Common Challenges, Shared Priorities

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

Volume 4 | December 2022

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Production of this document is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

Unless otherwise indicated, this product uses data provided by Canada's provinces and territories.

Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6
Phone: 613-241-7860
Fax: 613-241-8120
cihi.ca
copyright@cihi.ca

ISBN 978-1-77479-174-5 (PDF)

How to cite this document:
Canadian Institute for Health Information. *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Canada — Volume 4, December 2022*. Ottawa, ON: CIHI; 2022.

Cette publication est aussi disponible en français sous le titre *Défis communs liés aux priorités partagées : mesure de l'accès aux services à domicile et aux soins communautaires ainsi qu'aux services liés à la santé mentale et à l'utilisation de substances au Canada — volume 4, décembre 2022.*
ISBN 978-1-77479-175-2 (PDF)

Table of contents

About this report

This is the fourth and final companion report from the Canadian Institute for Health Information (CIHI) that describes the development and reporting of the Shared Health Priorities indicators that were endorsed by the federal, provincial and territorial governments in 2017.[1, i] The common purpose of the endorsement was to improve Canadians' access to home and community care, and to mental health and substance use services.[2] This release reflects the work of governments, patients, members of the public, health system leaders and measurement experts, as well as of Health Canada, Statistics Canada, the Mental Health Commission of Canada, the Canadian Centre on Substance Use and Addiction, and the Canadian Home Care Association. It has been a privilege to work together, and this report marks an important milestone — the full suite of 12 indicators is now available.[3]

This report focuses on how to interpret the results for the 3 new indicators, including the impact of COVID-19, and why these results matter to Canadians.

The 3 new indicators available in 2022 are

- Early Intervention for Mental Health and Substance Use Among Children and Youth;
- Navigation of Mental Health and Substance Use Services; and
- Death at Home or in Community.

Results for these 3 new indicators and for the 9 previously released indicators can be found in CIHI's Your Health System web tool; more information on the earlier measures can be found in the previous reports in this series.[4–6] These indicators will be updated and refined as more and better data becomes available. For this release, a number of enhancements have been made where possible, including

- More timely results;
- Region-level reporting; and
- New trend information (where data supports it).

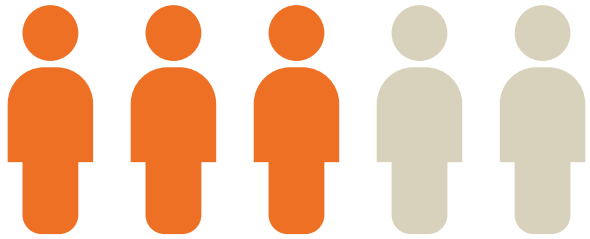
i. Recognizing the Government of Quebec's desire to exercise its jurisdiction in the areas of health care and social services and thus to assume full control over the planning, organization and management of services in these areas within its territory, in particular for the areas of mental health, addictions 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.

This is also the first time that the indicator results will include data from the COVID-19 pandemic period. Results during the pandemic and trends over time should be interpreted with caution. Access to home and community care, and to mental health and substance use services has been affected by the pandemic in many ways,[7, 8] including the following:

- In 2020, some care providers and clients placed their mental health or home care services and needs on hold, following public health directives and limiting contact with others.[9–11]
- Emergency departments began to triage people virtually, redirecting people who could be treated elsewhere and offering virtual visits to reduce crowding in waiting rooms.
- Hospitals prioritized life-saving and more urgent treatments, retrained and shifted human resources to support areas of greatest need (such as intensive care units) and delayed or canceled scheduled surgeries.
- Virtual care became a key tool for primary care physicians, specialists and many mental health care providers. It may be one of the enduring transformations coming out of the pandemic.
- Health care staffing shortages were exacerbated. Health care workers, including those providing home care and mental health services, were more likely to retire early or seek work in other sectors because of the increased demands of providing care during the pandemic. Home care workers, in particular, experienced significant fatigue, personal risk of infection, fear of transmission to family members and the loss of patients and colleagues.
- Prolonged public health measures intended to restrict the spread of COVID-19 have also led to unintended consequences, such as increases in harms caused by substance use.[12]

Reporting on each of the mental health and substance use indicators and home and community care indicators will not lead to immediate change. Over time, these indicators will tell a clearer story about access to care across the country, helping to identify gaps in services to improve care at the front lines and to better meet the needs of patients and their families. CIHI's future reporting will examine progress in these indicators to provide a more complete picture of how access to these services is being improved for Canadians.

Early Intervention for Mental Health and Substance Use Among Children and Youth



3 in 5 children and youth

with early needs accessed at least one community MHSU service

(Source: CIHI, 2022)

Navigation of Mental Health and Substance Use Services

2 in 5 Canadians

said they always or usually had support navigating MHSU services

(Source: CIHI, 2022)

Death at Home or in Community

Over half of Canadians

are dying at home or in the community

(Source: CIHI, 2020)

New indicators and results

This section of the report presents results for the 3 new indicators and information to assist with interpreting them.

A health indicator is a measure that summarizes information about a given priority topic on population health or health system performance.[13, 14] Health indicators aim to

- 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 — they 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.

Results for 2 of the new indicators — Early Intervention for Mental Health and Substance Use Among Children and Youth, and Navigation of Mental Health and Substance Use Services — are based on data collected from newly created surveys. Efforts have been made to ensure that the results reflect the experiences of Canadians in each province and territory, regardless of whether the services were publicly or privately funded. More information can be found in Appendix A.

Results for the Death at Home or in Community indicator are also being reported for the first time. There is some known variation in data coverage among jurisdictions.

These new indicators will continue to be refined and improved, and the initial results should be interpreted with caution.

Early Intervention for Mental Health and Substance Use Among Children and Youth

Definition

This indicator measures the proportion of children and youth age 12 to 24 with early mental health and substance use needs who accessed community-based mental health and substance use services in the past 6 months.

> Early mental health and substance use needs are defined as a new or pre-existing functional impairment or a perceived need for care reported by children and youth in the last 6 months. Children and youth who reported severe impairment with an onset prior to the past 6 months were excluded.

Rationale

This measure indicates whether children and youth in Canada are accessing early intervention services when they have early mental health and substance use needs. Early intervention can help reduce symptoms and the severity of the issues and may help to avoid or delay progression to a diagnosed disorder.

This indicator can also

- Identify areas for improved health system integration and timely access to care; and
- Help to identify populations that experience barriers accessing mental health and substance use services.

Calculation

$$\frac{\text{Total number of individuals age 12 to 24 who accessed at least one community mental health and substance use service in the last 6 months}}{\text{Total number of individuals age 12 to 24 who had early mental health and substance use needs in the last 6 months}} \times 100$$

Indicator results are estimated using a survey weighted approach for analysis of non-probability survey samples.[32] The required population-level information for weighting was obtained through the Canadian Community Health Survey.[33]

Table 1 Data availability for Early Intervention for Mental Health and Substance Use Among Children and Youth

Data source	Year	Coverage
Early Intervention for Mental Health and Substance Use Among Children and Youth Survey	2022	All provinces and territories

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted.
Respondents completed the survey based on their own experience (i.e., results are self-reported). The survey was not to be completed by a proxy (e.g., a parent or caregiver).

Data limitations and caveats

- Early intervention occurs in a variety of community settings. This indicator focuses on access to formal services (i.e., those with a mandate to provide mental health and/or substance use services to children and youth), whether publicly or privately funded. Informal supports, such as those provided by friends and family, are outside the scope of the indicator and are excluded. Emergency department visits and inpatient hospital stays are also out of scope.
- Survey results should be considered only representative of the surveyed population. The survey was conducted in a way that not everyone in the population had an equal chance of participating. The use of social media recruitment and non-probabilistic sampling resulted in selection and participation bias. Weighting methods were used to reduce bias, but the following limitations should be noted:
  - The survey was available in French and English. People who do not speak either of these languages would have been unable to complete the survey.
  - Those without internet access or with low computer literacy would not have had the same opportunity to participate in the survey (non-coverage bias).
  - Participants age 13 and younger in Quebec and age 12 and younger in the rest of Canada required parental consent to complete the survey, which may have contributed to a lower response rate for the 12-to-14-years age group. Additional limitations for that age group may be a result of social media recruitment and the required age to have social media accounts.
  - Assessing mental health and/or substance use services in the previous 6 months is subject to the respondents' ability to remember their experience (recall bias).
- Incentives to complete the survey, in the form of a $100 gift card draw, were offered outside of Quebec, potentially impacting participation.
- Indicator results based on fewer than 50 respondents are not reported.

