Common Challenges, Shared Priorities

Measuring Access to Home and Community Care and to Mental Health and Addictions Services in Canada

Volume 2 | August 2020

Canadian Institute
for Health Information

Institut canadien
d'information sur la santé

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About this report

As the population ages, more Canadians need home care or services in the community to help them manage their health conditions and live safely at home. For Canadians of all ages, timely access to mental health and addictions services is an area of growing concern, with mental health problems affecting 1 in 5 Canadians every year.[1]

In August 2017, the federal, provincial and territorial (FPT) governments endorsed A Common Statement of Principles on Shared Health Priorities, accompanied by an $11 billion federal investment over 10 years. Their common purpose was to improve Canadians' access to home and community care, and to mental health and addictions services.[2] While these objectives predate the COVID-19 pandemic, they continue to reflect areas of high need for Canadians.

To measure progress on these Shared Health Priorities, the Canadian Institute for Health Information (CIHI) is working with all provinces and territories to develop and report on a focused set of 12 pan-Canadian indicators.[i] Over time, these indicators will begin to tell a clearer story about access to care across the country, identify where there are gaps in services, and help make meaningful changes in order to improve the experiences of Canadian patients and their families.

This is CIHI's second annual companion report on this measurement work. It describes the progress made to date on indicator development and reporting, how to interpret indicator results and why these results matter to Canadians. For the first time, we're publishing results for 3 new indicators, based on 2018–2019 data:

- Self-Harm, Including Suicide;
- Caregiver Distress; and
- New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home.

This report is intended to help Canadians understand what the new indicators are measuring, their strengths and limitations, and the factors that can potentially influence the results. In recognition of the efforts underway to combat the coronavirus across the country, the public release of this report was delayed from May of this year. Provincial and territorial results for previously released indicators can be found in CIHI's Your Health System web tool. (See Table 1 for the public release schedule of all 12 Shared Health Priorities indicators.)

Reporting on each of the mental health and addictions and home and community care indicators will not lead to immediate change. It will take time for investments to improve care at the front lines and to better meet the needs of patients and their families. The impact of COVID-19 on the indicators is also not yet known, and it will take time for it to be fully reflected in the data. Therefore, the numbers included in this report represent a baseline from which changes can be measured over time. Every year until 2022, new indicators will be released, and existing indicators will be updated and refined as more and better data becomes available.

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i. Recognizing the Government of Quebec's desire to exercise its jurisdiction in the areas of health care and social services and thus to assume full control over the planning, organization and management of services in these areas within its territory, in particular for the areas of mental health, addictions and home health care, the Government of Canada and the Government of Quebec entered on March 10, 2017, into an asymmetrical agreement distinct from the present statement of principles and based on the asymmetrical agreement of September 2004. Specifically, the Government of Quebec will continue to report to Quebec residents on the use of funds designated for health care, and will continue to collaborate with other governments around information sharing and best practices.

Self-Harm

In 2018,

**25,000
Canadians
were hospitalized
or died** by intentionally
harming themselves
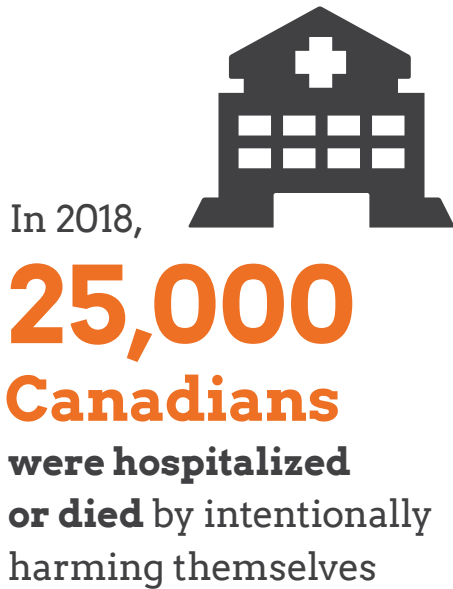
(Source: CIHI, 2018)

Caregiver distress

96% of individuals
receiving long-term
home care have an
unpaid caregiver
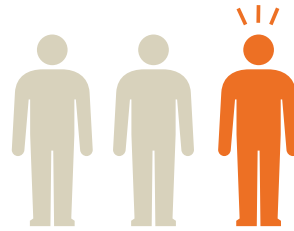
**More
than 1 in 3**
of these caregivers
are distressed

(Source: CIHI, 2018)

Long-term care

About 1 in 9
newly admitted
long-term care
residents potentially
could have been

**cared
for at
home**

(Source: CIHI, 2018)

Background

Indicator selection

From October 2017 to July 2018, CIHI led a rigorous process to select the Shared Health Priorities indicators. We held extensive consultations with governments, sector stakeholders, measurement experts and people with lived experience, through interviews, online surveys and focus groups. The consultations identified clear priorities around filling important information gaps in the areas of mental health and addictions and home and community care. Members of the public who participated in the consultations described dimensions of access to care that were most important to them: shorter wait times, the availability of appropriate services, improved patient experience, support in navigating the health system and prevention.

CIHI worked with sector and measurement experts to evaluate approximately 100 measures for each area. The 3 guiding principles used to choose the final 12 were

- Relevance
  - The choice was based on whether the topic was a priority for health systems and Canadians, not on how easy it was to get information on the topic.
- Balance
  - It was important to ensure the indicators reflected different dimensions of access to care for each priority area.
- Impact
  - The indicators had to measure an aspect of access to care where improvements to health systems could be made that are meaningful to patients.

In June 2018, the final list of 12 indicators proposed by the CIHI-FPT working groups was officially endorsed by FPT health ministers.[3]

In September 2018, the Shared Health Priorities Advisory Council was established to guide the development of the indicators.[4] Council members include representatives from provinces and territories, Health Canada and Statistics Canada, while observers include representatives from the Canadian Home Care Association, the Mental Health Commission of Canada and the Canadian Centre on Substance Use and Addiction. CIHI is also facilitating discussions and gathering input for indicator development from provincial and territorial stakeholders, subject matter experts and patients.

Indicator reporting

We are now at the half-way point of indicator development, with the public release of results for 6 out of 12 Shared Health Priorities indicators. Table 1 provides the full list of indicators and their scheduled release dates.

Table 1   Indicator rollout and reporting

Year	Indicators			Indicator reporting
2019	Hospital Stays for Harm Caused by Substance Use*	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions*	Hospital Stay Extended Until Home Care Services or Supports Ready†	Indicator results are available in Your Health System: In Brief
2020	Self-Harm, Including Suicide*	Caregiver Distress†	New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home†	Indicator results are available in this report and on the Shared Health Priorities web page (Plus updated 2019 indicators available in Your Health System: In Brief)
2021	Wait Times for Community Mental Health Counselling*	Wait Times for Home Care Services†	Home Care Services Helped the Recipient Stay at Home†	— Plus updated 2019 and 2020 indicators
2022	Navigation of Mental Health and Addictions Services*	Early Identification for Early Intervention in Youth*	Death at Home/ Not in Hospital†	— Plus updated 2019, 2020 and 2021 indicators

* Mental health and addictions   † Home and community care

In 2019, results for 2 indicators of access to mental health and addictions services were released, as were results for 1 indicator of access to home and community care. More information on these measures can be found in Your Health System: In Brief and in CIHI's first companion report, *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Addictions Services, November 2019*.

New indicators and results

This section of the report presents indicator results and information to assist with interpretation of the 3 new indicators released in August 2020.

A health indicator is a measure that summarizes information about a given priority topic on population health or health system performance.[5, 6] Health indicators

- Provide comparable and actionable information across different geographic or organizational boundaries to track progress over time;

- Help identify opportunities for improvement, provide evidence to support health programs and policies, and monitor the success of interventions;

- Raise questions and bring attention to issues but do not provide answers about causes or explain variations on their own; and

- Provide part of the picture. Further drill-down, contextual information and other relevant indicators are required for a complete picture.

Self-Harm, Including Suicide

The following section discusses suicide and self-harm.

Help is available 24/7 if you need it:

- 9-1-1
- Your local crisis centre
- Kids Help Phone: 1-800-668-6868
- First Nations and Inuit Hope for Wellness Help Line: 1-855-242-3310
- 1-866-APPELLE (Quebec residents)
- Crisis Services Canada: 1-833-456-4566

Definition

This indicator measures the rate of hospital stays for and deaths from intentional self-harm, regardless of suicidal intent. Even when there is no intention to die, deliberate self-harm signals emotional distress that may end in accidental death or serious injury.

This combines CIHI's previous work examining hospital stays for self-injury with Statistics Canada's reporting of suicides.

Rationale

- A higher rate of hospital stays for and deaths from intentional self-harm may signal a lack of appropriate mental health care or addictions services, treatments and community supports.
- This indicator can also
  - Increase awareness about the extent of self-harm;
  - Estimate hospital resources used to treat self-harm; and
  - Assist in monitoring the effectiveness of treatment and prevention policies and services.

Calculation

$$\frac{\text{Total number of hospital stays for self-harm not ending in death (age 10 and older)} + \text{Total number of deaths from self-harm (age 10 and older)}}{\text{Total population (age 10 and older)}} \times 100{,}000$$

To improve comparability across jurisdictions, the rate is adjusted for differences in the age distribution of the population.

Table 2   Data availability for Self-Harm, Including Suicide

Data source	Year	Coverage
Discharge Abstract Database and Hospital Morbidity Database	2018–2019	All provinces and territories
Vital Statistics, Statistics Canada*	2018 (calendar year)	All provinces and territories except Yukon
Coroner data, Yukon Bureau of Statistics	2018 (calendar year)	Yukon
Ontario Mental Health Reporting System	2018–2019	Ontario

Notes
*   Vital Statistics are publicly available on Statistics Canada's website. Statistics Canada provided additional information on age and sex directly to CIHI so we could standardize rates for this indicator.

