, September 2022. This work was done by ICES in response to a request by the Chiefs of Ontario First Nations Mental Health and Addictions Working Group under the Trilateral First Nations Health Senior Officials Committee, as a First Nations specific analysis following release of the Ontario Mental Health and Addictions (MHA) Scorecard. The mainstream reports provide comprehensive trends over time in Ontario's MHA system, including measures of MHA-related hospital and emergency department use access to receiving mental health care; and outcomes such as intentional self-injury and suicide. Since the performance of Ontario's MHA system for First Nations in Ontario was unknown, the First Nations report was intended to replicate that work in order to provide baseline data specifically for First Nations in Ontario. ICES received approval from the Chiefs of Ontario to use the Indian Register (IR) for this project on March 12, 2018. The IR is linked with ICES health administrative data to identify First Nations people in Ontario with a history of MHA-related service use and outcomes for First Nations people, compared to non- First Nations people. This is the first project to assess the ability of the MHA-system to provide services to the First Nations population in Ontario. ICES was funded for this project by the Ontario Ministry of Health (MOH).

Project Objectives

- Assess Mental Health and Addictions indicators, which describe the current state of MHA service provision among First Nation communities in Ontario
- Examine trends in performance indicators to assess changes over time in system performance and outcomes among First Nations people in Ontario
- To explore the impact of socio-demographic characteristics (e.g. age, sex) on mental health service use and access to care

The Mental Health and Addictions System Performance in First Nations in Ontario study includes the following indicators:

System Use: (Reported in the Interim report, October 2021)
1. Rates of MHA-related outpatient visits
2. Percentage of individuals with MHA-related outpatient visits
3. Rates of MHA-related emergency department visits
4. Rates of MHA-related hospitalizations
5. Median length of stay for psychiatric hospitalizations

Access to Care:
1. Emergency department as first point of contact for MHA care
2. Rates of emergency department re-visits within 30-days following a MHA emergency department visit
3. Rates of hospital readmission within 30-days following a MHA hospital discharge
4. Rates of outpatient visits within 7 days following a MHA hospital discharge

Outcomes:
5. Prenatal opioid exposure (POE) and neonatal abstinence syndrome (NAS)
6. Rates of death by suicide
7. Rates of emergency department visits for intentional self-injury
8. Use of physical restraints during MHA hospitalizations

KEY FINDINGS

INDICATOR CATEGORY: SYSTEM USE

System use indicators (outpatient visits, Emergency department visits, and hospitalizations) can be a measure of whether First Nations have access to services at the right place and the right time when addressing mental health and addictions issues. The indicators in this study did not measure access to community-based services and allied health care providers who do not bill OHIP for their services.

Outpatient physician services can be provided by a primary care provider (PCP), paediatrician, or psychiatrist. The data may tell us who is providing services to respond to MHA needs, but does not speak to the *unmet* needs in the community, particularly among those who do not have a PCP or cannot access them easily. The emergency department (ED) is an important MHA access point for people who have additional needs or if they are in crisis. The ED may also be the only access point for individuals who cannot find appropriate or timely care in outpatient and community settings. This includes whether an individual requires hospitalization for mental health and addictions care, and length of their stay, is influenced by a number of things such as: resources available in their home community, the severity of their illness requiring psychiatric hospitalization, and the regional availability of hospital beds, among other factors.

FINDINGS:

Outpatient visits
First Nations people are visiting primary care providers almost 3x more frequently compared to the rest of Ontario for MHA-related outpatient visits, particularly among young people, and those living outside of community. These results may be useful to advocate for human resource planning for more community-based non-physician services. Psychiatrists and pediatricians were seen infrequently, perhaps related to long waitlists for these specialists.

Emergency department visits
First Nations people had higher rates of visits to the Emergency Dept. for MHA concerns, and greater increases over time than non-First Nations people, with the top 2 reasons being substance-related and addictive disorders, and anxiety disorders. ED visits for alcohol-related disorders and “other” drugs and addictions increased over time to a much greater extent among First Nations people compared with non-First Nations people. Alcohol withdrawal remains the primary cause for ED visits and hospitalizations.

