

# The Mental Health of Children and Youth in Ontario

**2017 Scorecard**

**CHART PACK**

September 2017





# The Mental Health of Children and Youth in Ontario: 2017 Scorecard

---

## Chart Pack

MHASEF Research Team,

With a contribution by the Ministry of Children  
and Youth Services

**September 2017**

---

## Publication Information

---

Published by the Institute for Clinical Evaluative Sciences (ICES)

© 2017 Institute for Clinical Evaluative Sciences.  
All rights reserved.

This publication may be reproduced in whole or in part for noncommercial purposes only and on the condition that the original content of the publication or portion of the publication not be altered in any way without the express written permission of ICES. To seek this information, please contact [communications@ices.on.ca](mailto:communications@ices.on.ca).

### INSTITUTE FOR CLINICAL EVALUATIVE SCIENCES

G1 06, 2075 Bayview Avenue  
Toronto, Ontario M4N 3M5  
Telephone: 416-480-4055  
Email: [communications@ices.on.ca](mailto:communications@ices.on.ca)

---

## How to cite this publication

MHASEF Research Team. *The Mental Health of Children and Youth in Ontario: 2017 Scorecard. Chart Pack*. Toronto, ON: Institute for Clinical Evaluative Sciences; 2017.

**ISBN: 978-1926850-74-0** (Online)



## Authors' Affiliations

The MHASEF (Mental Health and Addictions Scorecard and Evaluation Framework) Research Team includes the following individuals (in alphabetical order):

### **Abigail Amartey, MPH**

Epidemiologist, Institute for Clinical Evaluative Sciences

### **Maria Chiu, MSc, PhD**

Staff Scientist, Institute for Clinical Evaluative Sciences / Assistant Professor, Dalla Lana School of Public Health and Institute of Health Policy, Management and Evaluation, University of Toronto

### **Evgenia (Jenny) Gatov, MPH**

Epidemiologist, Institute for Clinical Evaluative Sciences

### **Astrid Guttmann, MDCM, MSc, FRCPC**

Chief Science Officer and Senior Core Scientist, Institute for Clinical Evaluative Sciences / Staff Paediatrician, Division of Paediatric Medicine, Hospital for Sick Children / Associate Senior Scientist, Child Health Evaluative Sciences, SickKids Research Institute / Professor, Department of Paediatrics and Institute of Health Policy, Management and Evaluation, University of Toronto

### **Michael Lebenbaum, MSc**

Epidemiologist, Institute for Clinical Evaluative Sciences

### **Paul Kurdyak, MD, PhD, FRCPC**

Program Lead, Mental Health and Addictions and Senior Core Scientist, Institute for Clinical Evaluative Sciences / Director, Health Outcomes and Performance Evaluation Research Unit, Institute for Mental Health Policy Research, Centre for Addiction and Mental Health / Associate Professor, Department of Psychiatry and Institute of Health Policy, Management and Evaluation, University of Toronto

### **Natasha Saunders, MD, MSc, FRCPC**

Adjunct Scientist, Institute for Clinical Evaluative Sciences / Staff Paediatrician, Division of Paediatric Medicine, Hospital for Sick Children / Assistant Professor, Department of Paediatrics, University of Toronto / Associate Scientist, Child Health Evaluative Sciences, SickKids Research Institute

### **Simone Vigod, MD, MSc, FRCPC**

Adjunct Scientist, Institute for Clinical Evaluative Sciences / Scientist, Women's College Research Institute / Assistant Professor, Department of Psychiatry and Institute of Health Policy, Management and Evaluation, University of Toronto / Staff Psychiatrist, Women's College Hospital

### **Julie Yang, MA**

Senior Research Project Manager, Institute for Clinical Evaluative Sciences

---

## Acknowledgements

---

### Institute for Clinical Evaluative Sciences

#### Research Analysts

Ruth Croxford, MSc  
Christina Diong, MSc  
Sumei Gu, MSc  
Laura Holder, MSc  
Ying Liu, MSc  
Prosanta Mondal, MSc  
Priscila Pequeno, MSc  
Zhan Yao, MSc

#### Medical Geographer

Peter Gozdyra, MA

---

### Ministry of Children and Youth Services

Child and Youth Mental Health Program  
Email: [mcsinfo.mcys@ontario.ca](mailto:mcsinfo.mcys@ontario.ca)

---

### Reviewers

#### Melanie Barwick, PhD, CPsych

Head, Child and Youth Mental Health Research Unit,  
The Hospital for Sick Children / Senior Scientist, Child  
Health Evaluative Sciences, SickKids Research  
Institute / Associate Professor, Department of  
Psychiatry and Dalla Lana School of Public Health,  
University of Toronto

#### Mariette J. Chartier, RN, PhD

Research Scientist, Manitoba Centre for Health Policy  
/ Assistant Professor, Department of Community  
Health Sciences, University of Manitoba

#### Aryeh Gitterman, MEd, EdD

Affiliate Scientist, Institute for Clinical Evaluative  
Science / Distinguished Visiting Professor, School  
of Child and Youth Care, Ryerson University

---

### Data

Data were provided by the Drug and Alcohol Treatment  
Information System; Immigration, Refugees and  
Citizenship Canada (IRCC); the Institute for Clinical  
Evaluative Sciences (ICES); Kinark Child and Family  
Services; and the Ontario Ministry of Children and  
Youth Services. Datasets from IRCC, ICES and Kinark  
were linked using unique, encoded identifiers and  
analyzed at ICES. Parts of this report are based  
on data and information compiled and provided by the  
Canadian Institute for Health Information (CIHI).  
However, the analyses, conclusions, opinions and  
statements expressed herein are those of the  
authors, and not necessarily those of CIHI.

---

### Funding

This study was supported by ICES, which is funded by  
an annual grant from the Ontario Ministry of Health  
and Long-Term Care (MOHLTC). The opinions, results  
and conclusions reported in this paper are those of the  
authors and are independent from the funding sources.  
No endorsement by ICES or the MOHLTC is intended or  
should be inferred.

## Statement on Indigenous Mental Health Data

For over 15 years, mental health has been established as a key priority by First Nations in Ontario. Today, First Nations leaders across Ontario are still calling for action to address the mental health of their children and youth. In February 2016, First Nations leaders from Nishnawbe Aski Nation in Northern Ontario declared a State of Emergency related to the mental health crisis in their communities. In a parallel gathering, the Chiefs of Ontario, the Ontario SPOR Support Unit, the Centre for Rural and Northern Health Research, and ICES hosted a First Nations Health Research Symposium where First Nations community members set priorities for health research in Ontario. Mental health and addictions was the top priority.

In this provincial scorecard, we do not present Indigenous-specific mental health data. ICES has relationships and data governance agreements with Indigenous organizations that acknowledge the inherent rights of First Nations, Métis and Inuit peoples to determine how data are used to tell their stories and to heal their communities. As a result, ICES works directly with Indigenous partners and communities to ensure that indicators are contextualized in a way that supports the substantial work that Indigenous people are undertaking. This involves working in close partnership, respecting the diversity of Indigenous communities, integrating Indigenous perspectives and acknowledging the impacts of ongoing colonialism.

Currently, ICES is working directly with the Métis Nation of Ontario to provide Métis-specific mental health indicators. In addition, we are working with First Nations communities and the Chiefs of Ontario to respond to the research priorities set in February 2016 for the analysis of First Nations mental health and addictions data.

# Contents

<b>ii</b>	Publication Information	<b>1</b>	<b>LIST OF EXHIBITS</b>
<b>iii</b>	Authors' Affiliations		
<b>iv</b>	Acknowledgements	<b>14</b>	<b>1.0 RESULTS BY LOCAL HEALTH INTEGRATION NETWORK AND BY CHILD AND YOUTH MENTAL HEALTH SERVICE AREA</b>
<b>v</b>	Statement on Indigenous Mental Health Data	<b>19</b>	<b>2.0 INDICATORS FOR CHILD AND YOUTH MENTAL HEALTH: FULL RESULTS</b>
		<b>215</b>	<b>3.0 SUMMARY OF MCYS CHILD AND YOUTH MENTAL HEALTH PERFORMANCE INDICATORS, 2015/16</b>

## List of Exhibits

**EXHIBIT 1.1** Indicators for child and youth mental health, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 1.2** Indicators for child and youth mental health, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.1** Number of children and youth seen by a psychiatrist per 1,000 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.1.2** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.1.3** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.4** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.5** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.6** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.1.7** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.8** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.1.9** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.1.10** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.1** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by physician specialty, in Ontario, 2006 to 2014

**EXHIBIT 2.2.2** Number of outpatient physician visits related to mental health and addictions per 100 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.2.3** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by age group and physician specialty, in Ontario, 2006 to 2014

**EXHIBIT 2.2.4** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.2.5** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.2.6** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.2.7** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.2.8** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.2.9** Number of outpatient visits to any physician specialty related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.10** Number of outpatient visits to a general practitioner or family physician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.11** Number of outpatient visits to a psychiatrist per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.12** Number of outpatient visits to a paediatrician mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.13** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.2.14** Number of outpatient visits to any physician specialty related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.15** Number of outpatient visits to a general practitioner or family physician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.16** Number of outpatient visits to a psychiatrist per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.2.17** Number of outpatient visits to a paediatrician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.3.1** Number of children and youth treated for alcohol and drug problems per 10,000 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.3.2** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.3.3** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by type of substance, in Ontario, 2006 to 2014

**EXHIBIT 2.3.4** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group and type of substance, in Ontario, 2006 to 2014

**EXHIBIT 2.3.5** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.3.6** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.3.7** Number of children and youth treated for alcohol and drug problems per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.3.8** Number of children and youth treated for alcohol and drug problems per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.4.1** Number of hospitalizations for eating disorders per 10,000 population aged 7 to 24 years, overall and by sex, in Ontario, 2003 to 2014

**EXHIBIT 2.4.2** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by age group, in Ontario, 2003 to 2014

**EXHIBIT 2.4.3** Median length of stay in hospital for eating disorders among children and youth aged 7 to 24 years, in Ontario, 2003 to 2014

**EXHIBIT 2.4.4** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.4.5** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.4.6** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.4.7** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.4.8** Number of hospitalizations for eating disorders per 10,000 standard population aged 7 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.4.9** Number of hospitalizations for eating disorders per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, three-year average for 2012 to 2014

**EXHIBIT 2.4.10** Number of hospitalizations for eating disorders per 10,000 standard population aged 7 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.4.11** Number of hospitalizations for eating disorders per 10,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, three-year average for 2012 to 2014

**EXHIBIT 2.5.1** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.5.2** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.5.3** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 2.5.4** Length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by 25th, 50th and 75th percentiles, in Ontario, 2006 to 2014

**EXHIBIT 2.5.5** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.6** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.7** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.8** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.9** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.5.10** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.11** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.5.12** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.5.13** Median length of stay for psychiatric hospitalizations of 0-to-24-year-olds, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.6.1** Prevalence of neonatal abstinence syndrome per 1,000 hospital births, overall and by sex, in Ontario, 2002 to 2014

**EXHIBIT 2.6.2** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by maternal age at first delivery, in Ontario, 2002 to 2014 combined

**EXHIBIT 2.6.3** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.6.4** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014



**EXHIBIT 2.6.5** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.6.6** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (standardized), by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.6.7** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (standardized), by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.7.1** Number of deaths by suicide per 100,000 population aged 10 to 24 years, overall and by sex, in Ontario, 2003 to 2012

**EXHIBIT 2.7.2** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by age group, in Ontario, 2003 to 2012

**EXHIBIT 2.7.3** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by suicide method and sex, in Ontario, 2003 to 2012 combined

**EXHIBIT 2.7.4** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by suicide method and age group, in Ontario, 2003 to 2012 combined

**EXHIBIT 2.7.5** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by sex, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.6** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by age group, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.7** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.8** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.9** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.10** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012 [map]

**EXHIBIT 2.7.11** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.7.12** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2010 to 2012 [map]

**EXHIBIT 2.8.1** Number of emergency department visits for deliberate self-harm per 10,000 population aged 10 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.8.2** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.8.3** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by method of self-harm, in Ontario, 2006 to 2014

**EXHIBIT 2.8.4** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.8.5** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.8.6** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.8.7** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.8.8** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Local Integration Health Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.8.9** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.8.10** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.8.11** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.1** Number of emergency department visits related to mental health and addictions per 1,000 population aged 0 to 24 years, overall and by sex, 2006 to 2014

**EXHIBIT 2.9.2** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, 2006 to 2014

**EXHIBIT 2.9.3** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, 2006 to 2014

**EXHIBIT 2.9.4** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.5** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.6** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.7** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.8** Number of emergency department visits related to mental health and addictions per 1,000 population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.9.9** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.10** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.11** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.9.12** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.1** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.10.2** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.10.3** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 2.10.4** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.5** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.6** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.7** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.8** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.10.9** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.10** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.11** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.10.12** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.1** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by physician specialty, in Ontario, 2006 to 2014

**EXHIBIT 2.11.2** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge, by physician specialty and sex, in Ontario, 2006 to 2014

**EXHIBIT 2.11.3** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by age group and physician specialty, in Ontario, 2006 to 2014

**EXHIBIT 2.11.4** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by type of disorder and physician specialty, in Ontario, 2006 to 2014

**EXHIBIT 2.11.5** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.6** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.7** Number of outpatient visits related to mental health and addictions (MHA) within 7 days of an incident MHA-related hospital discharge per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by type of disorder and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.8** Number of outpatient visits related to mental health and addictions (MHA) within 7 days of an incident MHA-related hospital discharge per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.9** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.11.10** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by hospital type and weighted hospital discharge volume, in Ontario, 2014

**EXHIBIT 2.11.11** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.12** Number of outpatient visits to any physician specialty within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.13** Number of outpatient visits to a general practitioner or family physician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.14** Number of outpatient visits to a psychiatrist within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.15** Number of outpatient visits to a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.16** Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.17** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area and physician specialty, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.11.18** Number of outpatient visits to any physician specialty within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.19** Number of outpatient visits to a general practitioner or family physician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.20** Number of outpatient visits to a psychiatrist within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.21** Number of outpatient visits to a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.11.22** Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.12.1** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related ED visit, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.12.2** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.12.3** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 2.12.4** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.5** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.6** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.7** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.8** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.12.9** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related ED visit, by hospital type and weighted ED discharge volume, in Ontario, 2014

**EXHIBIT 2.12.10** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.11** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.12.12** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.12.13** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.12.14** Proportion of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions that resulted in a hospital admission, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.1** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital admission, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.13.2** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.13.3** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 2.13.4** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by sex, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.5** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by age group, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.6** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.7** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.8** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per crude 100 population aged 0 to 24 years with an incident MHA-related hospital admission, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.13.9** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital admission, by hospital type and weighted hospital discharge volume, in Ontario, 2014

**EXHIBIT 2.13.10** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.13.11** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.13.12** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014



**EXHIBIT 2.13.13** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.13.14** Number and proportion of incident hospital admissions related to mental health and addictions that resulted in readmission within 30 days of discharge, in Ontario, from 2006 to 2014

**EXHIBIT 2.14.1** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 population aged 0 to 24 years with an MHA-related ED visit, overall and by sex, in Ontario, 2006 to 2014

**EXHIBIT 2.14.2** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by age group, in Ontario, 2006 to 2014

**EXHIBIT 2.14.3** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 2.14.4** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by sex, in Ontario, three-year average for 2013 to 2014

**EXHIBIT 2.14.5** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by age group, in Ontario, three-year average from 2012 to 2014

**EXHIBIT 2.14.6** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.14.7** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by neighbourhood income quintile, in Ontario, three year average from 2012 to 2014

**EXHIBIT 2.14.8** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

**EXHIBIT 2.14.9** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.14.10** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014 [map]



**EXHIBIT 2.14.11** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

**EXHIBIT 2.14.12** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014 [map]

**EXHIBIT 2.14.13** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care who were or were not hospitalized during their ED visit per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

**EXHIBIT 3.1** Ministry of Children and Youth Services child and youth mental health performance indicators, Ontario, 2015/16

# 1.0

## Results by Local Health Integration Network and by Child and Youth Mental Health Service Area

**EXHIBIT 1.1** Indicators for child and youth mental health, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

Lowest rate      Highest rate

Indicators*	Ontario	Erie St. Clair	South West	Waterloo Wellington	Hamilton Niagara Haldimand Brant	Central West	Mississauga Halton	Toronto Central	Central	Central East	South East	Champlain	North Simcoe Muskoka	North East	North West
<b>Contextual Indicators</b>															
<b>System Use</b>															
Number of children and youth seen by a psychiatrist per 1,000 population aged 0 to 24 years	21.0	25.1	25.5	20.7	20.7	15.5	21.5	30.6	19.7	21.7	25.1	17.3	20.1	15.1	10.6
Number of MHA-related outpatient visits to any physician specialty per 100 population aged 0 to 24 years	32.4	36.5	39.2	29.0	37.2	22.4	26.0	42.2	28.2	31.3	36.9	35.7	34.4	30.3	28.0
Number of MHA-related outpatient visits to a general practitioner or family physician per 100 population aged 0 to 24 years	16.5	20.3	20.7	15.5	21.1	11.9	13.3	14.3	12.4	15.1	20.6	18.1	20.6	18.7	18.7
Number of MHA-related outpatient visits to a psychiatrist per 100 population aged 0 to 24 years	8.1	8.2	10.5	6.9	6.3	5.1	7.9	17.9	8.2	7.2	7.8	8.4	6.3	4.1	3.3
Number of MHA-related outpatient visits to a paediatrician per 100 population aged 0 to 24 years	7.8	8.0	7.9	6.7	9.7	5.4	4.8	10.0	7.5	9.0	8.5	9.2	7.4	7.6	6.0
Number of children and youth treated for alcohol and drug problems per 10,000 population aged 0 to 24 years	39.0	33.0	40.5	30.6	53.7	13.2	14.9	22.0	11.1	28.8	34.6	55.2	25.2	101.9	124.7
Number of children and youth admitted for treatment of eating disorders per 10,000 population aged 0 to 24 years	2.2	1.8	2.8	2.1	2.9	0.8	1.7	3.3	1.6	1.4	1.7	3.1	2.7	3.7	1.3
Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years	6.0	6.3	6.3	5.7	5.5	7.0	6.3	7.3	5.0	4.7	6.3	7.7	4.0	4.3	5.0
<b>Outcomes</b>															
Prevalence of neonatal abstinence syndrome per 1,000 hospital births	5.5	14.2	6.0	3.8	7.1	1.1	1.4	1.5	1.5	3.8	8.4	3.4	14.9	14.7	48.1
Number of deaths by suicide per 100,000 population aged 10 to 24 years	5.9	4.2	5.2	5.7	6.2	5.0	4.3	4.0	3.9	4.2	7.1	5.6	6.6	13.6	33.0
Number of ED visits for deliberate self-harm per 10,000 population aged 10 to 24 years	30.0	27.1	37.2	36.3	32.4	19.2	20.9	24.3	15.2	29.1	38.1	38.4	33.5	48.3	92.8
Number of MHA-related ED visits per 1,000 population aged 0 to 24 years	16.3	19.3	18.1	15.7	17.2	11.0	11.4	16.2	10.6	16.2	20.0	18.2	20.4	27.1	37.7
Number of MHA-related hospitalizations per 1,000 population aged 0 to 24 years	4.8	5.4	5.3	5.3	5.2	3.6	3.1	4.8	3.5	4.2	4.8	4.0	6.9	9.3	10.4

\*Rates are age- and sex-standardized.

MHA = mental health and addictions; ED = emergency department

Lowest rate      Highest rate



Indicators*	Ontario	Erie St. Clair	South West	Waterloo Wellington	Hamilton Niagara Haldimand Brant	Central West	Mississauga Halton	Toronto Central	Central	Central East	South East	Champlain	North Simcoe Muskoka	North East	North West
<b>System Performance Indicators</b>															
<b>Access</b>															
Number of outpatient visits to any physician specialty within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	36.2	27.1	30.7	34.7	39.7	41.0	45.1	48.9	45.3	39.8	23.2	43.9	31.9	29.0	19.6
Number of outpatient visits to a general practitioner or family physician within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	10.8	7.0	8.9	11.8	11.2	10.7	16.0	6.4	16.1	16.3	9.2	13.1	13.8	7.7	8.3
Number of outpatient visits to a psychiatrist within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	14.5	12.5	13.3	13.1	14.6	20.5	20.4	24.5	14.8	16.9	9.4	15.8	11.6	9.2	3.5
Number of outpatient visits to a paediatrician within 7 days of an incident hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	6.6	6.3	6.3	5.2	8.5	4.1	4.6	12.5	8.1	2.8	3.1	9.6	2.2	7.6	7.2
Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or a paediatrician within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	3.9	1.2	2.0	4.6	4.3	5.0	3.8	5.5	6.1	3.4	1.5	4.6	4.4	4.4	0.4
<b>Quality</b>															
Number of MHA-related ED revisits within 30 days of an incident MHA-related ED visit per 100 population aged 0 to 24 years with an incident MHA-related ED visit	7.8	9.4	7.1	6.4	7.8	5.7	8.1	7.2	7.0	8.5	7.4	8.2	7.4	7.9	9.5
Number of MHA-related readmissions within 30 days of an incident MHA-related hospital admission per 100 population aged 0 to 24 years with an incident MHA-related hospital admission	8.1	7.7	6.2	10.3	11.0	10.9	7.4	9.6	6.7	7.3	6.8	7.5	4.8	6.0	7.2
<b>Early identification</b>															
Number of children and youth for whom the ED was the first point of contact for MHA per 100 population aged 0 to 24 years with an MHA-related ED visit	45.1	42.5	48.0	42.2	40.7	53.9	48.7	45.2	46.8	41.7	44.9	41.7	42.8	48.8	52.6

\* Rates are age- and sex-standardized.

MHA = mental health and addictions; ED = emergency department

**EXHIBIT 1.2** Indicators for child and youth mental health, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

Lowest rate      Highest rate

Indicators*	Ontario	Stormont, Dundas and Glengarry	Prescott and Russell	Ottawa	Lanark/Leeds and Grenville	Frontenac/Lennox/Addington	Hastings/Prince Edward/Norumberland	Haliburton/Kawartha Lakes/Peterborough	Durham	York	Toronto	Peel	Dufferin/Wellington	Halton	Hamilton	Niagara	Haldimand-Norfolk	Brant	Waterloo	Elgin/Oxford	Chatham-Kent	Essex	Lambton	Middlesex	Huron/Perth	Grey/Bruce	Simcoe	Renfrew	Nipissing/Parry Sound/Muskoka	Greater Sudbury/Manitowlin/Sudbury	Algoma	Timiskaming/Cochrane	Thunder Bay	Kenora/Rainy River
Contextual Indicators																																		
System Use																																		
Number of children and youth seen by a psychiatrist per 1,000 population aged 0 to 24 years	21.0	18.1	14.1	17.8	18.6	30.6	21.7	25.0	23.4	19.2	23.7	17.4	17.2	24.2	18.6	22.5	16.1	23.9	22.6	21.6	18.1	26.4	26.3	31.3	23.6	14.0	20.5	16.9	11.3	17.7	19.4	12.2	11.7	9.0
Number of MHA-related outpatient physician visits to any physician specialty per 100 population aged 0 to 24 years	32.4	31.9	29.9	37.4	34.0	43.3	32.1	45.2	34.1	28.3	31.8	22.0	29.1	34.1	35.0	39.0	36.2	38.2	29.4	39.9	40.1	33.5	43.3	47.4	26.1	24.1	34.1	30.5	30.9	36.4	28.2	22.5	34.5	17.6
Number of MHA-related outpatient visits to a general practitioner or family physician per 100 population aged 0 to 24 years	16.5	16.5	18.2	17.8	20.5	24.1	16.6	22.5	16.5	13.0	12.2	11.7	15.8	17.5	20.1	22.4	22.4	21.6	15.5	24.1	23.0	18.5	23.7	23.5	13.4	14.6	19.7	19.9	21.5	21.3	16.2	14.5	21.0	14.4
Number of MHA-related outpatient visits to a psychiatrist per 100 population aged 0 to 24 years	8.1	7.1	5.5	9.5	6.0	10.0	6.6	7.4	7.5	7.7	11.8	5.8	5.1	9.5	6.2	5.7	4.5	7.6	7.7	6.9	5.7	8.7	8.5	15.0	8.2	2.8	6.5	4.0	2.9	5.4	5.5	2.3	4.3	1.5
Number of MHA-related outpatient visits to a paediatrician per 100 population aged 0 to 24 years	7.8	8.3	6.1	10.0	7.6	9.2	8.9	15.3	10.1	7.6	7.8	4.5	8.2	7.1	8.8	10.9	9.3	9.0	6.2	9.0	11.3	6.3	11.2	8.8	4.6	6.8	7.9	6.6	6.6	9.7	6.4	5.8	9.2	1.7
Number of hospitalizations for eating disorders per 10,000 population aged 0 to 24 years	2.2	1.9	2.2	3.4	2.7	2.4	0.9	1.6	1.8	1.7	1.9	1.0	2.3	2.7	3.3	2.4	3.2	2.0	2.1	2.4	1.0	1.6	3.1	2.8	1.4	5.0	2.5	2.3	2.6	5.1	5.0	1.4	2.1	0.0
Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years	6.0	4.7	7.8	9.0	6.3	7.0	5.3	6.7	4.3	4.3	6.3	7.0	6.0	5.8	8.0	3.3	4.7	3.0	5.7	6.7	8.0	7.3	4.3	7.3	3.7	3.0	4.0	3.0	4.3	5.0	4.7	3.7	5.0	4.7
Outcomes																																		
Number of deaths by suicide per 100,000 population aged 10 to 24 years	5.9	4.3	13.0	4.5	10.3	5.8	6.3	4.3	4.8	3.7	3.8	4.2	4.0	6.2	6.3	5.3	6.1	9.7	7.0	5.2	4.8	2.1	10.9	4.4	2.4	9.8	6.4	8.8	12.0	7.8	10.4	25.5	20.3	52.1
Number of emergency department visits for deliberate self-harm per 10,000 population aged 10 to 24 years	30.0	32.8	28.3	41.0	38.6	36.2	37.5	52.4	31.2	15.7	19.3	16.6	38.6	28.3	31.3	35.6	29.5	38.1	37.5	27.3	22.7	26.8	32.2	42.2	34.7	39.0	30.1	31.5	48.7	38.7	49.5	59.9	59.7	142.7
Number of MHA-related ED visits per 1,000 population aged 0 to 24 years	16.3	20.8	15.6	17.6	18.9	22.6	17.0	25.8	18.5	10.3	12.7	10.4	17.5	14.1	17.9	17.1	16.5	17.5	15.0	17.1	18.1	18.4	23.4	16.5	17.5	25.7	19.8	23.9	24.8	21.8	26.3	37.0	32.9	46.0
Number of MHA-related hospitalizations per 1,000 population aged 0 to 24 years	4.7	3.5	3.7	3.9	4.8	5.2	3.9	4.2	5.0	3.4	4.0	2.9	5.5	4.7	4.4	6.2	3.8	6.8	5.3	5.2	4.3	4.2	10.2	5.2	4.7	6.7	6.6	5.9	6.3	10.1	11.2	9.5	11.0	9.9

\*Rates are age- and sex-standardized.

MHA = mental health and addictions; ED = emergency department

Lowest rate Highest rate

Indicators*	Ontario	Stormont, Dundas and Glengarry	Prescott and Russell	Ottawa	Lanark/Leeds and Grenville	Frontenac/Lennox/Addington	Hastings/Prince Edward/ Northumberland	Haliburton/Kawartha Lakes/ Peterborough	Durham	York	Toronto	Peel	Dufferin/Wellington	Halton	Hamilton	Niagara	Haldimand-Norfolk	Brant	Waterloo	Elgin/Oxford	Chatham-Kent	Essex	Lambton	Middlesex	Huron/Perth	Grey/Bruce	Simcoe	Renfrew	Nipissing/Parry Sound/Muskoka	Greater Sudbury/Mantoulin/ Sudbury	Algoma	Timiskaming/Cochrane	Thunder Bay	Kenora/Rainy River
System Performance Indicators																																		
Access																																		
Number of outpatient visits to any physician specialty within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	36.2	27.1	28.2	44.1	27.3	26.2	19.6	38.3	36.0	42.5	49.5	41.5	29.7	49.5	31.6	41.7	25.9	22.2	34.2	24.2	14.0	20.4	39.2	31.3	33.7	18.7	41.3	30.6	18.1	19.8	33.0	31.2	23.0	15.0
Number of outpatient visits to a general practitioner or family physician within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	10.8	9.4	6.7	13.9	11.5	6.2	9.4	13.3	19.0	12.6	11.0	10.8	9.5	16.2	8.3	12.6	11.8	6.6	11.1	12.4	5.8	8.9	3.9	5.6	9.7	6.5	17.0	12.2	9.3	8.0	15.7	5.9	7.6	8.7
Number of outpatient visits to a psychiatrist within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	14.5	7.8	6.7	19.0	6.3	13.4	7.5	16.0	12.0	11.6	23.5	22.3	14.3	21.6	13.4	15.4	5.2	6.8	13.7	8.5	4.8	8.2	19.2	18.8	15.0	3.7	11.8	4.1	3.4	8.3	8.7	11.8	4.3	2.0
Number of outpatient visits to a paediatrician within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	6.6	9.0	7.0	5.2	8.2	4.3	1.5	1.8	2.2	10.6	9.6	3.2	1.9	8.1	7.4	6.9	8.3	7.6	5.6	2.1	2.8	2.1	14.6	3.7	7.7	6.7	8.0	11.6	4.9	2.2	7.4	5.4	10.5	3.7
Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or paediatrician within 7 days of an incident MHA-related hospital discharge per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge	3.9	0.8	7.6	4.9	1.1	2.2	1.1	7.2	2.6	7.5	4.9	5.1	3.9	3.2	1.4	5.9	0.5	1.2	3.8	0.8	0.6	1.1	1.4	3.2	1.3	1.7	4.5	2.5	0.3	1.1	1.1	8.1	0.4	0.5
Quality																																		
Number of MHA-related ED revisits within 30 days of an incident ED visit per 100 population aged 0 to 24 years with an incident MHA-related ED visit	7.8	8.7	8.0	8.1	8.0	7.7	7.4	7.8	9.1	7.1	6.9	6.8	6.4	8.3	7.8	8.1	7.0	5.0	6.3	6.5	5.8	11.2	7.5	6.3	5.1	11.3	7.6	6.9	7.1	6.5	7.7	8.9	10.3	9.0
Number of readmissions within 30 days of an MHA-related incident hospital admission per 100 population aged 0 to 24 years with an incident MHA-related hospital admission	8.1	2.9	9.7	8.6	6.8	7.6	4.9	4.6	7.7	8.0	8.1	11.5	5.0	11.6	5.7	11.6	12.4	6.5	13.9	5.7	4.9	6.2	9.8	5.2	8.0	4.3	4.6	3.9	5.5	6.9	5.0	5.3	7.0	5.1
Early identification																																		
Number of children and youth for whom the ED was the first point of contact for MHA per 100 population aged 0 to 24 years with an MHA-related ED visit	45.1	47.7	39.2	40.2	44.0	43.3	46.7	41.0	38.8	46.2	47.4	51.9	46.8	41.6	41.3	38.1	49.0	42.0	40.5	48.0	40.0	42.0	41.7	45.3	47.7	53.2	43.6	45.6	44.2	39.6	48.8	55.5	49.1	56.1

\* Rates are age- and sex-standardized.