Key results

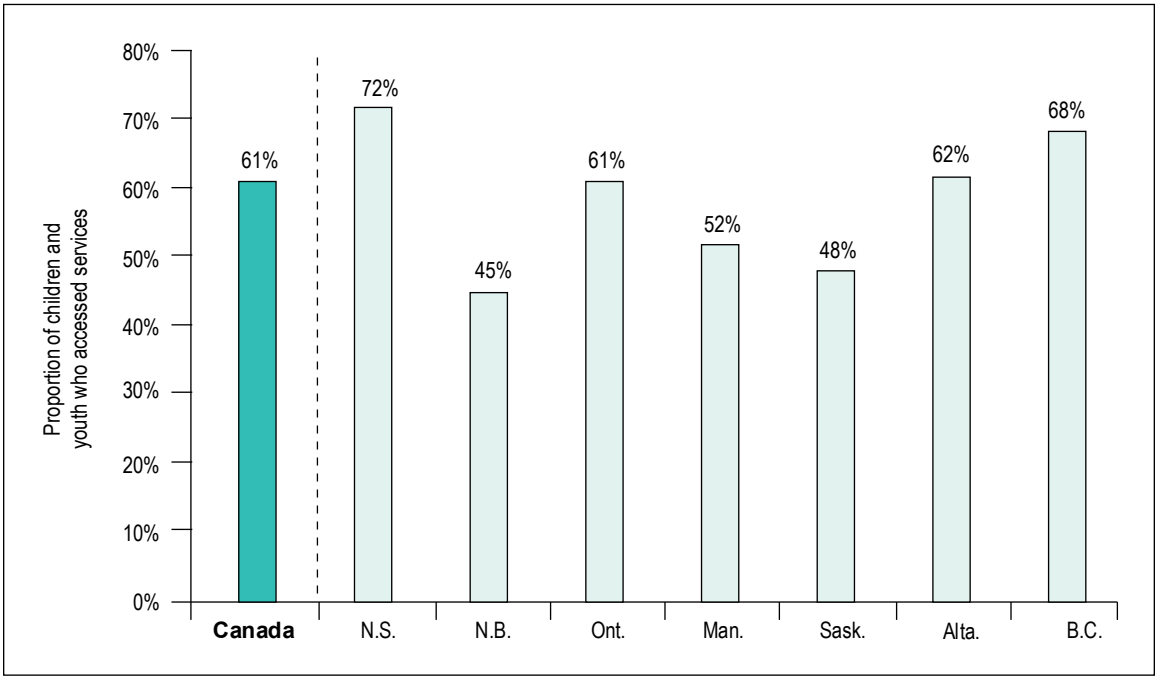
3 in 5 children and youth with early needs accessed community mental health and substance use services

For the majority of people living with a mental disorder, their symptoms begin before the age of 18.[15] In Canada, up to 20% of children and youth — approximately 1.2 million individuals — are affected.[16] Early interventions can help to avoid or delay the progression of a disorder and limit the lifelong effects on one's health and well-being.

In 2022, 3 in 5 (61%) children and youth in Canada who were experiencing self-reported mild to moderate functional impairment or a perceived need for care accessed mental health and substance use services.

Mental health services are diverse and can be provided in a number of settings. Counselling and therapy were accessed by almost three-quarters (74%) of children and youth with self-reported early needs. This was followed by school-based services (49%) — such as guidance counsellors, social workers and school nurses — and crisis support services (31%) — such as telephone lines, mobile outreach teams and other on-demand support. Approximately 5% of children and youth accessed services focused on Indigenous Peoples and/or culturally based services for immigrants, refugees or racialized individuals.

Figure 1 Proportion of children and youth with self-reported early needs who accessed mental health and substance use services, by jurisdiction, 2022



Jurisdiction	Canada	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.
Number of respondents	**2,088**	53	54	666	82	62	318	301

Notes

Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling).
Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Results for Newfoundland and Labrador, Prince Edward Island, Yukon, the Northwest Territories and Nunavut are suppressed due to small sample sizes.
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.
The overall Canada result includes survey responses from the jurisdictions not shown.

Source

Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Access to community-based mental health and substance use services for children and youth with self-reported early needs varied among provinces and territories. Many factors can influence early access, including

- The availability of mental health services and supports in jurisdictions, how these services are arranged specifically for children and youth, and how individuals qualify for them;[17, 18]
- Awareness of available services and how to access them;

- School boards' focus on understanding the needs of students and on collaborating with community partners to deliver supports;[19]
- The proportion of individuals living in rural communities spread across a vast area. These individuals may face longer travel times to in-person services and limited internet access for virtual services;
- Stigmatization, real or perceived, and its effect on patient decision-making and help-seeking behaviour;
- Other social determinants of health — such as income, education, gender, language, social networks, housing, and personal and/or intergenerational trauma — that influence the level of mental health support needs and access to services;[20] and
- Population health, such as the prevalence of concurrent health conditions (including chronic conditions and disabilities).

Impact of COVID-19 on early intervention for mental health and substance use among children and youth

The pandemic has had an impact on mental health and substance use among younger Canadians, including an increase in symptoms of depression and anxiety.[21, 22] Young women, youth living in urban or suburban areas, youth living in larger households and youth with poorer baseline mental and physical health have been most vulnerable to mental health challenges and concerns.[23] The pandemic has also exacerbated the mental health challenges of sexual and gender minority youth.[24] Kids Help Phone reported double the number of interactions (phone calls, texts, use of self-directed help resources) in 2020 compared with 2019.[25] Accessing early mental health and substance use services could have been impacted in many ways:

- School closures and shifts to virtual learning limited the support available for children and youth from their network of friends and teachers.
- Some health services were suspended, and access was limited (e.g., services regularly provided by a school guidance counsellor or social worker).
- In-person appointments shifted to virtual care. The ability of service providers to provide virtual care varied, as did children and youth's access to technology and private spaces for confidential appointments.
- Parents and guardians may have faced increased stress and isolation, job loss and financial pressure.

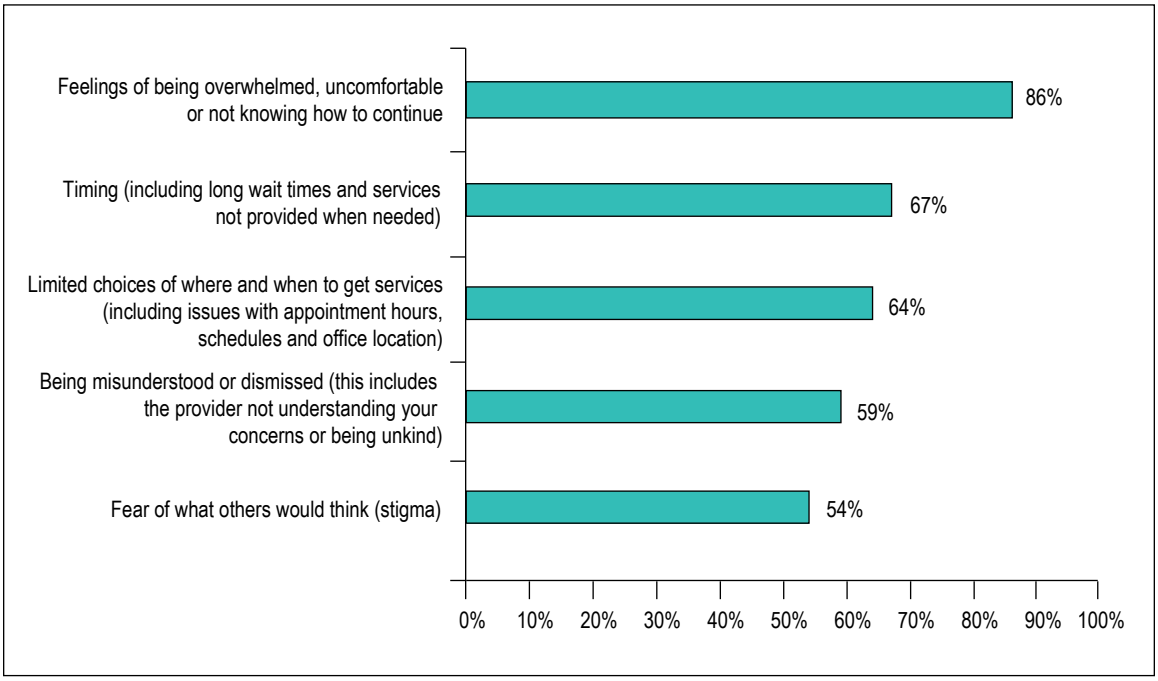
More than half of children and youth who accessed services in Canada said they were not easy to access

While 61% of young Canadians said that they accessed early intervention services, they also indicated that they overcame significant barriers to do so.

The most common barrier to accessing mental health and substance use services among survey respondents was feelings of being overwhelmed, uncomfortable and not knowing how to continue, followed by timing (e.g., long wait times) and limited choices of where and when to get services.

Financial barriers, such as not being able to afford the cost of private services, are difficult to assess among children as they may not make financial decisions and may not fully understand their family's financial situation. However, for older youth age 18 to 24, more than half (57%) of respondents said that the cost of services was a barrier.

Figure 2 Top 5 barriers reported by children and youth to accessing mental health and substance use services, 2022



Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Fewer boys and young men with self-reported early needs accessed early intervention services

54% of boys and young men accessed early intervention services compared with 63% of girls and young women and 77% of non-binary children and youth.[ii] Many studies have shown that males show less help-seeking behaviour for mental health and substance use issues and access fewer services.[26]

Almost 80% of transgender[iii] and non-binary[iv] children and youth with mental health or substance use issues accessed early intervention services, whereas 58% of cisgender children and youth accessed early intervention services. While these findings suggest that transgender and non-binary children and youth are more likely to receive access to early intervention services, it should be noted that transgender youth face significant health disparities and poor mental health outcomes related to depression, self-harm and suicide.[27, 28] The types of services accessed by transgender and non-binary youth differed in that they accessed more school-based services and counselling and therapy than cisgender youth did. This is consistent with previous research that indicates that non-binary youth are more likely to access services through gender-affirming care, extracurricular activities related to their identities, and supportive relationships with school counsellors and social workers.[29, 30]

Access to early intervention also varied by sexual orientation. Children and youth with mental health or substance use needs who identified as heterosexual had the lowest proportion of accessing early mental health and substance use services (56%). Gay or lesbian individuals reported the highest access (85%), followed by bisexual and pansexual individuals (75%) and those who reported another sexual orientation (74%). This aligns with literature indicating that individuals identifying at gay, lesbian or another sexual orientation seek care from mental health care professionals at higher rates than heterosexual individuals.[31]