In Ontario, hospital records for mental health and addictions are collected through the Ontario Mental Health Reporting System. In other provinces and the territories, these records are collected in the Discharge Abstract Database and Hospital Morbidity Database.

Yukon coroner data and the Ontario Mental Health Reporting System are open data sets, meaning that historical data can be added to the database at any time. The data used for this report was extracted from the Yukon Bureau of Statistics in September 2019 and from the Ontario Mental Health Reporting System in November 2019.

Data limitations and caveats

- Due to different data collection cycles, death data is available by calendar year, while data on self-harm hospitalizations is available by fiscal year. To include the most recent data in the indicator results, a blended approach was used to capture overall self-harm events within 1 year.

- Hospital stays are included if patients are documented as having intentionally (rather than accidentally) harmed themselves. However, the data does not indicate whether or not the intent of the person was to die.

- Due to data limitations, this indicator *underestimates* the prevalence of self-harm and should be considered the *minimum* rate. For example, the indicator's definition does not include

  - Emergency department visits for self-harm.

    o Due to incomplete data coverage across the country, emergency department visits are not included in this indicator. The likelihood of being admitted to hospital for self-harm (rather than being treated in the emergency department only or through outpatient services) may vary among hospitals and regions.

  - Self-harm that occurs in the community and does not result in a hospital stay or a death.

  - Hospital stays or deaths where injuries were documented as accidental or undetermined but may have actually been intentional.

    o There is currently no reliable method to identify intentional self-harm in these records.

  - Hospital stays for self-harm that ended in death but were not documented as suicide by a coroner.

    o These cases represent a small number compared with overall suicide counts and were not included in the calculation.

  - Suicide deaths that were not yet determined by coroners and reported to Statistics Canada at the time indicator results were calculated.

    o Due to improvements in timeliness, the duration of data collection was shortened for 2018 compared with previous years. As a result, there may be fewer deaths captured in official statistics at the time of public reporting, as there may be a lag time for coroners to complete their investigations and for deaths to be officially recorded as suicides. The 2016, 2017 and 2018 data is therefore considered preliminary.

In Canada and internationally, misclassification of suicide and self-harm is a concern, and efforts are underway to improve reporting of these events to support public health surveillance and prevention efforts. This indicator can be improved over time as more and better data becomes available, including data for emergency department visits.

Key results

There is a 7-fold variation in Self-Harm, Including Suicide rates across provinces and territories

In 2018–2019, almost 25,000 Canadians stayed in hospital after intentionally harming themselves or died by suicide. This is the equivalent of almost 70 self-harm events every day. Hospitalizations for self-harm are more than 5 times as frequent as suicides. The majority (98%) of patients with hospital stays for self-harm left the hospital alive; 4 out of 5 (80%) were discharged home, while over 10% had conditions that were serious enough to require transfer to another facility for further care.

Of the nearly 25,000 Canadians who harmed themselves last year, more than 3,800 died as a result of their injuries. These deaths were much more likely to occur in the community (89%) than in the hospital.

Rates of Self-Harm, Including Suicide varied more than 7-fold among provinces and territories. Deaths as a proportion of all cases of self-harm also varied widely by province and territory, from 6% in Prince Edward Island to 27% in Manitoba. The breakdown of hospitalizations and deaths is important to consider, as differences in overall self-harm rates may reflect different patterns of treatment for self-harm in hospitals by jurisdiction. For example, a low rate of hospital stays may be the result of patients being treated outside of inpatient hospital care, such as in an outpatient clinic, emergency department or crisis centre.

Figure 1 Age-standardized rate of Self-Harm, Including Suicide per 100,000, by province and territory, 2018–2019
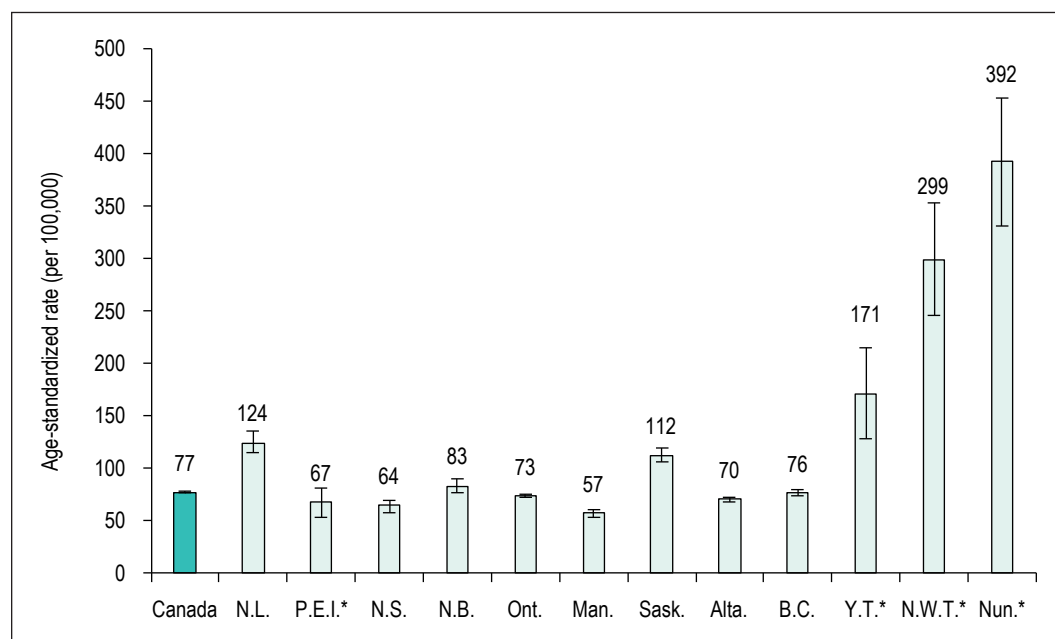
Jurisdiction	N.L.	P.E.I.*	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.*	N.W.T.*	Nun.*
Number of self-harm events (hospital stays and deaths)	532	88	529	539	9,229	677	1,137	2,636	3,296	60	122	165
Proportion that are deaths	13%	6%	24%	20%	14%	27%	20%	22%	12%	8%	8%	12%
Rate of death per 100,000 population (age-standardized)*	15	4	14	16	10	16	22	15	9	12	24	48

Notes

*   Due to the low number of deaths in these jurisdictions, suicide rates can fluctuate significantly from year to year.

The line at the top of each bar shows the confidence interval (CI), which is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information; Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of Statistics, 2018.

Many factors can influence the rate of hospital stays for and deaths from self-harm, including

- Timely access to mental health and addictions services in the community.
  - This includes whether services are available, wait times for care, how easy it is to navigate the system, and how well services are coordinated with each other and with primary care.
- Social determinants of health, such as income, employment, education, housing, food security, social support networks, and personal or intergenerational trauma.
- Population health, such as the prevalence of concurrent health conditions.
  - These can include mental health conditions, addictions disorders, chronic conditions and disabilities.
- Stigmatization, real or perceived, and cultural perceptions about mental health and addictions.
  - This may impact a person's decision-making about whether and where to seek help.
- Variation in care practices between provinces and territories.
  - Some jurisdictions may be more likely than others to admit those who self-harm with less serious injuries to an inpatient hospital bed, depending on the perceived threat the patient is to themselves, bed availability and the availability of services outside of the hospital (such as community or outpatient services).

More breakdowns of self-harm and suicide by province and territory can be found in Appendix A.

More females are hospitalized for self-harm, but males are more likely to die

It is important to know who is most likely to self-harm in order to more effectively target prevention efforts and mental health services in the community. Hospitalization rates for self-harm were higher for females than males across most age groups, with the highest rates seen in female children and youth. For girls and women age 10 to 24, self-harm hospitalization rates were 3 times as high as rates for males in this age group.

The picture looks different, however, when looking at deaths from self-harm. Suicide rates were higher for males of any age group compared with females, and they were highest for males age 45 to 64 compared with other age groups.

Figure 2   Rate of Self-Harm, Including Suicide per 100,000,
by age and sex, 2018–2019
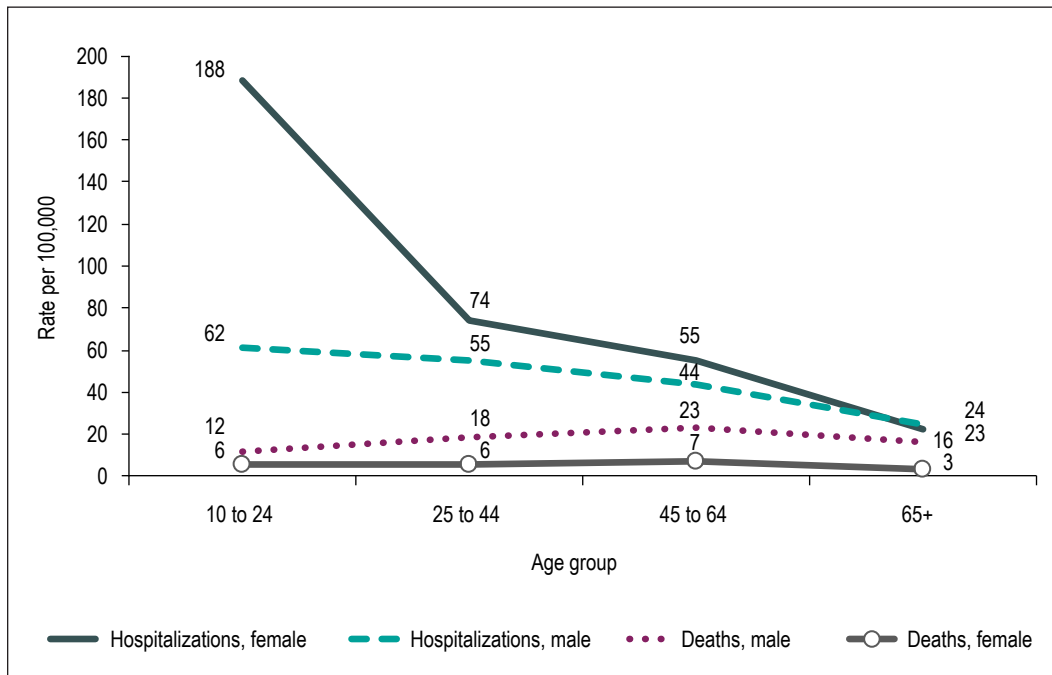
Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for
Health Information; Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of
Statistics, 2018.