MHA = mental health and addictions; ED = emergency department

## 2.0

# Indicators for Child and Youth Mental Health: Full Results

---

# Contextual Indicators: System Use

---

**2.1** Rate at which children and youth were seen by a psychiatrist

**2.2** Rate of outpatient physician visits for mental health and addictions conditions by children and youth

**2.3** Rate at which children and youth were treated for alcohol and drug problems

**2.4** Rate of hospitalizations for eating disorders among children youth

**2.5** Length of stay for psychiatric hospitalizations among children and youth



## 2.1 Rate at which children and youth were seen by a psychiatrist

### Rationale

Psychiatrists are physicians who specialize in mental health and addictions. Their services are funded through the Ontario Health Insurance Plan and for a child or youth to be seen, require a referral from another physician. This is a different service than those provided by psychologists who are often, though not always, privately funded or funded through community agencies. Measuring the number of individuals who are seen by a psychiatrist is one measure of access to specialized care.

### Results

A gradual increase was observed between 2006 and 2014 in the rate at which children and youth were seen by a psychiatrist. This was largely driven by a rapid increase in the number of youths aged 14 to 21 years, who had the highest rates of psychiatrist visits. Rates of psychiatrist visits among the younger age groups remained stable.

Rates of psychiatrist visits were highest among children and youth living in the highest-income neighbourhoods and among non-immigrants. Considerably more children and youth saw a psychiatrist in the Toronto Central and South East Local Health Integration Networks (LHINs), and in the Frontenac/Lennox/Addington and Middlesex Child and Youth Mental Health Service Areas. The age- and sex-standardized rate of children and youth who saw a psychiatrist was lowest in the North West LHIN and in the Thunder Bay and Kenora/Rainy River Child and Youth Mental Health Service Areas.

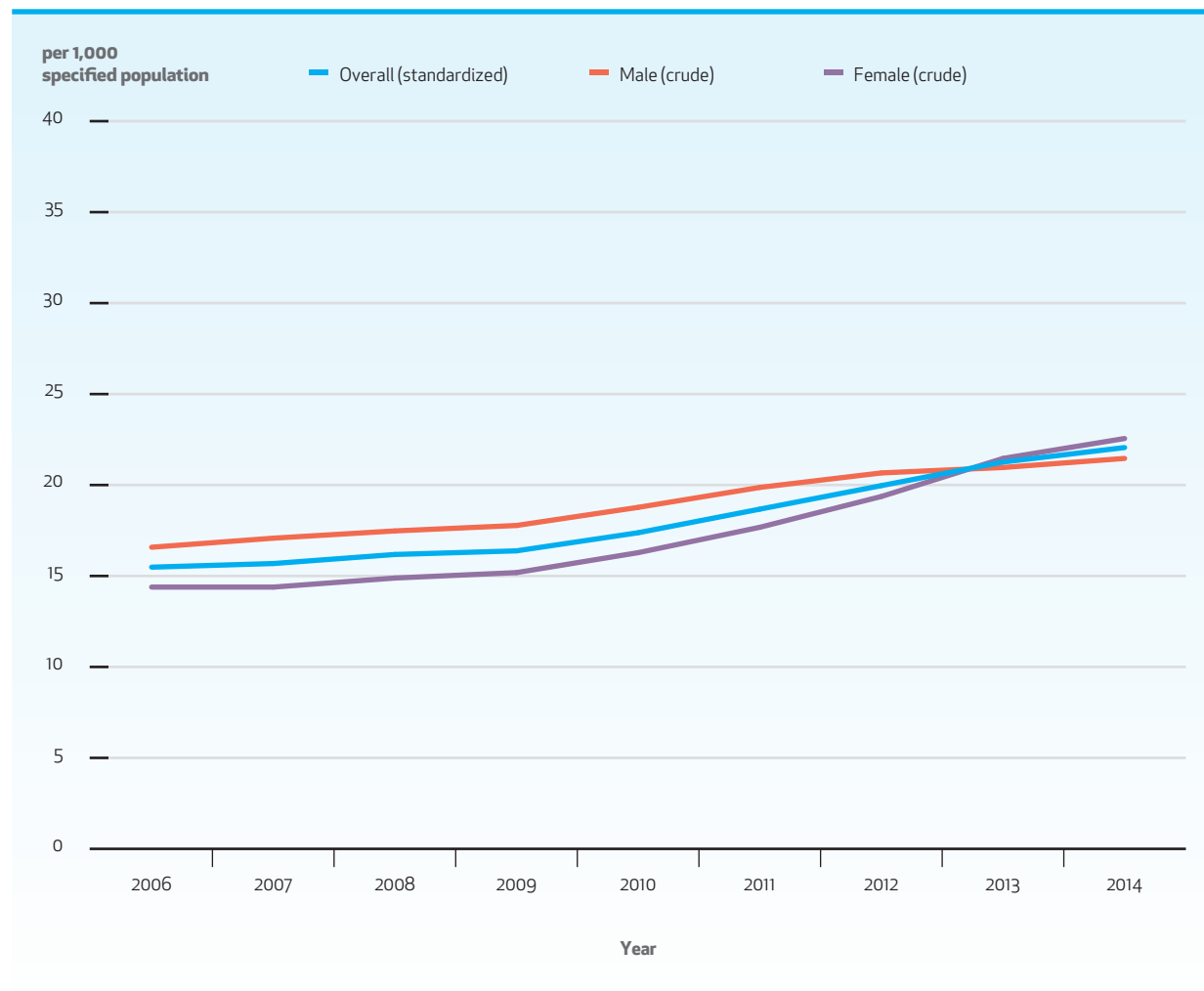
### Interpretation

The number of children and youth seen by psychiatrists increased over time, particularly among individuals aged 14 to 21 years. This increase may reflect greater accessibility, greater demand or an increase in awareness coupled with destigmatization. Higher rates were observed among children and youth residing in wealthier neighbourhoods and in LHINs with large urban centres, suggesting that factors other than need were influencing access to specialist care.

**EXHIBIT 2.1.1** Number of children and youth seen by a psychiatrist per 1,000 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

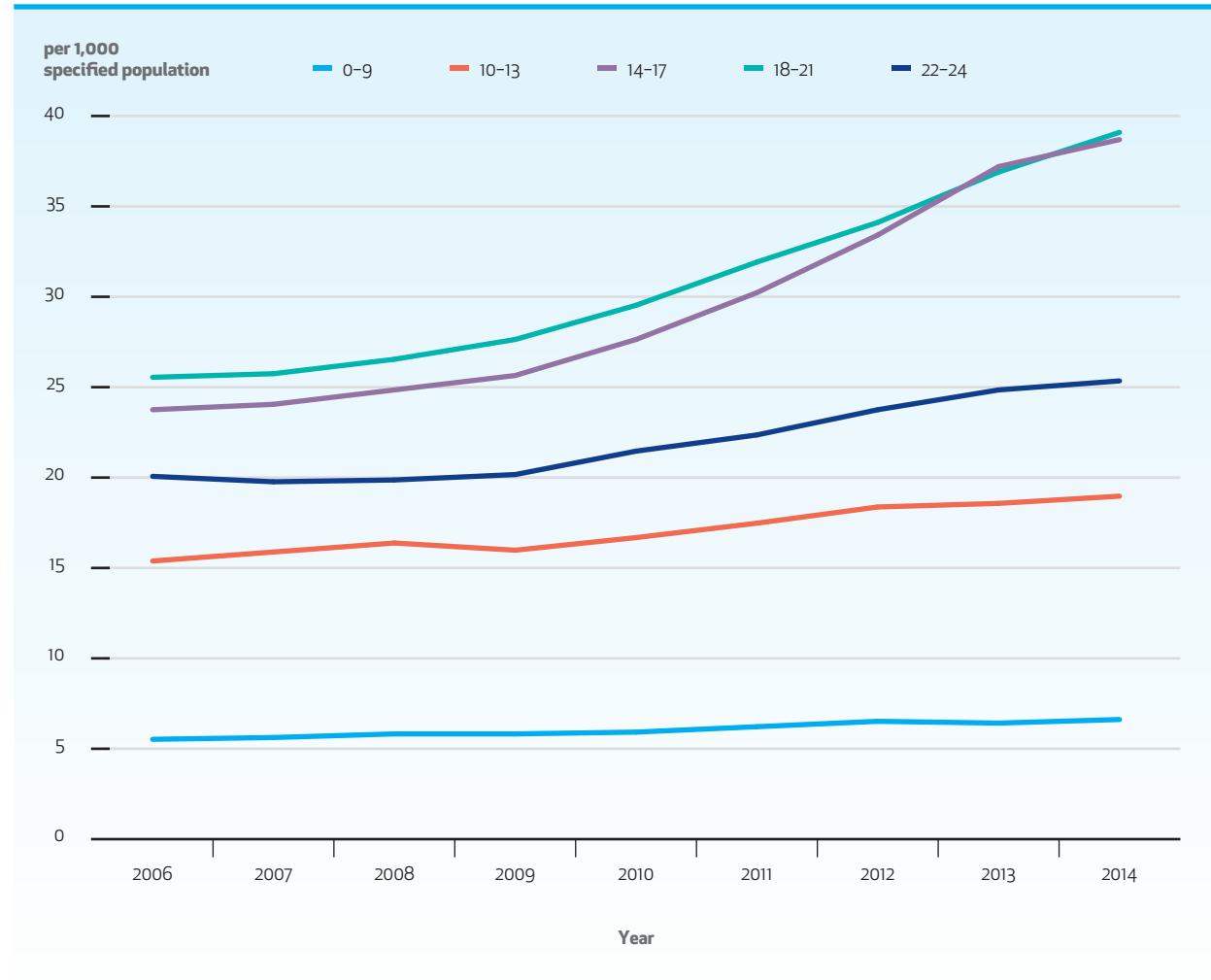
## Key Finding

- The rate at which children and youth were seen by a psychiatrist increased between 2006 and 2014.



**EXHIBIT 2.1.2** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014**Key Finding**

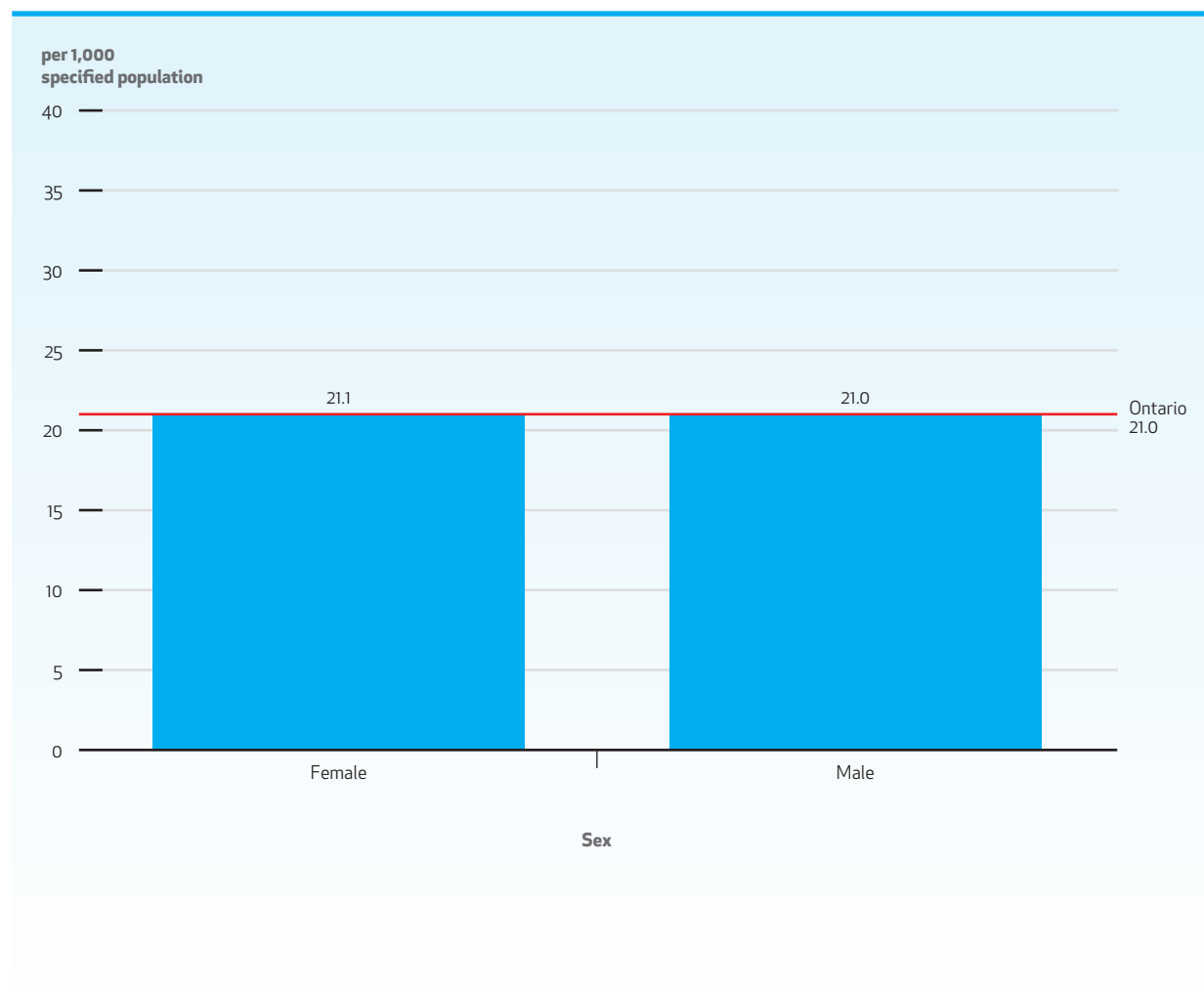
- The rate at which children and youth were seen by a psychiatrist increased between 2006 and 2014, particularly among those aged 14 to 17 and 18 to 21.



**EXHIBIT 2.1.3** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

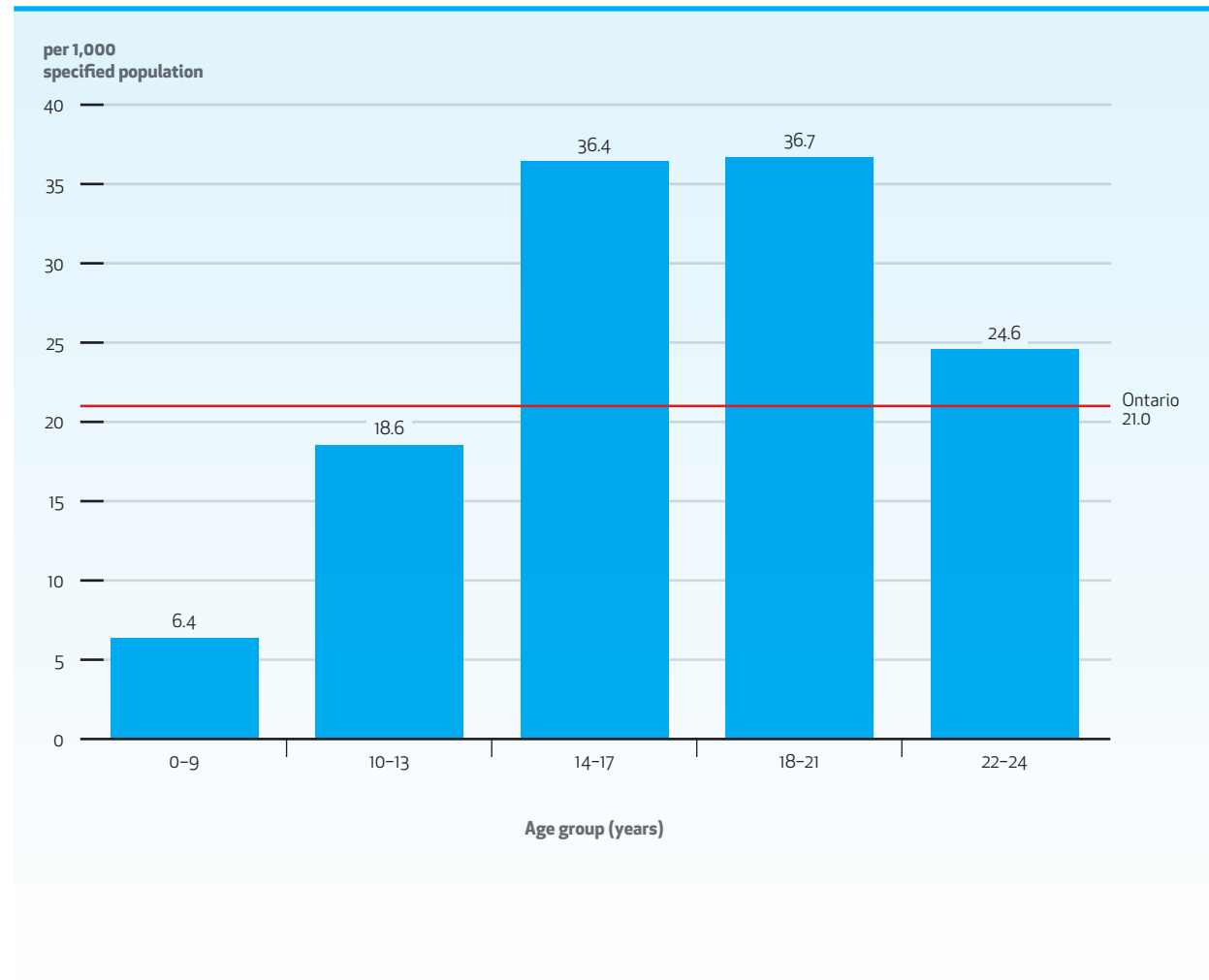
- Between 2012 and 2014, the average rate at which children and youth were seen by a psychiatrist was almost identical for males and females.



**EXHIBIT 2.1.4** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

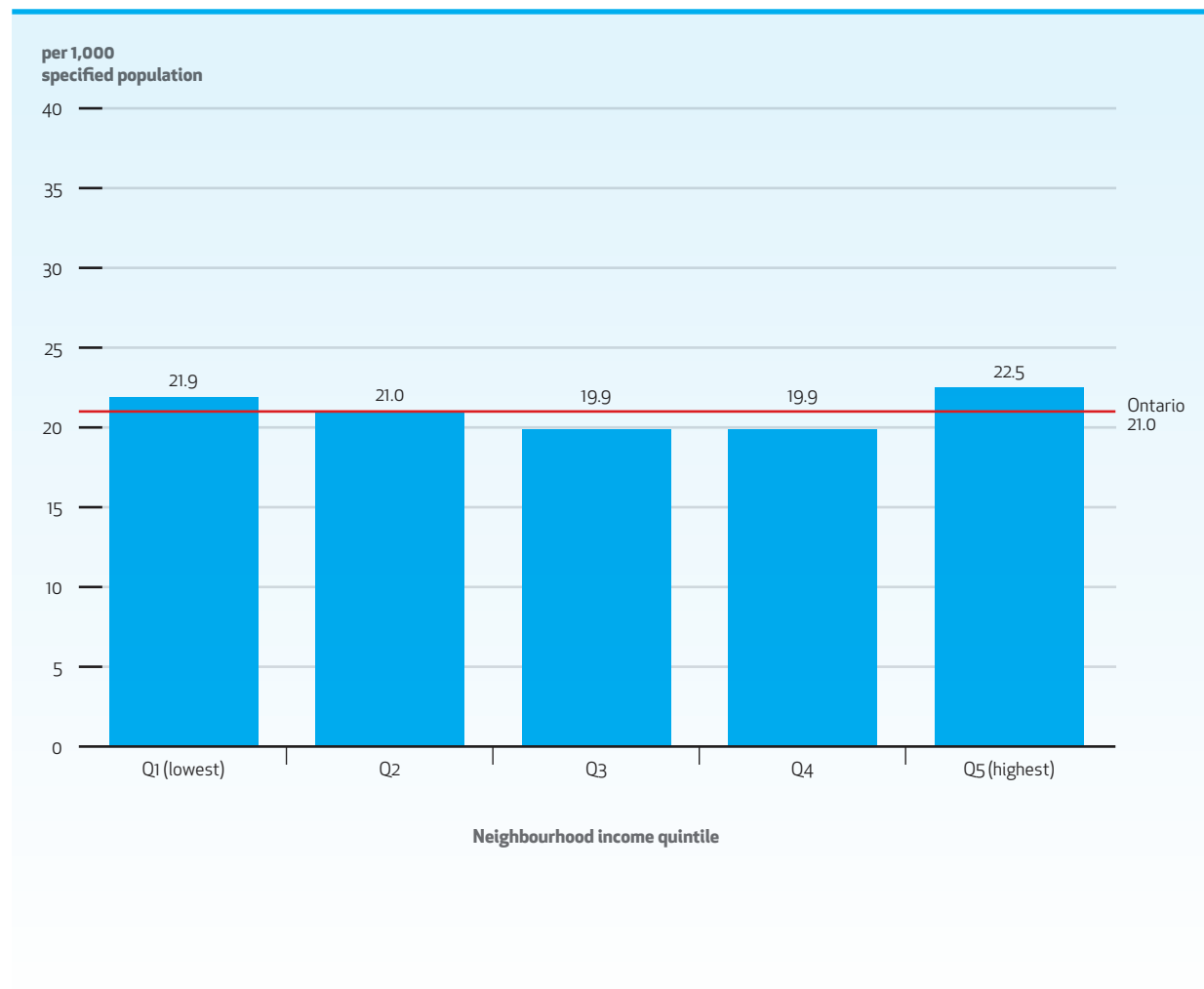
- Between 2012 and 2014, the average rate at which children and youth were seen by a psychiatrist was highest among those aged 14 to 21.



**EXHIBIT 2.1.5** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

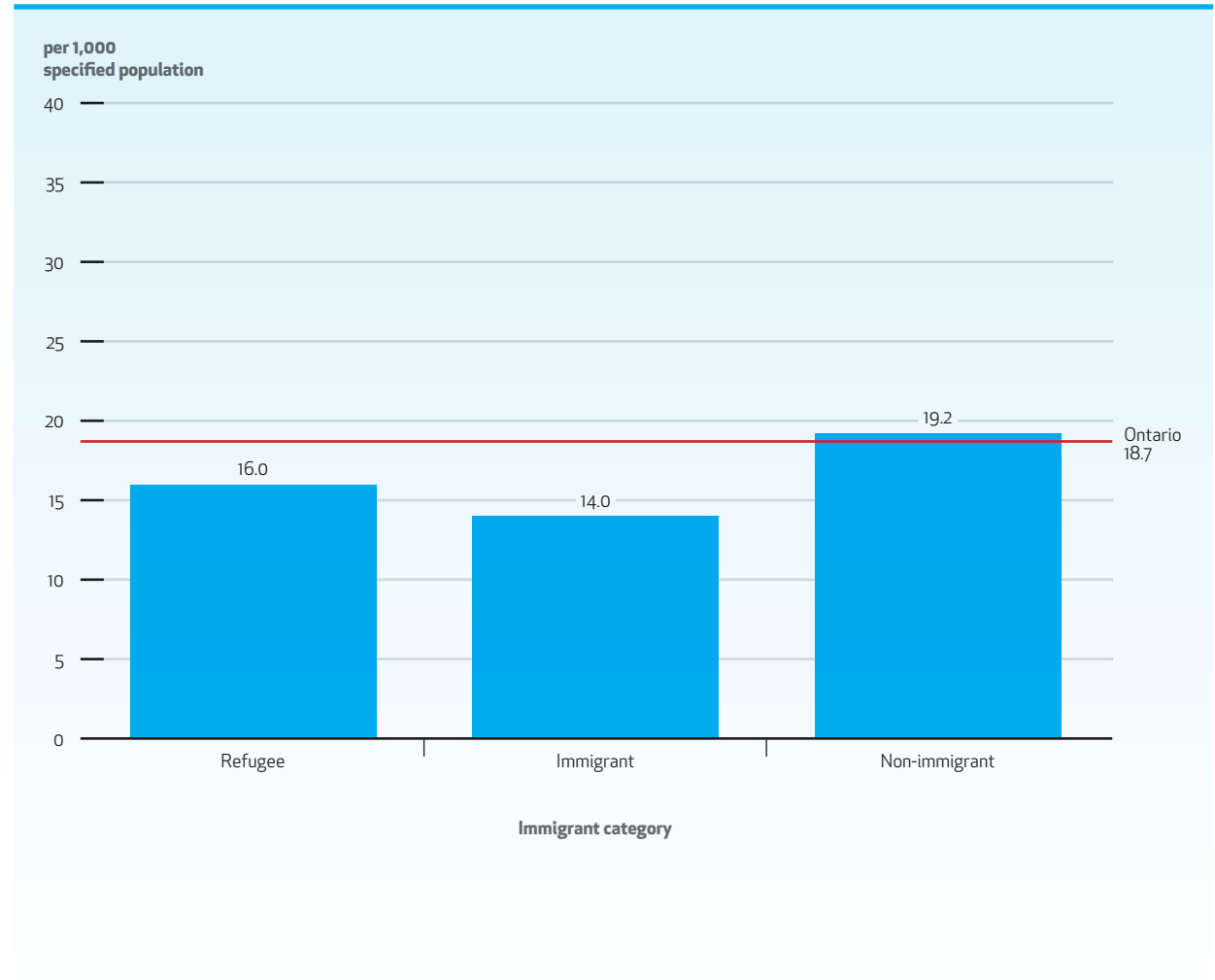
- Between 2012 and 2014, the average rate at which children and youth were seen by a psychiatrist was highest among those living in the wealthiest neighbourhoods.



**EXHIBIT 2.1.6** Number of children and youth seen by a psychiatrist per 1,000 crude population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

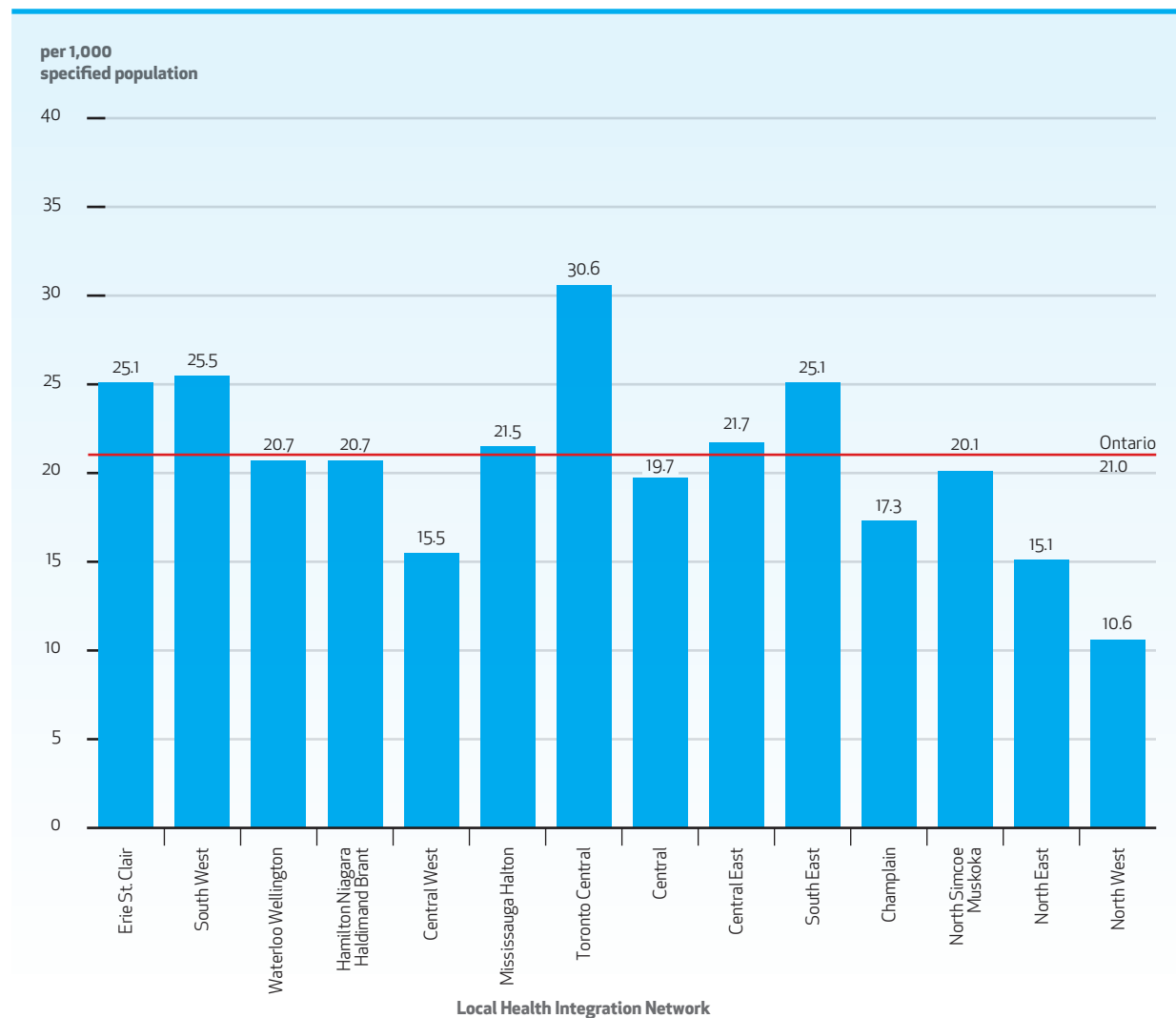
- Between 2010 and 2012, the average rate at which children and youth were seen by a psychiatrist was highest among non-immigrants and lowest among immigrants.