Hospitalizations
First Nations people had higher rates of MHA hospitalizations compared to Non-First Nations people. These rates increased over time most notably among First Nations people aged 14-24 years, more than doubling among 14-17 year-olds from 2009-2019. The three most common reasons for MHA hospitalizations were substance-related and addictive disorders, mood disorders, and schizophrenia among both First Nations people and Non-First Nations people. However, First Nations people had shorter median lengths of stay compared to non-First Nations.

INDICATOR CATEGORY: ACCESS TO CARE

Access to care in the community for mental health services is reflected by measuring the use of a hospital for Mental Health and Addictions care by individuals who need services but cannot find them in the community. The high rate of use of the emergency department as a first point of contact and for

unscheduled return visits for MHA care after a hospitalization or ED visit, can be a signal that there is inadequate access to outpatient physician- and community-based follow-up care. Individuals who need services may use the ED as their first point of contact with the health system for a variety of reasons, including long wait times, lack of services, or a lack of safe or culturally appropriate services. We were unable to measure these reasons within the scope of this study, but the results indicate an overall need for additional community-based supports along the continuum of care in prevention and early intervention, as well as follow-up treatment and wraparound supports.

FINDINGS:

Use of the Emergency department for Mental Health and Addictions care
The use of the ED as the first point of contact for MHA care was similar among First Nations people and non-First Nations people. First Nations people living within a First Nations community used ED as first-contact more frequently than those living outside a community.
First Nations people were less likely to use the ED as a first-contact for substance-related and addictive disorders compared to non-First Nations people. However, mood disorders, anxiety disorders, personality disorders, and intentional self-injury were more frequently the cause for ED visits among First Nations people. Young people (10-17 year-olds) seem to be using the ED as a first point of contact more than older people, suggesting that young people have poor access to early intervention and preventative care. They should not be having their first experience with mental health care through the ED.

Revisits to the ED within 30 days
From 2009 – 2019, the rates of a revisit to the ED within 30 days of a previous ED visit for a MHA diagnosis trended upward for all MHA diagnoses. Between 2017 and 2019, **First Nations people had 1.5 times higher rates of** 30-day MHA ED revisits compared with non-First Nations people. Repeated unscheduled emergency department visits for mental health and addictions (MHA) care could mean there is inadequate access to follow-up care in the community or outpatient settings, particularly where ED may be the only after-hours care available in a community. This trend may also signal growing care needs now and in the future.

Readmissions within 30 days after discharge from Psychiatric Hospitalization Between 2017 and 2019, the rate of 30-day MHA hospital readmissions was slightly higher among First Nations people compared with non-First Nations people. Among both First Nations people and non-First Nations people, the greatest increase in MHA hospital readmission rates over time (2009-2019) was for substance-related disorders**.**

Rates of outpatient visits within 7 days following a MHA hospital discharge
First Nations people had lower rates of 7-day outpatient follow-up with any care provider, particularly with psychiatrists, compared with non-First Nations people. First Nations people were seen less frequently than non-First Nations within 7 days for follow-up, across all types of MHA diagnoses.

Frequent use of the ED for mental health and addictions (MHA) as a *first point of contact* for care, and repeated unscheduled frequent ED visits for follow-up care may mean that access to outpatient physician and community-based care are inadequate within First Nations community or outpatient settings, particularly where ED may be the only after-hours care available in a community. Early follow-up after hospital discharge likely helps to improve continuum of care for treatment and communication between health care providers and patients which may prevent hospital readmission. The gaps in outpatient care are also evidenced by the low rates of 7-day follow-up for outpatient visits after a psychiatric hospital discharge. Higher rates for First Nations people presenting at the ED without any prior help for intentional self-injury/suicide attempts means that our health care system is

failing to respond to their needs and is not accessible to people in crisis. The experience of stigma and racism can also be strong deterrents for accessing the ED for MHA care.

This upward trend in ED use may also signal growing mental health care needs now and in the future. In the years since the analysis conducted in this report, closures of EDs across Ontario have been necessitated by impacts of the COVID-19 pandemic, threatening an already fragile Mental Health service system.

