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Mental Illness in Manitoba: A Guide For RHA Planners

MANITOBA CENTRE FOR HEALTH POLICY

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based on the report:
*Patterns of Regional
Mental Illness Disorder
Diagnoses and Service
Use in Manitoba: A
Population-Based Study;*
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If someone were to ask you how many Manitobans get treated for a mental illness in a five-year period, what would you say? One in 30? One in 20? One in 10?

If you said one in 10 you'd be closest. But the problem is more serious than that. The truth is that between 1997 and 2002, more than 1 in 4 Manitobans had at least one mental illness diagnosis. During that time, they used nearly half the days that people spent in our province's hospitals.

Startling isn't it? And that's not to mention the equally profound effect mental illness has on the use of physicians, home care, nursing homes and pharmaceuticals. It can have a devastating effect on people's lives. It also has a staggering impact on Manitoba's health care system.

For many of you, these facts may be startling, but nothing more. But for Manitoba's Regional Health Authorities (RHAs), such information is vital to the successful planning of health care services. This report by MCHP offers them a comprehensive look at mental illness and its demands on their health care services.

Now it has been said that research is always stronger when the users have a say in what is studied and how it is studied. So this project is of particular interest and relevance to RHAs, especially those in rural and northern Manitoba, because they played a major part in what was studied and how. Mental illness was targeted as a critical aspect of planning for rural and northern RHAs by *The Need To Know Team*: a collaboration of researchers from MCHP and high-level planners

from each of the non-Winnipeg RHAs and Manitoba Health.

The Need To Know Team is funded through the Canadian Institutes of Health Research. Its underpinnings are simple: by having researchers working closely with decision-makers, perhaps research can be brought closer to policy. In other words, the hope is to smooth the transition between analysis and application, between paper and practice.

What we looked at

This study looks at males and females (aged 10 or more) over a five-year period (1997/98–2001/02). The use of health care services are examined from a population-based perspective—meaning where patients live, not where they receive the care. So a person from, say, Burntwood may be hospitalized in Winnipeg, but the hospitalization counts as a Burntwood hospitalization.

Most comparisons are between what we call *cumulative disorders* and *no disorders*. Occasionally we refer to *other disorders*.

Cumulative disorders comprises those who were diagnosed with one or more of the following mental illnesses: depression; anxiety disorders; substance abuse; schizophrenia; personality disorders. *No disorders* means those who had no diagnosis for a mental illness during that same time. Those who had at least one mental illness diagnosis, but not one of the *cumulative disorders*, fall into the *other disorders* group.

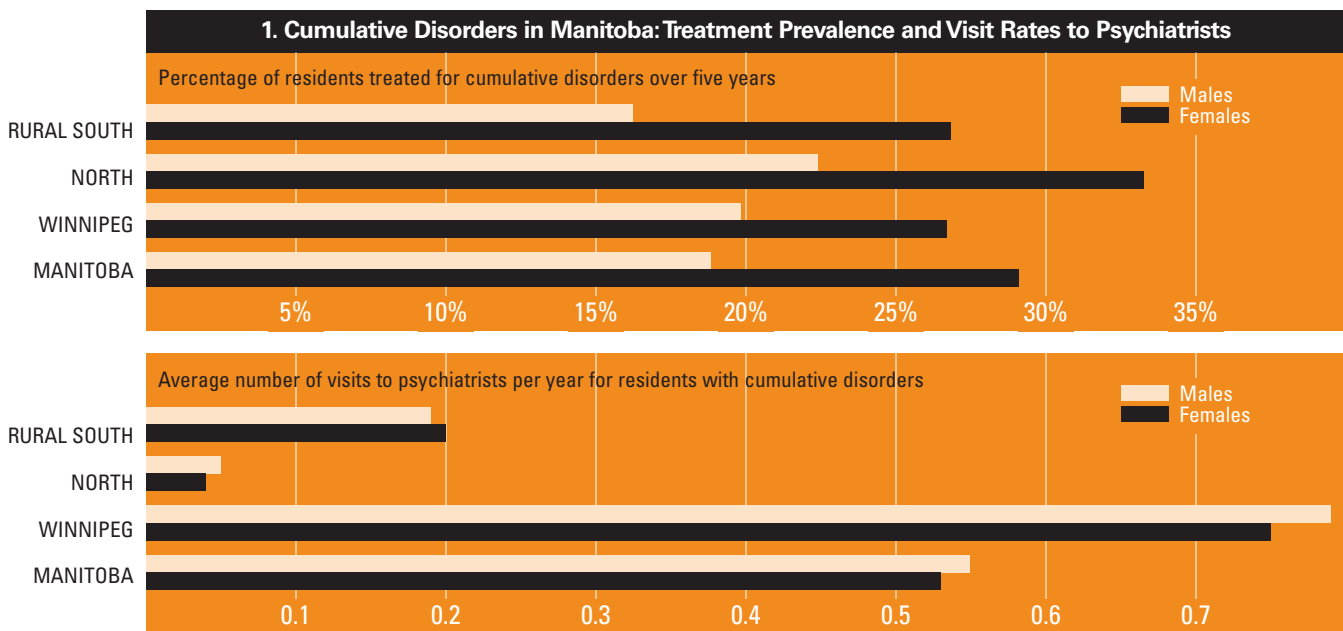
We should also point out that we use the term “treatment prevalence” rather than “prevalence.” Just because someone receives treatment for an illness doesn’t mean they have the illness for sure. Also, some people that may have an illness don’t even go to see their doctor. So the data can’t tell us how many people, say, *have* dementia (prevalence); it can tell us how many people were *treated* for dementia (treatment prevalence)—a fine but important distinction.