**EXHIBIT 2.1.7** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate at which children and youth were seen by a psychiatrist was highest among those in the Toronto Central and South East LHINs and lowest among those in the North West LHIN.

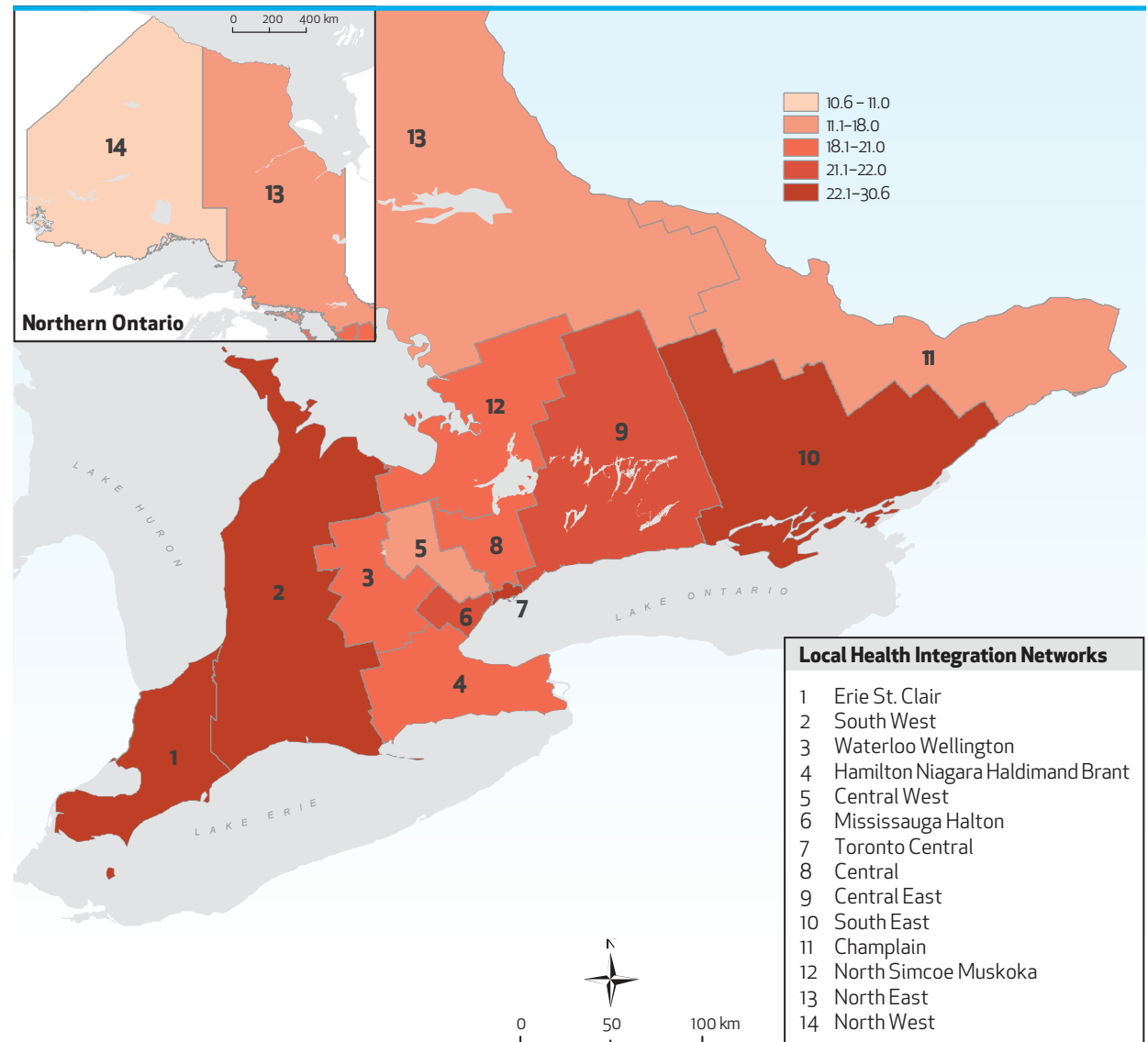




**EXHIBIT 2.1.8** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

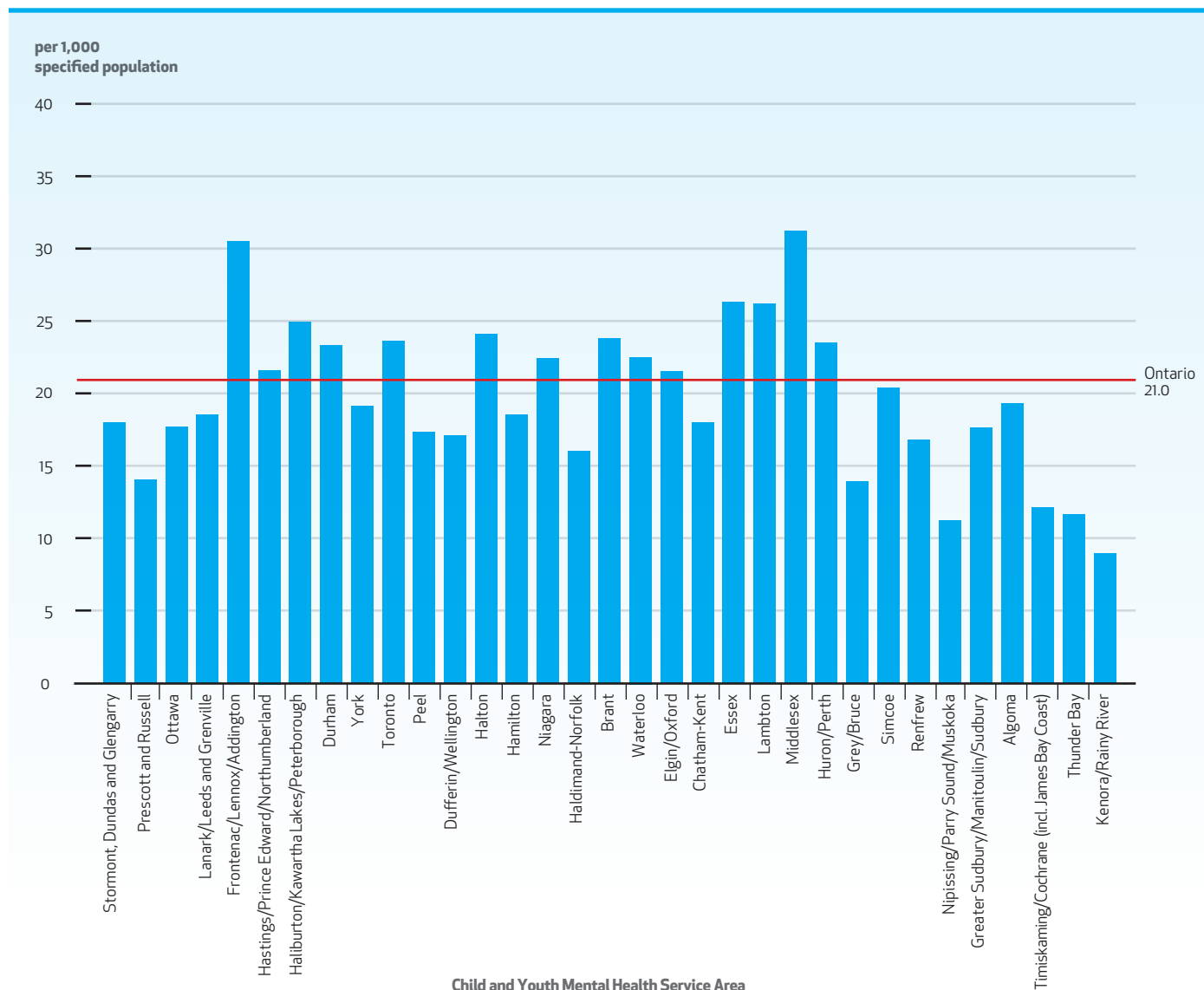
- Between 2012 and 2014, the average age- and sex-standardized rate at which children and youth were seen by a psychiatrist was highest among those in the Toronto Central and South East LHINs and lowest among those in the North West LHIN.



**EXHIBIT 2.1.9** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

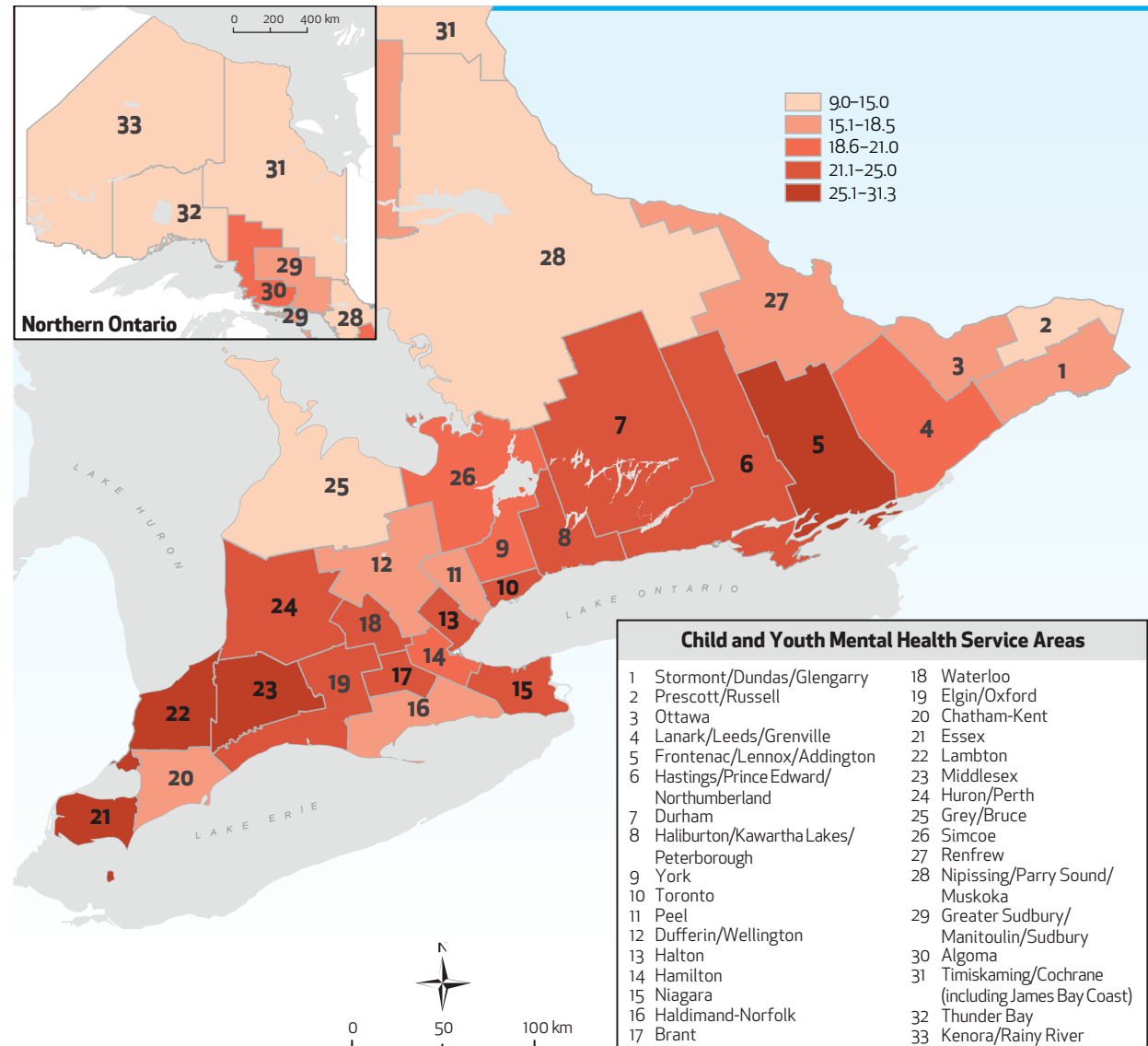
- Among Child and Youth Mental Health Service Areas, the average age- and sex-standardized rate at which children and youth were seen by a psychiatrist between 2012 and 2014 was highest in Frontenac/Lennox/Addington and lowest in Thunder Bay and Kenora/Rainy River.



**EXHIBIT 2.1.10** Number of children and youth seen by a psychiatrist per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Among Child and Youth Mental Health Service Areas, the average age- and sex-standardized rate at which children and youth were seen by a psychiatrist between 2012 and 2014 was highest in Frontenac/Lennox/Addington and lowest in Thunder Bay and Kenora/Rainy River.



## 2.2 Rate of outpatient physician visits for mental health and addiction conditions by children and youth

### Rationale

Although there are many providers of mental health and addictions services, the use of physician services for mental health and addictions problems (currently the only outpatient service for which data are available) provides a measure of service needs. Knowledge of the rate of and trends for outpatient visits according to the type of physician could help in human resource planning.

### Results

Rates of outpatient physician visits increased between 2006 and 2014. General practitioners and family physicians (GP/FPs) provided the bulk of outpatient care related to mental health and addictions, followed by psychiatrists and paediatricians. Across most physician specialties, there was an age gradient whereby children and youth in the older age groups had higher rates of outpatient visits. The reverse gradient was observed for paediatricians.

Children and youth from the highest- and lowest-income neighbourhoods had the highest rates of outpatient physician visits across all physician specialties. Psychiatrists provided more outpatient care to children and youth in high-income neighbourhoods, and GP/FPs provided more care to those in low-income neighbourhoods. In general, non-immigrant children and youth had higher rates of mental health and addiction-related outpatient physician visits. A strong geographic difference was observed between the Toronto Central Local Health Integration Network and the remaining LHINs,

especially those in northern Ontario. Children and youth in the Toronto Central LHIN received more specialized psychiatric and paediatric care. GP/FP visits were most common for children and youth in the Hamilton Niagara LHIN. The Middlesex Child and Youth Mental Health Service Area had the highest rate of outpatient visits by children and youth for mental health and addiction problems, while Kenora/Rainy River had the lowest.

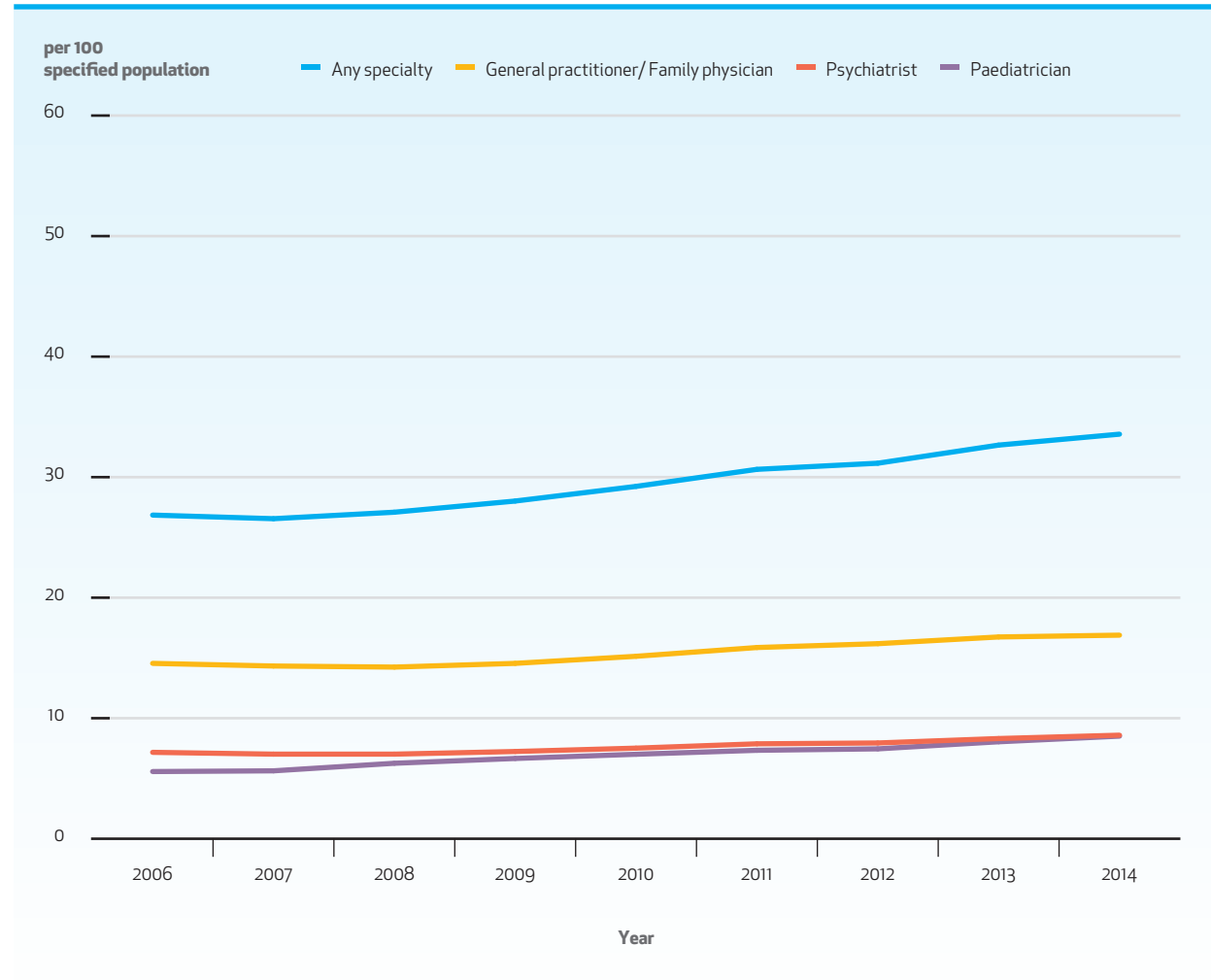
### Interpretation

The majority of physician mental health and addictions care in outpatient settings was delivered by GP/FPs. These primary care providers and generalists should continue to be supported to ensure they can continue to provide the bulk of mental health physician services. The overall increasing trend across all physician specialties may reflect increased awareness and de-stigmatization of mental health and addictions. Greater geographic variation suggests that rates of outpatient visits are driven by physician availability rather than degree of need.

**EXHIBIT 2.2.1** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by physician specialty, in Ontario, 2006 to 2014

## Key Finding

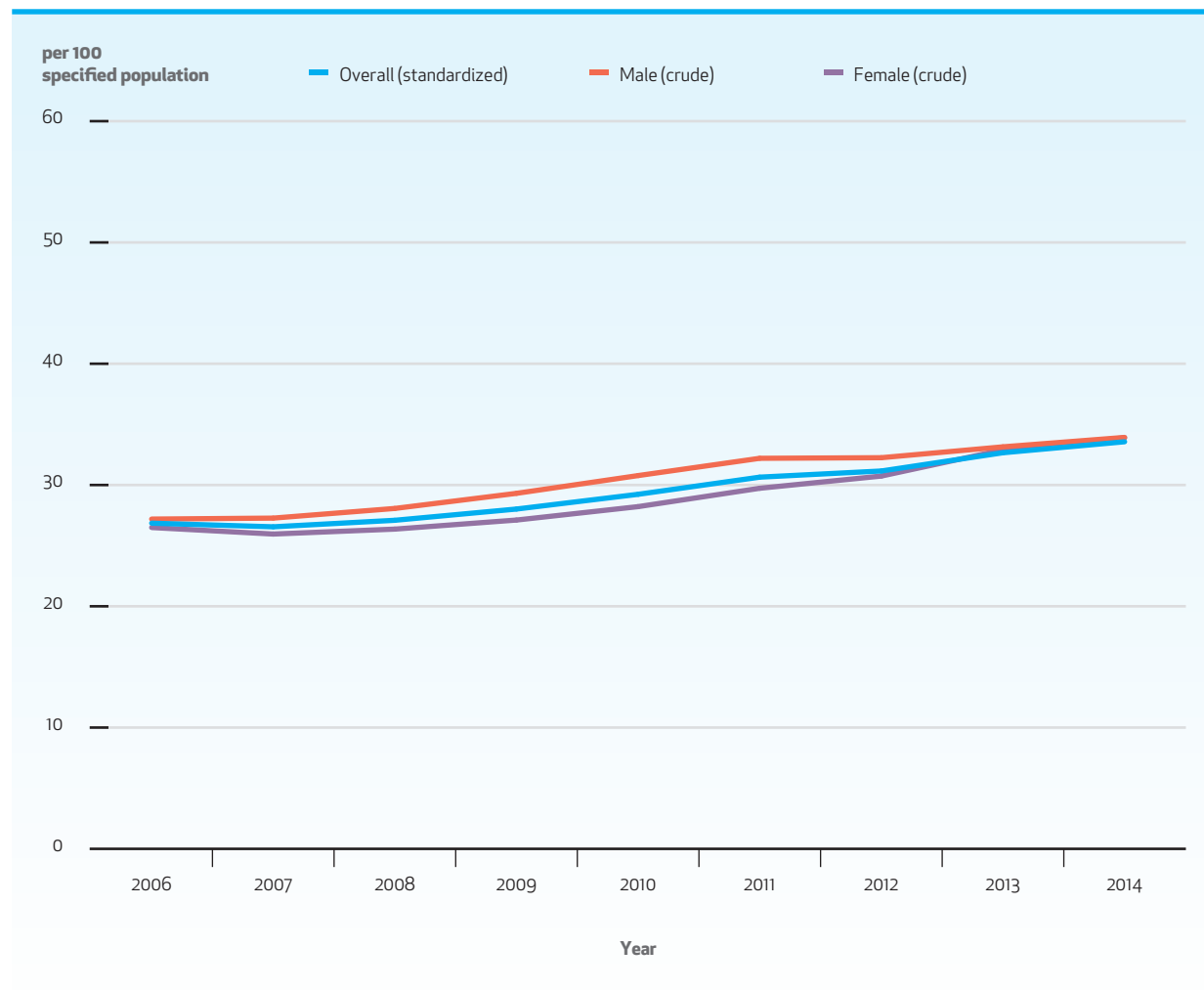
- Rates of outpatient visits to physicians for mental health and addictions increased between 2006 and 2014 for all physician specialties and were highest among general practitioners and family physicians.



**EXHIBIT 2.2.2** Number of outpatient physician visits related to mental health and addictions per 100 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

## Key Findings

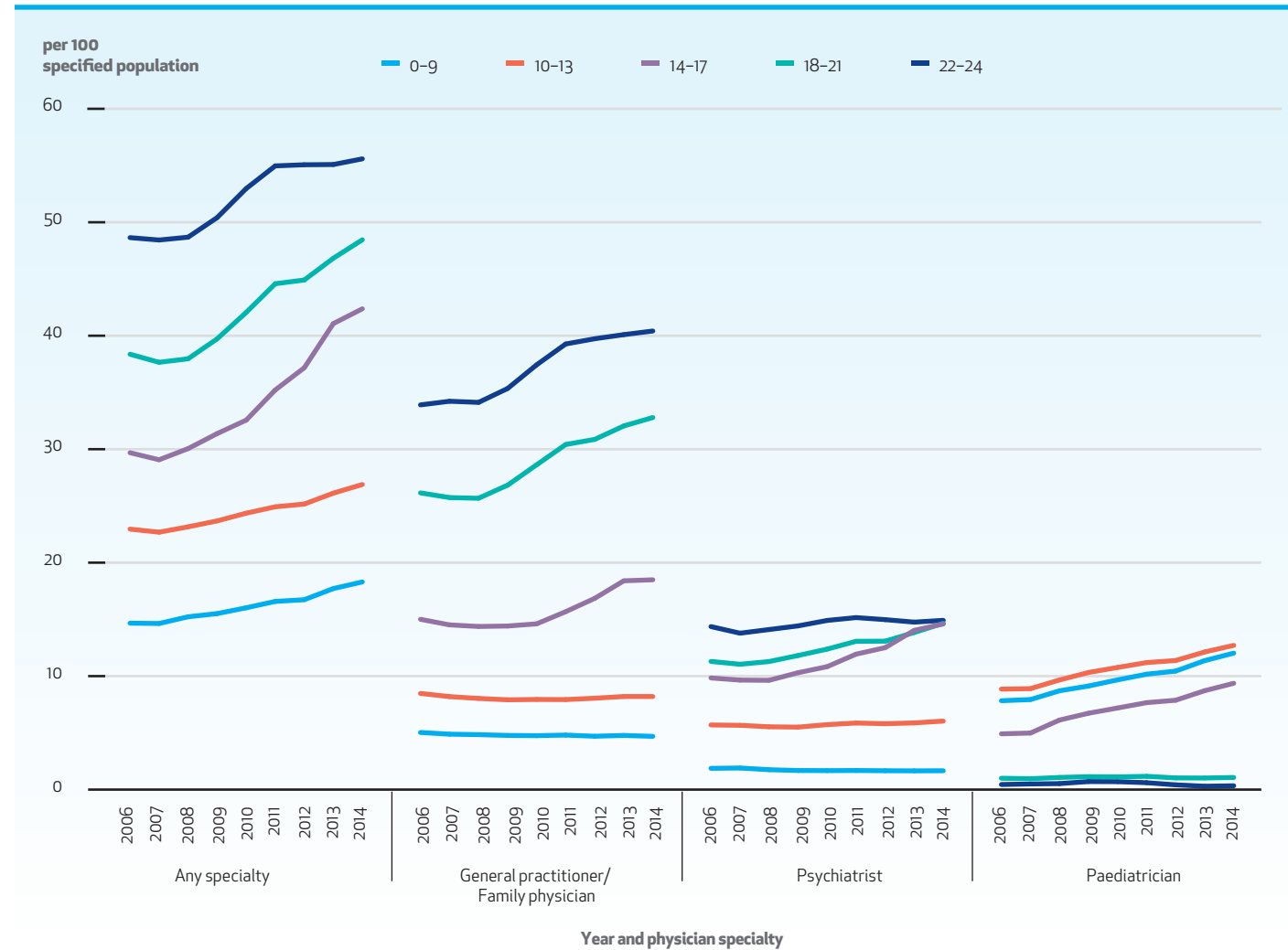
- Overall rates of outpatient visits related to mental health and addictions increased between 2006 and 2014.
- Rates were initially higher for males than for females but the two rates have converged in recent years.



**EXHIBIT 2.2.3** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by age group and physician specialty, in Ontario, 2006 to 2014

## Key Findings

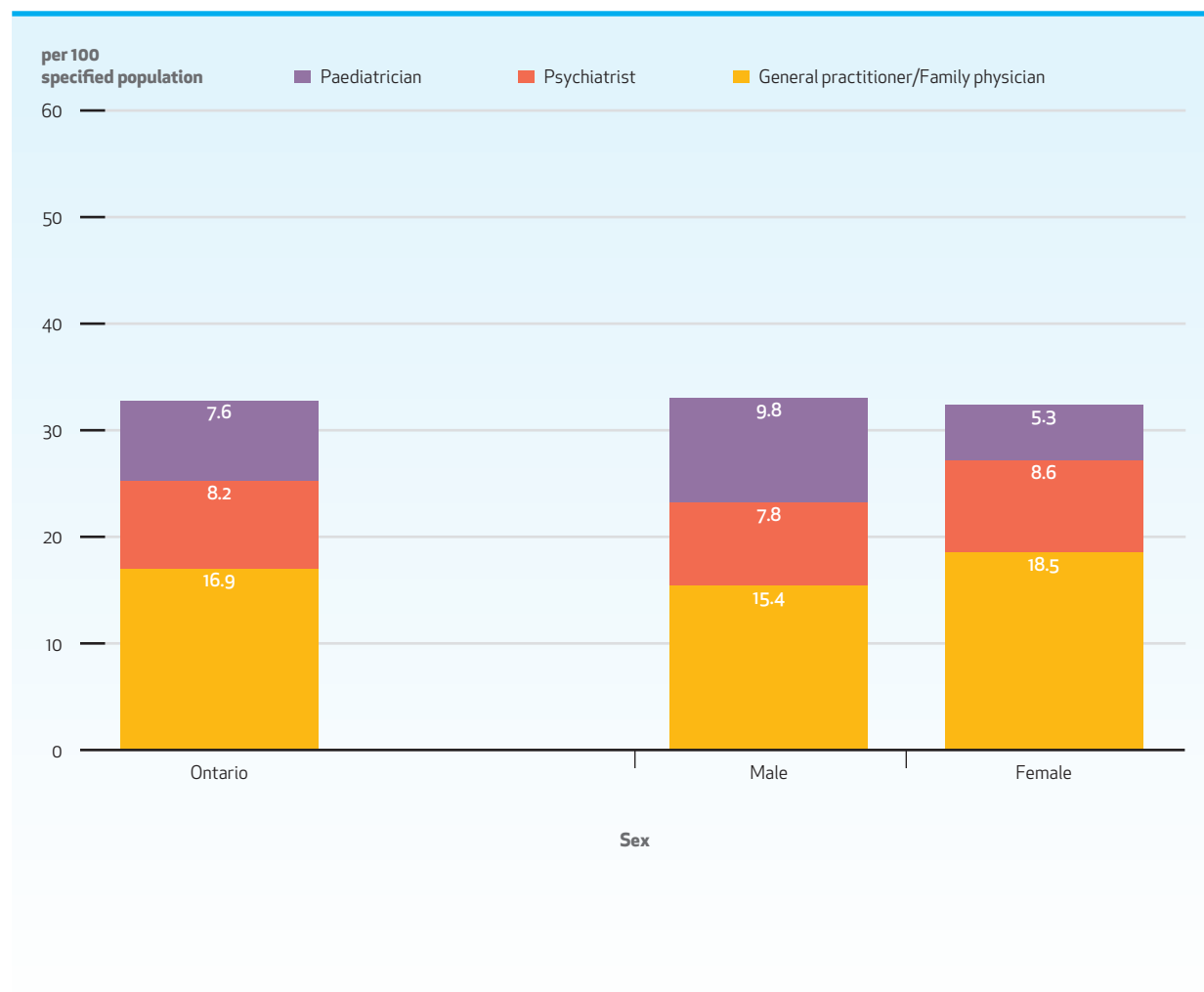
- The rate of outpatient visits to psychiatrists and either general practitioners or family physicians for mental health and addictions (MHA) was highest among the older age groups and increased between 2006 and 2014, particularly among youth aged 14 to 24.
- MHA-related outpatient visits to paediatricians increased for all age groups.