Self-harm impacts Canadians of all income levels. However, Canadians living in the
lowest-income neighbourhoods had twice the rate of hospital stays (104 per 100,000)
compared with those living in the highest-income neighbourhoods (49 per 100,000).

In addition, people in rural or remote areas were more likely to have a hospital stay for
self-harm (74 per 100,000) compared with those in urban areas (63 per 100,000). This may
be partly due to differences in how health services are delivered. For example, people who
live in urban areas may be less likely to be admitted to hospital for self-harm, as there may
be more treatment options in the community (e.g., specialized or outpatient clinics).

About 1 in 9 (11%) of those who were hospitalized for self-harm had at least one other
hospital stay for self-harm within the same year. Repeat hospital stays may signal
inadequate follow-up care for mental health in the community after patients with self-harm
are discharged from hospital. Women of all ages were more likely than men to have repeat
hospital stays for self-harm.

Figure 3   Percentage of patients with self-harm who had repeat
hospital stays for self-harm within a year, by age and
sex, 2018–2019
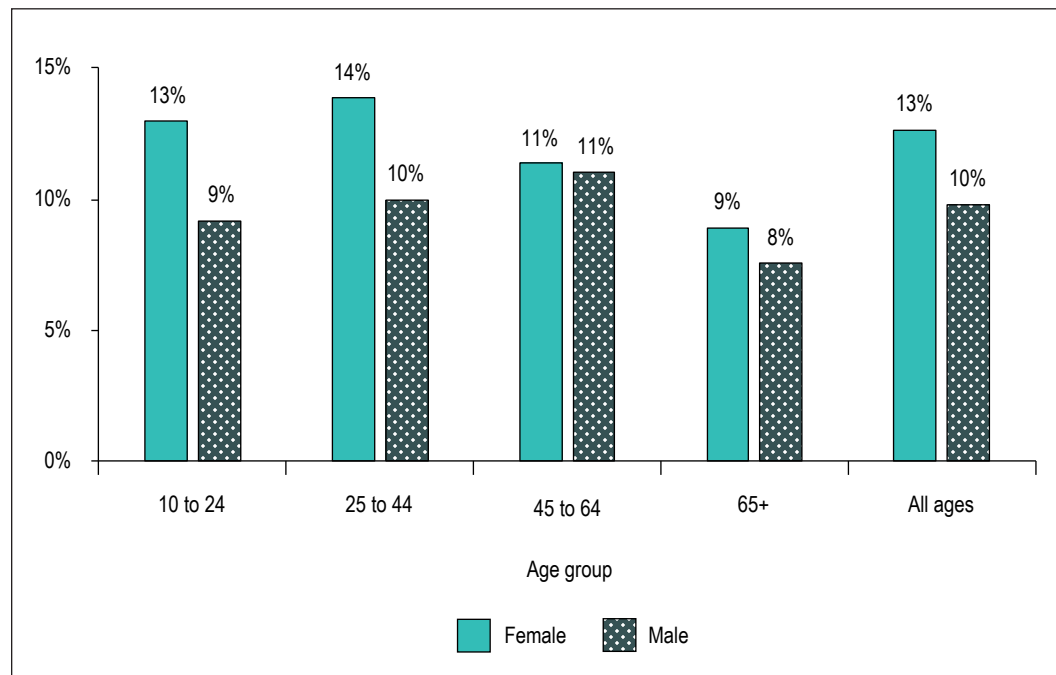
Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for
Health Information; Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of
Statistics, 2018.

Almost 3 out of 4 Canadians with a hospital stay for self-harm are also treated for a mental health condition

About three-quarters (74%) of individuals hospitalized for self-harm also received care for a concurrent mental health condition during their hospital stay.[ii] The most common conditions included mood disorders (e.g., depression, bipolar disorder), substance-related and addictive disorders, and other mental health disorders (including post-traumatic stress disorder). Females were more likely to have concurrent mood and personality disorders, while males were more likely to be treated for substance-related disorders and schizophrenia.

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ii.   Those who did not receive mental health treatment during their hospitalization for self-harm may have been referred to
outpatient or community mental health services after their hospital stay, though there is insufficient data to determine this.

Figure 4   Percentage of hospital stays for self-harm with a concurrent mental health condition, by sex, 2018–2019
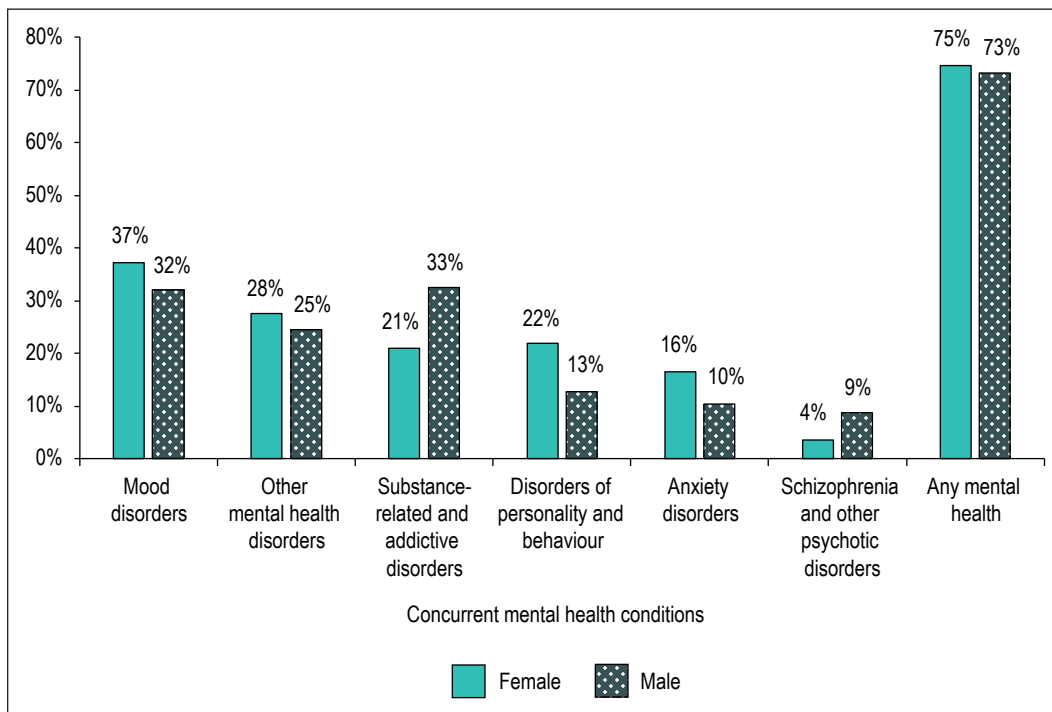
Note
Only mental health conditions that were treated during the hospital stay are included.
Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information.

Poisoning was the most common mode of self-harm, accounting for 82% of all hospital stays. The majority of drugs involved in self-harm poisonings are available by prescription only, such as antidepressants, benzodiazepines and antipsychotics. The single most common non-prescription drug used for self-harm was 4-aminophenol derivatives, commonly listed as acetaminophen and sold in pharmacies. Other studies also point to the use of non-prescription painkillers as a means of self-harm. One study of emergency department visits found that among youth age 12 to 17, about 40% of self-harm poisonings involved substances that are not prescribed and were most often from the acetaminophen group.[7] While acetaminophen is generally safe for people, acute overdose is commonly associated with liver failure.[8] The risk of self-harm from acetaminophen is of interest to many policy-makers around the world. Hospital admissions for acetaminophen poisoning decreased in Australia after sales were restricted[9] and, in the United Kingdom, acetaminophen poisoning deaths declined after legislation was introduced to reduce access.[10]

Links to other CIHI resources

- Self-Harm, Including Suicide indicator
  - [Shared Health Priorities](#) — Indicator results and infographics
  - [Definitions and methodology information](#)
- Data holdings and resources
  - [Mental health and addictions information](#)
  - [Hospital Morbidity Database metadata](#)
  - [Ontario Mental Health Reporting System metadata](#)
- CIHI's existing work
  - [Care for Children and Youth With Mental Disorders](#)
  - [*Self-Harm and Assault: A Closer Look at Children and Youth*](#)
  - Self-Harm Hospitalizations in [Your Health System: In Depth](#) — Indicator results available by health region

Links to other Statistics Canada resources

- Statistics Canada's existing work on suicide
  - [Suicide in Canada: Key statistics](#)

Caregiver Distress

Definition

This indicator measures the proportion of unpaid caregivers who experience distress while caring for a family member or friend who receives publicly funded home care services and supports. The measure is adjusted to account for differences in the severity of the home care recipients' health problems.

Rationale

- A higher rate of Caregiver Distress may signal the need for more effective and appropriate home care services and community supports.
- This indicator can also
  - Measure the burden of unpaid caregiving; and
  - Identify where additional resources are needed to assist caregivers, to help prevent burnout and to allow the people they are caring for to stay at home for as long as possible. This may include more hours of formal home care, access to different types of services (e.g., meals, housework, respite care) and help with navigating the system.

Calculation

$$\frac{\text{Number of people receiving home care with a caregiver in distress}}{\text{Total number of people receiving home care who have a caregiver}} \times 100$$

- A caregiver can be a spouse, child, relative, friend or neighbour who provides unpaid care to a person receiving publicly funded home care on a long-term basis (defined as more than 60 days of service).