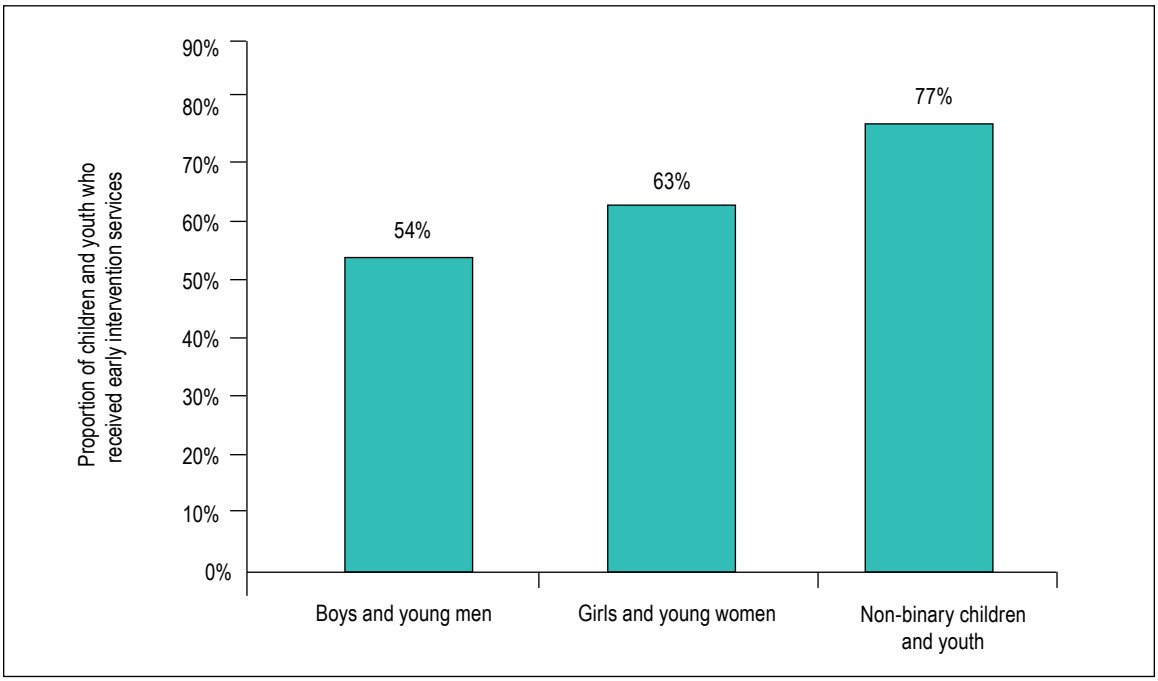
---

ii. In this report, “non-binary persons” is used as an umbrella term referring to all individuals who identified as non-binary explicitly or who provided another gender as a survey response (e.g., agender, genderqueer, genderfluid, gender-nonconforming). It also includes persons whose reported gender is both male and female, neither male nor female, or either male or female in addition to another gender. Individuals who are classified as non-binary persons in this report do not necessarily use this label to describe their gender identity.

iii. In this report, “transgender persons” includes persons whose reported gender does not correspond to their assigned sex at birth. Specifically, it includes transgender (trans) men and women (e.g., a transgender man was assigned female sex at birth but reports male gender).

iv. Transgender and non-binary persons include all persons whose reported gender does not correspond to their reported sex at birth.

Figure 3 Proportion of children and youth who accessed early mental health and substance use services, by gender, 2022



Notes

Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.

Source

Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Links to other CIHI resources

- Early Intervention for Mental Health and Substance Use Among Children and Youth indicator
  - Your Health System: In Brief — Indicator results and infographics
  - Indicator library — Definitions and methodology information
  - Shared Health Priorities — Additional information about indicators to monitor access to mental health and substance use services
- Data holdings and resources
  - Mental health and substance use information
  - Mental health and substance use: Data holdings
- CIHI's existing work
  - *Hospital Stays for Harm Caused by Substance Use Among Youth Age 10 to 24*
  - *Health System Resources for Mental Health and Addictions Care in Canada*
  - Unintended consequences of COVID-19: Impact on harms caused by substance use, self-harm and accidental falls
  - Mental health of children and youth in Canada

Navigation of Mental Health and Substance Use Services

Definition

This indicator measures the proportion of individuals age 15 and older who always or usually had the support necessary to navigate mental health and substance use services in the past year, once they accessed a service.

Navigation includes moving within a service or between different types of services. While many people will receive the care they need from the first professional they seek support from, this indicator is intended to reflect the experience of Canadians who needed to speak with someone else to get appropriate services. This includes being referred to another provider within the same service or having to navigate to another type of service.

Note: Canadians who did not need additional services after the first professional they connected with are excluded from this indicator.

Rationale

A higher proportion of people who had support while navigating mental health and substance use services may indicate that Canadians are efficiently and effectively receiving the care that they need.

This indicator can also

- Identify areas for improved health system integration and timely access to care; and
- Help to identify populations that experience differences when navigating mental health and substance use services.

Calculation

$$\frac{\text{Total number of individuals who always or usually had support}}{\text{Total number of individuals who always, usually, sometimes, rarely or never had support}} \times 100$$

Individuals included in the results were age 15 and older at the time of the survey and had received mental health and/or substance use services in the previous 12 months. Individuals who didn't need support (7%), who didn't need another service (15%) or who refused to answer or answered "don't know" (3%) were excluded from the indicator.

Indicator results are estimated using a survey weighted approach for analysis of non-probability survey samples.[32] The required population-level information for weighting was obtained through the Canadian Community Health Survey.[33]

Table 2 Data availability for Navigation of Mental Health and Substance Use Services

Data sources	Year	Coverage
Navigation of Mental Health and Substance Use Services Survey	2022	All provinces and territories

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted.
Respondents completed the survey based on their own experience (i.e., results are self-reported). The survey was not to be completed by a proxy (e.g., a parent or caregiver).

Data limitations and caveats

- Survey results should be considered only representative of the surveyed population. The survey was conducted in a way that not everyone in the population had an equal chance of participating. The use of social media recruitment and non-probabilistic sampling resulted in selection and participation bias. Weighting methods were used to reduce bias, but the following limitations should be noted:
  - The survey was available in French and English. People who do not speak either of these languages would have been unable to complete the survey.
  - Those without internet access or with low computer literacy would not have had the same opportunity to participate in the survey (non-coverage bias).
  - Assessing mental health and/or substance use services in the previous 12 months is subject to the respondents' ability to remember their experience (recall bias).
- Incentives to complete the survey, in the form of a $100 gift card draw, were offered outside of Quebec, potentially impacting participation.
- Indicator results based on fewer than 50 respondents are not reported.

Key results

2 in 5 Canadians always or usually had support navigating mental health and substance use services

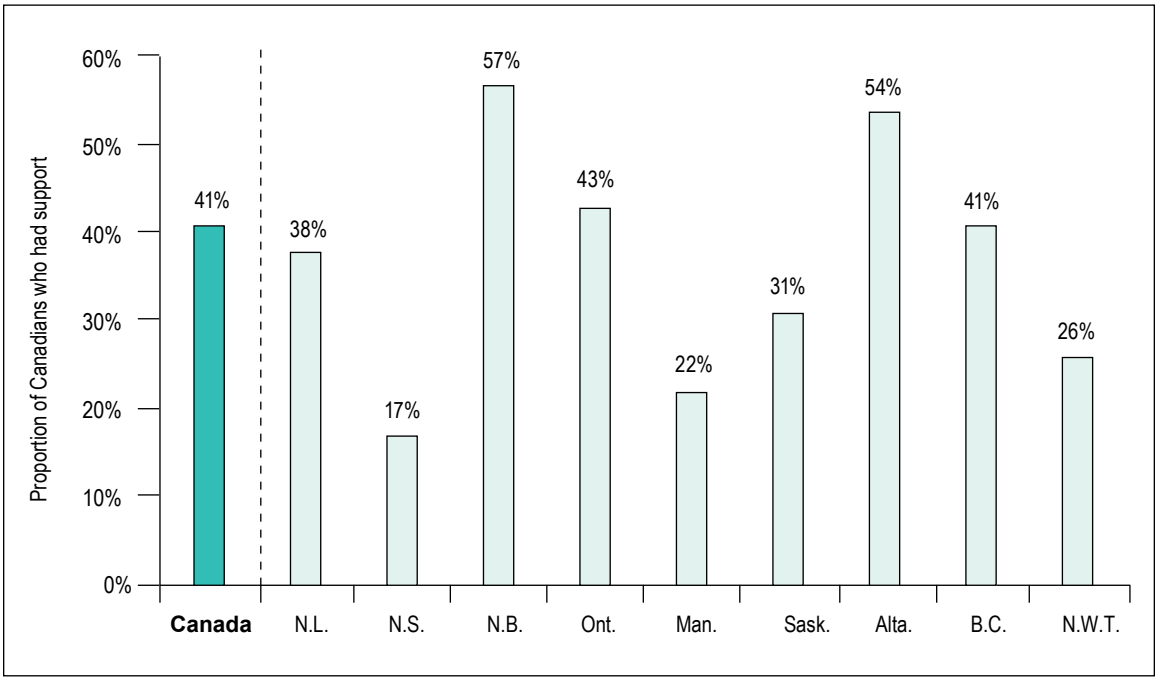
For those seeking care for mental health and substance use, navigating the health system and its complex arrangement of services can be particularly challenging. Compared with other types of health care, like cancer care, it can be difficult to know what services are available and how to access services that will meet one's needs. As a result, many people do not receive the care they need from the first professional they connect with and require support to access another service. This support may be limited, particularly in areas where services are limited.

Seamless navigation requires an organized health system across many disciplines that minimizes delays or gaps in care and improves the patient experience.[34] A well-coordinated system can effectively deliver care without burdening patients, their families and other caregivers.

Survey respondents may have accessed multiple types of mental health or substance use services, or they may have navigated within a service type. The most common services were those provided by family doctors, nurse practitioners and specialists (77%), followed by counsellors or therapists (71%) and trained peer support groups (31%). Approximately 30% of individuals also accessed more urgent care, such as crisis support services (including help lines and mobile outreach teams) and the emergency department.

41% of Canadians said that they always or usually had support navigating within or between mental health and substance use services.

Figure 4 Proportion of Canadians who responded that they always or usually had support navigating within or between mental health and substance use services, by jurisdiction, 2022



Jurisdiction	Canada	N.L.	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.	N.W.T.
Number of respondents	**4,034**	150	92	129	1,029	189	146	733	869	63

Notes

Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling).
Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Results for Prince Edward Island, Yukon and Nunavut are suppressed due to small sample sizes.
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.
The overall Canada result includes survey responses from the jurisdictions not shown.