**EXHIBIT 2.2.4** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

- Between 2012 and 2014, the overall rate of MHA-related outpatient physician visits was similar for males and females.
- The rate of visits to paediatricians was higher for males.
- In contrast, the rate of visits to GP/FPs was higher for females.

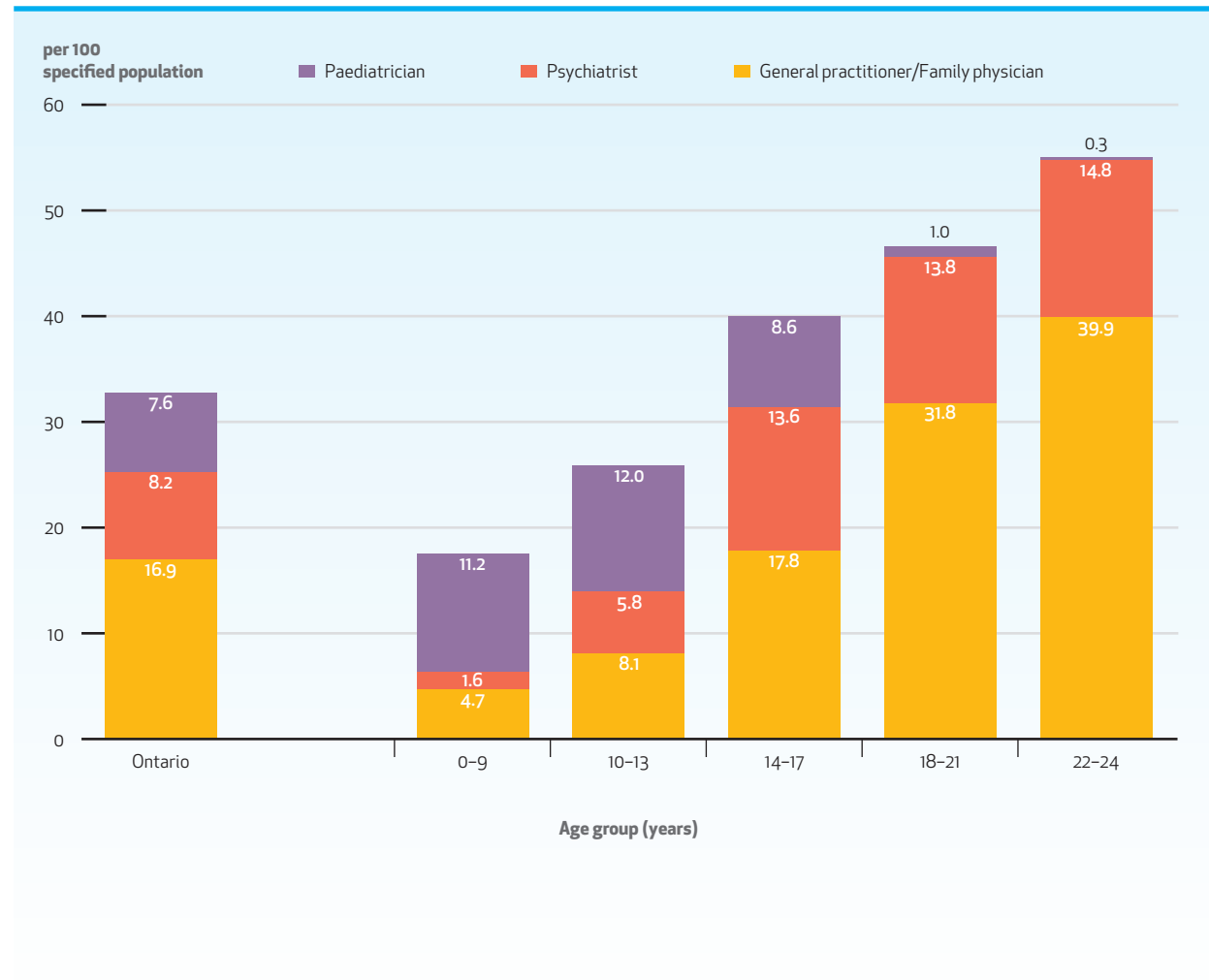




**EXHIBIT 2.2.5** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

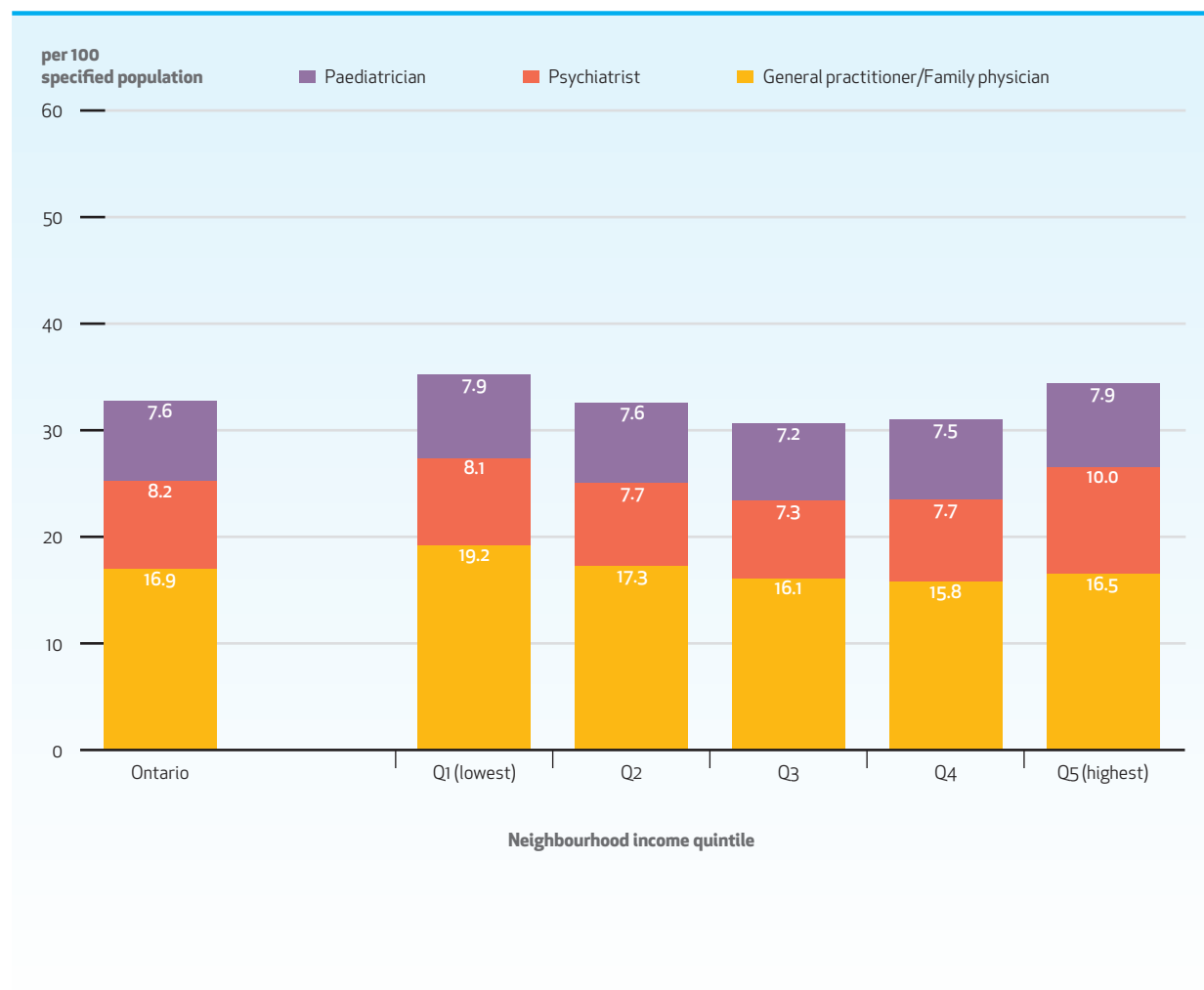
- Between 2012 and 2014, the average rate of MHA-related outpatient physician visits was higher for the older age groups. This was driven primarily by high rates of psychiatrist and GP/FP visits in these groups.
- Among the two youngest age groups (0 to 9 years and 10 to 13 years), the majority of outpatient visits were to paediatricians.



**EXHIBIT 2.2.6** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

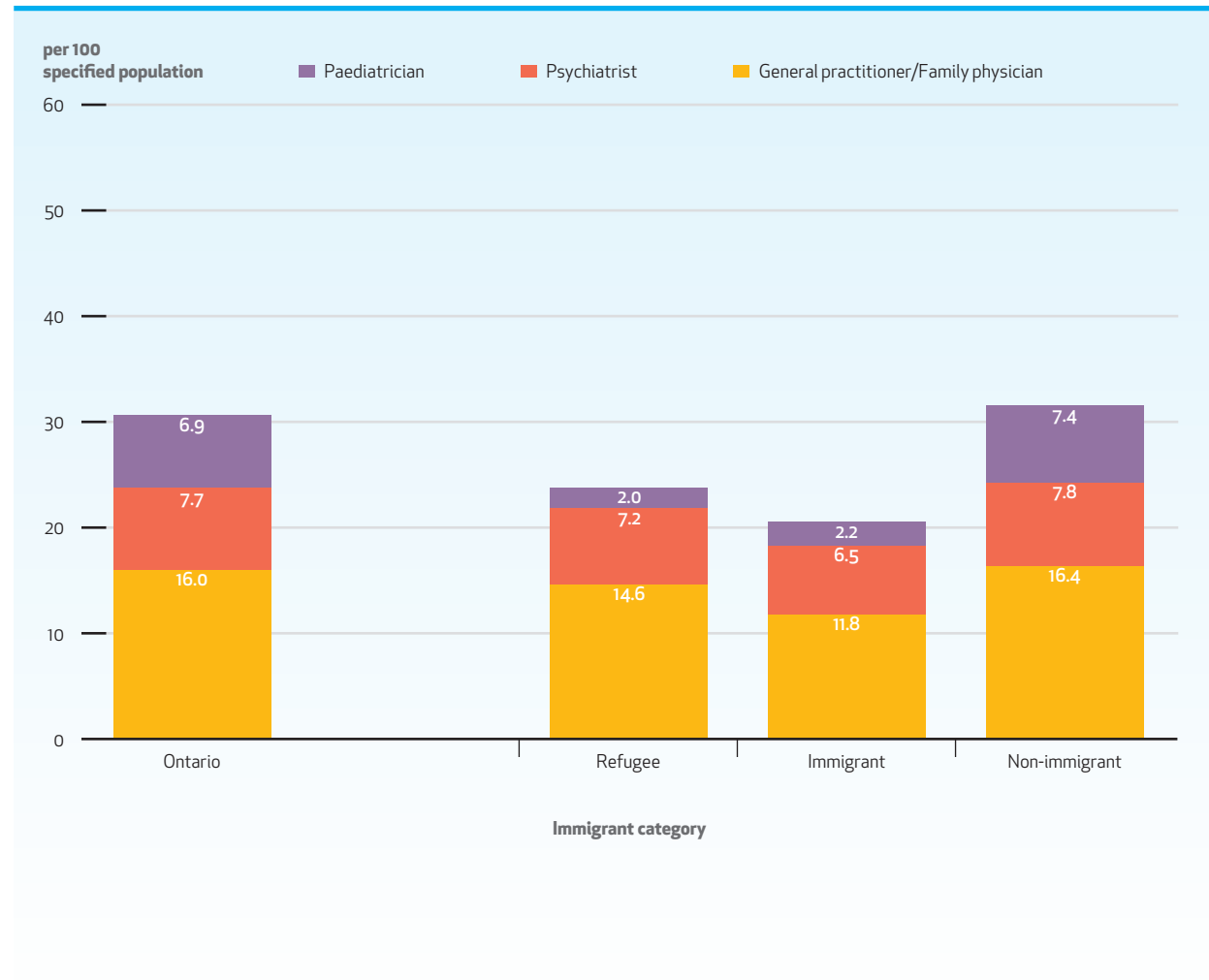
- Between 2012 and 2014, the average rate of MHA-related outpatient physician visits was highest in both the poorest and wealthiest neighbourhoods.
- The rate of visits to psychiatrists was highest in the wealthiest neighbourhoods.



**EXHIBIT 2.2.7** Number of outpatient physician visits related to mental health and addictions per 100 crude population aged 0 to 24 years, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

## Key Findings

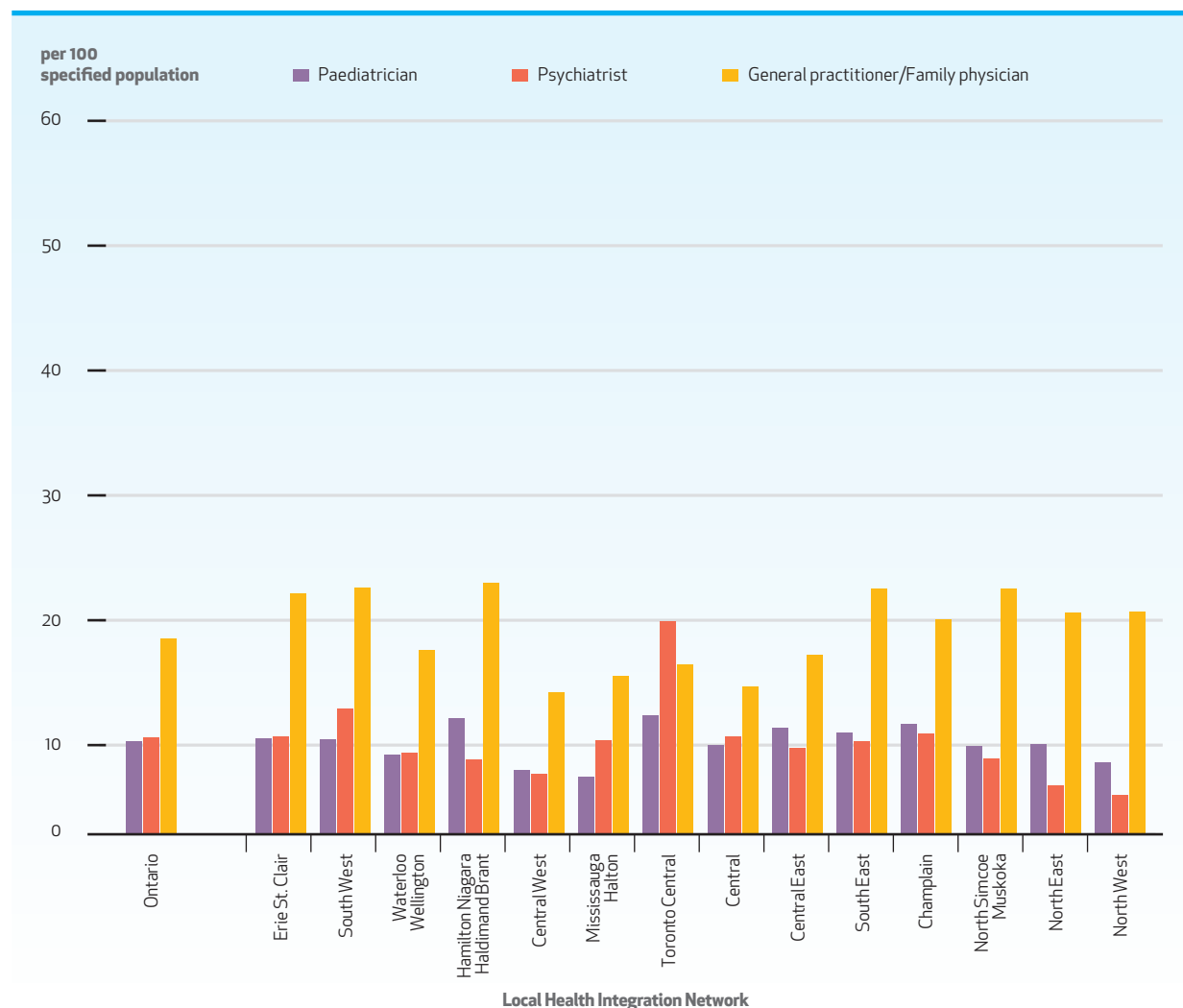
- Between 2010 and 2012, the average rate of MHA-related outpatient physician visits was highest among non-immigrants, followed by refugees.
- The rates of paediatrician visits was highest among non-immigrants, followed by immigrants.



**EXHIBIT 2.2.8** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

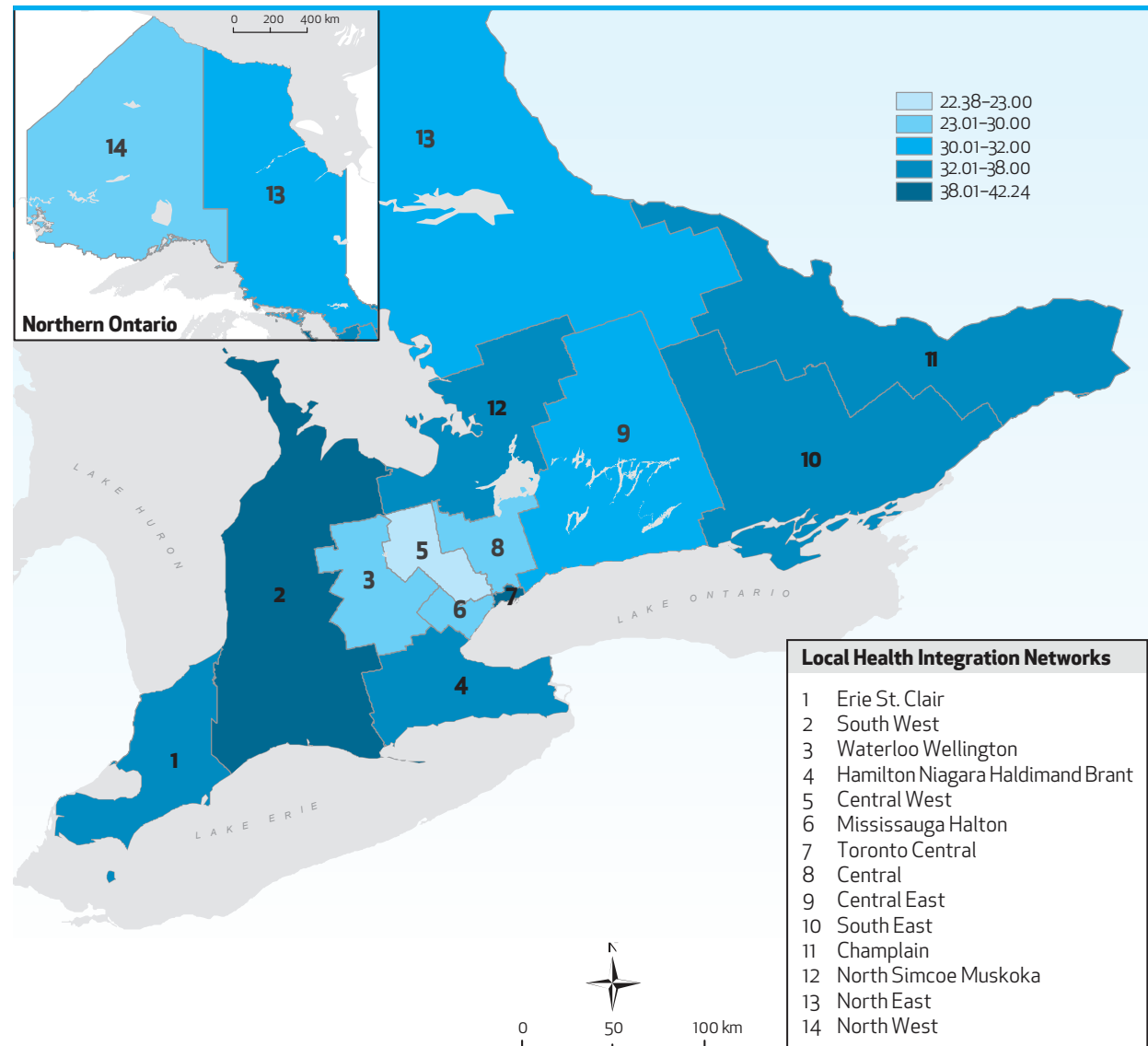
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient physician visits was highest for individuals in the Toronto Central and South West LHINs and lowest for those in the Central West LHIN.
- Specifically, the rate of outpatient visits to a psychiatrist was highest in the Toronto Central LHIN and lowest in the North East LHIN; the rate of outpatient physician visits to a GP/FP was highest in the Hamilton Niagara LHIN and lowest in the Central West LHIN; the rate of outpatient visits to a paediatrician was highest in the Toronto Central LHIN and lowest in the Mississauga Halton LHIN.
- In the Toronto Central LHIN, the rate of psychiatrist visits was higher than the rate of GP/FP visits.



**EXHIBIT 2.2.9** Number of outpatient visits to any physician specialty related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

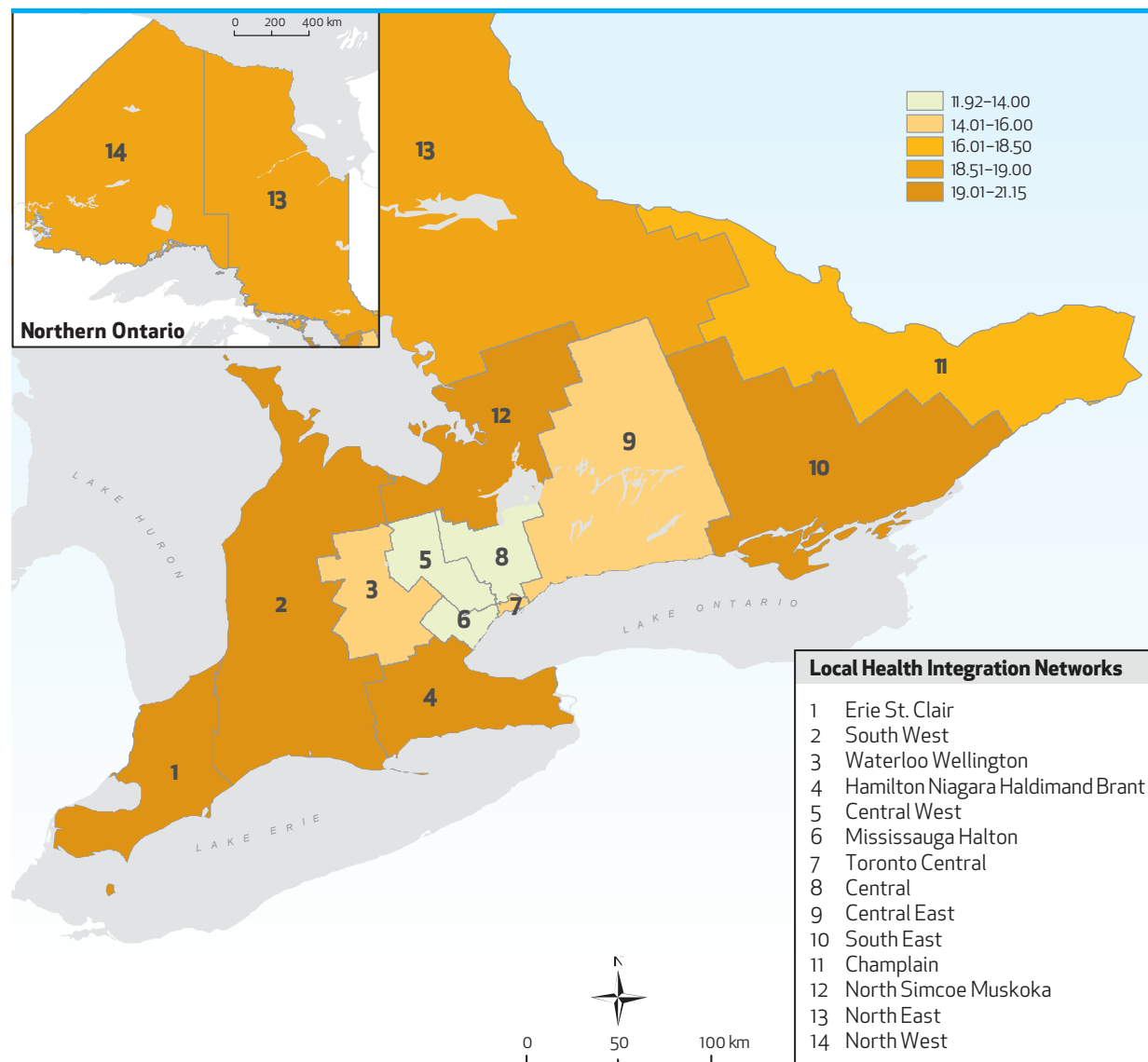
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits was highest for individuals in the Toronto Central and South West LHINs and lowest for those in the Central West LHIN.



**EXHIBIT 2.2.10** Number of outpatient visits to a general practitioner or family physician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

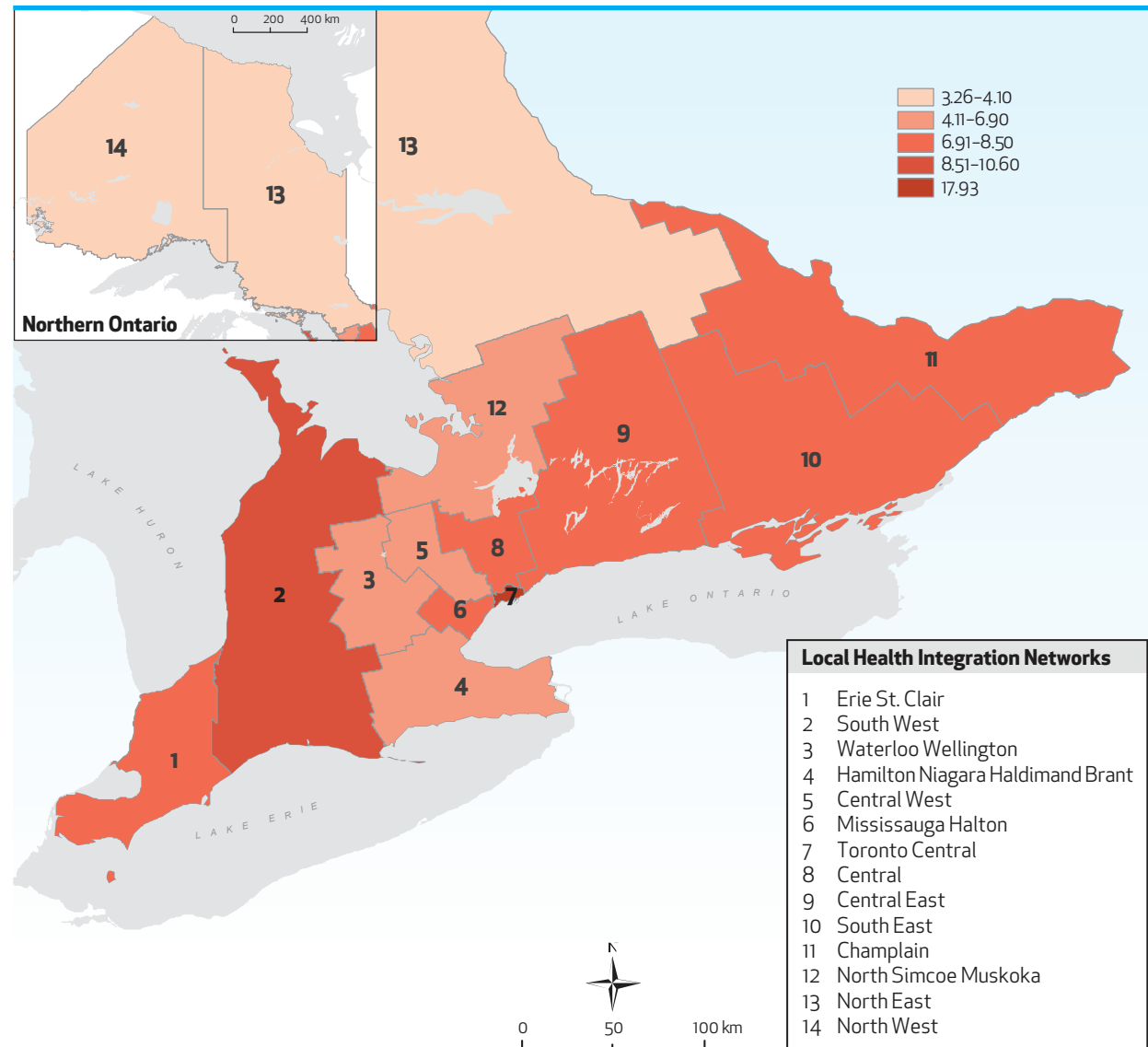
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits to a GP/FP was highest for children and youth in the Hamilton Niagara LHIN and lowest for those in the Central West LHIN.