- Caregivers of individuals who receive home care are identified as distressed if they experience feelings of distress, anger or depression, or if they are unable to continue in their caring activities. Identification is based on a clinical assessment conducted by a trained health professional.

- To make this indicator more comparable among provinces and territories, it has been risk-adjusted to account for differences in the severity of health problems of those receiving home care. This includes

  – The amount of support the individual requires with personal care routines, such as eating, using the toilet, brushing their teeth and dressing;

  – Their level of cognitive function, such as memory, decision-making, communication and alertness; and

  – The degree of health instability or risk of serious decline at the time of the home care assessment.

Table 3   Data availability for Caregiver Distress

Data source	Year	Coverage
Home Care Reporting System	2018–2019	Complete: Newfoundland and Labrador, Nova Scotia, Ontario, Saskatchewan, Yukon
		Partial: Alberta (all regions except Calgary Zone), British Columbia (all regions except Northern Health)

Note
Data collected in the Home Care Reporting System is based on the Resident Assessment Instrument–Home Care © and interRAI Home Care © assessments.

Data limitations and caveats

- Some individuals who receive home care services live in supportive housing (e.g., assisted living, community care residences) or private retirement homes and may have access to more supports than those living in private homes. However, the data does not specify which clients are in supportive housing versus private housing arrangements.

- This indicator does not include caregivers of those who receive publicly funded home care on a short-term basis (less than 60 days), of individuals who receive only privately funded services, or of those who do not receive any formal home care services at all. As a result, it provides a partial picture of caregiver distress in the population at large.

- The results are based on data with partial coverage in Alberta (excludes Calgary Zone) and British Columbia (excludes Northern Health). Despite the partial coverage, the reported results are considered representative of those provinces and can be compared.

Key results

More than one-third of individuals who care for a person receiving home care are distressed

Unpaid caregivers play a vital role in our health systems by supporting people with health challenges to stay at home or in the community, and helping to ensure the sustainability of health services for the future.[11] In 2018–2019, approximately 96% of Canadians who received home care services on a long-term basis had an unpaid caregiver. Providing care to a family member or friend can be a demanding job that has a profound impact on the caregiver — emotionally, mentally, financially and physically — particularly if access to support services is lacking.[12]

In 2018–2019, more than one-third of unpaid caregivers of individuals who received home care in the reporting provinces or territories were distressed (34.7%). Of these, the majority (83%) experienced distress, anger or depression, while more than half (55%) indicated they were unable to continue in their role as caregivers.

Figure 5 Risk-adjusted rate of Caregiver Distress by province and territory, 2018–2019
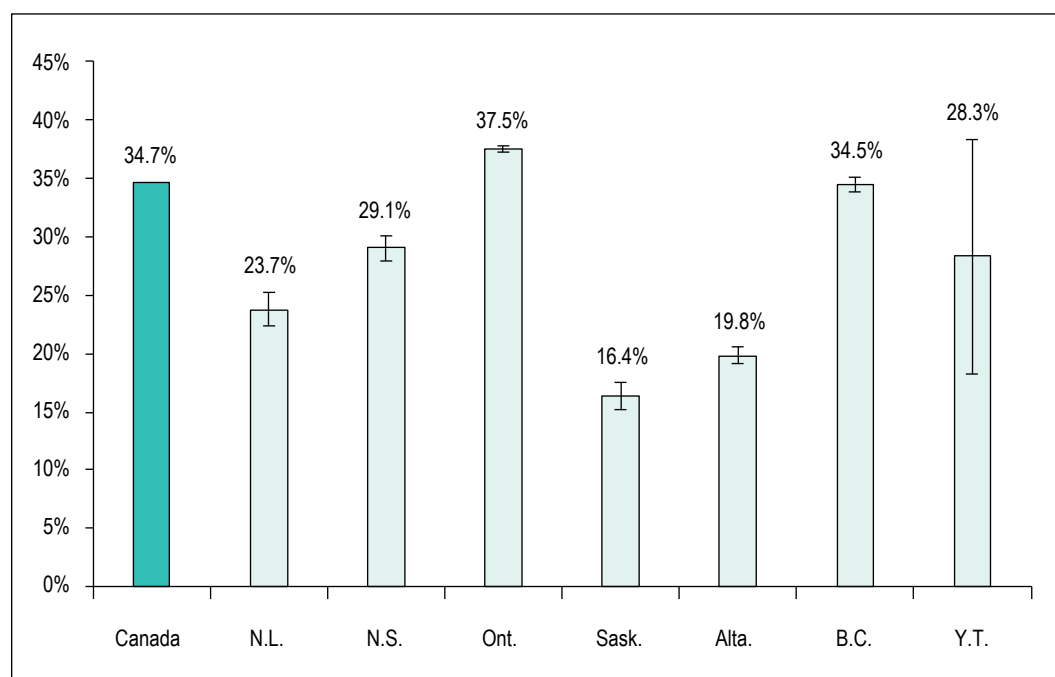
Jurisdiction	N.L.	N.S.	Ont.	Sask.	Alta.	B.C.	Y.T.
Number of long-term home care clients with 2+ assessments and a caregiver	5,322	8,492	128,358	6,251	19,867	20,972	185
Crude rate of caregivers in distress	17.0%	24.1%	40.7%	13.5%	14.8%	31.6%	14.6%

Notes
The line at the top of each bar shows the confidence interval (CI), which is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different. Rates are age-adjusted.

Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Crude rates, in addition to risk-adjusted rates, are helpful to understand the overall rate of caregiver distress in a given jurisdiction regardless of health differences between the people being cared for. When a province has a higher crude rate than risk-adjusted rate, such as Ontario, it signals that people receiving home care in the province may have higher needs than the Canadian average, potentially contributing to more caregiver distress overall.

Many factors can influence Caregiver Distress rates, including

- The availability of home care services in provinces and territories.
  - For example, if services are difficult to access, have a cost or do not meet the needs of the individual receiving home care, caregiver distress is likely to be higher.[12, 13] On the other hand, services that accommodate changing needs or that include supports such as adult day programs, meal delivery services and community social supports may contribute to reducing caregiver distress.[13–15]
- Living arrangements, such as retirement homes or supportive housing.
  - These types of homes may provide more on-site care and supports for residents and their families, though funding models may vary between regions.[11, 13]
- The availability of long-term care beds.
  - Placement in a nursing home or long-term care facility may be appropriate for those living at home with very high needs (e.g., a person with advanced dementia and physical disabilities). However, long waits for beds may place more burden on caregivers and influence rates of distress.[13, 16]

Survey snapshot

Figure 6   Percentage of Canadian caregivers who reported
their caregiving responsibilities were stressful or
very stressful in the General Social Survey, 2018

Notes
This survey reports on levels of stress experienced by caregivers in Canadian provinces, regardless of
services received. It includes non-institutionalized people age 15 and older who live in the 10 provinces only.
The survey response rate was 52.8%.
The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical
agreement distinct from the present statement of principles, based on the asymmetrical agreement of
September 2004. Therefore, Quebec provincial results are not included in this report.
Source
Statistics Canada. Special tabulation based on the 2018 General Social Survey on Caregiving and Care
Receiving. Received January 2020.

Many Canadians who do not receive formal home care services also have caregivers who
could be distressed. Every 5 years, Statistics Canada conducts a survey of a representative
sample of all Canadian caregivers. According to the 2018 General Social Survey, 34% of
Canadian caregivers reported that their caregiving responsibilities were stressful or very
stressful. Over half responded that they felt anxious or worried (62%) or tired (59%), and
many said they felt overwhelmed (42%) or experienced sleep disturbances (41%) while
caring for a friend or family member.

Caregivers are nearly twice as likely to be distressed if they live with the person receiving home care

Distress is twice as high among caregivers who live with the individual they are caring for (47%) compared with those who do not (24%). Among the caregivers who co-reside, about half are spouses and a third are adult children caring for their parents. These caregivers are more likely to care for individuals who require more assistance with activities of daily living (68%) compared with those who do not co-reside (55%). Increased levels of distress could also be the result of taking on more responsibility, providing around-the-clock support to the person they are living with and being unable to take a break.[12, 15] In jurisdictions where caregivers are more likely to live with the individual receiving home care, there are more caregivers with distress.

Figure 7   Rate of Caregiver Distress and percentage of individuals who co-reside, 2018–2019
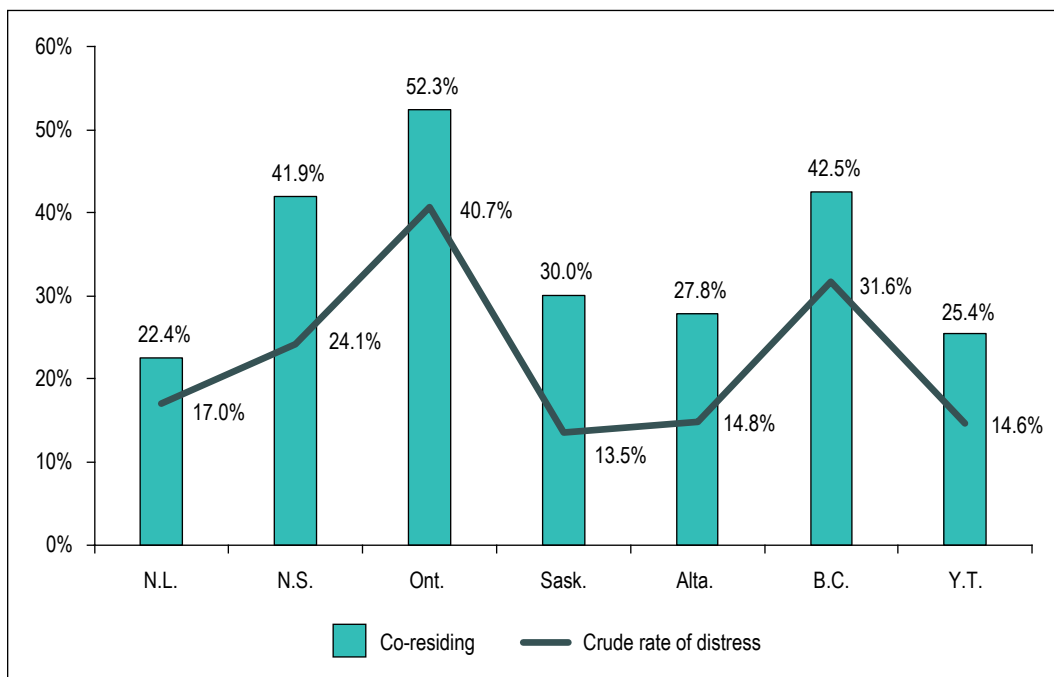
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

For caregivers in distress, time spent caring is the equivalent of a full-time job

Caregivers who were distressed spent an average of 38 hours a week providing care to the family member or friend receiving home care — the equivalent of a full-time job. This is twice the number of caregiving hours provided by caregivers who were not distressed (19 hours a week).