Source

Navigation of Mental Health and Substance Use Services Survey, 2022, Canadian Institute for Health Information.

The proportion of Canadians who were supported when navigating mental health and substance use services varied among provinces and territories. Many factors can influence whether an individual feels supported with service navigation, including

- The level of support required to navigate within and between services, which is in turn impacted by the availability of mental health services and supports in jurisdictions, how these services are arranged and how individuals qualify for them;[16, 17]
- How easy it is to navigate the system and how well services are coordinated with each other, particularly the strength of connections between community services, primary health care providers and specialists;
- The proportion of individuals living in rural communities spread across a vast area. These individuals may face longer travel times to in-person services and limited internet access for virtual services;
- Stigmatization, real or perceived, and its effect on patient decision-making and help-seeking behaviour;
- Levels of income, education and employment that determine the extent of one's financial limitations;[35]
- Other social determinants of health — such as gender, language, social networks, housing, and personal and/or intergenerational trauma — that influence the level of mental health support needs and access to services;[20] and
- Population health, such as the prevalence of concurrent health conditions (including chronic conditions and disabilities).

Impact of COVID-19 on navigating within and between mental health and substance use services

The pandemic and related public health measures to limit the number of COVID-19 cases has impacted the mental health of Canadians. Surveys have found declining mental health among Canadians and high levels of anxiety and loneliness.[36, 37] Receiving support when navigating mental health and substance use services could have been impacted in many ways:

- Demands for mental health and substance use services increased during the pandemic, leading to an increase in mental health services provided by physicians, in the rate of frequent emergency department visits and in hospitalizations for substance-related harms.[38] These demands increased the burden on the health system, requiring additional resources to ensure effective coordination of care for those navigating within and between services.
- Changes to service delivery added complexity and potential confusion for individuals navigating services and for health professionals providing referrals. For example, provinces and territories shifted to providing virtual mental health and substance use services.
- Social isolation and loneliness increased, which can have serious consequences for mental and physical health, and individuals may have been left to navigate the health system on their own.

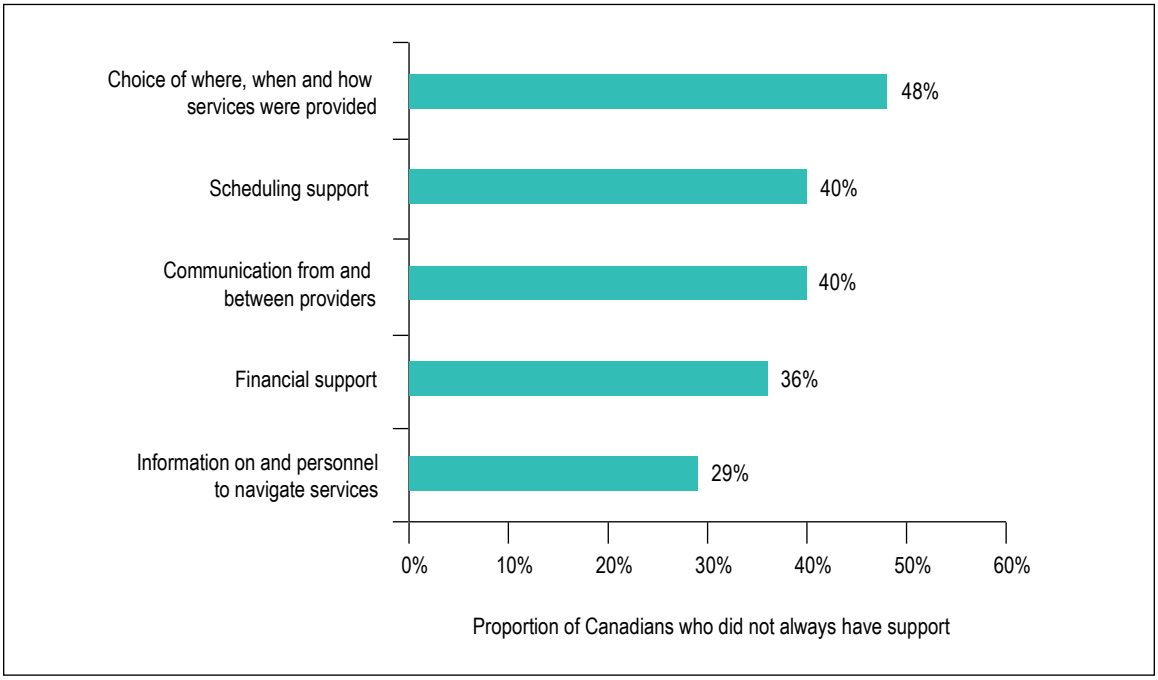
Additional support is needed to navigate mental health and substance use services

29% of Canadians responded that they rarely or never had the support needed to navigate within and between mental health and substance use services. This highlights the complexity of referrals or hand-offs between services and demonstrates the importance of effectively communicating about available services.

Respondents who did not always have support would have benefitted from additional help. More choice of where, when and how services were provided was something that would have made a difference in their care for 48% of respondents. Scheduling support, and communication from and between providers were also identified by 40% of respondents.

More than one-third of respondents also noted that financial support would have helped; those who rarely or never had trouble making ends meet were better supported than those who always or usually had trouble making ends meet (49% versus 38%, respectively). This is consistent with past reports showing that Canadians of all ages with a mental health or substance use disorder have reported that they could not afford the financial cost of obtaining mental health services.[39]

Figure 5 Proportion of Canadians who did not always have support who would have found the following helpful in navigating mental health and substance use services, 2022



Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling).
Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Navigation of Mental Health and Substance Use Services Survey, 2022, Canadian Institute for Health Information.

Sexual and gender minorities were less supported when navigating mental health and substance use services

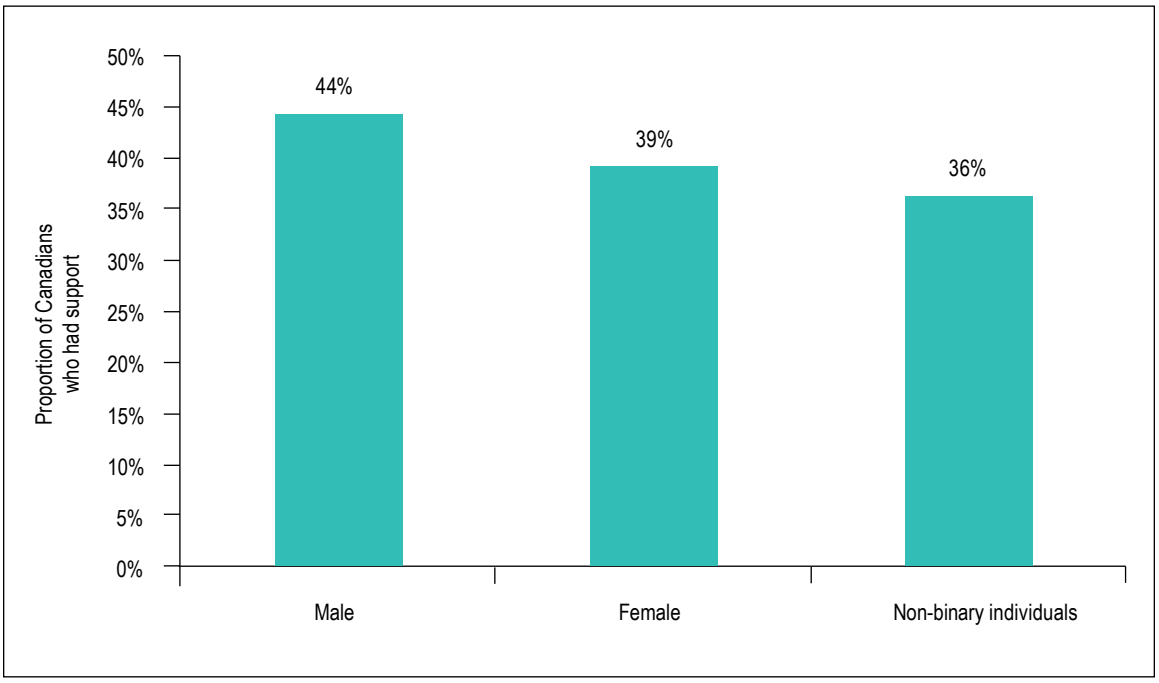
There are gender differences in the use of mental health and substance use services. Women are more likely to seek care for health concerns than men, though men will get help once a problem reaches a threshold.[40] A higher proportion of males (44%) had support to navigate mental health and substance use services compared with females (39%) and non-binary persons (36%).[v]

v. In this report, "non-binary persons" is used as an umbrella term referring to all individuals who identified as non-binary explicitly or who provided another gender as a survey response (e.g., agender, genderqueer, genderfluid, gender-nonconforming). It also includes persons whose reported gender is both male and female, neither male nor female, or either male or female in addition to another gender. Individuals who are classified as non-binary persons in this report do not necessarily use this label to describe their gender identity.

Some individuals are a different gender than their sex assigned at birth, including those who identify as female, male or another gender. 32% of transgender[vi] and non-binary individuals[vii] had support compared with 42% of cisgender individuals.

Sexual orientation also impacts the use of mental health and substance use services. People who identify as gay, lesbian or another sexual orientation seek care from mental health care professionals at higher rates than heterosexual individuals.[31] Results from this indicator also show that a lower proportion of people who identified as gay, lesbian or another sexual orientation said they had support to navigate mental health and substance use services compared with those identifying as heterosexual (38% versus 42%, respectively).

Figure 6 Proportion of Canadians who responded that they always or usually had support navigating within or between mental health and substance use services, by gender, 2022



Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Navigation of Mental Health and Substance Use Survey, 2022, Canadian Institute for Health Information.

vi. In this report, "transgender persons" includes persons whose reported gender does not correspond to their assigned sex at birth. Specifically, it includes transgender (trans) men and women (e.g., a transgender man was assigned female sex at birth but reports male gender).
vii. Transgender and non-binary persons include all persons whose reported gender does not correspond to their reported sex at birth.