**EXHIBIT 2.2.11** Number of outpatient visits to a psychiatrist per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

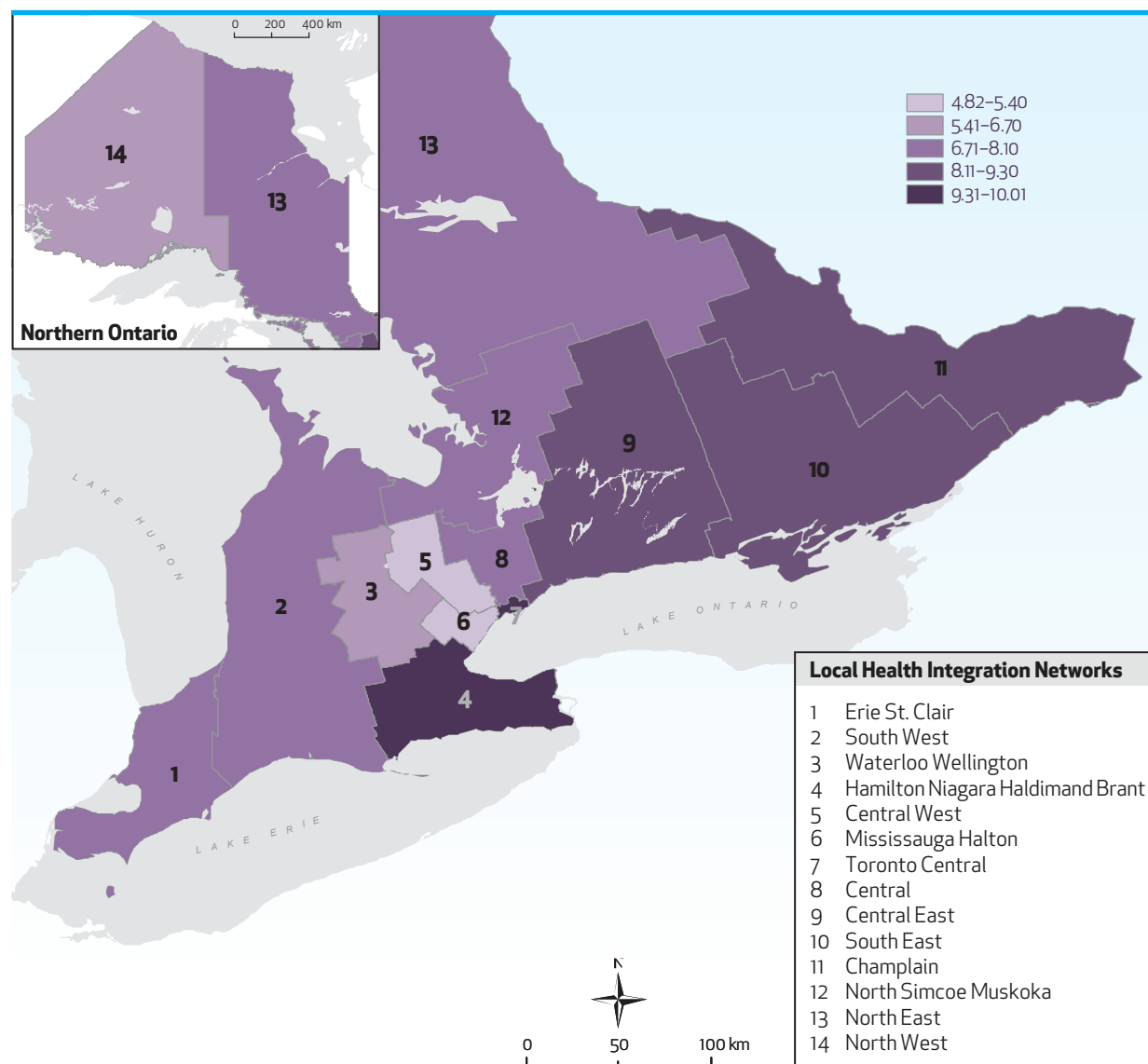
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits to a psychiatrist was highest for children and youth in the Toronto Central LHIN and lowest for those in the North East LHIN.



**EXHIBIT 2.2.12** Number of outpatient visits to a paediatrician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits to a paediatrician was highest for children and youth in the Toronto Central LHIN and lowest for those in the Mississauga Halton LHIN.

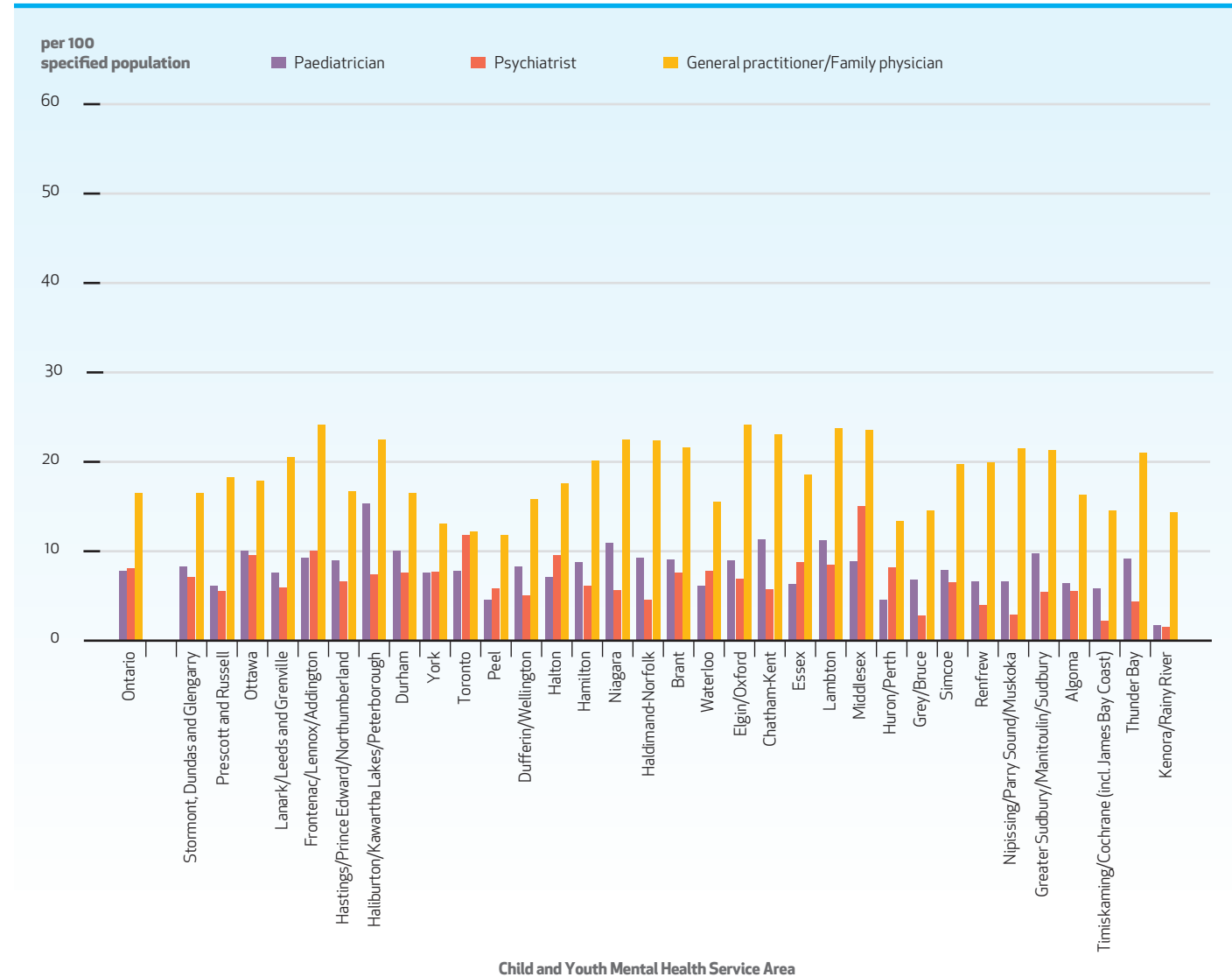




**EXHIBIT 2.2.13** Number of outpatient physician visits related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

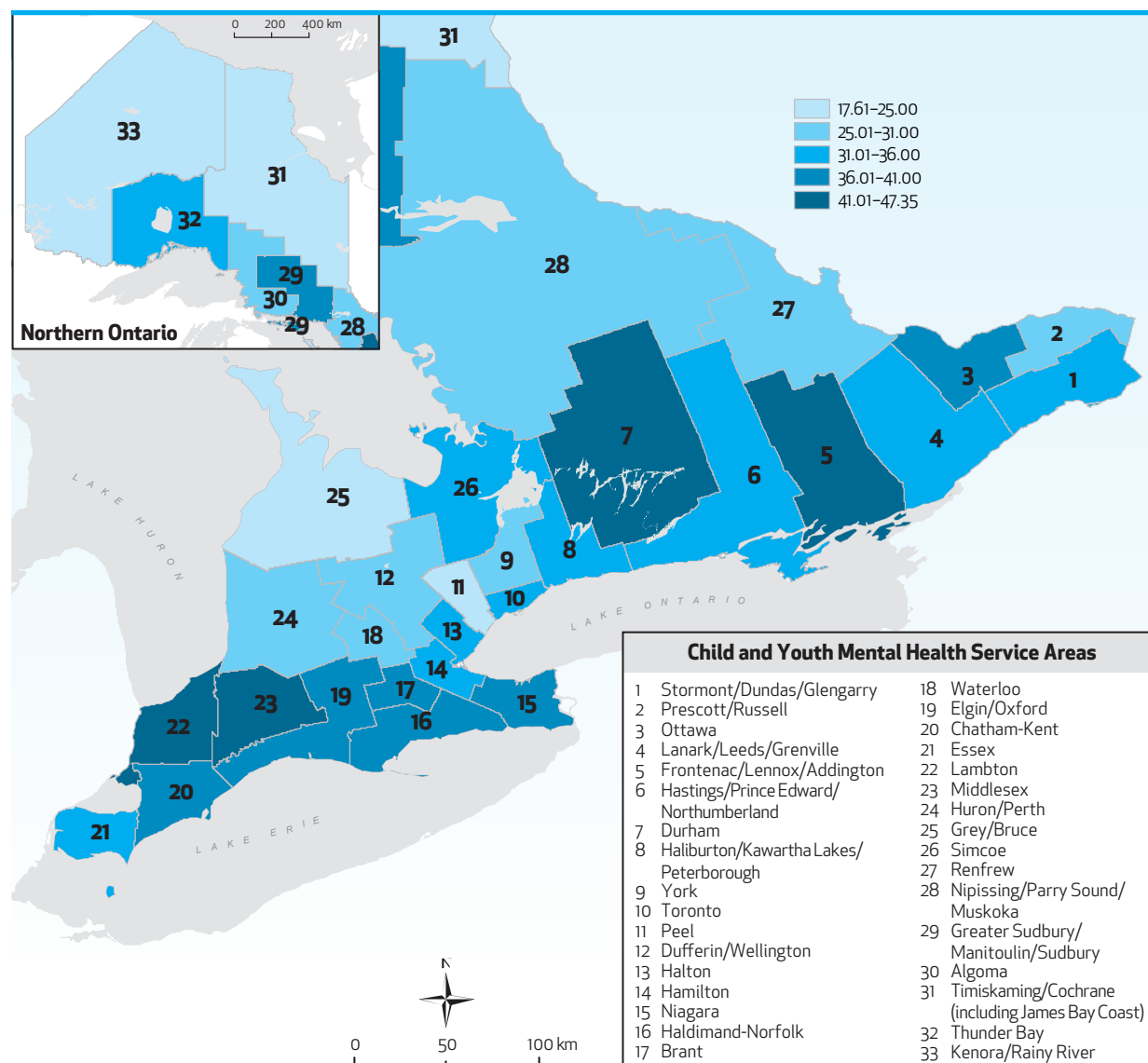
- Between 2012 and 2014 among Child and Youth Mental Health Service Areas, average age- and sex-standardized rates of MHA-related outpatient physician visits were highest in Middlesex and lowest in Kenora/Rainy River; this was driven largely by rates of visits to psychiatrists.
- MHA-related outpatient visits to GP/FPs were highest in Elgin/Oxford and Frontenac/Lennox/Addington, and lowest in Peel.
- MHA-related outpatient visits to paediatricians were highest in Haliburton/Kawartha Lakes/Peterborough and lowest in Kenora/Rainy River.



**EXHIBIT 2.2.14** Number of outpatient visits to any physician specialty related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

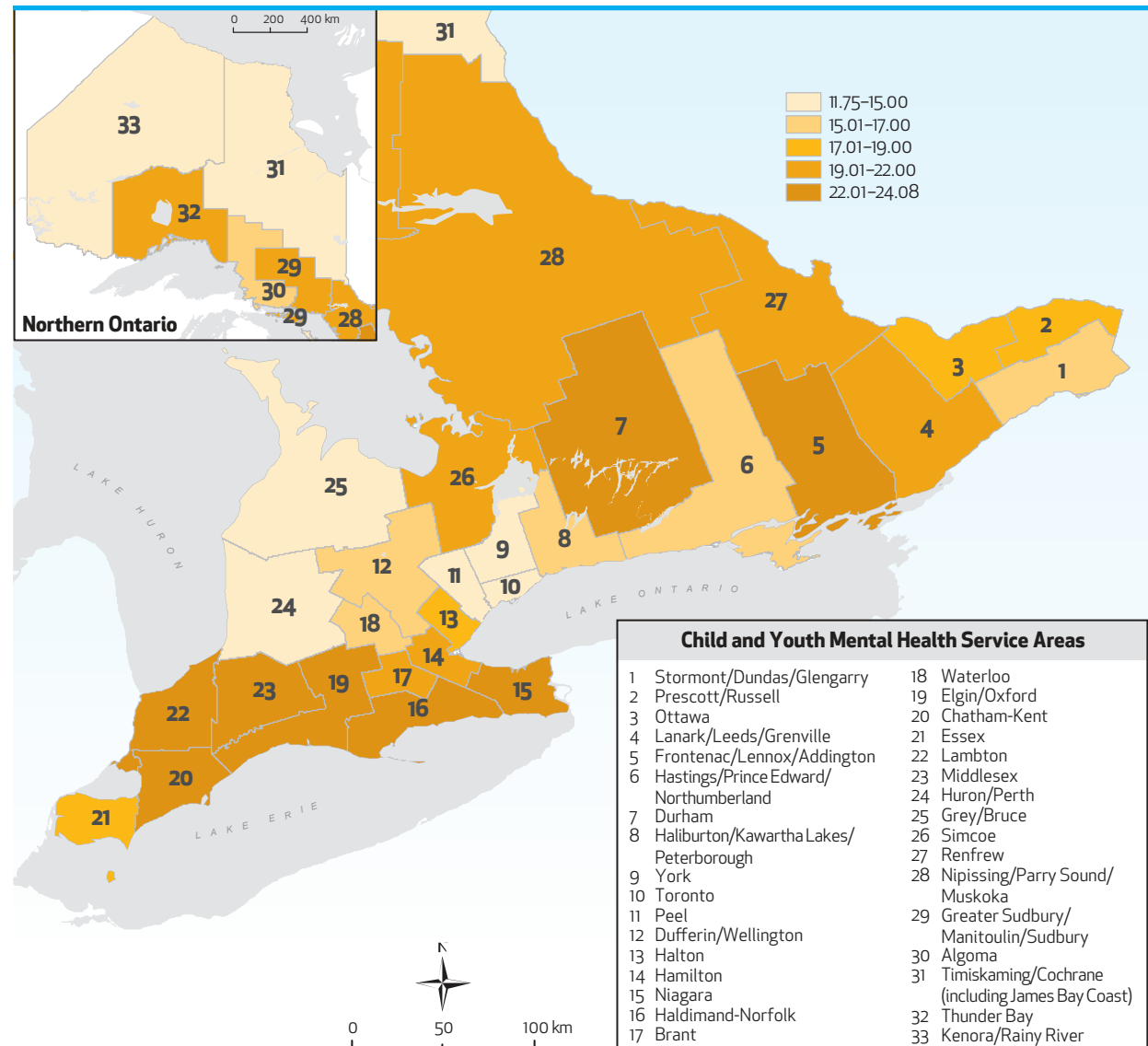
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient physician visits in the Child and Youth Mental Health Service Areas was highest in Middlesex and lowest in Kenora/Rainy River.



**EXHIBIT 2.2.15** Number of outpatient visits to a general practitioner or family physician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

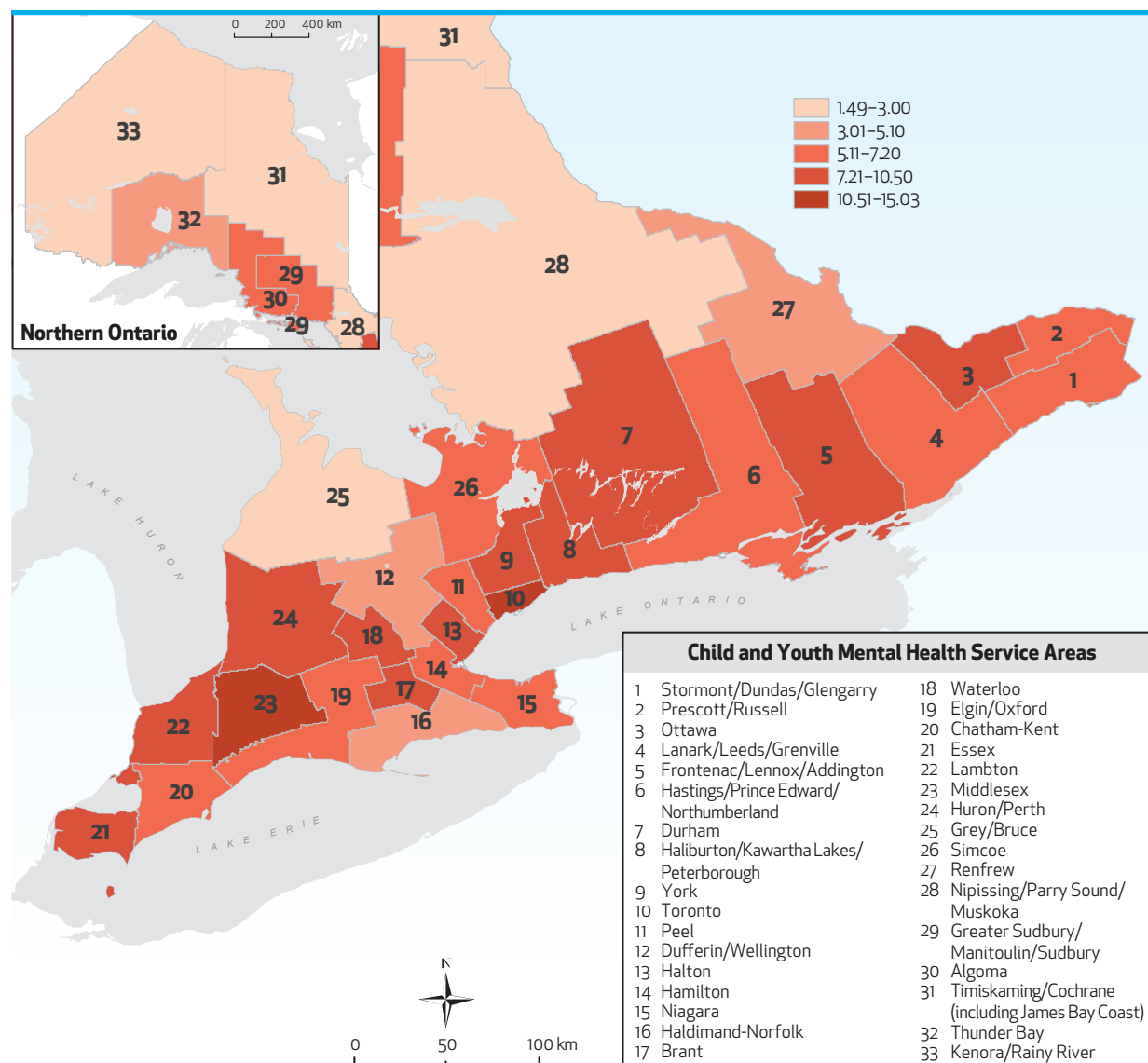
- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits to GP/FPs in the Child and Youth Mental Health Service Areas was highest in Elgin/Oxford and Frontenac/Lennox/Addington and lowest in Peel.



**EXHIBIT 2.2.16** Number of outpatient visits to a psychiatrist per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

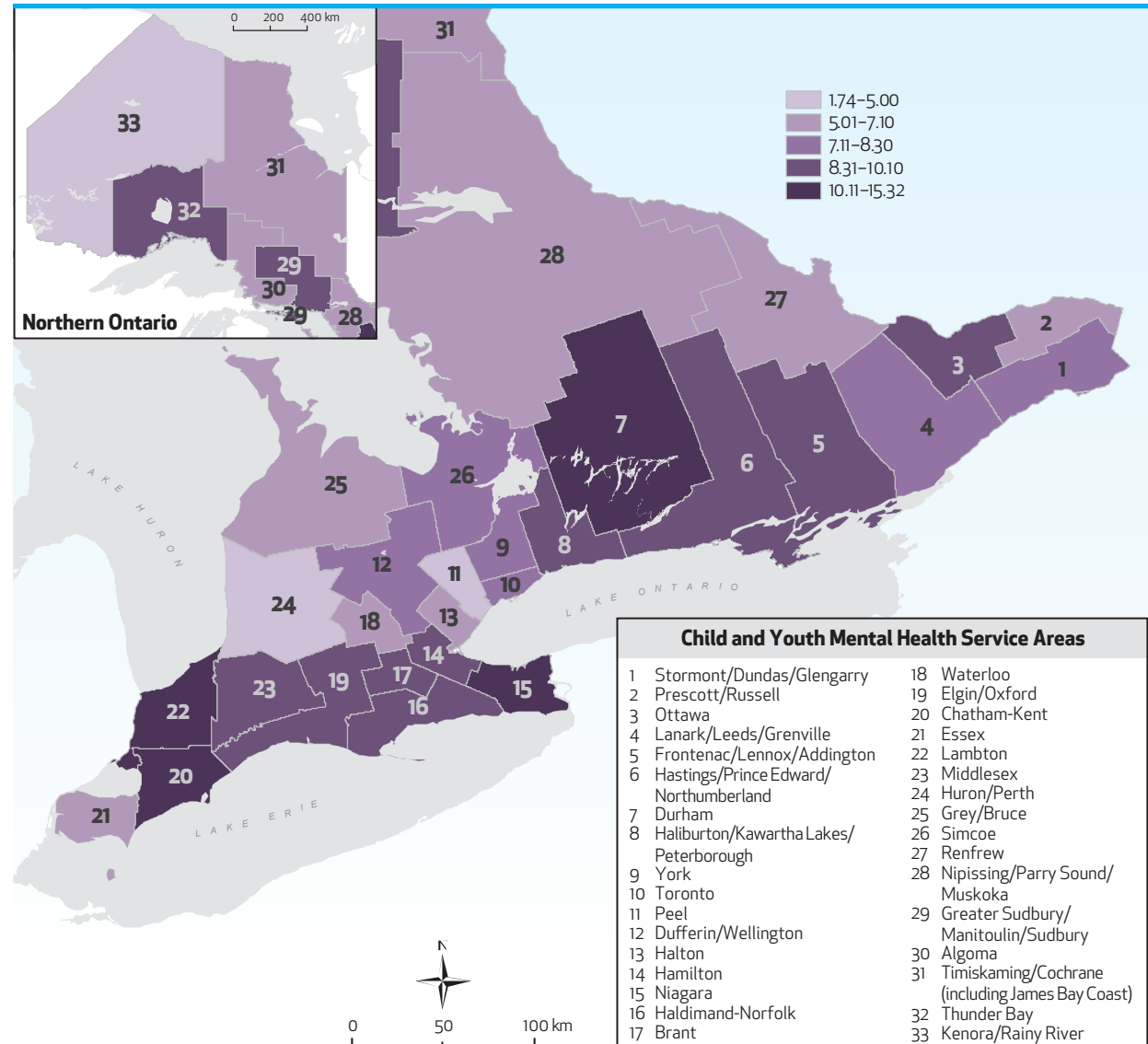
- Between 2012 and 2014, the average age- and sex-standardized rate of outpatient visits to a psychiatrist in the Child and Youth Mental Health Service Areas was highest in Middlesex and lowest in Kenora/Rainy River.



**EXHIBIT 2.2.17** Number of outpatient visits to a paediatrician related to mental health and addictions per 100 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of MHA-related outpatient visits to a paediatrician in the Child and Youth Mental Health Service Areas was highest in Haliburton/Kawartha Lakes/Peterborough and lowest in Kenora/Rainy River.



## 2.3 Rate at which children and youth were treated for alcohol and drug problems

### Rationale

Tracking drug and alcohol treatment rates over time may provide insight into both the prevalence of these problems, and access to and use of such services.

### Results

Individuals may list up to five problem substances during intake for treatment, so rates for different substances are not mutually exclusive. Overall, rates at which children and youth were treated for alcohol and drug problems decreased over time. Rates were higher for males than females and were higher in the older age groups. The highest rates of treatment were for cannabis and alcohol. While treatment rates for most problem substances declined over time, those for tobacco and opioids increased. Treatment rates were highest in the North West and North East LHINs and lowest in the Central LHIN.

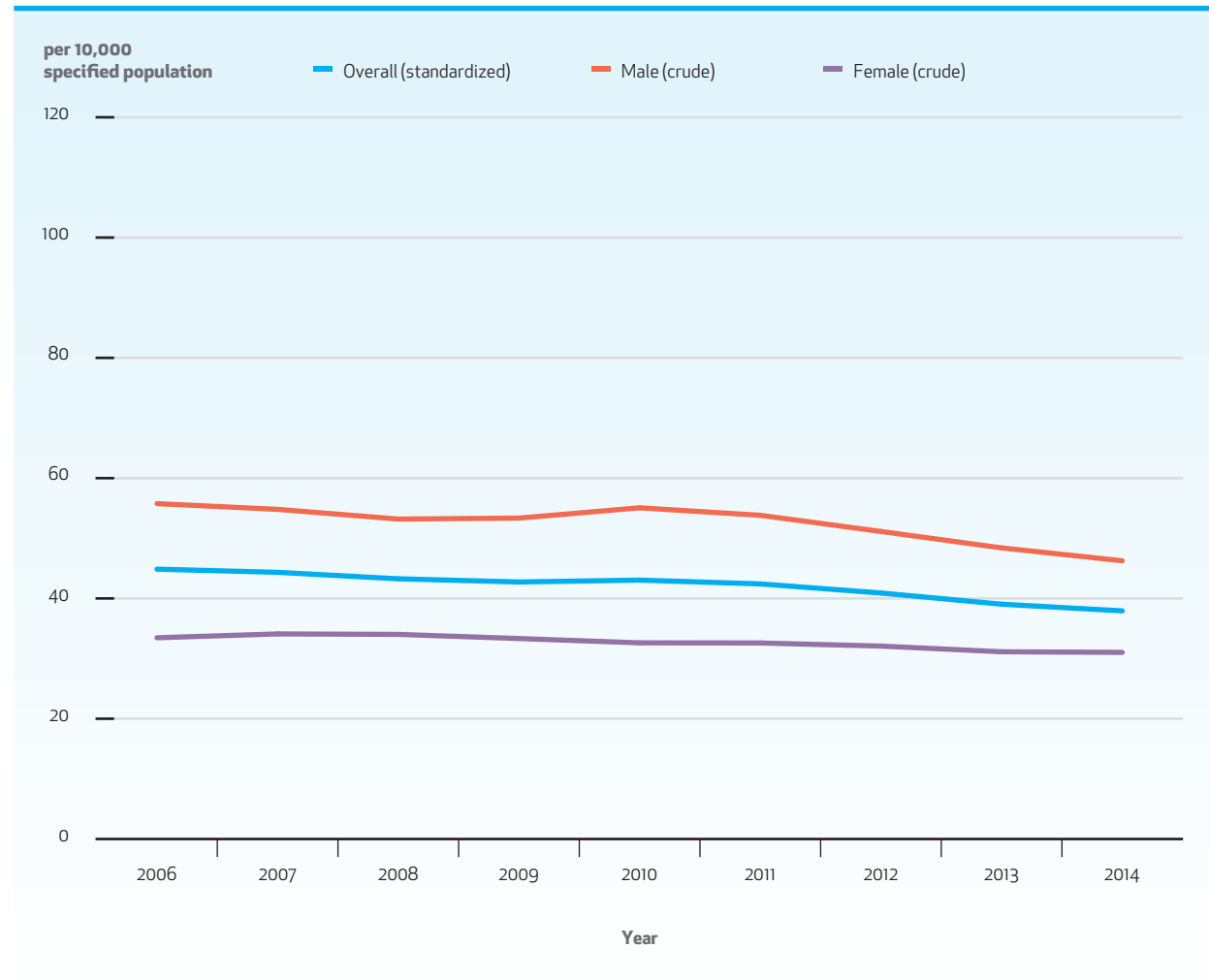
### Interpretation

Although the rates at which children and youth were treated for alcohol and drug problems declined over time, the fact that rates were highest in the northern regions suggests there may be a need for targeted prevention and treatment strategies in these regions. The increasing rates of opioid-related treatment over time may reflect both the prevalence of the problem as well as the current focus on treatment.