Figure 8   Average number of caregiver hours per week, 2018–2019
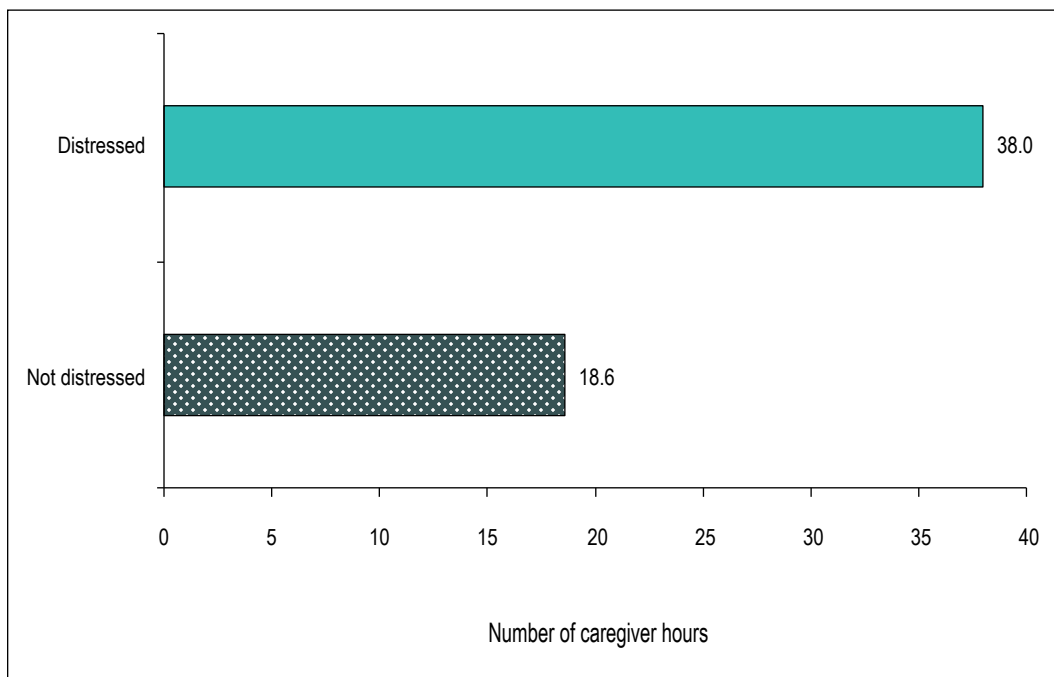
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

7 out of 10 caregivers in distress care for individuals who need substantial help with personal care activities

Among caregivers who are distressed, 7 out of 10 supported individuals who required substantial assistance with personal care activities, including bathing or showering, eating, dressing, brushing their teeth, and getting to and from the toilet or in and out of bed. 6 out of 10 (61%) of all caregivers cared for individuals who needed extensive help or who were totally dependent for personal care. Rates of Caregiver Distress rose as the level of assistance for personal care increased.

Figure 9   Percentage of caregivers reporting distress by number
of personal care activities requiring substantial help,
2018–2019

Figure 9: Percentage of caregivers reporting distress by number of personal care activities requiring substantial help, 2018–2019. Bar chart with values: 0 activities = 24.0%, 1 = 30.4%, 2 = 38.2%, 3 = 42.4%, 4 = 46.8%, 5 = 52.1%, 6+ = 54.0%. X-axis labeled "Number of activities."
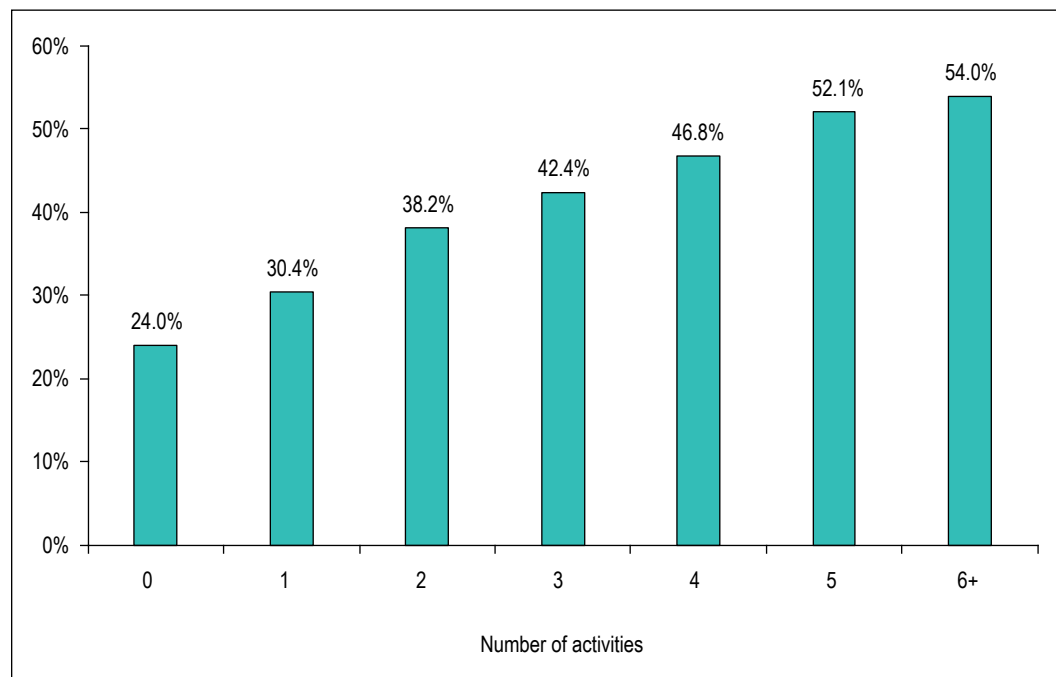
Note
Increasing number of personal care activities requiring substantial help by the caregiver, ranging from 0 (no
activities require substantial help) to 6+ (6 or more activities require substantial help).
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Caregivers are more likely to be distressed if they care for someone who wanders or resists care

Caregivers are twice as likely to be in distress when the person receiving home care
has behavioural problems, such as wandering, being resistant to care, or demonstrating
verbally or physically challenging behaviours. Similarly, over half of individuals receiving
home care who demonstrated symptoms of depression or who experienced unrealistic
fears and repetitive anxious concerns had caregivers who were distressed. Communication
difficulties, such as having trouble making oneself understood or understanding others, were
also associated with increased caregiver distress, as were physical challenges, such as
experiencing falls.

These difficulties likely place more intensive demands on the caregiver. For example, a person with dementia who wanders may require constant monitoring to ensure they are safe, which could disrupt the caregiver's ability to get enough sleep.[17] However, studies show that individuals with complex needs can be supported at home when there is sufficient access to appropriate home care services.[11, 15, 18]

Table 4 Percentage of caregivers reporting distress by health and behavioural characteristics of the person being cared for, 2018–2019

	Rate of Caregiver Distress	
Clinical characteristics of person receiving home care services	Presence of difficulty	Absence of difficulty
Verbally or physically challenging behaviours	64%	33%
Wandering	62%	33%
Resisting care	60%	32%
Signs of depression*	54%	29%
Unrealistic fears/repetitive anxious concerns	53%	31%
Trouble making self understood or understanding others	46%	24%
Bladder incontinence	39%	27%

Note
* Based on having 3 or more symptoms on the Resident Assessment Instrument–Home Care Depression Rating Scale, which is a clinical screen for depression that includes items such as feelings of sadness, sad or worried expression, persistent anger and tearfulness.
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Links to other CIHI resources

- Caregiver Distress indicator
  - [Shared Health Priorities](#) — Indicator results and infographics
  - [Definitions and methodology information](#)
- Data holdings and resources
  - [Home Care Reporting System metadata](#)
  - *[Home Care Reporting System and RAI-Home Care](#)*
- CIHI's existing work
  - *[Supporting Informal Caregivers — The Heart of Home Care](#)*
  - *[Dementia in Canada](#)* — Report with results on challenges and supports for unpaid caregivers
  - *[Home Care Quality Indicators](#)*

New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home

Definition

This indicator measures the percentage of people who were newly admitted to long-term care who had similar health characteristics as people living well at home with formal supports in place.

Rationale

This indicator may help to

- Provide an indication of where more effective home care services and community supports could potentially delay or prevent premature admission to long-term care. This in turn may help to

  - Provide better experiences for Canadians, by supporting the desire of most seniors to remain at home for as long as possible; and

  - Ensure that long-term care facilities are able to provide care for people with more complex health needs.

- Highlight the importance of effective assessments, placement policies and integration of services across the health care continuum.