A slightly higher proportion of Canadians age 65 and older had support when navigating within or between mental health and substance use services than those younger than 65. In terms of educational attainment, those who had not completed high school were least likely to have had support compared with those who had completed high school or some post-secondary education.

Links to other CIHI resources

- Navigation of Mental Health and Substance Use Services indicator
  - Your Health System: In Brief — Indicator results and infographics
  - Indicator library — Definitions and methodology information
  - Shared Health Priorities — Additional information about indicators to monitor access to mental health and substance use services
- Data holdings and resources
  - Mental health and substance use information
  - Mental health and substance use: Data holdings
- CIHI's existing work
  - *Hospital Stays for Harm Caused by Substance Use Among Youth Age 10 to 24*
  - *Health System Resources for Mental Health and Addictions Care in Canada*
  - Unintended consequences of COVID-19: Impact on harms caused by substance use, self-harm and accidental falls
  - Mental health of children and youth in Canada

Death at Home or in Community

Definition

This indicator measures the proportion of individuals who die outside of hospitals each calendar year, at home or in the community.

The location where a person resides at the end of life is defined as follows:

- Hospitals: Acute care hospital settings and emergency departments.
- Home and community: Many types of home-like and community-based living situations, including personal residences; long-term care facilities; hospices; nursing homes; residential homes; complex continuing care facilities, including palliative care units; and group care.

Rationale

Access to community-based end-of-life services is a key enabler of dying at home, which is where the majority of Canadians report that they would prefer to die. A higher proportion of deaths at home or in the community, rather than in hospital, may indicate that Canadians are getting access to community-based services for end-of-life care.

This indicator can also

- Identify where additional services are required to support people to die at home or in the community; and
- Monitor progress being made toward shifting the place of death to home-like or community-based settings.

Calculation

$$\frac{\text{All deaths in Canada} - \text{Deaths in emergency departments and acute care hospitals}}{\text{All deaths in Canada}}$$

All deaths in Canada are quantified using the Canadian Vital Statistics Death Database and coroner data from the Yukon Bureau of Statistics. Deaths in emergency departments and acute care hospitals are quantified using data from CIHI's National Ambulatory Care Reporting System, Discharge Abstract Database, Hospital Morbidity Database and Ontario Mental Health Reporting System.

Deaths from external causes — including poisonings, assaults, self-harm and transport accidents — are excluded because they typically do not allow for choice in where a person dies.[41] In Yukon data, only homicides and self-harm are excluded due to data availability.

Table 3 Data availability for Death at Home or in Community

Data sources	Year	Coverage
Discharge Abstract Database and Hospital Morbidity Database	2020 (calendar year)	All provinces and territories
National Ambulatory Care Reporting System	2020 (calendar year)	Complete: Quebec, Ontario, Alberta, Yukon Partial: Prince Edward Island, Nova Scotia, Manitoba, Saskatchewan, British Columbia No data: Newfoundland and Labrador, New Brunswick, Northwest Territories
Ontario Mental Health Reporting System	2020 (calendar year)	Complete: Ontario Partial: Manitoba
Vital Statistics, Statistics Canada*	2020 (calendar year)	All provinces and territories except Yukon
Coroner data, Yukon Bureau of Statistics	2020 (calendar year)	Yukon

Notes

* Vital Statistics data is publicly available on Statistics Canada's website. Statistics Canada provided a file directly to CIHI for this indicator in which sudden deaths were removed.

In Ontario, records for mental health and substance use hospital stays are collected through the Ontario Mental Health Reporting System. In other provinces and the territories, these records are collected in the Discharge Abstract 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 March 2022 and from the Ontario Mental Health Reporting System in August 2021.

Data limitations and caveats

- An individual's preferred location of death is not captured in this indicator. Some people may prefer hospital-based care at the end of life (especially if adequate community-based services are not available). In some regions, acute care hospitals may be the only place patients can access palliative care.
- Some hospitals provide care, such as inpatient palliative care, that is similar to that provided in community hospices. These are not distinguished in the data. Jurisdictions that provide this care in hospital may have a higher proportion of hospital deaths.[42]
- Emergency department data is not complete across Canada, which may slightly impact comparability of the results. In the 9 jurisdictions with incomplete emergency department coverage, results may somewhat overestimate the proportion of deaths at home or in the community. For those jurisdictions with complete emergency department data, approximately 10% to 15% of hospital deaths were recorded in the emergency department.
- This indicator does not take into account the length of stay in hospital. Many people have short stays in hospital prior to death.
- It is not possible to determine whether an individual accessed community-based services for end-of-life care.

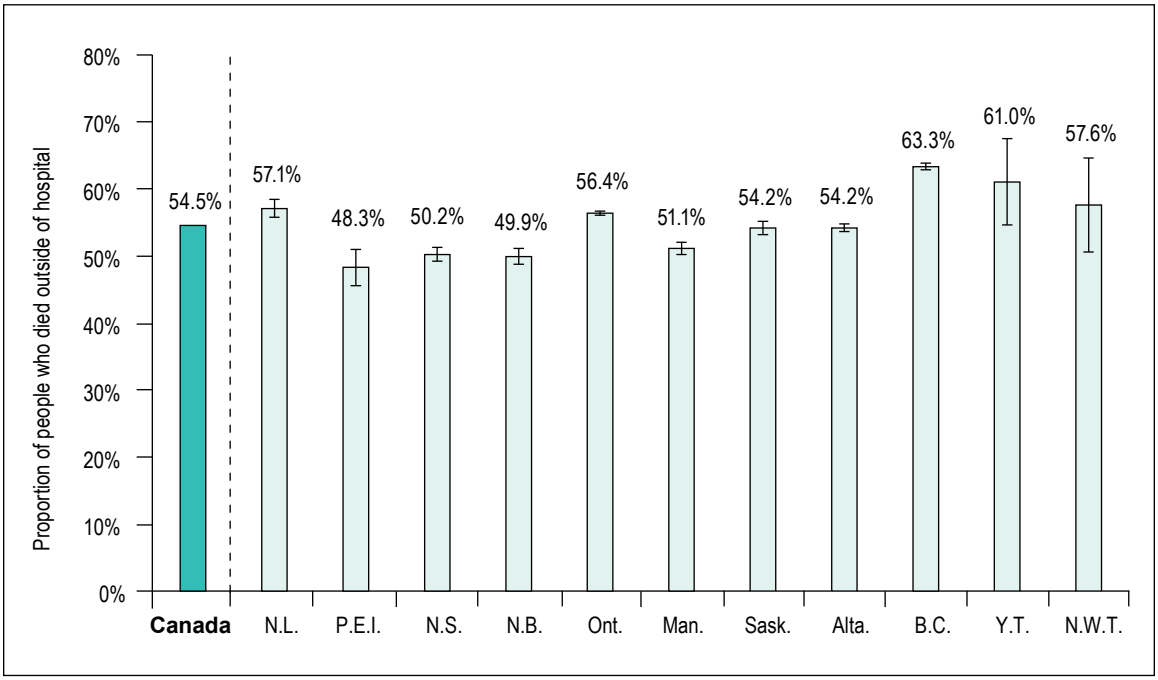
Key results

More than half of Canadians died at home or in the community

Receiving care and dying in one's preferred location can indicate patient- and family-centred care at the end of life. While a person's preference may change during the course of their illness, most Canadians prefer not to die in hospital. For example, a 2013 survey found that 75% of Canadians who had a preference would choose to die in their home.[43] A similar proportion of Canadian seniors felt confident that they would have enough services in their community to support them at the end of life in the location of their choice.[44]

Approximately 300,000 Canadians died in 2020, and just over half of those individuals (54.5%) died at home or in the community. This **excludes** deaths from **external causes** such as poisonings, assaults, self-harm and transport accidents, because these individuals would have had limited choice in where they spent their last days, or end-of-life services may not have been appropriate. These cases account for roughly 3% of all deaths.

Figure 7 Proportion of people who died at home or in the community, by jurisdiction, 2020



Jurisdiction	N.L.	P.E.I.	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.
Number of deaths	5,300	1,330	9,730	7,260	110,605	11,425	9,710	27,285	40,755	258	270
Number of community deaths	2,996	640	4,853	3,577	62,906	5,803	5,262	14,669	25,930	155	157

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 CIs 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

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

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

The rate of deaths at home or in the community varied among the provinces and territories. Many factors can influence the location of death, including

- The availability of sufficient health care support, such as home care, physician home visits and home-based palliative care, along with the appropriate medications, equipment and supplies, which have been shown to facilitate death at home and in the community;[45]
- The availability of informal caregivers, who can play a crucial role in providing care at home, including medical, personal, social and psychological care when appropriately supported;[46]
- How easy it is to navigate the system and how well services are coordinated with each other;
- Cause of death — patients with terminal illness such as cancer are more likely to receive palliative care services and die at home compared with patients with other conditions such as organ failure (e.g., heart failure) or frailty (e.g., dementia);[47]
- Predictability of death and the length of survival following diagnosis — for example, cancer patients who survive longer, and for whom the end of life is often foreseen, are more likely to have access to palliative care and die at home;[48]
- The proportion of rural communities spread across a vast area — jurisdictions with many of these communities may have more difficulty delivering home palliative care services;[49]
- Other social determinants of health, such as age, sex, gender, income, education, household composition, housing, food security and social support networks;[50–52] and
- Differences in population health, such as rates of chronic disease.

Impact of COVID-19 on death at home or in the community

The COVID-19 pandemic resulted in an increased number of Canadian deaths in 2020 compared with 2019. While some of the excess mortality can be attributed directly to COVID-19 infection, other factors such as delays in seeking and accessing treatment also likely contributed.[53]

Overall, a greater number of individuals died at home or in the community, including in long-term care, in 2020.[54, 55] The pandemic could have impacted an individual's location of death in many ways:[56]

- Patients at home or in the community might have avoided hospitals given fear of infection, concerns about restricted visiting and motivation to reduce pressure on hospital services.
- Fewer patients might have been transferred to hospital, particularly from long-term care.[57]
- Patients in hospital near the end of life may have been discharged to create space for those admitted with COVID-19.
- Staffing pressures in long-term care, home care and palliative care sectors have made it difficult to deliver services.