**EXHIBIT 2.3.1** Number of children and youth treated for alcohol and drug problems per 10,000 population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

## Key Findings

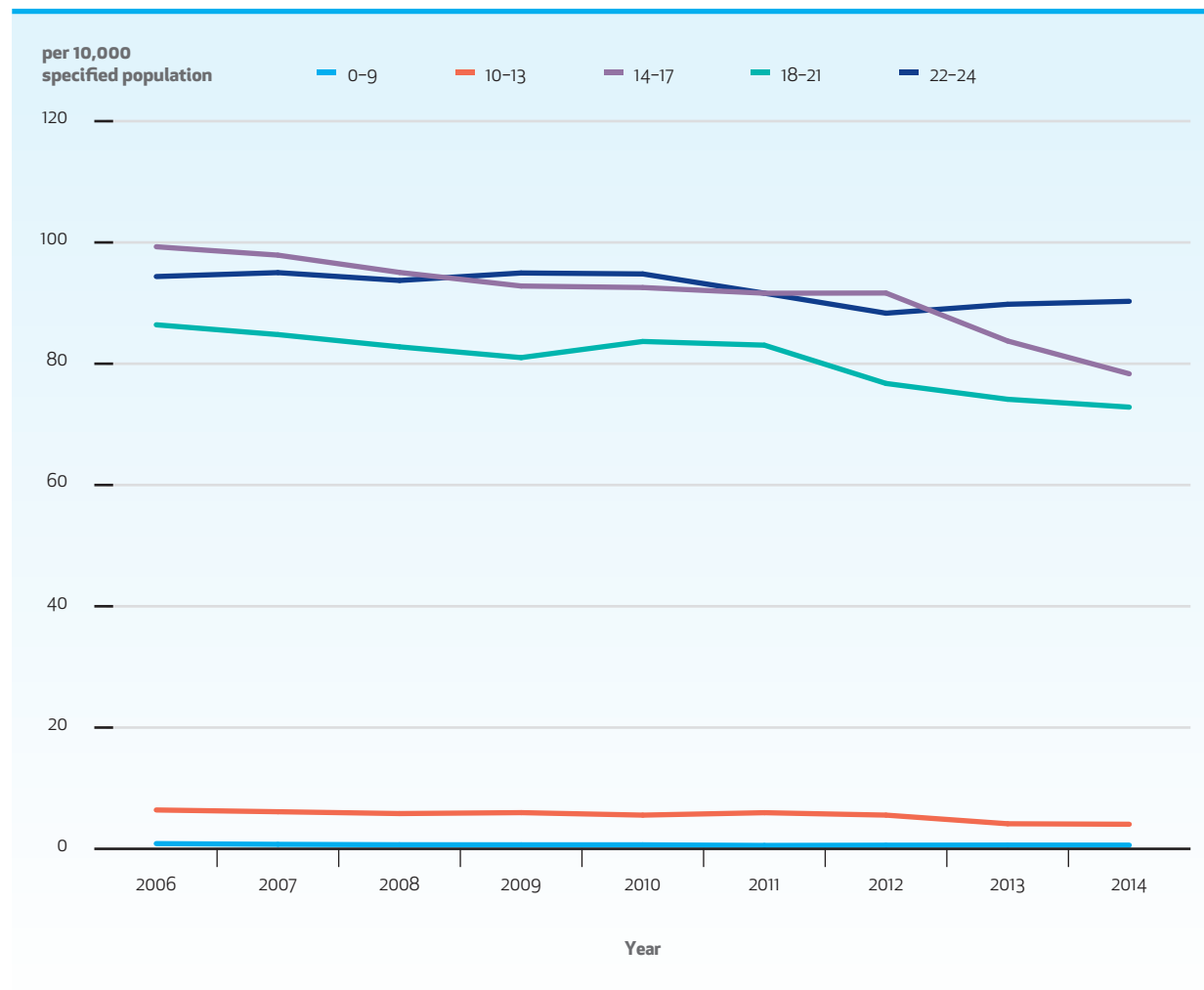
- Between 2006 and 2014, the overall rate at which children and youth were treated for alcohol and drug problems decreased slightly over time.
- The decrease was greater for males.



**EXHIBIT 2.3.2** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

## Key Findings

- Between 2006 and 2014, the rates at which children and youth were treated for alcohol and drug problems decreased for all age groups, with 14- to 17-year-olds experiencing the largest decrease over time.
- Treatment rates were lowest for children aged 0 to 9 years.

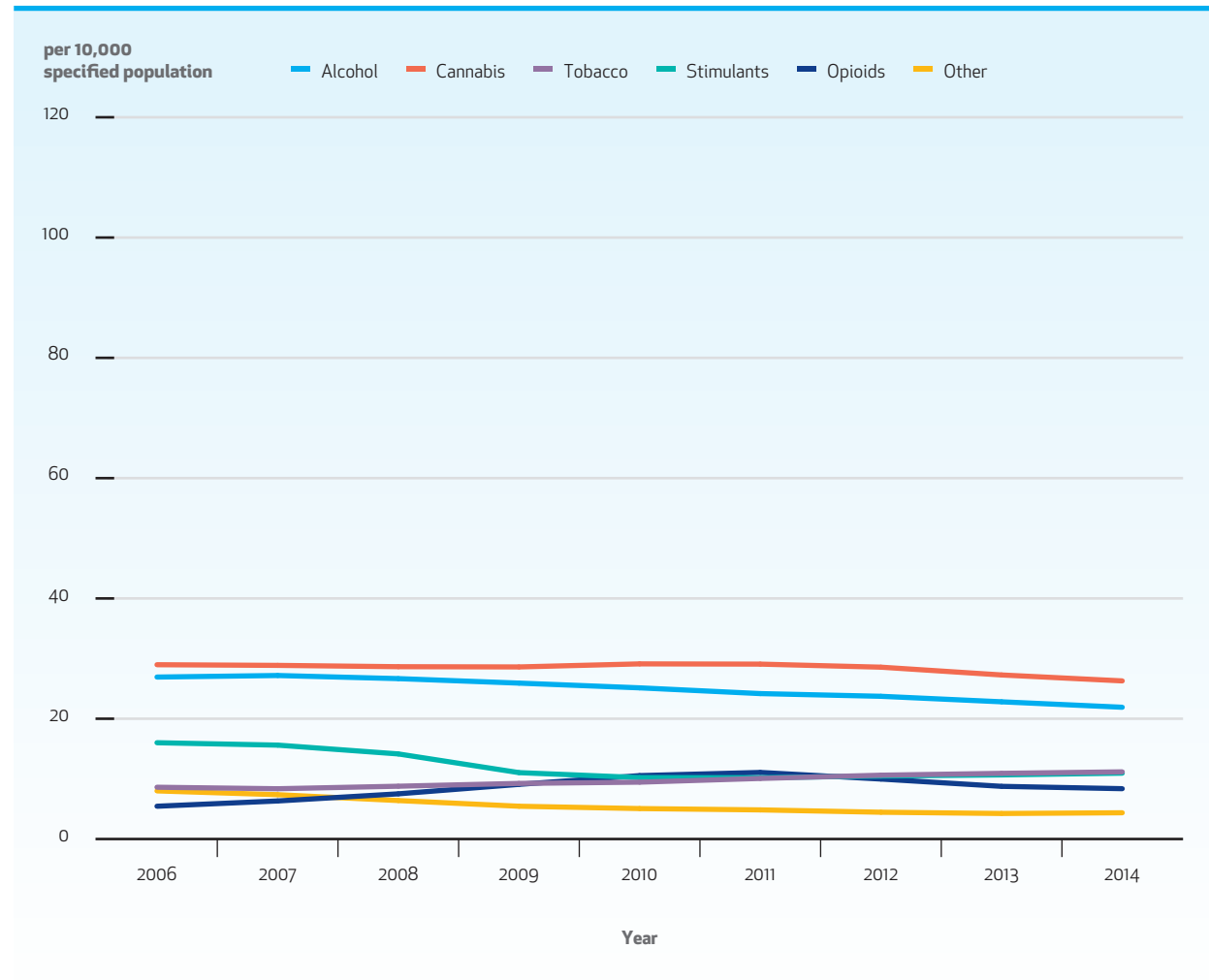




**EXHIBIT 2.3.3** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by type of substance, in Ontario, 2006 to 2014

## Key Finding

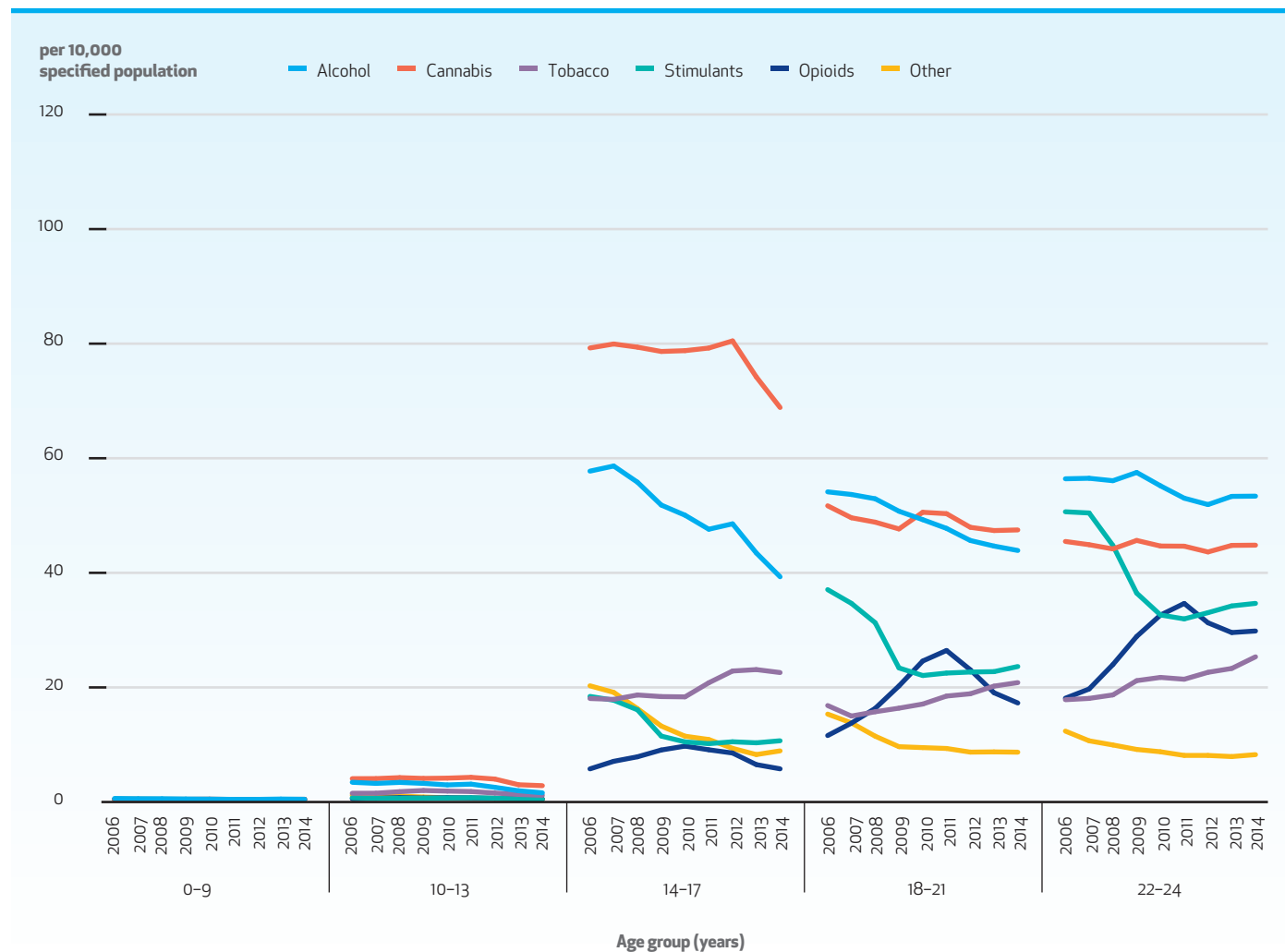
- Between 2006 and 2014, the rates at which children and youth were treated for alcohol and drug problems, by type of substance, decreased slightly. The largest decrease was observed among those treated for stimulant use.



**EXHIBIT 2.3.4** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group and type of substance, in Ontario, 2006 to 2014

## Key Findings

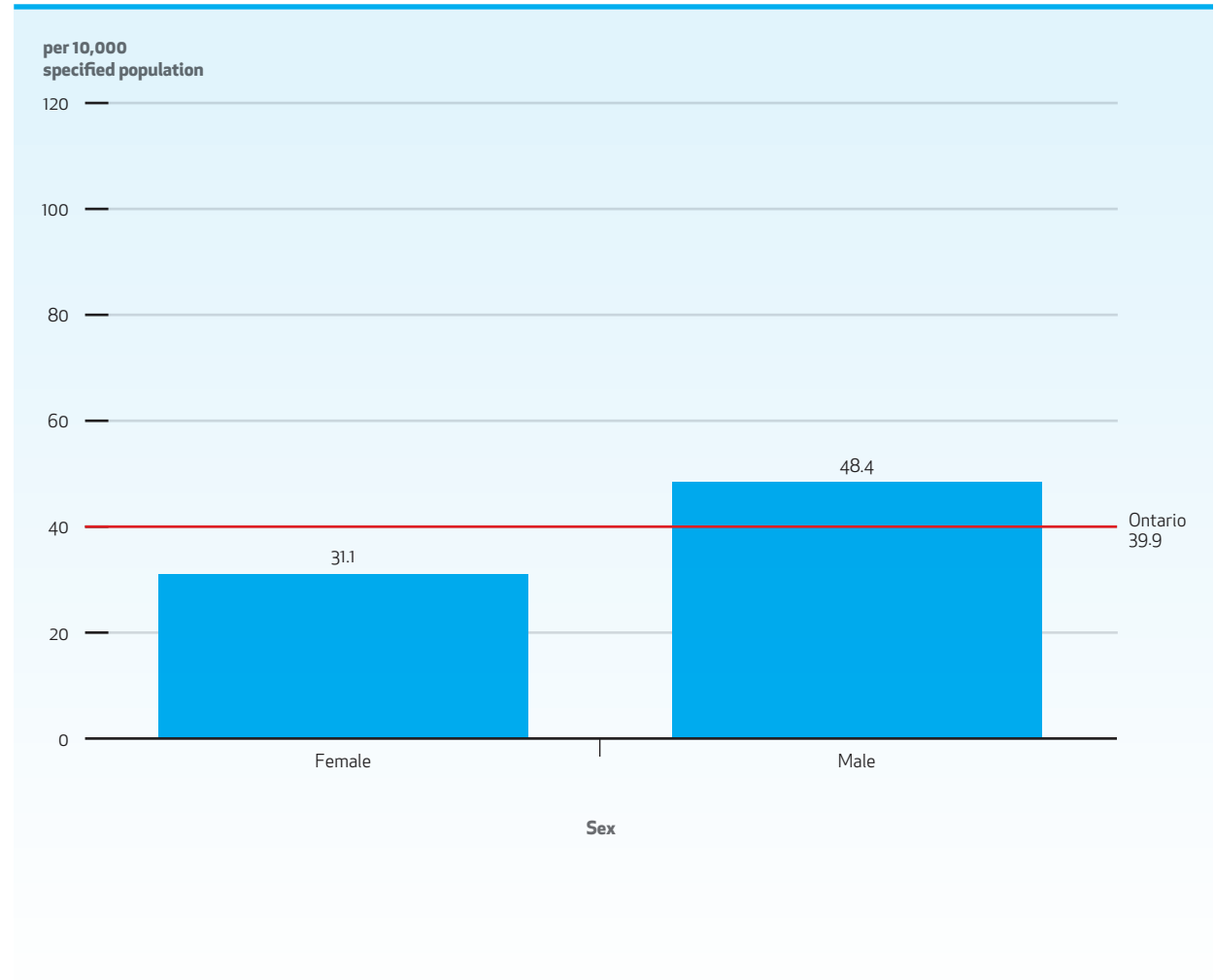
- The rates at which children and youth were treated for cannabis, alcohol, stimulants and other drug problems decreased between 2006 and 2014.
- The greatest drop in rates of treatment for cannabis and alcohol use was among 14- to 17-year-olds, and the greatest drop in rates of treatment for stimulant use was among 22- to 24-year-olds.
- Rates of treatment for tobacco and opioid use increased among youth aged 14 to 24 and 18 to 24, respectively.



**EXHIBIT 2.3.5** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

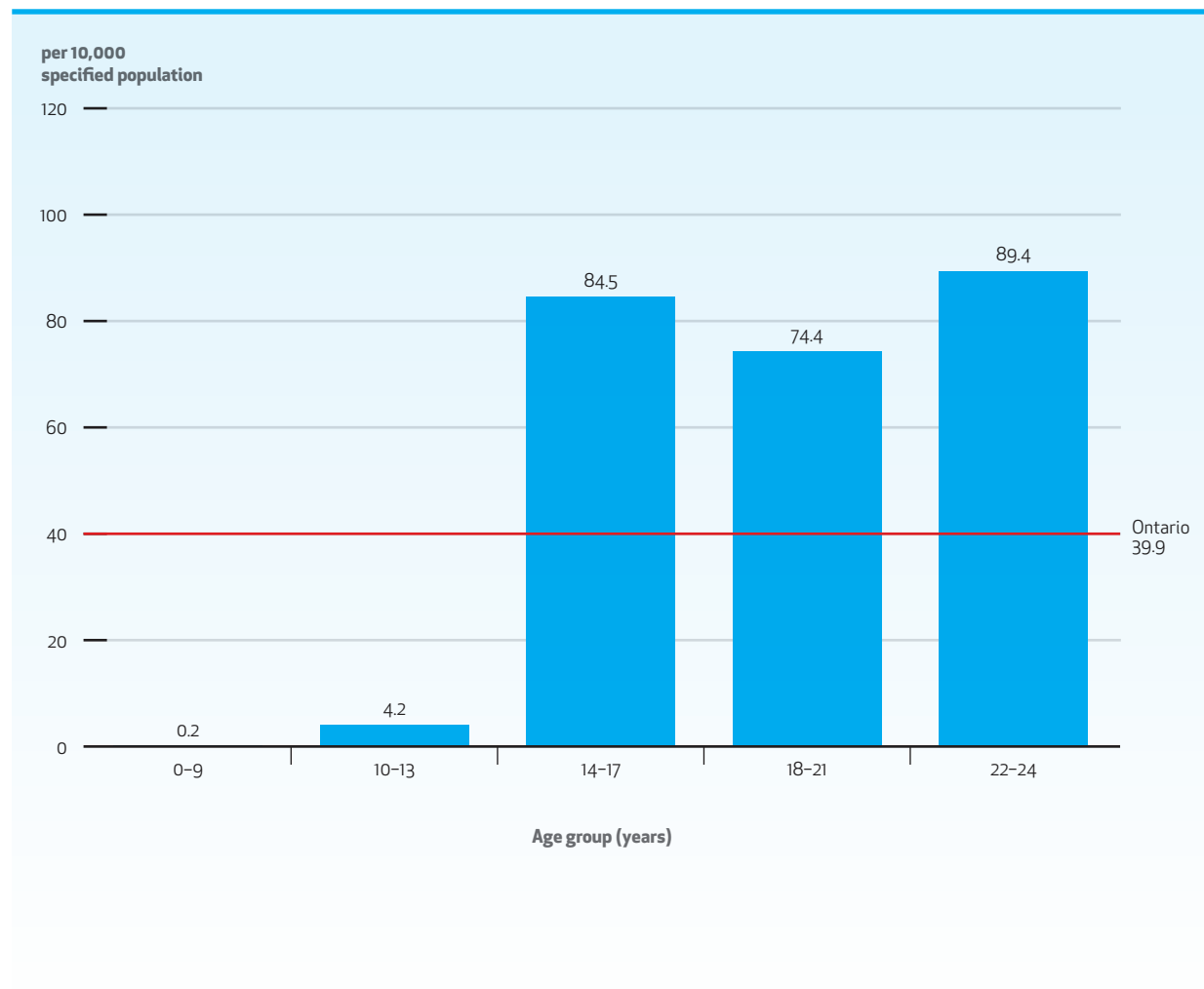
- Between 2012 and 2014, the average rate at which children and youth were treated for alcohol and drug problems was higher for males.



**EXHIBIT 2.3.6** Number of children and youth treated for alcohol and drug problems per 10,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

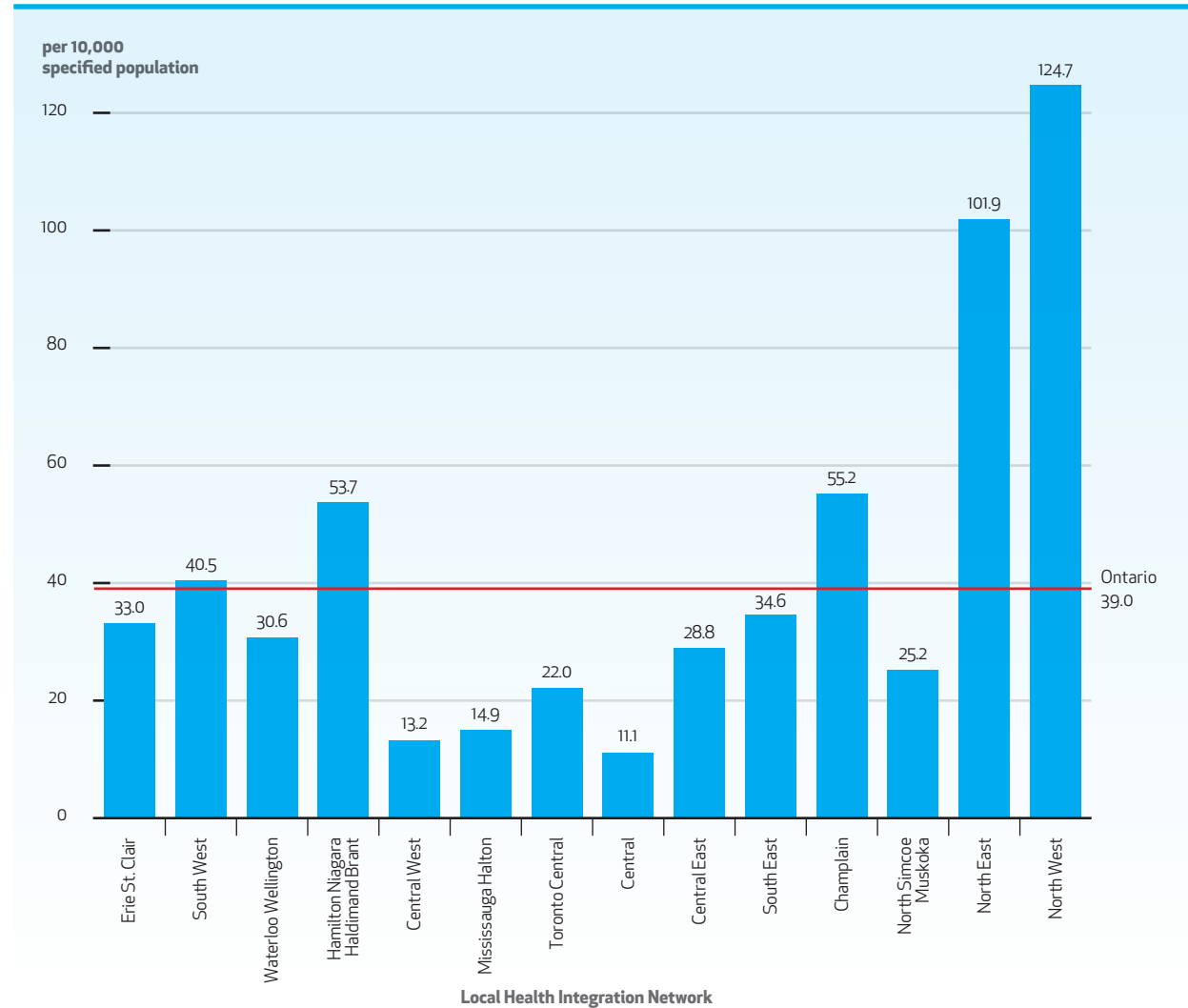
- Between 2012 and 2014, the average rate at which children and youth were treated for alcohol and drug problems was highest for 22- to 24-year-olds.



**EXHIBIT 2.3.7** Number of children and youth treated for alcohol and drug problems per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

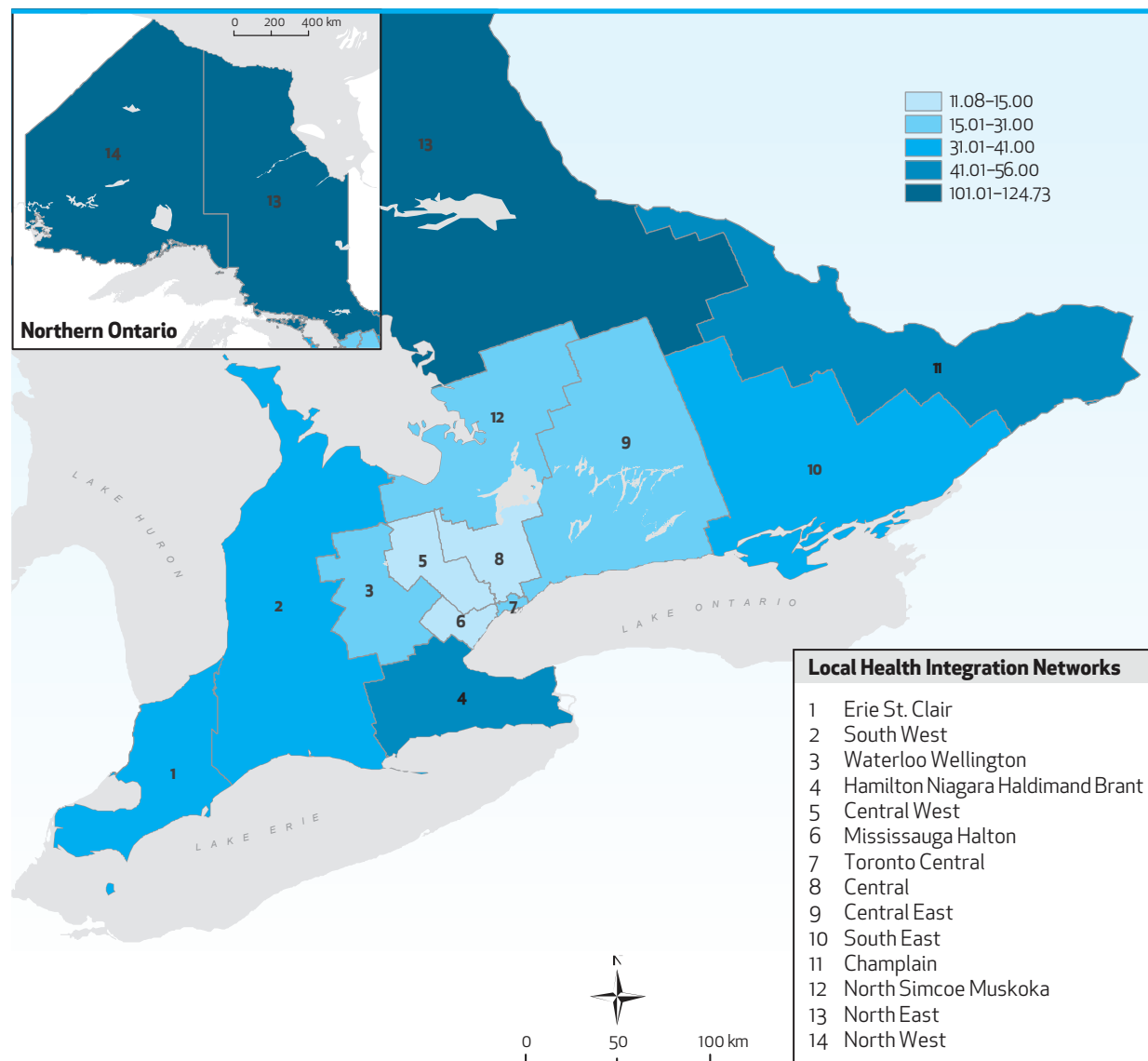
- Between 2012 and 2014, the average age- and sex-standardized rate at which children and youth were treated for alcohol and drug problems was highest in the North East and North West LHINs and lowest in the Central LHIN.



**EXHIBIT 2.3.8** Number of children and youth treated for alcohol and drug problems per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate at which children and youth were treated for alcohol and drug problems was highest in the North East and North West LHINs and lowest in the Central LHIN.



## 2.4 Rate of hospitalizations for eating disorders among children and youth

### Rationale

Tracking rates of hospitalizations for eating disorders among children and youth can provide insight on access to and utilization of such services. This indicator captures only hospitalizations in Ontario and does not reflect all eating disorder treatment, as a substantial proportion of child and youth eating disorders are managed in ambulatory settings.

### Results

Rates of hospitalizations for eating disorders were stable from 2003 to 2010 but have been increasing since. This increase in hospitalizations was only observed among females and among children and youth aged 14 to 17 years. The median length of stay for an eating disorder hospitalization reached a peak of about 35 days between 2007 and 2009; however, this had dropped to 21 days in 2014.

An income gradient was observed in which rates of hospitalizations were higher among children and youth living in more affluent neighbourhoods and lower among those living in the poorer neighbourhoods. Across immigrant categories, the hospitalization rate for eating disorders was higher for non-immigrant children and youth compared to refugees and immigrants. Variation in rates of hospitalizations were seen across Local Health Integration Networks and Child and Youth Mental Health Service Areas. By LHIN, the highest rates were found in the North East LHIN, while among Child and Youth Mental Health Service Areas, Greater Sudbury/Manitoulin/Sudbury, Grey/Bruce, and Algoma had the highest rates of hospitalization for eating disorders.