INDICATOR CATEGORY: OUTCOMES

Indicators such as Prenatal Opioid Exposure and Neonatal Abstinence Syndrome, deaths by suicide especially of young people, emergency department visits for intentional self-injury, and use of physical restraints during MHA hospitalizations may be used to measure positive and/or negative outcomes of services provided to First Nations, equitable access to those services and effectiveness of programming and policies.

FINDINGS

Prenatal opioid exposure (POE) and neonatal abstinence syndrome (NAS)
Prenatal Opioid Exposure among First Nations infants affects approximately 16% of infants overall. Rates vary from approximately 4% in Central and South West, to 31% of those in the North West1 and is mostly due to opioid agonist therapy for the treatment of opioid use disorders. Changing trends from the use of methadone to Suboxone from 2013 to 2019 is important as Suboxone is associated with better infant outcomes including less severe withdrawal. While there was a slight increase of POE over time from 2013 to 2015, these changes then stabilized, reflecting improved access to effective treatments for First Nations women. POE is higher among infants born to older mothers and lower among those born to teenage mothers and may indicate that more older mothers are being treated for opioid use disorder. First Nations communities in North West Ontario have the highest numbers of mothers who take opioids during pregnancy, with the majority of those mothers being treated for opioid use disorder. One consequence is that rates of infants born with Neonatal Abstinence Syndrome has increased, requiring longer hospital stays for infants for treatment of their symptoms. NAS is not, in and of itself, a risk factor for poor infant/child outcomes (such as development), and reflects in part the use of medications to treat opioid use disorder. It is far safer for the pregnancy (mother and fetus) to be treated for opioid use disorder than to either discontinue opioid use during pregnancy or take diverted prescriptions or illicit drugs (i.e. to not be treated for opioid use disorder).

There is little research on the long-term effects of POE and NAS, and the negative outcomes associated with the presence of withdrawal at birth. More work is needed to better understand the longer-term healing paths and treatment of mothers throughout their pregnancies, as well as the effect of integrated programming for a holistic approach with mothers, infants, and their families. Fear of child apprehension and poor access to services are strong deterrents of treatment. Funding to support improved access to culturally safe, equitable pre- and postnatal care among mothers of all ages may contribute significantly to better outcomes in terms of opioid use during pregnancy now and in generations to come. Additionally, support for First Nations midwifery as an integral component of

[1] The 14 LHINs were clustered into five “Ontario Health Interim and Transitional Regions” (the “Interim Regions”). The 14 LHINS were organized under five Interim Regions. Northwest region formally known as the North West LHIN. https://www.osler.com/en/resources/regulations/2019/ontario-taking-next-steps-to-integrate-health-care-system#_ftnref3

the health care system would improve outcomes with follow up for wholistic culturally appropriate post-pregnancy follow-up care as an option with doctor-supported hospital births.

Death by suicide
The data on deaths by suicide are the most tragic and indicative of failure of the mental health system to support First Nations, especially our youth, in the time of life when supports are most needed. Data presented are likely an underestimate, since method of suicide is not consistently recorded, and do not always identify if the intent of a self-inflicted injury was suicide.

The rate of death by suicide is three times higher among First Nations than among non-First Nations, and is **very high in young First Nations individuals** aged 10-24 years, and higher among females than males. For non-First Nations in Ontario, the opposite is typically observed - deaths by suicide are rare in youth, and rates start to increase in adults. Data on death by suicide must be considered as a *symptom* of inequities and other social determinants of health, such as inadequate housing, poverty, intergenerational trauma, poor access or multiple barriers to services, and systemic racism in health care. As seen in other indicators in this study, ED visits among First Nations people for intentional self-injury are much higher than for non-First Nations. Those living in the North West region had the highest rates of ED visits for intentional self-injury; and First Nations females had higher rates of ED visits for intentional self-injury compared to First Nations males and non-First Nations females. Current policies and programming may be missing the target for First Nations youth and females.