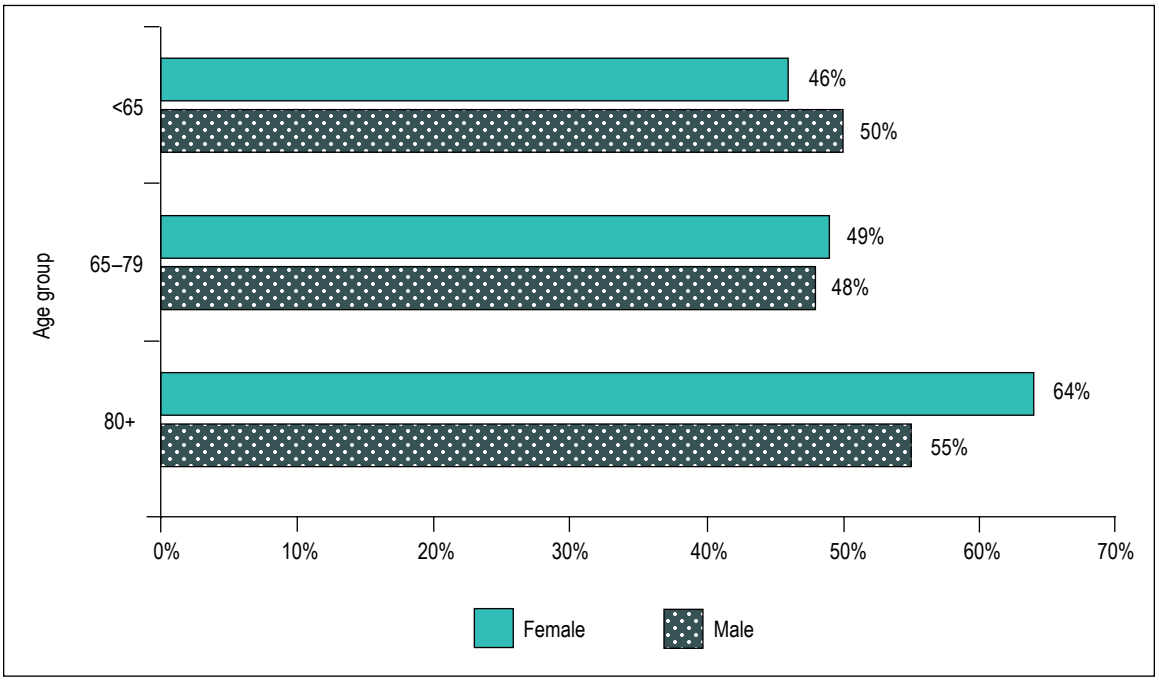
Older females were more likely to die at home or in the community

Understanding who dies at home or in the community compared with in a hospital can help to improve end-of-life care.

Overall, 58% of females and 52% of males died at home or in the community in 2020.

These differences by recorded sex or gender vary by age; however, it is unclear whether this is related to access to end-of-life care. Younger males are more likely to die in the community than females. They are also more likely to die suddenly from acute events such as heart attacks.[58] When focusing on those age 80 and older, 64% of females die at home or in the community compared with 55% of males. Females live longer than males and make up a greater proportion of those living in long-term care facilities at the end of life with conditions such as frailty and dementia. This could contribute to a higher number of community deaths, and further investigation is needed to understand whether these differences between women and men could be used to improve end-of-life care.

Figure 8 Proportion of people who died at home or in the community, by age and recorded sex or gender, 2020



Notes

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

Sources

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

Those who died in hospital were likely to come from home and have short stays

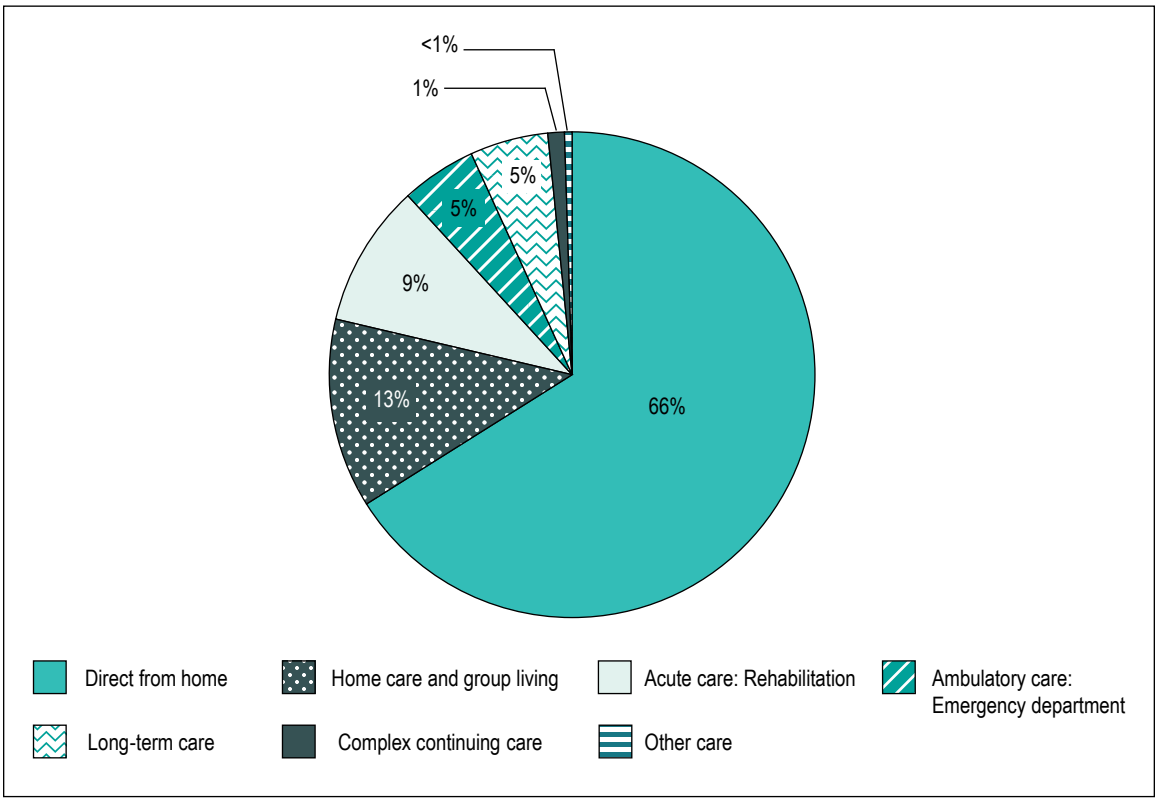
More than 40% of deaths occur in hospital. This could indicate that services to facilitate end of life in the community were not available or sufficient for these patients. That said, there may also be circumstances where the hospital might be the preferred location of the patient or their family. It is important to note that some individuals who have adequate supports in the community may not be comfortable dying at home, and death in hospital may not always indicate that these individuals' needs or desires were unmet.

5% of those who die in hospital are admitted from long-term care facilities. Hospital transfers among long-term care residents are common and in some cases deemed inappropriate.[59] These transfers may be due to many factors, including a lack of discussion about goals of care (e.g., tools like advanced directives), a lack of training or resources, or a need for more coordination across the health system to ensure long-term care facilities are able to handle end-of-life care.

The majority of those who die in hospital come directly from home. These individuals may or may not be receiving home care services — including designated palliative care that can provide more specialized services — or they may come from group living settings such as retirement homes with or without home care.

About one-quarter of patients die on the same day they are admitted to hospital (27% of those admitted from home, and 25% of those admitted from long-term care). For those admitted from long-term care facilities, these transfers to hospital at the end of life can potentially indicate inadequate care.[60]

Figure 9 Proportion of people who died in hospital, by location prior to admission, 2020



Notes

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

Sources

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

Patients and families identified a broad range of experiences with access to end-of-life care

To provide context for this indicator, 2 key themes about what high-quality end-of-life care looks like were identified by caregivers, family members and loved ones of patients. As shown in Figure 10, these themes were access to services and team-based approach (see Appendix B for more information).

Figure 10 Experiences with end-of-life care: What caregivers, family members and loved ones say

Note
See Appendix B for details of the qualitative study.
Source
Qualitative data, 2022, Canadian Institute for Health Information.

Links to other resources

- Death at Home or in Community indicator
  - Your Health System: In Brief — Indicator results and infographics
  - Indicator library — Definitions and methodology information
  - Shared Health Priorities — Additional information about indicators to monitor access to home and community care
- Data holdings and resources
  - Home care information
- CIHI's and OECD's existing work
  - CIHI: *Home Care Quality Indicators*
  - CIHI: *Access to Palliative Care in Canada*
  - CIHI: Medical assistance in dying
  - Organisation for Economic Co-operation and Development: End-of-life care: Health at a Glance 2021

Conclusion

This is CIHI's fourth and final companion report for the Shared Health Priorities indicators. Updated results for all 12 indicators can be found in CIHI's Your Health System web tool, with additional technical information in CIHI's indicator library.[14,36]

Since reporting on the Shared Health Priorities indicators started in 2018, governments have funded the collection of new data, and the number of jurisdictions included in the indicators' results has grown each year. This significant achievement is possible because of the considerable efforts made by the provinces and territories to develop common information standards, to improve data quality, to expand coverage in existing data holdings and to explore new data sources for public reporting. These combined efforts are notable, particularly in the midst of a global pandemic. The new data helps to provide a more comprehensive picture for Canadians on access to mental health and substance use services and to home and community care.

Table 4 provides the full list of indicators, their data sources and coverage by jurisdiction. CIHI will continue to work with the jurisdictions to improve data quality and coverage.