### Interpretation

Rates of hospitalizations for eating disorders have increased since 2010, particularly among females and youth aged 14 to 17 years. The rise in hospitalizations for eating disorders, as well as the decline in hospital length of stay, may be attributed to recent provincial efforts to increase resources for inpatient eating disorders services, as part of Ontario's mental health and addictions strategy. The variation seen in hospitalizations by sex and across age groups has been reported in past research.<sup>1</sup> Furthermore, variation across neighbourhood income quintiles may be a result of inequities in access or may be due to a higher prevalence of eating disorders in higher-income individuals.<sup>2,3</sup>

<sup>1</sup>Smink FR, van Hoeken D, Hoek HW. Epidemiology of eating disorders: incidence, prevalence and mortality rates. *Curr Psychiatry Rep.* 2012; 14(4):406–14.

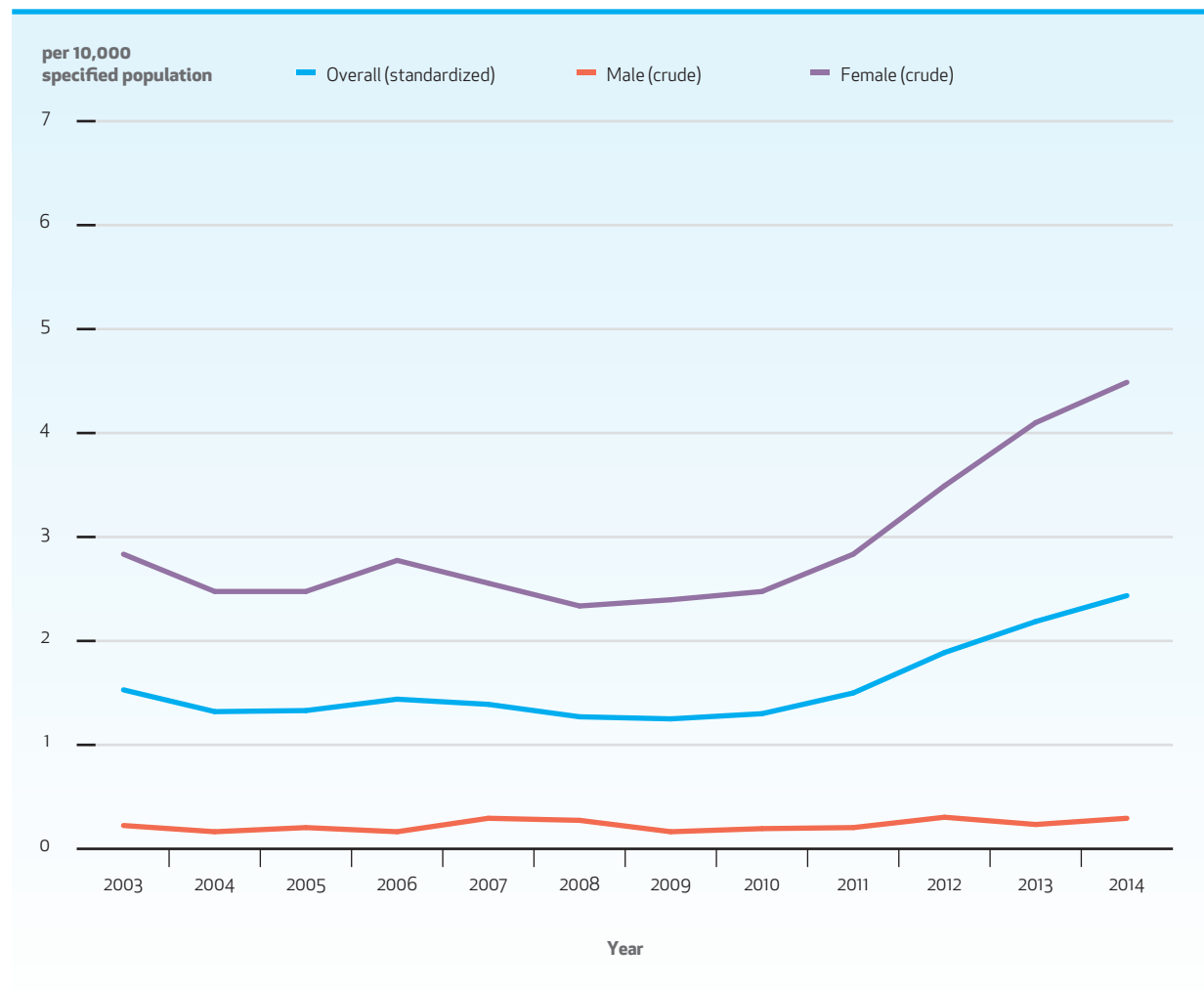
<sup>2</sup>Becker AE, Hadley Arrindell A, Perloe A, Fay K, Striegel-Moore RH. A qualitative study of perceived social barriers to care for eating disorders: perspectives from ethnically diverse health care consumers. *Int J Eat Disord.* 2010; 43(7):633–47.

<sup>3</sup>Ersine HE, Whiteford HA, Pike KM. The global burden of eating disorders. *Curr Opin Psychiatry.* 2016; 29(6):346–53.

**EXHIBIT 2.4.1** Number of hospitalizations for eating disorders per 10,000 population aged 7 to 24 years, overall and by sex, in Ontario, 2003 to 2014

## Key Finding

- Prior to 2010, rates of hospitalization for eating disorders were relatively stable; however, after 2011, rates increased, driven by females.

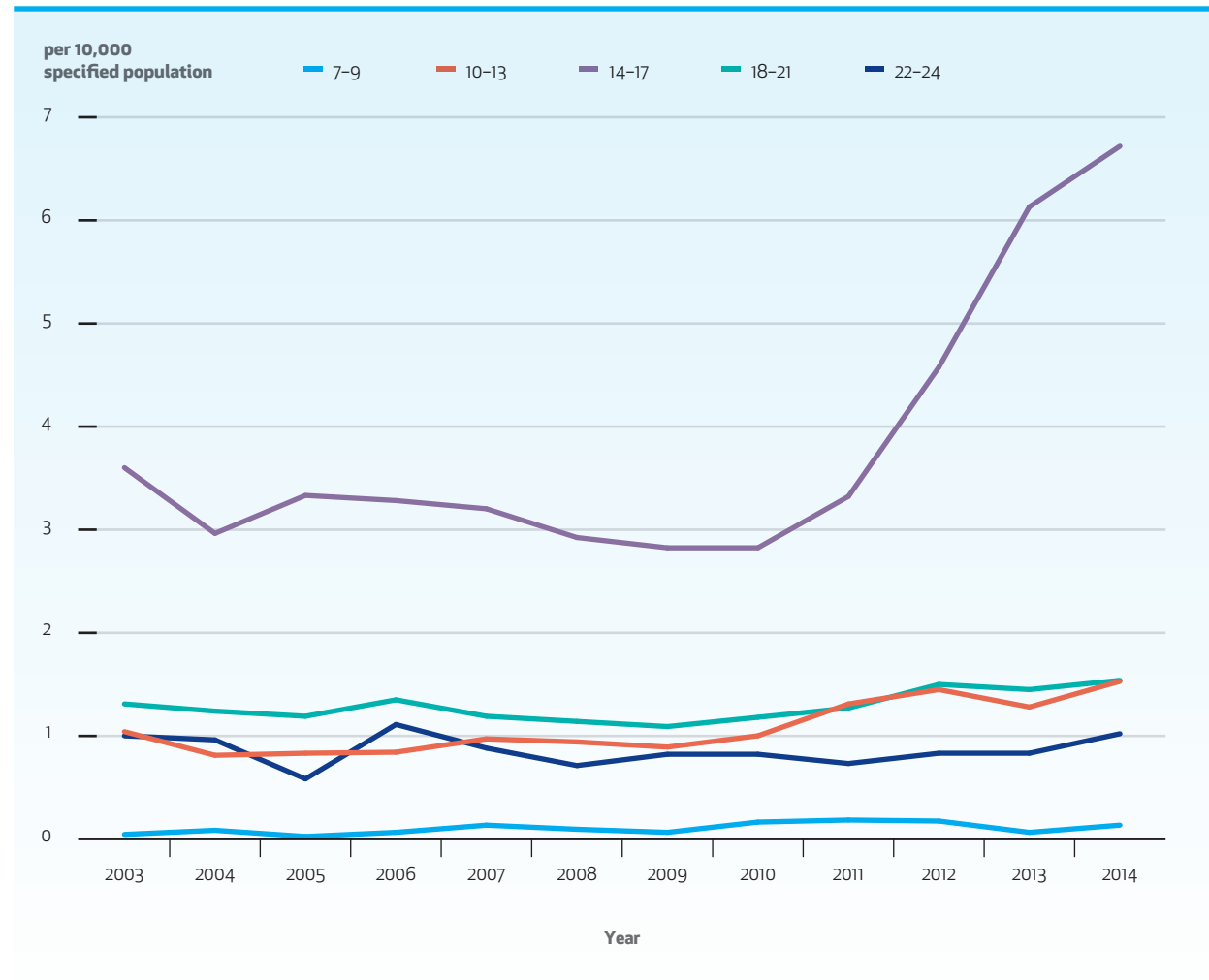




**EXHIBIT 2.4.2** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by age group, in Ontario, 2003 to 2014

## Key Findings

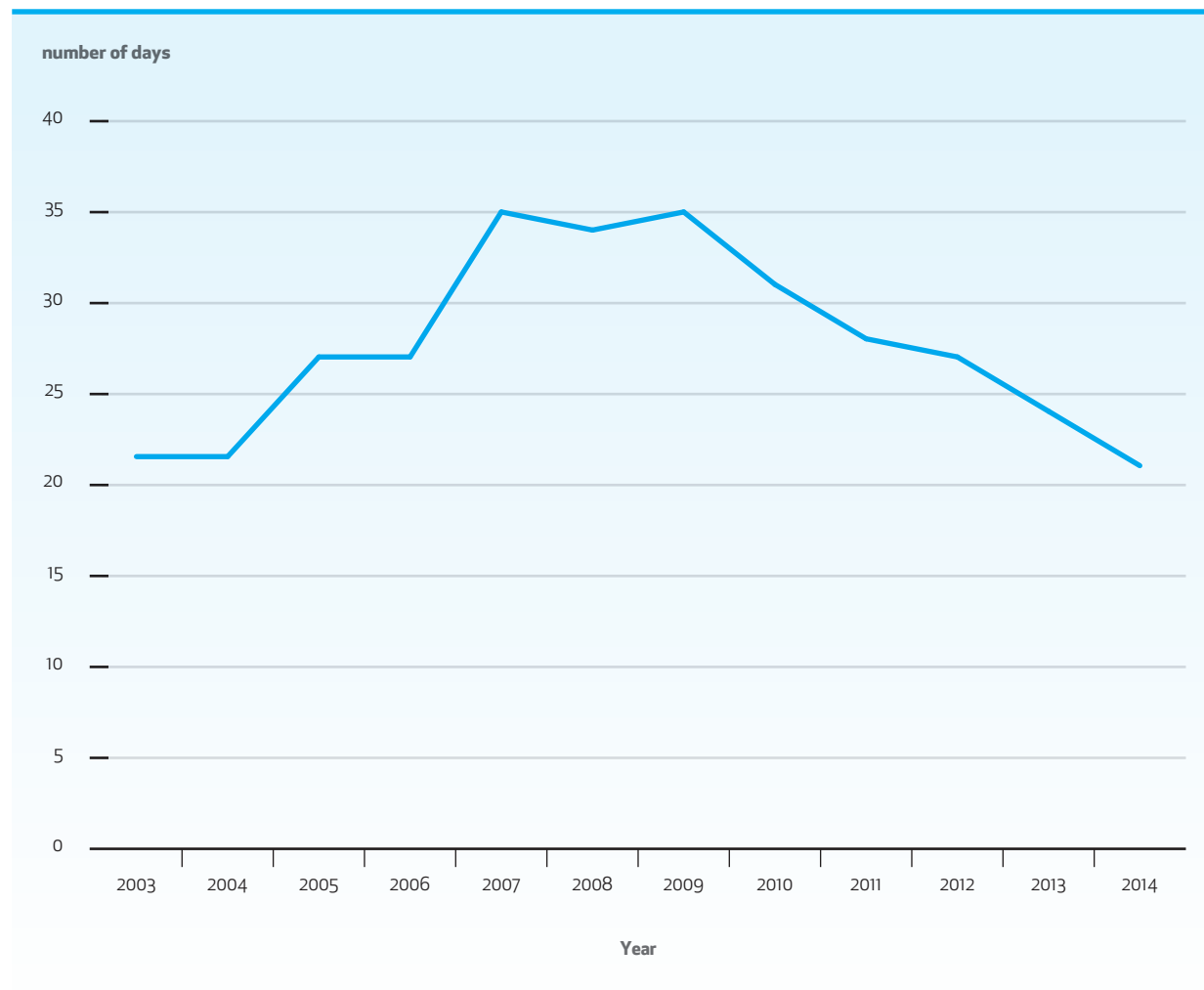
- The rates of hospitalizations for eating disorders was highest among youth aged 14 to 17.
- In this age group, the rate of hospitalizations increased over time, while for all other age groups no change occurred.



### EXHIBIT 2.4.3 Median length of stay in hospital for eating disorders among children and youth aged 7 to 24 years, in Ontario, 2003 to 2014

#### Key Finding

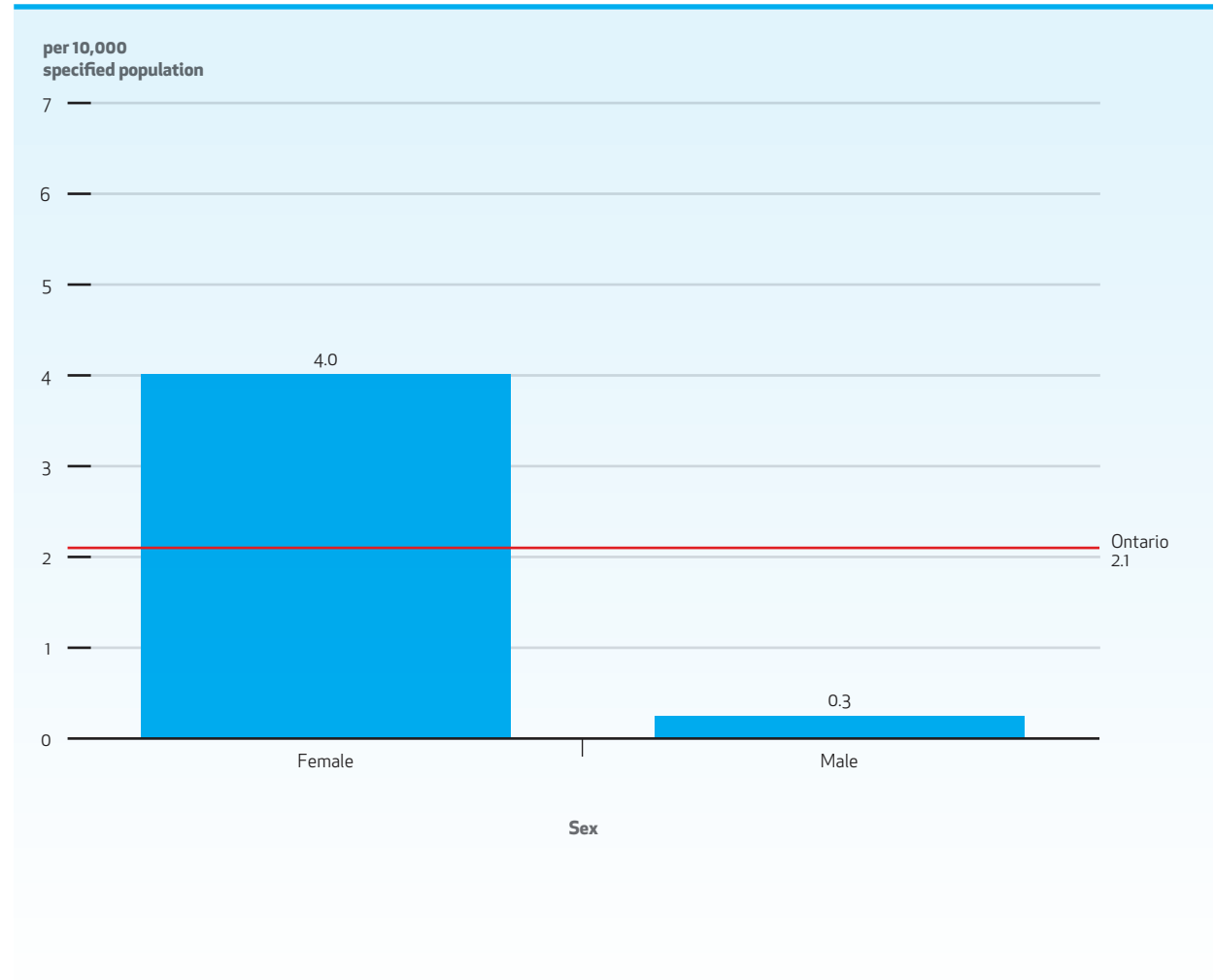
- The median length of stay in hospital for an eating disorder was highest between 2007 and 2009 at 35 days; in 2014, it had dropped to 21 days.



**EXHIBIT 2.4.4** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

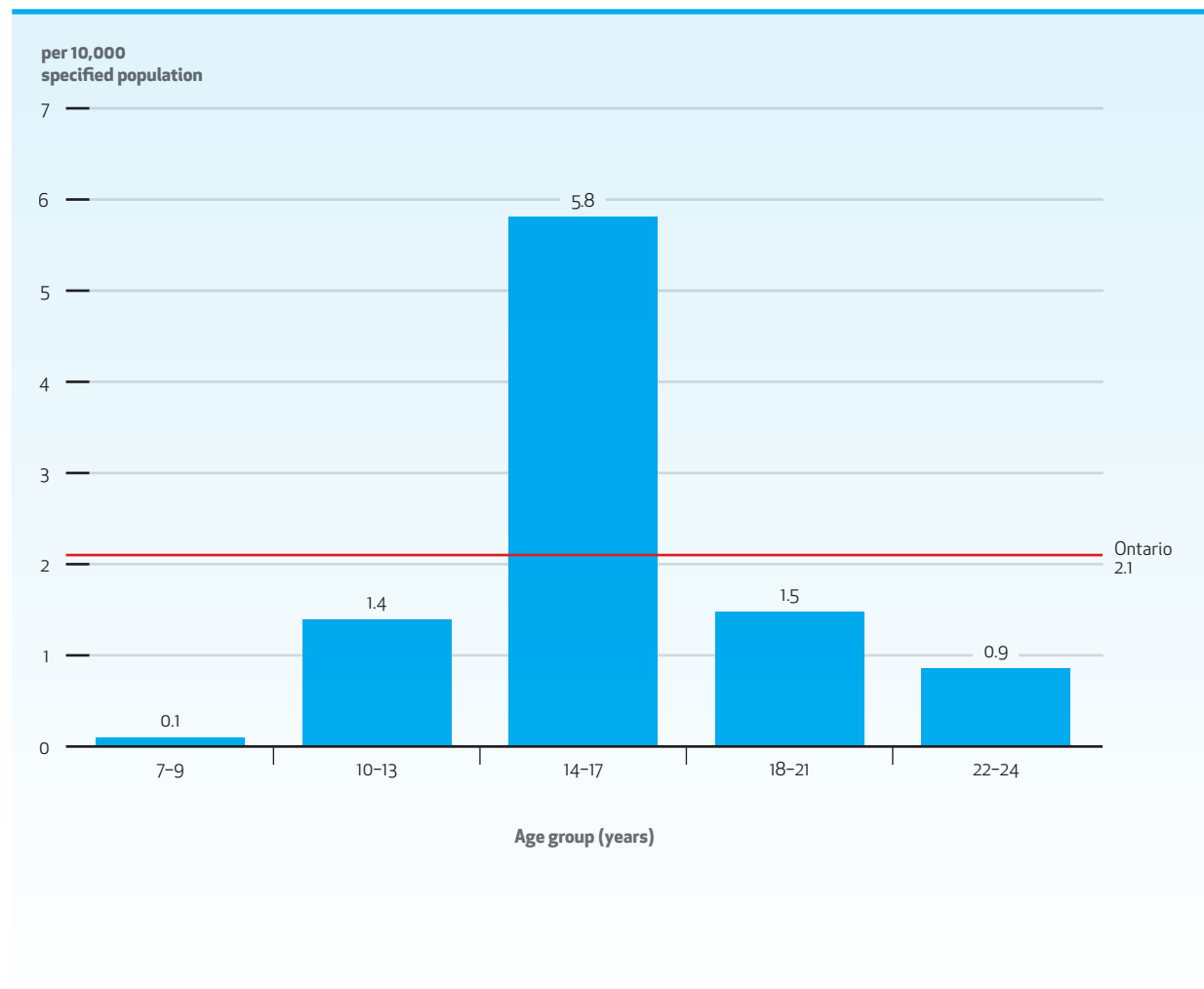
- From 2012 to 2014, hospitalizations for eating disorders were higher among females.



**EXHIBIT 2.4.5** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

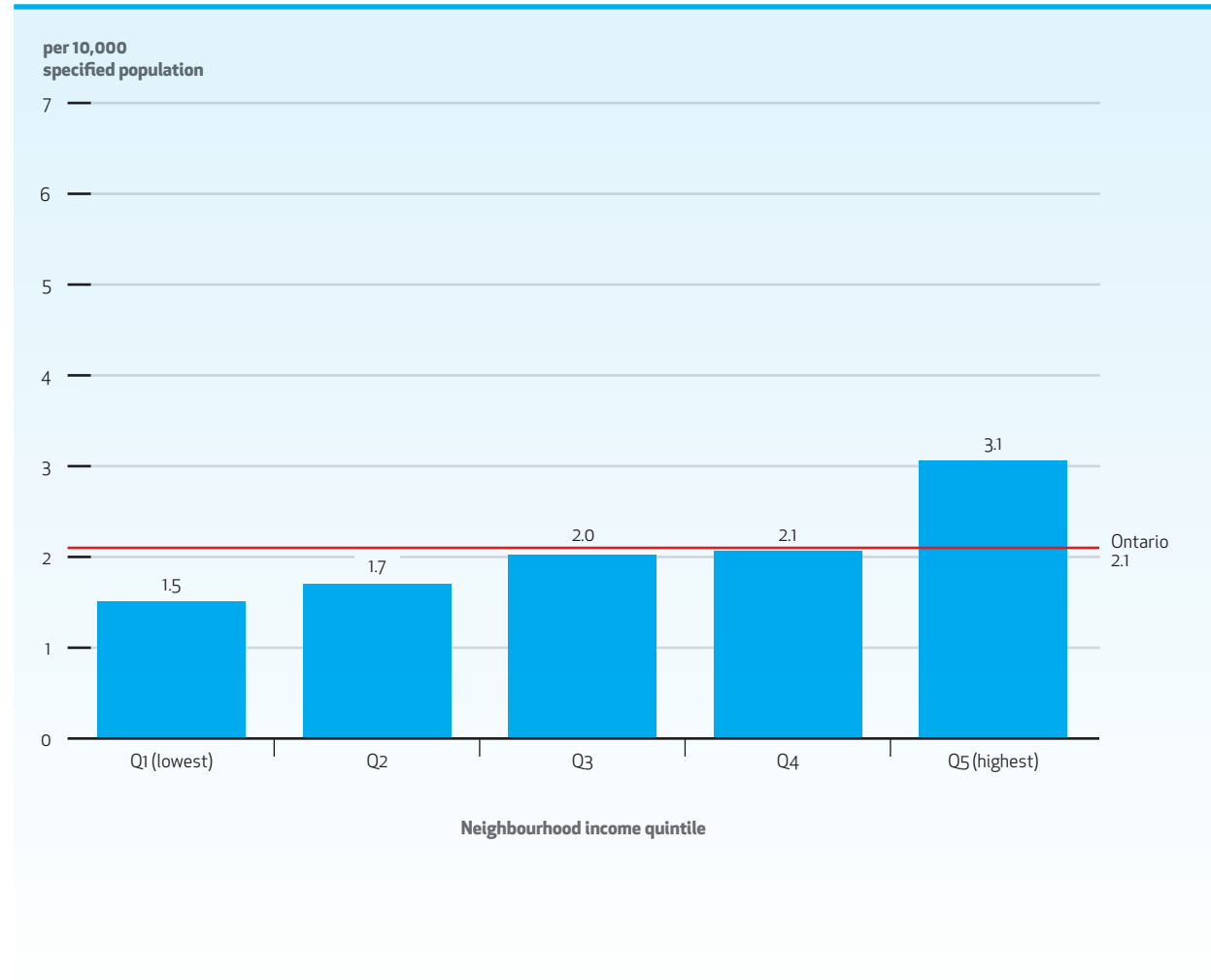
- Between 2012 and 2014, the average rate of hospitalizations for eating disorders was highest among youth aged 14 to 17.



**EXHIBIT 2.4.6** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

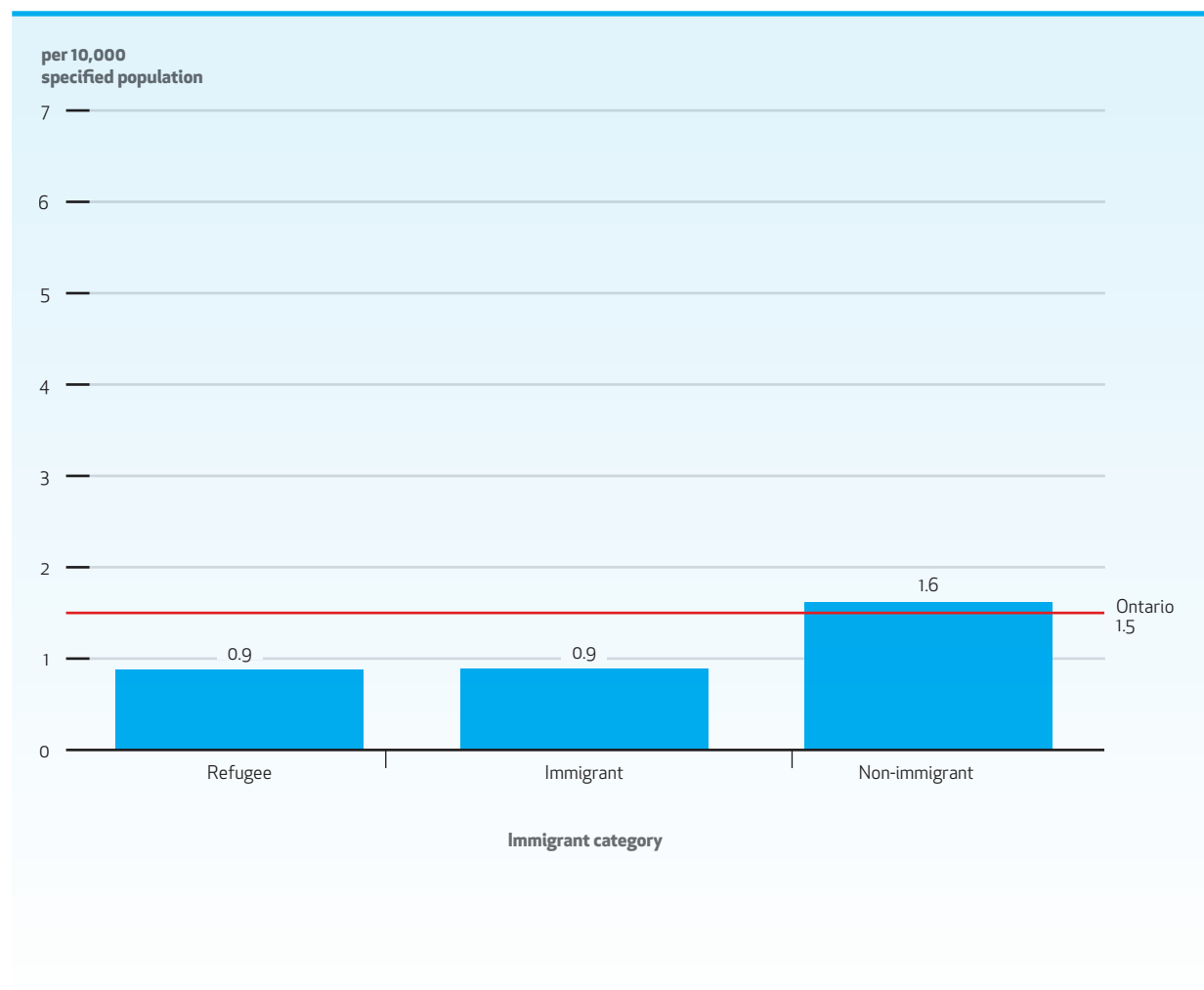
- Between 2012 and 2014, the average rate of hospitalizations for eating disorders was highest among children and youth in the wealthiest neighbourhoods and lowest for those in the poorest neighbourhoods.