Calculation

$$\frac{\text{Number of new long-term care residents with similar health characteristics as people living at home with formal supports in place}}{\text{Total number of new long-term care residents}} \times 100$$

- This indicator is based on a clinical assessment of residents who are newly admitted to long-term care. Residents potentially could be cared for at home if they have similar health characteristics as people who are receiving home care services on a long-term basis and are living well at home. This includes people with little or no cognitive impairment (e.g., trouble communicating or remembering) and who require limited assistance with activities of daily living (e.g., toilet use, bathing, eating). These people have also had no falls in the last 30 days, do not demonstrate verbally or physically challenging behaviours, and have not wandered.

- To improve comparability among provinces and territories, this indicator accounts for differences between long-term care residents and is risk-adjusted for age group, sex and living situation prior to admission to long-term care. It is also adjusted for schizophrenia and bipolar disorder, as these diagnoses increase the likelihood of institutionalization regardless of physical health or cognitive impairment.

Table 5 Data availability for New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home

Data source	Year	Coverage
Continuing Care Reporting System	2018–2019	Complete: Newfoundland and Labrador, Ontario, Alberta, British Columbia, Yukon
		Partial: Nova Scotia,* Manitoba, Saskatchewan

Notes
*   Due to small sample sizes and insufficient data coverage, results for Nova Scotia are not reported but are included in the Canada total. Data collected in the Continuing Care Reporting System is based on the Resident Assessment Instrument–Minimum Data Set 2.0 © assessment. See Table A1 for more information.

Data limitations and caveats

- This indicator includes only people who were newly admitted to a publicly funded long-term care facility in 1 year.
- It focuses on new long-term care residents who could potentially live well at home with access to formal home care, based on their health characteristics. However, the data is unable to determine whether they had unpaid caregivers or other types of supports or services prior to admission to long-term care.
- This indicator can be further refined as data collection across provinces and territories improves to better understand the needs of people before they are admitted to long-term care.

Key results

About 1 in 9 newly admitted long-term care residents could potentially be cared for at home

Most seniors want to remain at home for as long as possible.[19–21] However, some seniors with mild to moderate health conditions or physical limitations are admitted to long-term care, even though they may not require continuous care and could potentially have been cared for at home with proper supports in place.

In 2018–2019, 45,000 Canadians were admitted to a long-term care facility in reporting provinces and territories. Of these residents, about 11% (or 1 in 9) could potentially have been cared for at home, provided they had access to ongoing home care services and supports. This represents more than 5,000 long-term care spaces a year in reporting jurisdictions.

It also represents beds that could have been provided to people with greater needs who require care to be available 24 hours a day, 7 days a week. This is an important issue, as most provinces and territories have wait lists for access to publicly funded long-term care and, in some cases, the waits can be lengthy.

There is wide provincial and territorial variation in the proportion of new residents who potentially could have been cared for at home

Figure 10   Risk-adjusted percentage of New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home, by province and territory, 2018–2019
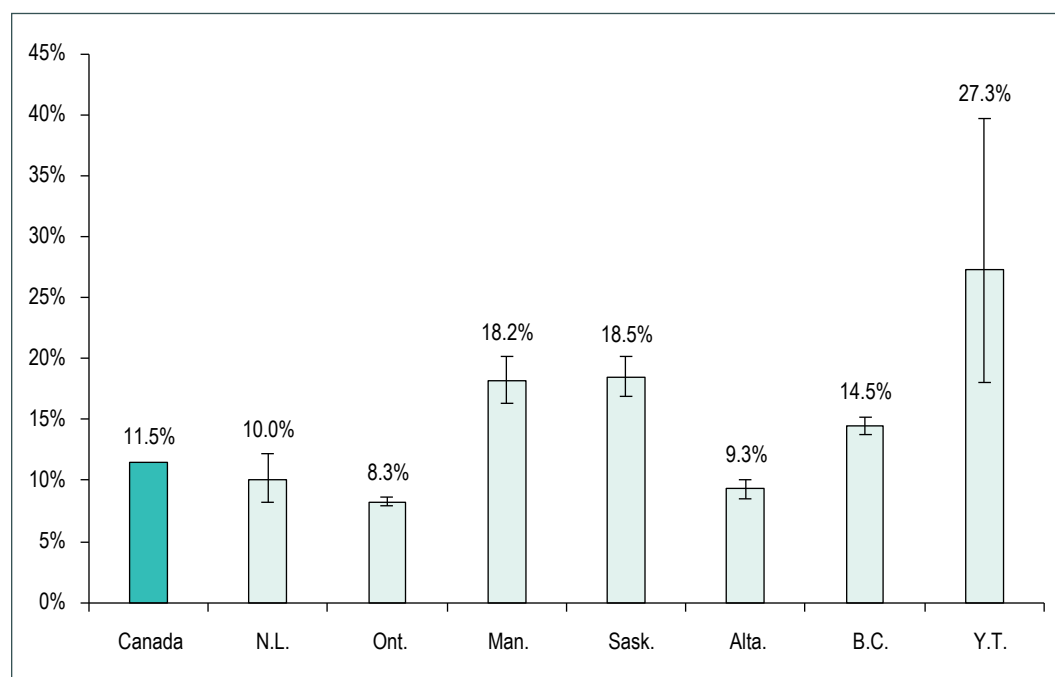
Number of new long-term care admissions, 2018–2019	N.L.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.
Potentially could have been cared for at home	102	2,099	348	506	585	1,457	27
Other new long-term care admissions	870	22,440	1,350	1,929	5,379	7,511	60
Total	972	24,539	1,698	2,435	5,964	8,968	87

Notes

The line at the top of each bar shows the confidence interval (CI), which is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different. Due to low sample sizes and incomplete data coverage, results for Nova Scotia are not reported separately but are included in the overall Canada rate.

Rates are risk-adjusted.

Source

Continuing Care Reporting System, 2018–2019, Canadian Institute for Health Information.

The proportion of new residents who potentially could have been cared for at home varied considerably among jurisdictions, with rates nearly twice as high in Saskatchewan (19%) and Manitoba (18%) as in Alberta (9%) and Ontario (8%). Rates in Yukon were the highest (27%) among reporting jurisdictions, but they should be interpreted with caution due to the small number of long-term care admissions.

Factors that can influence indicator rates include

- Access to home care services and supports.
  - This includes having the right types of services and sufficient home care hours to meet the needs of people so they can live at home.[13]
- The availability of unpaid caregivers.
- The availability of alternate living arrangements with additional supports for seniors, such as retirement homes or assisted living.
  - These types of homes may provide more on-site care and supports for residents and their families, avoiding or delaying inappropriate admission to long-term care.[13]
- Sparsely populated areas.
  - Jurisdictions with small populations spread across a vast area may have more difficulty delivering home care services, particularly in remote areas.
- The availability of long-term care beds.
  - This may influence placement policies and practices, such as the criteria for admission to long-term care.
- Integration of care across the continuum.
  - Transition planning and coordination of care between primary care, home care, social services, long-term care and hospitals can help to ensure that Canadians get the care they need in the appropriate setting and at the appropriate time.

Residents who potentially could have been cared for at home are more likely to live in rural areas and to live alone

Where people live and who they live with can influence their likelihood of entering long-term care. People who lived in rural areas were over 50% more likely than those living in urban areas to be admitted to long-term care even though they potentially could have been cared for at home with formal supports. This may be due to fewer home care services being offered in rural and remote areas.

Likewise, people living alone were twice as likely as those living with family members to be admitted to long-term care despite having lighter care needs. This may speak to the critical role of family supports and unpaid caregivers in allowing people to stay at home for as long as possible. Additionally, when older seniors are living alone, family members are sometimes concerned about their well-being and may lobby for their admission to long-term care.

Table 6   Location and living arrangement prior to being admitted to
long-term care

Resident characteristic	Potentially could have been cared for at home	Total new long-term care admissions	Those who potentially could have been cared for at home as percentage of total new admissions
Rural	1,140	6,944	16.4%
Urban	3,635	34,474	10.5%
Lived alone prior to admission	1,492	7,713	19.3%
Did not live alone	3,278	34,250	9.6%

Notes
Due to missing residential postal code, location prior to being admitted to long-term care is not included
for some residents.
Percentage is based on the crude rate and is not risk-adjusted.
Source
Continuing Care Reporting System, 2018–2019, Canadian Institute for Health Information.

2 out of 3 new long-term care residents are women; half are over age 85

In 2018–2019, of all new long-term care residents who potentially could have been cared for
at home, about 63% were women and 37% were men. The vast majority (over 90%) of these
new residents were age 65 and older, with a median age of 85. However, the age and sex
profiles of these residents were not significantly different from those of other newly admitted
long-term care residents.

In Canada, more women are admitted to long-term care overall because, on average, women
live longer than men. Since women often outlive their spouses, they are more likely to live
alone and less likely to have someone who can look after them when their health starts
to deteriorate.

Families identify health system navigation and financial difficulties as barriers to remaining at home

To better understand their experiences, CIHI collected information from residents, family
members and loved ones of residents who were admitted to a long-term care facility over the
past 3 years. They described the barriers that they faced in accessing home care services
that could have better supported them to stay at home. A qualitative analysis of focus group
discussions uncovered 4 overarching themes from participant experiences:

• Difficulty navigating the health care system

– Participants highlighted challenges with knowing who to call, what kind of services were
available, the amount of time required to coordinate services and the lack of continuity of
care across the system.

- Financial barriers
  - Publicly funded home care does not cover all costs associated with caring for someone at home, burdening families with significant out-of-pocket expenses. Rural families in particular face the specific financial challenges of higher travel costs for medical appointments and limited availability of home care services and supports.

- Responsiveness
  - Participants emphasized the importance of reliable home care staff for quality care, as well as the need for services that were flexible and adaptive to the changing needs of the person receiving care.

- Access to special services
  - Participants highlighted the need for social and emotional support, help with non-medical needs, and language and cultural services.