CIHI will also 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. Indicator reporting will also facilitate ongoing monitoring of the impact of COVID-19 and the unintended consequences of the pandemic response on the health of Canadians and their access to care.

Table 4 Indicator reporting, 2022

Indicator	Year of initial release and stream	Data sources	Coverage by jurisdiction
Hospital Stays for Harm Caused by Substance Use	Year 1 (2019) Mental health and substance use	Hospital Morbidity Database, Discharge Abstract Database, National Ambulatory Care Reporting System (In Ontario, hospital data for this indicator is also captured through the Ontario Mental Health Reporting System)	All provinces and territories
Frequent Emergency Room Visits for Help With Mental Health and Substance Use	Year 1 (2019) Mental health and substance use	National Ambulatory Care Reporting System	Complete coverage: Quebec, Ontario, Alberta, Yukon Partial coverage: Prince Edward Island, Nova Scotia, Manitoba, Saskatchewan, British Columbia
Hospital Stay Extended Until Home Care Services or Supports Ready	Year 1 (2019) Home and community care	Discharge Abstract Database	All provinces and territories except Quebec
Self-Harm, Including Suicide	Year 2 (2020) Mental health and substance use	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	Home Care Reporting System, Integrated interRAI Reporting System	Complete coverage: Newfoundland and Labrador, Nova Scotia, Ontario, Alberta, Saskatchewan, Yukon Partial coverage: British Columbia (all regions except Northern Health)
New Long-Term Care Residents Who Potentially Could Have Been Cared for at Home	Year 2 (2020) Home and community care	Continuing Care Reporting System, Integrated interRAI Reporting System	Complete coverage: Newfoundland and Labrador, Ontario, Alberta, New Brunswick, Saskatchewan, British Columbia, Yukon Partial coverage: Nova Scotia, Manitoba

Indicator	Year of initial release and stream	Data sources	Coverage by jurisdiction
Wait Times for Community Mental Health Counselling	Year 3 (2021) Mental health and substance use	New provincial/territorial data collection	Complete coverage: Newfoundland and Labrador, Nova Scotia, New Brunswick Partial coverage: Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories
Wait Times for Home Care Services	Year 3 (2021) Home and community care	New provincial/territorial data collection	Complete coverage: Quebec, Ontario, Saskatchewan, British Columbia Partial coverage: New Brunswick, Manitoba, Alberta, Northwest Territories
Home Care Services Helped the Recipient Stay at Home	Year 3 (2021) Home and community care	Canadian Community Health Survey (Statistics Canada)	Complete coverage: All provinces Territorial data to be available in future years
Early Intervention for Mental Health and Substance Use Among Children and Youth	Year 4 (2022) Mental health and substance use	Early Intervention for Mental Health and Substance Use Among Children and Youth Survey	All provinces and territories
Navigation of Mental Health and Substance Use Services	Year 4 (2022) Mental health and substance use	Navigation of Mental Health and Substance Use Services Survey	All provinces and territories
Death at Home or in Community	Year 4 (2022) Home and community care	Hospital Morbidity Database, Discharge Abstract Database, National Ambulatory Care Reporting System Vital Statistics (Statistics Canada) (In Ontario, hospital data for this indicator is also captured through the Ontario Mental Health Reporting System)	Complete coverage: Quebec, Ontario, Alberta, Yukon Partial coverage: Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia, Northwest Territories

Note
All data sources are from CIHI except where noted.

Appendices

Appendix A: Survey development and data collection

Development of the indicators Navigation of Mental Health and Substance Use Services, and Early Intervention for Mental Health and Substance Use Among Children and Youth followed CIHI's established indicator development methodology. This included a scoping review, as well as stakeholder engagement through expert advisory groups and additional consultations. Experts included representatives from across Canada with backgrounds in research, clinical practice and policy. People with lived and living experience were engaged throughout the indicator development process, including concept definition, survey development and testing.

CIHI contracted and worked with a vendor that is experienced with large survey data collection and mental health to develop and implement the survey testing and data collection strategy.

For each indicator, CIHI created a concise patient-reported survey that took between 10 and 15 minutes to complete. Each survey included screening questions, questions around the main indicator and demographic questions. Each survey underwent cognitive and pilot testing in French and English. The cognitive testing confirmed that the survey questions used appropriate language, were easily understood and flowed well, and that the length of the surveys was reasonable.

Pilot testing that used a random sampling methodology (random digit dialing and mail-outs) revealed that it would not be possible to achieve the sample size required for reporting, so a social media–based recruitment strategy was implemented for full data collection. The surveys were also combined and administered together to facilitate survey completion.

CIHI and its vendor promoted the survey on social media (Facebook, Instagram, TikTok, Snapchat, Twitter) through stakeholder engagement and paid ads. The survey was available for 8 weeks. Reference copies of the Navigation of Mental Health and Substance Use Services Survey and the Early Intervention for Mental Health and Substance Use Among Children and Youth Survey are available on CIHI's Shared Health Priorities web page.

Appendix B: Qualitative study on access to end-of-life services

Participants for this qualitative study were recruited through a bulletin developed in collaboration with CIHI's Patient Engagement Office that was sent to various caregiver associations across Canada.

17 potential candidates contacted CIHI and were screened using an online survey to gauge their experience and perspectives, with the intent of identifying a diverse demographic sample with representation across various gender, social and cultural identities, geographic regions in Canada, types of experiences and clinical knowledge.

Ultimately, 7 participants from 5 provinces were selected for one-on-one interviews. Interviews were conducted online between January and February 2022. 3 team members independently coded and analyzed the interview data and identified 5 core themes through conventional content analysis. When appropriate, we examined the data through a trauma-informed lens.

Appendix C: Text alternatives for figures

Figure 1: Proportion of children and youth with self-reported early needs who accessed mental health and substance use services, by jurisdiction, 2022

Jurisdiction	Proportion of children and youth who accessed services
Canada	61%
N.S.	72%
N.B.	45%
Ont.	61%
Man.	52%
Sask.	48%
Alta.	62%
B.C.	68%

Notes

Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Results for Newfoundland and Labrador, Prince Edward Island, Yukon, the Northwest Territories and Nunavut are suppressed due to small sample sizes.
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.
The overall Canada result includes survey responses from the jurisdictions not shown.

Source

Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Figure 2: Top 5 barriers reported by children and youth to accessing mental health and substance use services, 2022

Barrier	Proportion of children and youth who reported barriers
Feelings of being overwhelmed, uncomfortable or not knowing how to continue	86%
Timing (including long wait times and services not provided when needed)	67%
Limited choices of where and when to get services (including issues with appointment hours, schedules and office location)	64%
Being misunderstood or dismissed (this includes the provider not understanding your concerns or being unkind)	59%
Fear of what others would think (stigma)	54%

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Figure 3: Proportion of children and youth who accessed early mental health and substance use services, by gender, 2022

Gender	Proportion of children and youth who received early intervention services
Boys and young men	54%
Girls and young women	63%
Non-binary children and youth	77%

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Early Intervention for Mental Health and Substance Use Among Children and Youth Survey, 2022, Canadian Institute for Health Information.

Figure 4: Proportion of Canadians who responded that they always or usually had support navigating within or between mental health and substance use services, by jurisdiction, 2022

Jurisdiction	Proportion of Canadians who had support
Canada	41%
N.L.	38%
N.S.	17%
N.B.	57%
Ont.	43%
Man.	22%
Sask.	31%
Alta.	54%
B.C.	41%
N.W.T.	26%

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Results for Prince Edward Island, Yukon and Nunavut are suppressed due to small sample sizes.
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.
The overall Canada result includes survey responses from the jurisdictions not shown.
Source
Navigation of Mental Health and Substance Use Services Survey, 2022, Canadian Institute for Health Information.

Figure 5: Proportion of Canadians who did not always have support who would have found the following helpful in navigating mental health and substance use services, 2022

Supports that would have helped	Proportion of Canadians who did not always have support
Choice of where, when and how services were provided	48%
Scheduling support	40%
Communication from and between providers	40%
Financial support	36%
Information on and personnel to navigate services	29%

Notes
Survey responses were collected between April 25, 2022, and June 26, 2022.
Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.
Source
Navigation of Mental Health and Substance Use Services Survey, 2022, Canadian Institute for Health Information.

Figure 6: Proportion of Canadians who responded that they always or usually had support navigating within or between mental health and substance use services, by gender, 2022

Gender	Proportion of Canadians who had support
Male	44%
Female	39%
Non-binary individuals	36%

Notes

Survey responses were collected between April 25, 2022, and June 26, 2022.

Survey recruitment was completed through social media, including advertisements (i.e., non-probabilistic sampling). Results were then weighted by age, sex and sexual orientation, education and Indigenous identity.

Source

Navigation of Mental Health and Substance Use Services Survey, 2022, Canadian Institute for Health Information.

Figure 7: Proportion of people who died at home or in the community, by jurisdiction, 2020

Jurisdiction	Proportion of people who died outside of hospital	Lower confidence interval	Upper confidence interval
Canada	54.5%	Not applicable	Not applicable
N.L.	57.1%	55.7%	58.4%
P.E.I.	48.3%	45.6%	50.9%
N.S.	50.2%	49.2%	51.2%
N.B.	49.9%	48.8%	51.1%
Ont.	56.4%	56.1%	56.7%
Man.	51.1%	50.2%	52.0%
Sask.	54.2%	53.2%	55.2%
Alta.	54.2%	53.6%	54.8%
B.C.	63.3%	62.9%	63.8%
Y.T.	61.0%	54.6%	67.5%
N.W.T.	57.6%	50.5%	64.6%

Notes

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 CIs 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

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

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

Figure 8: Proportion of people who died at home or in the community, by age and recorded sex or gender, 2020

Age group	Female	Male
<65	46%	50%
65–79	49%	48%
80+	64%	55%

Notes

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

Sources

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

Figure 9: Proportion of people who died in hospital, by location prior to admission, 2020

Location	Proportion
Direct from home	66%
Home care and group living	13%
Acute care: Rehabilitation	9%
Ambulatory care: Emergency department	5%
Long-term care	5%
Complex continuing care	1%
Other care	<1%

Notes

Information for all provinces and territories, except Yukon, was obtained from Statistics Canada's Canadian Vital Statistics Death Database. Coroner data for Yukon was provided directly to CIHI from the Yukon Bureau of Statistics.