Key findings

- ❑ Of all Manitobans aged 10 and older, 24% are in the cumulative disorders group, 13% in the other disorders group, leaving 63% with no diagnoses for a mental illness.
- ❑ In Brandon (the district of Brandon East in particular), Winnipeg, and the North, treatment prevalence for cumulative disorders is high; in the Rural South it’s low (Fig. 1).
- ❑ People with mental illness visit physicians, are hospitalized (Fig. 2) and use home care more than twice as often as people with no mental illness. But only about 1 in 5 of their physician visits and 1 in 10 of their hospitalizations are for mental illness.
- ❑ People with mental illness are roughly twice as likely to be hospitalized for physical com-

plaints—respiratory, circulatory, digestive, and most other illnesses (Fig. 2).

- ❑ While only 19% of males are in the cumulative disorders group, they account for 37% of all hospitalizations for males. They use 41% of all short-stay days, and 52% of all long-stay days. For females, 29% have cumulative disorders, yet account for 44% of female hospitalizations, 47% of short-stay days, and 52% of long-stay days.
- ❑ In Winnipeg and Brandon there is a strong tie between mental illness and income levels; poorer areas have the highest treatment prevalence. We don’t see the same pattern in rural areas.
- ❑ People with cumulative disorders from the highest income areas, both urban and rural, have the highest psychiatrist visit rate.
- ❑ People (cumulative disorders and no disorders) from the lowest income areas, both urban and rural, have the highest all-cause (for mental or physical illness) hospitalization rate.
- ❑ About 83% of nursing home residents have at least one mental illness diagnosis, and about 75% of those admitted in 2002/03 were diagnosed with a mental illness in the previous five years.



- The most frequent users of psychiatrists are people aged 35-55. Rates for young adults are low, and extremely low for people 60 or older.
- Male Manitobans commit suicide at three times the rate that females do. But female Manitobans attempt suicide twice as often as males. The highest rates for attempted suicide are in the north. Across all RHAs, the rate of attempted suicide is highest among the young, those 15-25 years old.

Highlighting areas of concern

One can see from some of the key findings just how serious the problem with mental illness is in Manitoba. For most of us—health care planners in particular—many questions come to mind.

First and foremost, how is the health care system coping? Those with the most need should be the biggest users of health care services. In particular, we are talking about people

from low-income areas where rates of illness—including mental illness—are generally the highest. So are these groups the highest users of health care services?

The answer is yes and no.

When we look at all-cause hospitalizations, we do see the expected needs-based relationship. We see that people from low-income areas (highest overall proportion of mental illness) have the highest hospitalization rates. So hospitals seem to be responding appropriately to the greater need.

Home care is *somewhat* needs-based. In urban areas, home care rates are highest in lower-income neighbourhoods. Although the same cannot be said for all non-urban areas, there appears to be a trend in that direction.

Unfortunately, the same cannot be said for visits to physicians (outside of hospital). There, the alarming disconnect between need and use raises a number of questions.