Figure 11   Barriers to accessing home care:
What residents, caregivers and families say
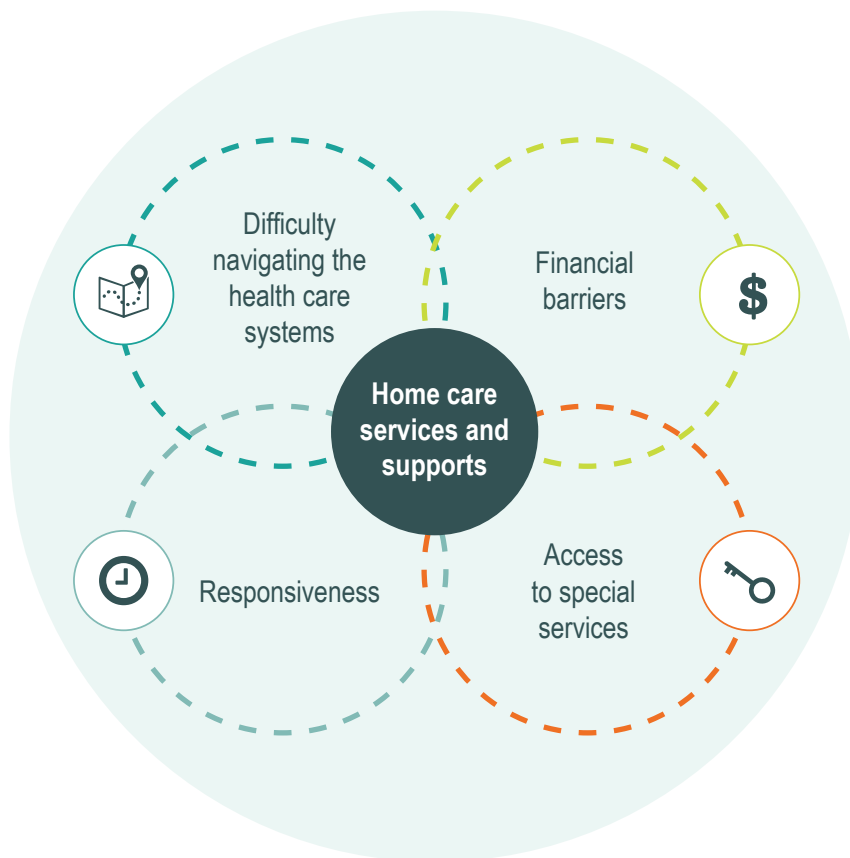
Note
See Appendix C for details of the qualitative study.
Source
Qualitative data, 2019, Canadian Institute for Health Information.

Links to other CIHI resources

- New Long-Term Care Residents Who Potentially Could Have Been Cared for at
  Home indicator
  - [Shared Health Priorities](#) — Indicator results and infographics
  - [Definitions and methodology information](#)
- Data holdings and resources
  - [Continuing Care metadata](#)
  - [*Continuing Care Reporting System and RAI-MDS 2.0*](#)
  - [Home Care Reporting System metadata](#)
  - [*Home Care Reporting System and RAI–Home Care*](#)
- CIHI's existing work
  - [Quick Stats: *Profile of Residents in Residential and Hospital-Based Continuing Care, 2018–2019*](#)
  - [*Seniors in Transition: Exploring Pathways Across the Care Continuum*](#)

Progress report

Results for 6 priority indicators have now been released, with plans to report on all
12 indicators of access to home and community care and to mental health and addictions
services by 2022. This work would not be possible without the efforts of all provinces and
territories, which have participated in expert advisory groups on indicator development,
shared existing data with CIHI, and built data collection and information systems where
there are gaps.

In addition, CIHI has worked closely and collectively with its partners on the development
of the Shared Health Priorities indicators, including Health Canada, Statistics Canada, the
Mental Health Commission of Canada, the Canadian Centre on Substance Use and Addiction
and the Canadian Home Care Association, as well as sector stakeholders, clinical experts and
people with lived experience.[4]

Updated results for the indicators released in 2019 can be found in CIHI's [Your Health
System](#) web tool, with additional technical information in CIHI's [Indicator Library](#) and
contextual information in the [2019 companion report](#).[22, 23] (The 2019 indicators are Hospital
Stays for Harm Caused by Substance Use, Frequent Emergency Room Visits for Help With
Mental Health and/or Addictions, and Hospital Stay Extended Until Home Care Services or
Supports Ready.)

Work to date on the indicators planned for release in 2021 includes

CIHI

• Developing working definitions for home care wait times and community mental health
  wait times;

• Collecting pilot data from provinces and territories for these wait time indicators;

• Engaging with patients and caregivers about their experiences accessing care; and

Statistics Canada

• Leading the development of and collecting data for an indicator measuring whether home
  care services helped recipients stay at home.

Work is also progressing on the final 3 indicators planned for release in 2022: Navigation of
Mental Health and Addictions Services, Early Identification for Early Intervention in Youth, and
Death at Home/Not in Hospital. This includes establishing expert advisory groups, conducting
literature and scoping reviews, exploring options for indicator definitions and data sources,
and developing approaches for patient engagement.

The goal of these efforts is to measure access to services that matter to Canadians, ultimately
leading to improved care. Table 7 shows where comparable data is available to report on the
12 indicators at the time this report was published.
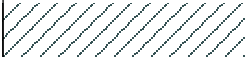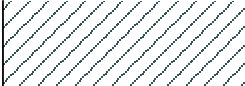
From a data perspective, it is important to highlight the considerable efforts made by
the provinces and territories to expand coverage in existing data holdings, develop
common information standards to improve data quality and explore new data sources for
public reporting. These combined efforts help to provide a more comprehensive picture
for Canadians on access to mental health and addictions services and to home and
community care.

More information on CIHI's data holdings and their coverage by province and territory is
updated regularly on CIHI's website.

Table 7   Indicator development progress

Indicator	Year and stream	Status of standard definition	Data sources	Coverage by jurisdiction
Hospital Stays for Harm Caused by Substance Use	Year 1 (2019) Mental health and addictions	Complete	Hospital Morbidity Database, Discharge Abstract Database (In Ontario, hospital data for this indicator is also captured through the Ontario Mental Health Reporting System and the National Ambulatory Care Reporting System)	All provinces and territories
Frequent Emergency Room Visits for Help With Mental Health and/or Addictions	Year 1 (2019) Mental health and addictions	Complete	National Ambulatory Care Reporting System	Complete coverage: Ontario, Alberta, Yukon Partial coverage: Prince Edward Island, Nova Scotia, Manitoba, Saskatchewan, British Columbia Plans to participate/ expand coverage: Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia, Northwest Territories, Nunavut
Hospital Stay Extended Until Home Care Services or Supports Ready	Year 1 (2019) Home and community care	Complete	Discharge Abstract Database	All provinces and territories except Quebec

Indicator	Year and stream	Status of standard definition	Data sources	Coverage by jurisdiction
Self-Harm, Including Suicide	Year 2 (2020) Mental health and addictions	Complete	Hospital Morbidity Database, Discharge Abstract Database Vital Statistics (Statistics Canada) (In Ontario, hospital data for this indicator is also captured through the Ontario Mental Health Reporting System and the National Ambulatory Care Reporting System)	All provinces and territories
Caregiver Distress	Year 2 (2020) Home and community care	Complete	Home Care Reporting System, Resident Assessment Instrument–Home Care, interRAI Home Care	Complete coverage: Newfoundland and Labrador, Nova Scotia, Ontario, Saskatchewan, Yukon Partial coverage: Alberta (all regions except Calgary Zone), British Columbia (all regions except Northern Health) Plans to participate/ expand coverage: Prince Edward Island, New Brunswick, Manitoba, Alberta, Northwest Territories, Nunavut
New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home	Year 2 (2020) Home and community care	Complete	Continuing Care Reporting System, Resident Assessment Instrument–Minimum Data Set 2.0 (or interRAI Long-Term Care Facilities ©)	Complete coverage: Newfoundland and Labrador, Ontario, Alberta, British Columbia, Yukon Partial coverage: Nova Scotia, Manitoba, Saskatchewan Plans to participate/ expand coverage: Prince Edward Island, New Brunswick, Northwest Territories, Nunavut

Indicator	Year and stream	Status of standard definition	Data sources	Coverage by jurisdiction
Wait Times for Community Mental Health Counselling	Year 3 (2021) Mental health and addictions	Working definition finalized — In progress	New provincial/territorial data collection	Under development
Wait Times for Home Care Services	Year 3 (2021) Home and community care	Working definition finalized — In progress	New provincial/territorial data collection	Under development
Home Care Services Helped the Recipient Stay at Home	Year 3 (2021) Home and community care	Questions added to existing survey — Data collection started in January 2020 and was suspended in March 2020 due to COVID-19. Planned to resume in fall 2020.	Canadian Community Health Survey (Statistics Canada)	All provinces and territories
Navigation of Mental Health and Addictions Services	Year 4 (2022) Mental health and addictions	New definition required	To be determined	Under development
Early Identification for Early Intervention in Youth	Year 4 (2022) Mental health and addictions	New definition required	To be determined	Under development
Death at Home/ Not in Hospital	Year 4 (2022) Home and community care	New definition required	To be determined	Under development

Note

All data sources are from CIHI except where noted.

Conclusion

Surveys consistently show that Canadians want shorter wait times for and better access to the health services they need. Some of the most pressing needs across the country are for timely access to mental health and addictions services, as well as for care in the community to assist older seniors.

Improving access to these services will not be easy. It may require new ways of coordinating care and of navigating the system for patients and their families. The Shared Health Priorities indicators also reflect complex public health challenges with no easy fixes. The impact of the COVID-19 pandemic and its strain on health system resources may further highlight the need to improve services in these areas.

However, *better information is a good place to start*. With 6 indicators now reported publicly, and 6 more in development, Canadians and health planners are starting to have a clearer baseline picture of access to care in these priority areas prior to the pandemic.