Results are based on partial emergency department data coverage for Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. No data is currently available for Nunavut.

Sources

National Ambulatory Care Reporting System, Hospital Morbidity Database and Ontario Mental Health Reporting System, 2020, Canadian Institute for Health Information; Canadian Vital Statistics Death Database, 2020, Statistics Canada; and Yukon Bureau of Statistics, 2020.

Figure 10: Experiences with end-of-life care: What caregivers, family members and loved ones say

Caregivers, family members and loved ones of patients identified 2 key themes for high-quality end-of-life care.

The first theme was access to services. This includes an awareness of what is going on and what options patients have for their care, as well as availability of services and resources for both the patient and their family and caregivers.

The second theme was a team-based approach. This includes involving persons with life-limiting illnesses in their own care planning, provided this aligns with their preference. It also includes care that is carried out as part of a multidisciplinary team with clear roles and responsibilities, as well as involving care partners and the community in the journey, with family and caregivers complementing other services.

Note
See Appendix B for details of the qualitative study.
Source
Qualitative data, 2022, Canadian Institute for Health Information.

References

1. Government of Canada. A common statement of principles on shared health priorities. Accessed September 1, 2022.

2. Government of Canada. Shared health priorities and safe long-term care fund. Accessed September 1, 2022.

3. Canadian Institute for Health Information. Shared health priorities. Accessed September 1, 2022.

4. Canadian Institute for Health Information. *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Addictions Services in Canada, November 2019*. November 2019.

5. Canadian Institute for Health Information. *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Addictions Services in Canada — Volume 2, August 2020*. August 2020.

6. Canadian Institute for Health Information. *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Canada — Volume 3, May 2021*. May 2021.

7. Canadian Institute for Health Information. CIHI's COVID-19 data and information. Accessed September 1, 2022.

8. Canadian Institute for Health Information. COVID-19 Intervention Timeline in Canada [web tool]. Accessed September 1, 2022.

9. Government of Canada. COVID-19 pandemic guidance for the health care sector. Accessed September 1, 2022.

10. Canadian Medical Association. *A Struggling System: Understanding the Health Care Impacts of the Pandemic, November 2021*. November 2021.

11. Centre for Addiction and Mental Health. *Mental Health in Canada: COVID-19 and Beyond: CAMH Policy Advice, July 2020*. July 2020.

12. Canadian Institute for Health Information. Unintended consequences of COVID-19: Impact on harms caused by substance use, self-harm and accidental falls. Accessed September 1, 2022.

13. Canadian Institute for Health Information. What is an indicator?. Accessed September 1, 2022.

14. Canadian Institute for Health Information. Indicator library. Accessed September 1, 2022.

15. Mental Health Commission of Canada. Children and youth. Accessed September 1, 2022.

16. Canadian Mental Health Association. Fast facts about mental health and mental illness. Accessed September 1, 2022.

17. Malla A, Shah J, Iyer S, et al. Youth mental health should be a top priority for health care in Canada. *Canadian Journal of Psychiatry*. April 2018.

18. Brownlie EB, Chaim G, Heffernan O, et al. Youth services system review: Moving from knowledge gathering to implementation through collaboration, youth engagement, and exploring local community needs. *Canadian Journal of Community Mental Health*. October 2017.

19. Government of Ontario. Mental health and student supports. Accessed September 1, 2022.

20. Government of Canada. Strengthening Canada's approach to substance use issues. Accessed September 1, 2022.

21. Samji H, Wu J, Ladak A, et al. Mental health impacts of the COVID-19 pandemic on children and youth — A systematic review. *Child and Adolescent Mental Health*. August 2022.

22. Centre for Addiction and Mental Health. COVID-19 national survey dashboard. Accessed September 1, 2022.

23. Hawke LD, Szatmari P, Cleverley K, et al. Youth in a pandemic: A longitudinal examination of youth mental health and substance use concerns during COVID-19. *BMJ Open*. October 2021.

24. Chaiton M, Musani I, Pullman M, et al. Access to mental health and substance use resources for 2SLGBTQ+ youth during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*. October 2021.

25. Kids Help Phone. You are not alone. Accessed September 1, 2022.

26. Sagar-Ouriaghli I, Godfrey E, Bridge L, et al. Improving mental health service utilization among men: A systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American Journal of Men's Health*. 2019.

27. Veale JF, Watson RJ, Peter T, et al. Mental health disparities among Canadian transgender youth. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*. January 2017.

28. Reisner SL, Vetters R, Leclerc M, et al. Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*. March 2015.

29. Saewyc EM, Thawer Z, O'Dwyer C, et al. *Gender-Diverse: A Spotlight on the Health of Trans and Non-Binary Young People in BC*. 2021.

30. Tordoff DM, Wanta JW, Collin A, et al. Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*. February 2022.

31. Platt LF, Wolf JK, Scheitle CP. Patterns of mental health care utilization among sexual orientation minority groups. *Journal of Homosexuality*. 2018.

32. Wu C. Statistical inference with non-probability survey samples (with discussion). *Survey Methodology*. 2022.

33. Government of Canada. Canadian community health survey. Accessed September 1, 2022.

34. Anderson JE, Larke SC. Navigating the mental health and addictions maze: A community-based pilot project of a new role in primary mental health care. *Mental Health in Family Medicine*. March 2009.

35. Moroz N, Moroz I, D'Angelo MS. Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*. November 2020.

36. Statistics Canada. *Survey on COVID-19 and Mental Health, February to May 2021*. September 2021.

37. Organisation for Economic Co-operation and Development. *Tackling the Mental Health Impact of the COVID-19 Crisis: An Integrated, Whole-of-Society Response*. May 2021.

38. Canadian Institute for Health Information. Your Health System: In Brief. Accessed September 1, 2022.

39. Slaunwhite AK. The role of gender and income in predicting barriers to mental health care in Canada. *Community Mental Health Journal*. July 2015.

40. Smith K, Matheson FI, Moineddin R, et al. Gender differences in mental health service utilization among respondents reporting depression in a national health survey. *Health*. January 2013.

41. Lunney J, Lynn J, Foley D, et al. Patterns of functional decline at the end of life. *JAMA*. May 2003.

42. Webber C, Chan R, Scott M, et al. Delivery of palliative care in acute care hospitals: A population-based retrospective cohort study describing the level of involvement and timing of inpatient palliative care in the last year of life. *Journal of Palliative Medicine*. July 2021.

43. Canadian Hospice Palliative Care Association. *What Canadians Say: The Way Forward Survey Report, December 2013*. December 2013.

44. Canadian Institute for Health Information. *How Canada Compares: Results From the Commonwealth Fund's 2021 International Health Policy Survey of Older Adults in 11 Countries, March 2022*. March 2022.

45. O'Neill B, Rodway A. ABC of palliative care: Care in the community. *BMJ*. 1998.

46. Brazil K, Bedard M, Willison K. Factors associated with home death for individuals who receive home support services: A retrospective cohort study. *BMC Palliative Care*. March 2002.

47. Canadian Institute for Health Information. *Access to Palliative Care in Canada*. 2018.

48. Burge F, Lawson B, Johnston G. Trends in the place of death of cancer patients, 1992–1997. *CMAJ*. February 2003.

49. Giesbrecht M, Crooks VA, Castleden H, et al. Palliating inside the lines: The effects of borders and boundaries on palliative care in rural Canada. *Social Science & Medicine*. November 2016.

50. Gallo WT, Baker MJ, Bradley EH. Factors associated with home versus institutional death among cancer patients in Connecticut. *Journal of the American Geriatrics Society*. June 2001.

51. Jayaraman J, Joseph KS. Determinants of place of death: A population-based retrospective cohort study. *BMC Palliative Care*. May 2013.

52. Costa V, Earle CC, Esplen MJ, et al. The determinants of home and nursing home death: A systematic review and meta-analysis. *BMC Palliative Care*. January 2016.

53. Public Health Agency of Canada. *COVID-19 and Deaths in Older Canadians: Excess Mortality and the Impacts of Age and Comorbidity*. 2021.

54. 54. Statistics Canada. Deaths, by place of death (hospital or non-hospital). Accessed September 1, 2022.

55. Canadian Institute for Health Information. COVID-19's impact on long-term care. Accessed September 1, 2022.

56. Higginson IJ, Brooks D, Barclay S. Dying at home during the pandemic: Increase in home deaths could be because of preference or pressure. *BMJ*. June 2021.

57. Canadian Institute for Health Information. COVID-19's impact on hospital services. Accessed September 1, 2022.

58. World Health Organization. Global health estimates: Leading causes of death. Accessed September 1, 2022.

59. Menec VH, Nowicki S, Blandford A, et al. Hospitalizations at the end of life among long-term care residents. *The Journals of Gerontology: Series A, Biological Sciences and Medical Sciences*. March 2009.

60. Preetha K, Williams H, Maharaj I. Patterns of end-of-life care: Place of death and terminal hospitalization among long-term-care residents. *Journal of Hospice and Palliative Nursing*. April 2020.

media@cihi.ca

CIHI Ottawa
495 Richmond Road
Suite 600
Ottawa, Ont.
K2A 4H6
613-241-7860

CIHI Toronto
4110 Yonge Street
Suite 300
Toronto, Ont.
M2P 2B7
416-481-2002

CIHI Victoria
880 Douglas Street
Suite 600
Victoria, B.C.
V8W 2B7
250-220-4100

CIHI Montréal
1010 Sherbrooke Street West
Suite 602
Montréal, Que.
H3A 2R7
514-842-2226

cihi.ca

22438-1022