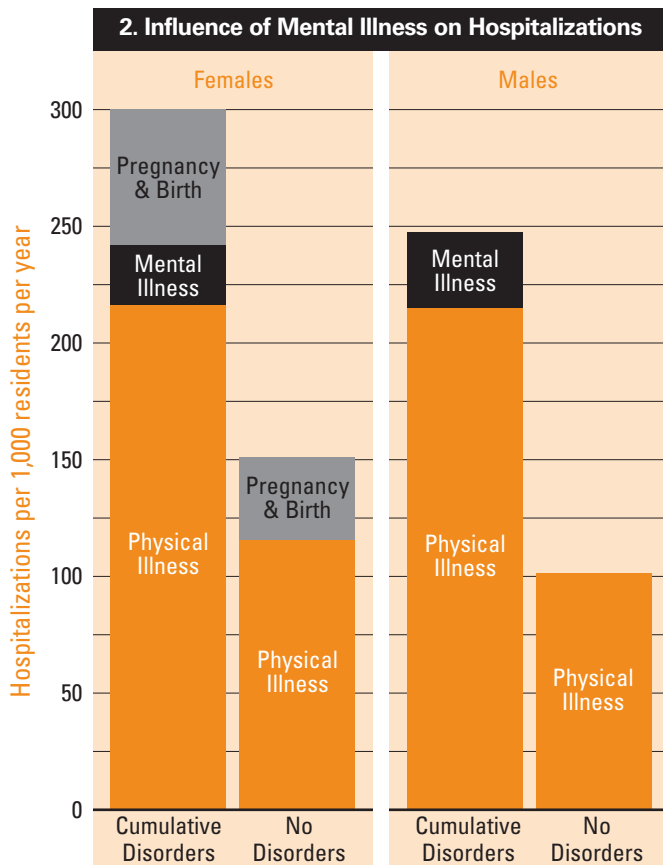
For example, those who are most likely in need of a psychiatrist's care are the least likely to get it. It is not the poor who see psychiatrists the most; curiously, it is those from high-income areas—where treatment prevalence for mental illness is lowest—who are the highest users of psychiatrists. And in the North, where the proportion of cumulative disorders is highest, the rates of seeing a psychiatrist are lowest (Fig. 1).

Health care planners may also find it curious that the most frequent users of psychiatrist services are 35-55 year olds. Yet we know that people over 60 have the highest proportion of mental illness diagnoses. We know they have the highest rate of seeing their doctor for reasons of mental illness. So why aren't they the age group with the highest visit rate to psychiatrists?

All-cause physician visit rates also seem unrelated to need (except for those in urban areas with cumulative disorders). Visit rates are similar across all income areas, but if they were responding to need, we should see higher visit rates among those with lower incomes.

Treatment settings: Which is right?

Issues of appropriateness will continue to be a focus for health care planners in the treatment



of mental illness. Where is the best place—combining quality care with making the most of limited resources—to treat mental health patients?

A closer look at Brandon seems germane to such a discussion. Amid much discussion about de-institutionalization, Brandon Mental Health Centre was closed in 1998. What we see now in Brandon (especially Brandon East) and the nearby RHAs of Assiniboine and Parkland, is that there are high rates of acute care hospital use for mental illness. In Central and Inter-lake RHAs, where many patients are still treated in mental health centres, the use of acute care hospitals to treat mental illness is much lower.

So it seems that the hospitals are picking up the slack left by the closure of mental health centres. Was this the plan? Probably. (For example, Brandon Hospital has a 25-bed psychiatric unit.) Has it lead to better overall outcomes for patients? At the same time is it more cost-effective? The data can't tell us that. But it is certainly something RHA planners will be looking at closely.

We should also add a word about nursing homes. We know that over three-quarters of nursing home residents have at least one mental illness diagnosis. So planners may want to ensure a couple of things in particular: that the staff in these facilities are trained to provide care to address mental health needs as well as physical; that people in nursing homes are being referred for treatment.

In our analyses of individuals who attempted or completed suicide, some risk factors became apparent—such as age, sex, RHA and area income. Another risk factor was that the individual had a diagnosis of a mental illness in the previous year. In other words, prior to their suicide or attempt, they had contact with a health care provider for mental health issues.

Being aware of some “predictors” for suicide, it follows that there may be “windows of opportunity” for health care to intervene: to stop some suicides before they happen.

For example, we know that attempted suicides rates are high in Nor-Man and Burnt-

wood RHAs. And we know the majority of those attempting suicide are young people. We also know that referral rates to psychiatrists are very low for young adults and for those living in rural and remote areas of the province. Knowing this, planners can look for ways to ensure greater access to psychiatrist services in these areas.

And finally, a word about data. The data sources we had available (for details, see the full report) did give us a good illustration of mental illness in Manitoba. But having more sources of data would help give us a more complete picture. To that end, there are a few recommendations we'd like to make.

First: since under-reporting of suicide is a concern, we'd like to see Vital Statistics updated to include post-mortem cause of death.

Second: Manitoba needs a consistent, province-wide, mental health services data collection system to enhance comparison between RHAs. Across the province, there should be strict guidelines for what data must be collected, and how it is coded and put in the system. Currently different RHAs have different systems, making many useful comparisons difficult to impossible.

Third: since salaried psychiatrists and psychologists don't have to submit a claim to get paid, sometimes there is no written record sent to Manitoba Health of what their patients were treated for. If it were mandatory for all of them to submit claims, even if it isn't for payment, there would be more useful data available for RHA planners.

This look at the staggering impact of mental illness in Manitoba has answered a lot of questions, questions that the RHAs themselves wanted answered. It has also spawned many more. But its purpose is not to advise, rather to inform—to help steer health care planners in the right direction. The next challenge facing RHAs will be to take what we have found together and transform it into action. And to see if collaborations like *The Need To Know* Team will improve that process.

WANT THE COMPLETE REPORT?

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