Rates of emergency department visits for intentional self-injury
This indicator highlights individual visits to an emergency department for a nonfatal self-poisoning or self-injury, carried out with at least some attempt to end one's life. Between 2017 and 2019, the rate of emergency department visits for intentional self-injury was over 6 times higher among First Nations people compared with non-First Nations people. Females and those aged 14 – 24 years of age had higher rates of emergency department visits for intentional self-injury compared with males and these trends are continuing over time. Rates of emergency department visits for intentional self-injury were highest for those people living in North West, Toronto Central, South West, and Central West regions. Poisoning represented 65% of all Intentional self-injury attempts among First Nations people. In a related report[2] more frequent follow-up was not associated with better outcomes. Timely access to mental health care after intentional self-injury was poor at 31%. Follow-up care had virtually no association with subsequent risk; treatment "as usual" was insufficient. Care after an intentional self-injury event must include evidence-based wraparound care and other healing modalities founded in First Nations culture, based on the First Nations Mental Wellness Continuum Framework https://Health.chiefs-of-ontario.org/resources/.

Use of physical restraints during MHA hospitalizations
When caring for individuals with severe mental illness who are in acute crisis, reducing the risk for harm to self or others is a priority for hospital staff. The practice of using physical restraints (external devices, materials or equipment that are attached to or near a person's body to hinder freedom of movement) is intended to prevent suicide or aggressive acts. Other, less restrictive forms of reducing agitation are preferred whenever possible and psychiatric hospitals have been strongly encouraged to minimize the use of restraints.

[2] Jon Hunter, Robert Maunder, Paul Kurdyak, Andrew S. Wilton, Andrea Gruneir, Simone Vigod, Mental health follow-up after deliberate self-harm and risk for repeat self-harm and death, Psychiatry Research, Volume 259, 2018, Pages 333-339. https://www.sciencedirect.com/science/article/pii/S016517811730879X

The use of physical restraints during psychiatric hospitalizations has been increasing since 2016, and is higher among males than females. First Nations people experience similar rates of use of physical restraints during psychiatric hospitalizations compared to non-First Nations.
Physical restraint use was similar between First Nations people living outside or within a First Nations community during psychiatric hospitalizations, and were used most frequently for people diagnosed with schizophrenia and other psychotic disorders.

KEY CONSIDERATIONS / RECOMMENDATIONS

Taken together, these findings present important service delivery implications, and support the need for additional health human resources within communities as has been identified by First Nations Leadership. Adequate sustainable funding would allow First Nations to access critical, culturally relevant services in a timely manner close to home such as “wrap-around” services including more culturally appropriate care such as traditional healers, access to elders, midwives, counsellors, and the ongoing need for treatment for alcohol use disorder. Ontario is generally under-serviced to meet the needs of First Nations patients at the community level, and the gap between services provided and actual need is not measured. Higher rates of system use is not indicative of good access to appropriate care.

Further attention to a number of factors influencing these results can influence effective changes with program and policy planning.

- Provision for adequate health human resources within communities as has been identified as a need by First Nation Leadership. Support for traditional healers and land-based programs, as well as harm reduction programs are urgently needed.
- Timely and accessible mental health services to reduce the long waitlists for services for children/youth especially for psychiatrist services is critical as evidenced by the high use of EDs and rates of death by suicide.
- Supports for provision of First Nations midwifery would provide a benefit to families with supportive wholistic care for the mother and baby through traditional methods of birthing and childcare.
- The need for trauma-informed mental health supports for many First Nations will continue to escalate in the coming years, as a result of the Truth and Reconciliation process which began in 2009, recent Indian Residential School recoveries, and the effects of the COVID-19 pandemic.
- Virtual access to specialists would improve care for those living in rural/remote areas.
- Policy and programming planning needs to focus on supporting prevention, harm reduction, and crisis management and recovery. Drug formularies, and prescribing guidelines need to consider unintended consequences of more dangerous street-sourced drugs being inserted into the supply.
- Systemic racism within the health care system must be addressed as stigma and discrimination prevents many individuals from seeking medical care or harm-reduction programs.