With annual reporting of results, the indicators will tell us more about how access to care is evolving over time. It will be important to monitor the impact of COVID-19 and whether the pandemic is having unintended consequences on the health of Canadians by measuring access to mental health and addictions services and to home and community care.

The indicators will spark many questions about what is driving the numbers and how best to improve results. CIHI will continue to facilitate conversations, and to support researchers and health partners who want to further investigate the results. Over the longer term, indicator reporting will allow health system planners and providers to understand what is working well and where improvements are still needed, to learn from best practices and each other's successes, and to design and manage more effective programs to meet the needs of Canadians.

Appendix A: Self-Harm, Including Suicide, breakdown by type of harm event, 2018–2019

Jurisdiction	Type of harm event	Number of events	Rate per 100,000 population (age-standardized)
Newfoundland and Labrador	Self-harm, including suicide	532	124
	Suicide deaths	70	15
	Self-harm hospitalizations	472	113
Prince Edward Island	Self-harm, including suicide	88	67
	Suicide deaths	5	4
	Self-harm hospitalizations	86	65
Nova Scotia	Self-harm, including suicide	529	64
	Suicide deaths	125	14
	Self-harm hospitalizations	413	51
New Brunswick	Self-harm, including suicide	539	83
	Suicide deaths	110	16
	Self-harm hospitalizations	432	69
Ontario	Self-harm, including suicide	9,229	73
	Suicide deaths	1,275	10
	Self-harm hospitalizations	8,109	65
Manitoba	Self-harm, including suicide	677	57
	Suicide deaths	185	16
	Self-harm hospitalizations	511	43
Saskatchewan	Self-harm, including suicide	1,137	112
	Suicide deaths	225	22
	Self-harm hospitalizations	931	93
Alberta	Self-harm, including suicide	2,636	70
	Suicide deaths	570	15
	Self-harm hospitalizations	2,107	56
British Columbia	Self-harm, including suicide	3,296	76
	Suicide deaths	410	9
	Self-harm hospitalizations	2,928	69
Yukon	Self-harm, including suicide	60	171
	Suicide deaths	5	12
	Self-harm hospitalizations	55	158

Jurisdiction	Type of harm event	Number of events	Rate per 100,000 population (age-standardized)
Northwest Territories	Self-harm, including suicide	122	299
	Suicide deaths	10	24
	Self-harm hospitalizations	112	280
Nunavut	Self-harm, including suicide	165	392
	Suicide deaths	20	48
	Self-harm hospitalizations	145	343

Notes

Self-harm hospitalizations ending in death may also be counted as suicide deaths.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

Discharge Abstract Database, National Ambulatory Care Reporting System and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information.

Appendix B: New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home

Table B1   Data availability for Continuing Care Reporting System

Jurisdiction	Coverage	Sector	5+ years of data
N.L.	Full	Community	Yes
P.E.I.	None	n/a	n/a
N.S.	Partial*	Community	No
N.B.	Partial*	n/a	n/a
Que.	None	n/a	n/a
Ont.	Full	Community and hospital-based continuing care	Yes
Man.	Partial	Community and hospital-based continuing care	Yes
Sask.	Partial	Community	Yes
Alta.	Full	Community	Yes
B.C.	Full	Community	Yes
Y.T.	Full	Community	Yes
N.W.T.	None	n/a	n/a
Nun.	None	n/a	n/a

Notes
*   Will be suppressed for the 2020 release due to incomplete data coverage.
n/a: Not applicable.
Data collected in the Continuing Care Reporting System is based on the Resident Assessment Instrument–Minimum Data Set 2.0 assessment.
Source
Continuing Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Appendix C: Methodology notes for qualitative study

Families identify health system navigation and financial difficulties as barriers to remaining at home

Participants for this qualitative study were recruited through national patient networks, provincial/regional resident and family councils, CIHI's client affairs managers and CIHI's Patient Engagement Office. A pre-screening survey and telephone interview identified about 45 eligible participants. Of those people, 15 (including 2 long-term care residents) participated in 2 focus groups in July 2019.

A grounded theory approach was used to examine the data.[24] A content analysis revealed 4 overarching themes.[25] 3 team members independently completed coding, categorization, abstraction, comparison and concept mapping with an established reliability and rigour above 95%.

Appendix D: Text alternatives for figures

Figure 1: Age-standardized rate of Self-Harm, Including Suicide per 100,000, by province and territory, 2018–2019

Jurisdiction	Rate	Lower confidence interval	Upper confidence interval
Canada	77	76	78
N.L.	124	114	135
P.E.I.*	67	53	81
N.S.	64	58	69
N.B.	83	76	90
Ont.	73	72	75
Man.	57	53	61
Sask.	112	106	119
Alta.	70	67	72
B.C.	76	74	79
Y.T.*	171	128	215
N.W.T.*	299	246	353
Nun.*	392	331	453

Notes

*   Due to the low number of deaths in these jurisdictions, suicide rates can fluctuate significantly from year to year.

The confidence interval (CI) is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information; Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of Statistics, 2018.

Figure 2: Rate of Self-Harm, Including Suicide per 100,000, by age and sex, 2018–2019

Age group	Self-harm deaths, female	Self-harm deaths, male	Self-harm hospitalizations, female	Self-harm hospitalizations, male
10 to 24	6	12	188	62
25 to 44	6	18	74	55
45 to 64	7	23	55	44
65+	3	16	23	24

Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information;
Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of Statistics, 2018.

Figure 3: Percentage of patients with self-harm who had repeat hospital stays for self-harm within a year, by age and sex, 2018–2019

Age group	Female	Male
10 to 24	13%	9%
25 to 44	14%	10%
45 to 64	11%	11%
65+	9%	8%
All ages	13%	10%

Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health
Information; Canadian Vital Statistics, Death Database, 2018, Statistics Canada; and Yukon Bureau of Statistics, 2018.

Figure 4: Percentage of hospital stays for self-harm with a concurrent mental health condition, by sex, 2018–2019

Concurrent mental health conditions	Female	Male
Mood disorders	37%	32%
Other mental health disorders	28%	25%
Substance-related and addictive disorders	21%	33%
Disorders of personality and behaviour	22%	13%
Anxiety disorders	16%	10%
Schizophrenia and other psychotic disorders	4%	9%
Any mental health disorders	75%	73%

Note
Only mental health conditions that were treated during the hospital stay are included.
Sources
Hospital Morbidity Database and Ontario Mental Health Reporting System, 2018–2019, Canadian Institute for Health Information.

Figure 5: Risk-adjusted rate of Caregiver Distress by province and territory, 2018–2019

Jurisdiction	Rate	Lower confidence interval	Upper confidence interval
Canada	34.7%	—	—
N.L.	23.7%	22.3%	25.2%
N.S.	29.1%	28.0%	30.1%
Ont.	37.5%	37.3%	37.8%
Sask.	16.4%	15.1%	17.6%
Alta.	19.8%	19.1%	20.6%
B.C.	34.5%	33.8%	35.1%
Y.T.	28.3%	18.3%	38.3%

Notes
— Not applicable.
The confidence interval (CI) is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.
Rates are age-adjusted.
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Figure 6: Percentage of Canadian caregivers who reported their caregiving responsibilities were stressful or very stressful in the General Social Survey, 2018

Jurisdiction	Stressful or very stressful
Canada	33.8%
N.L.	27.4%
P.E.I.	21.8%
N.S.	34.6%
N.B.	28.1%
Ont.	34.8%
Man.	30.1%
Sask.	25.8%
Alta.	31.3%
B.C.	34.2%

Notes
This survey reports on levels of stress experienced by caregivers in Canadian provinces, regardless of services received. It includes non-institutionalized people age 15 and older who live in the 10 provinces only.
The survey response rate was 52.8%.
The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.
Source
Statistics Canada. Special tabulation based on the 2018 General Social Survey on Caregiving and Care Receiving. Received January 2020.

Figure 7: Rate of Caregiver Distress and percentage of individuals who co-reside, 2018–2019

Jurisdiction	Crude rate of distress	Co-residing
N.L.	17.0%	22.4%
N.S.	24.1%	41.9%
Ont.	40.7%	52.3%
Sask.	13.5%	30.0%
Alta.	14.8%	27.8%
B.C.	31.6%	42.5%
Y.T.	14.6%	25.4%

Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Figure 8: Average number of caregiver hours per week, 2018–2019

Caregivers who are . . .	Average number of caregiver hours per week
Not distressed	18.6
Distressed	38.0

Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Figure 9: Percentage of caregivers reporting distress by number of personal care activities requiring substantial help, 2018–2019

Number of personal care activities requiring substantial help	Caregiver distress
0	24.0%
1	30.4%
2	38.2%
3	42.4%
4	46.8%
5	52.1%
6+	54.0%

Note
Increasing number of personal care activities requiring substantial help by the caregiver, ranging from 0 (no activities require substantial help) to 6+ (6 or more activities require substantial help).
Source
Home Care Reporting System, 2018–2019, Canadian Institute for Health Information.

Figure 10: Risk-adjusted percentage of New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home, by province and territory, 2018–2019

Jurisdiction	Rate	Lower confidence interval	Upper confidence interval
Canada	11.5%	—	—
N.L.	10.0%	8.2%	12.2%
Ont.	8.3%	7.9%	8.6%
Man.	18.2%	16.3%	20.2%
Sask.	18.5%	16.9%	20.2%
Alta.	9.3%	8.6%	10.1%
B.C.	14.5%	13.7%	15.2%
Y.T.	27.3%	18.0%	39.7%

Notes

— Not applicable.

The confidence interval (CI) is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

Rates are risk-adjusted.

Due to low sample sizes and incomplete data coverage, results for Nova Scotia are not reported separately but are included in the overall Canada rate.

Source

Continuing Care Reporting System, 2018–2019, Canadian Institute for Health Information.

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