**EXHIBIT 2.4.7** Number of hospitalizations for eating disorders per 10,000 crude population aged 7 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

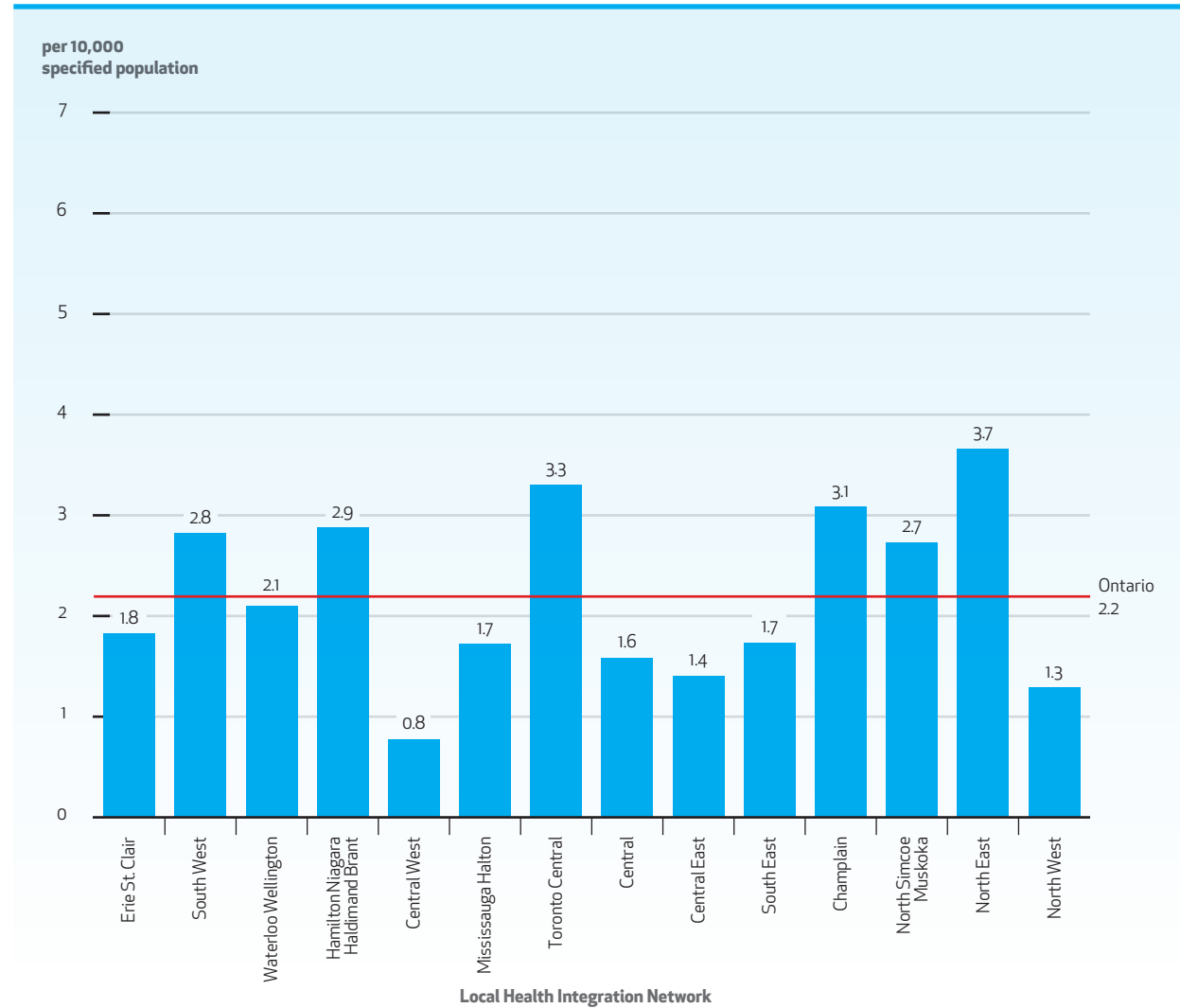
- From 2010 to 2012, hospitalizations for eating disorders were more common among non-immigrant children and youth.



**EXHIBIT 2.4.8** Number of hospitalizations for eating disorders per 10,000 standard population aged 7 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

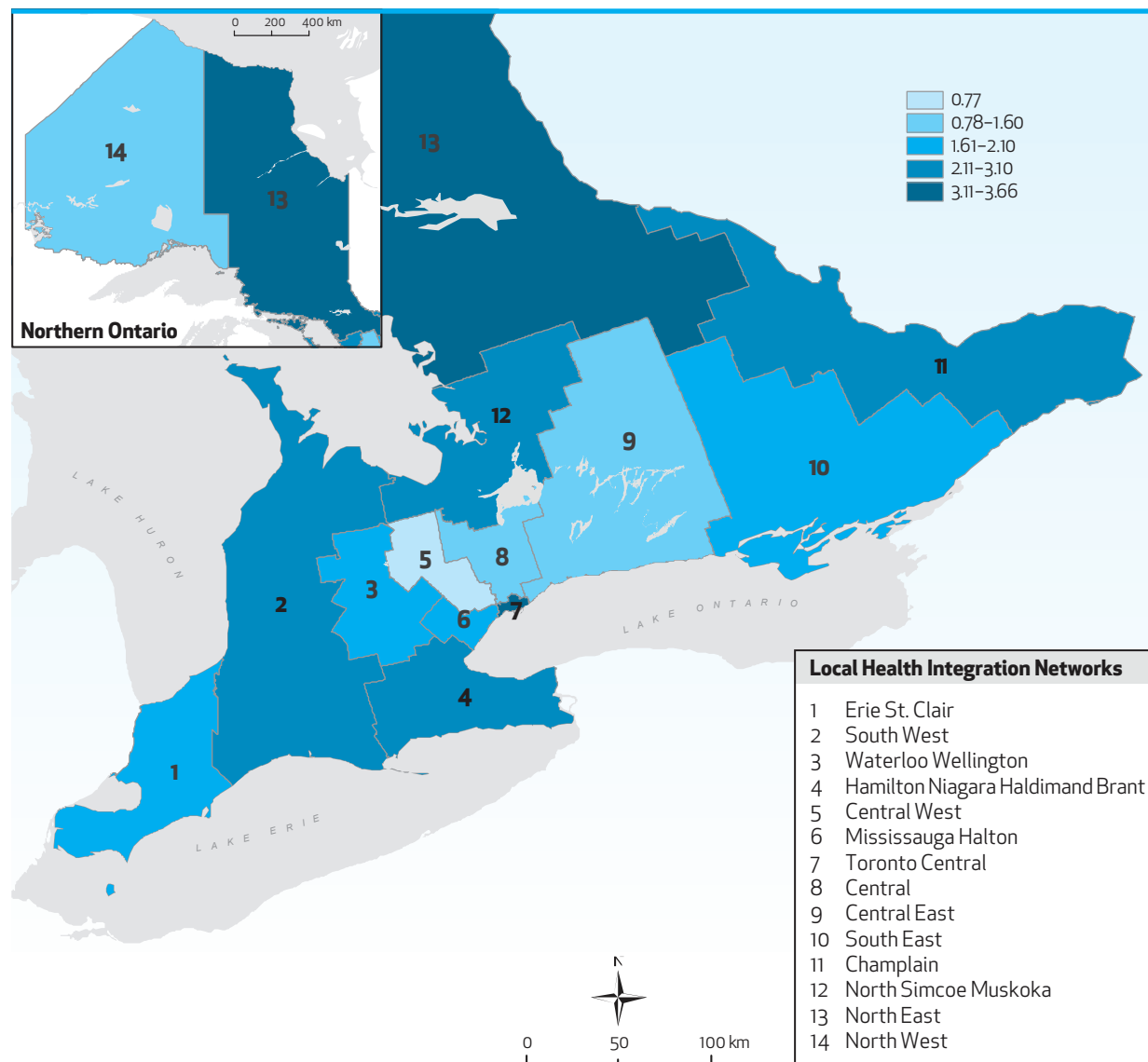
- From 2012 to 2014, the average rate of hospitalizations for eating disorders was highest in the North East and Toronto Central LHINs.



**EXHIBIT 2.4.9** Number of hospitalizations for eating disorders per 10,000 standard population aged 0 to 24 years, by Local Health Integration Network, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average rate of hospitalizations for eating disorders was highest in the North East and Toronto Central LHINs.

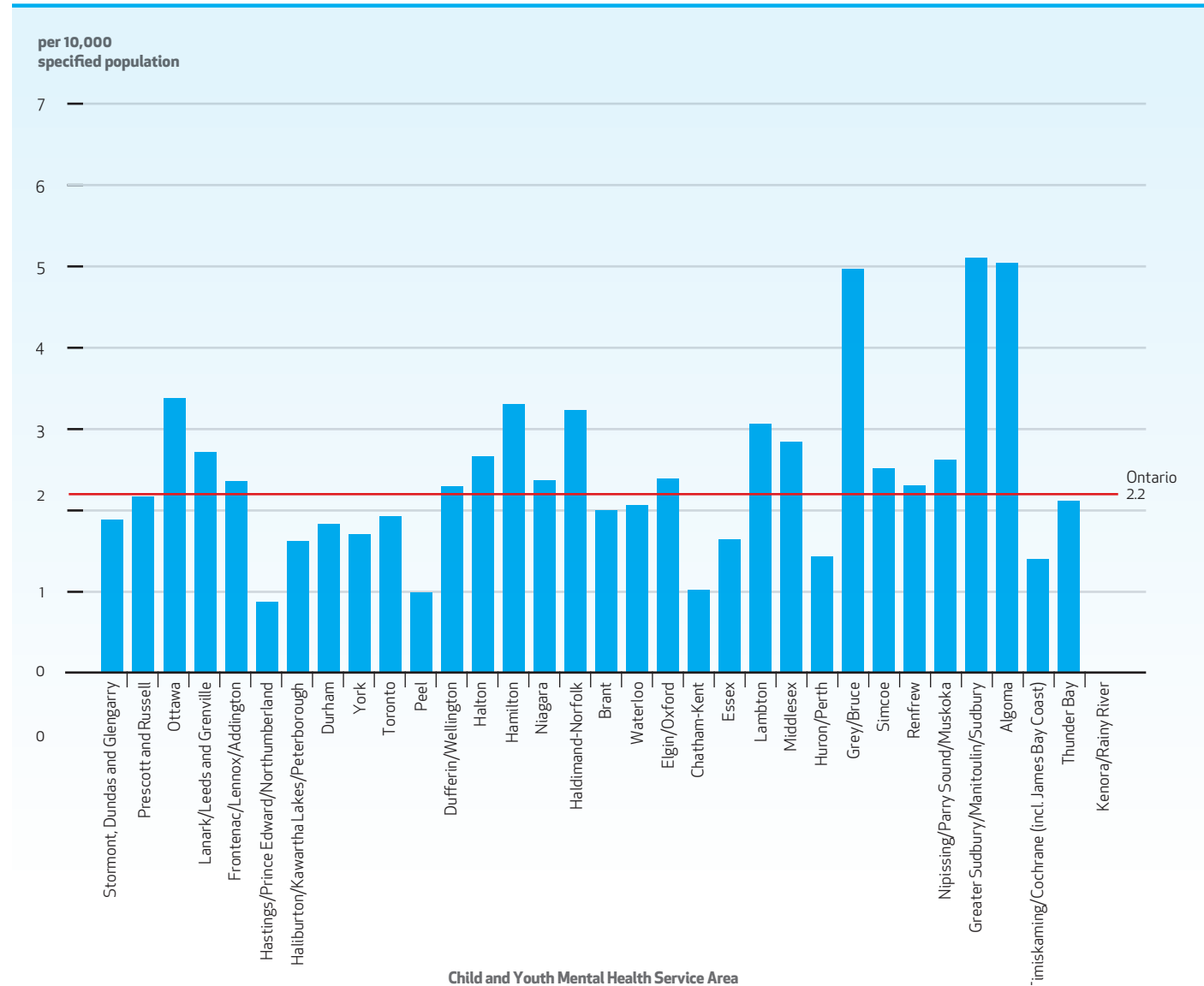




**EXHIBIT 2.4.10** Number of hospitalizations for eating disorders per 10,000 standard population aged 7 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

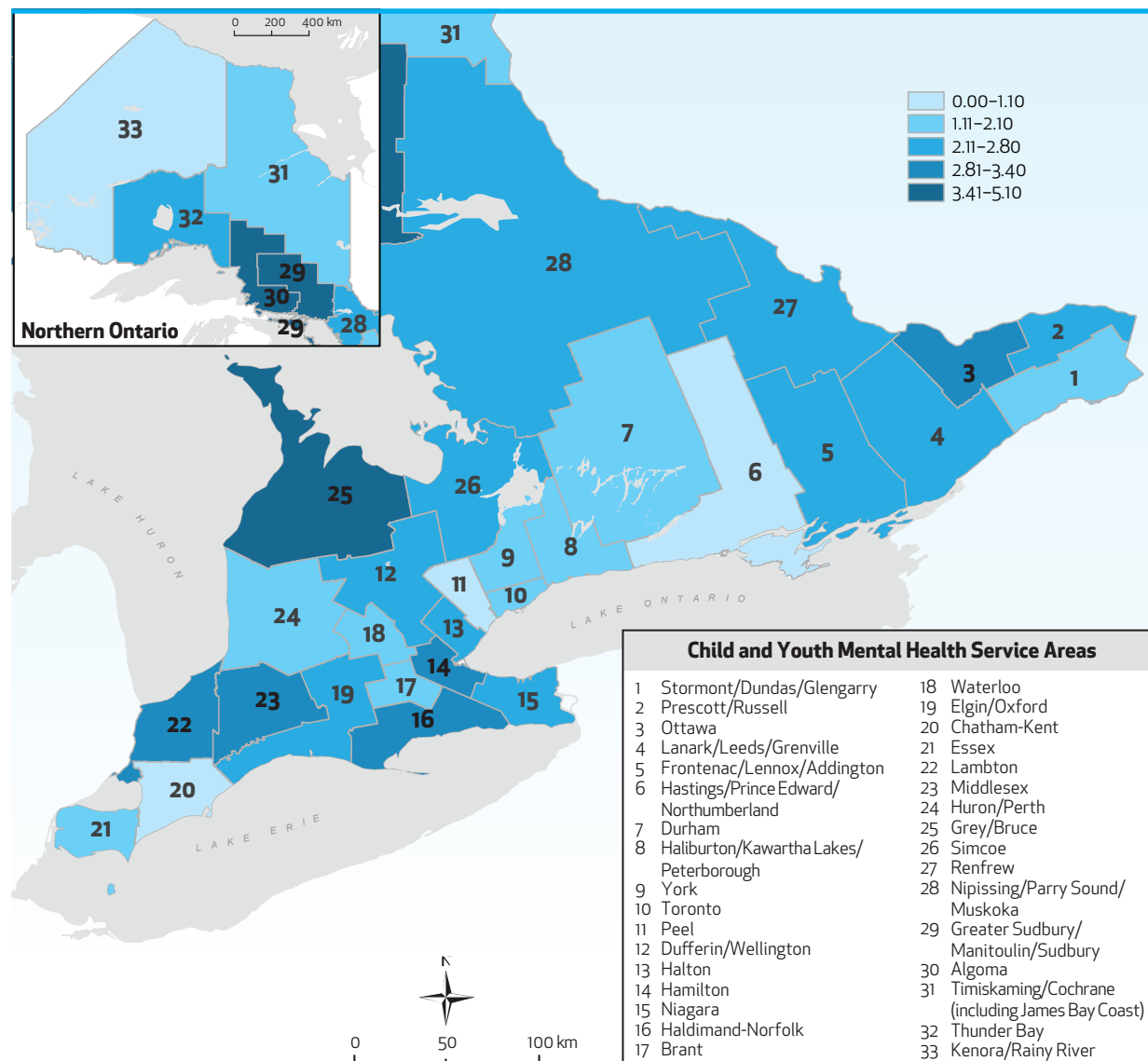
- Between 2012 and 2014, the average rate of hospitalizations for eating disorders was highest in the Greater Sudbury/Manitoulin/Sudbury, Grey/Bruce, and Algoma Child and Youth Mental Health Service Areas.



**EXHIBIT 2.4.11** Number of hospitalizations for eating disorders per 10,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average rate of hospitalization for eating disorders was highest in the Greater Sudbury/Manitoulin/Sudbury, Grey/Bruce, and Algoma Child and Youth Mental Health Service Areas.



## 2.5 Length of stay for psychiatric hospitalizations among children and youth

### Rationale

Length of stay for psychiatric hospitalizations can be affected by illness severity at admission, care processes during hospitalization, discharge planning, and availability of community resources to support discharge. When considered in conjunction with rates of hospitalizations, trends in length of stay could reflect the efficiency of the mental health and addictions system.

### Results

Median length of stay for psychiatric hospitalizations among children and youth stayed stable over time from 2006 to 2014 and was longest among males, and those aged 22 to 24 years. Across the major mental health and addictions diagnostic groups, median length of stay ranged from approximately two days for deliberate self-harm hospitalizations to 13 days for children and youth with schizophrenia.

Median length of stay did not vary across neighbourhood income quintiles. Children and youth who were refugees or immigrants had a slightly longer median length of stay compared to non-immigrants. Across the LHINs, the longest stays for psychiatric hospitalization were found in Champlain, Toronto Central, and Central West, and the shortest in North Simcoe Muskoka. By Child and Youth Mental Health Service Area, children and youth living in Ottawa had the longest length of stay (9 days), while those living in Brant, Grey/Bruce, and Renfrew had the shortest (3 days).

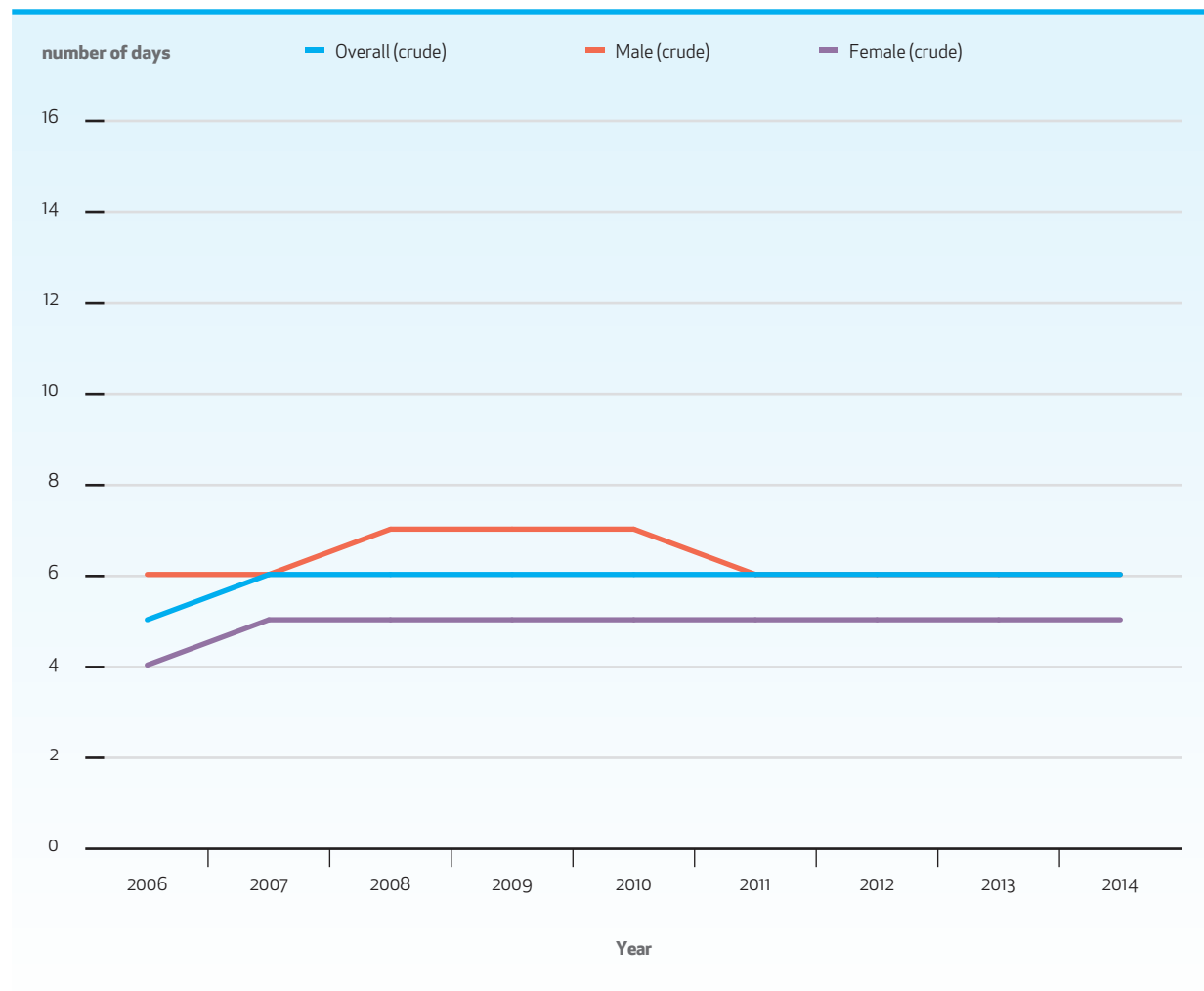
### Interpretation

Between 2006 and 2014, there was very little change in the number of days spent in the hospital for mental illnesses among children and youth in Ontario. The longest length of stay for psychiatric hospitalizations was found among those aged 22 to 24 years and this may be related to the higher prevalence of schizophrenia among this age group (schizophrenia typically has an onset in young adulthood). Those with schizophrenia has the longest length of stay compared to individuals with other mental health conditions. Geographically, the longest length of stay was found in the Champlain LHIN and corresponding Child and Youth Mental Health Service Areas, which may be explained by the presence of a large psychiatric inpatient unit for children and youth in eastern Ontario.

**EXHIBIT 2.5.1** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

## Key Findings

- From 2006 to 2014, the median length of stay for psychiatric hospitalizations among Ontario children and youth remained relatively stable.
- The median length of stay was slightly longer for males.



**EXHIBIT 2.5.2** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by age group, in Ontario, 2006 to 2014**Key Findings**

- The median length of stay for psychiatric hospitalizations remained relatively stable across most age groups, with the exception of children aged 0 to 9 years for whom median length of stay dropped to 4 days in 2014 after being as long as 8 days in 2007.
- The median length of stay was longest among those aged 22 to 24.



**EXHIBIT 2.5.3** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by type of disorder, in Ontario, 2006 to 2014

## Key Finding

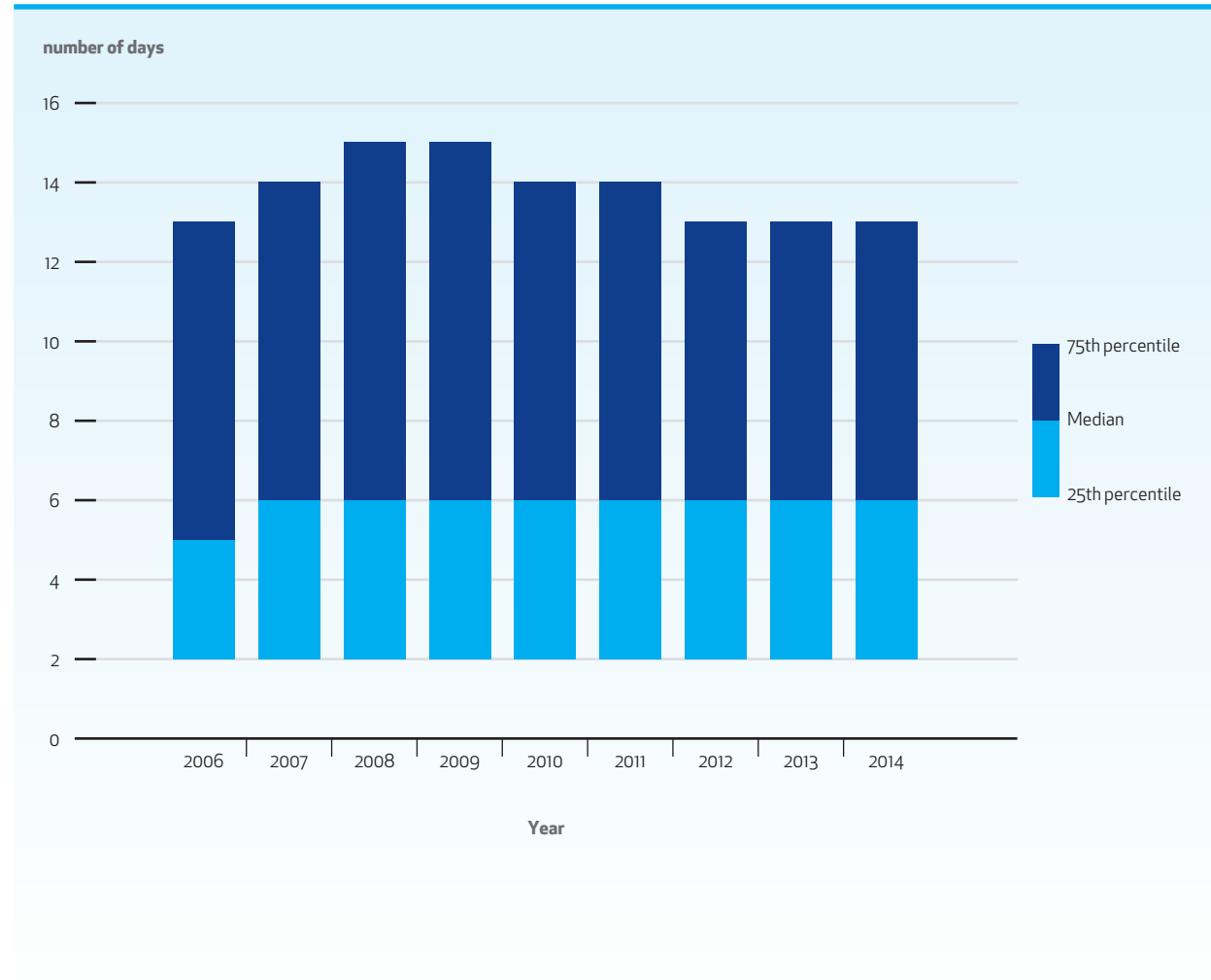
- From 2006 to 2014, children and youth hospitalized for schizophrenia had the longest median length of stay, and those hospitalized for deliberate self-harm had the shortest.



**EXHIBIT 2.5.4** Length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by 25th, 50th and 75th percentiles, in Ontario, 2006 to 2014

## Key Finding

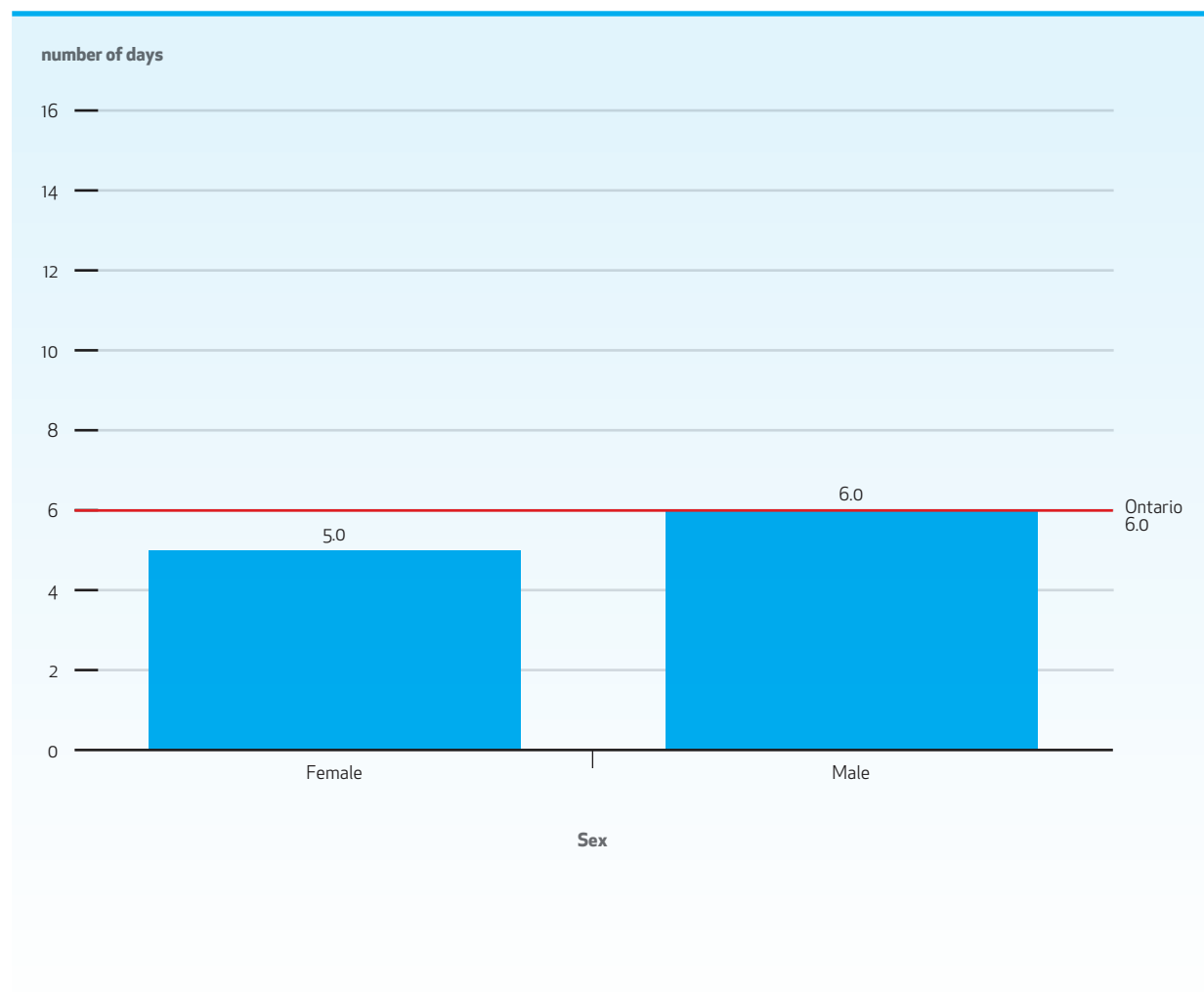
- From 2006 to 2014, length of stay for psychiatric hospitalizations among children and youth ranged from 2 days (25th percentile) to approximately 14 days (75th percentile), with a median length of stay in hospital of 6 days.



**EXHIBIT 2.5.5** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average median length of stay for psychiatric hospitalizations was longer for males.

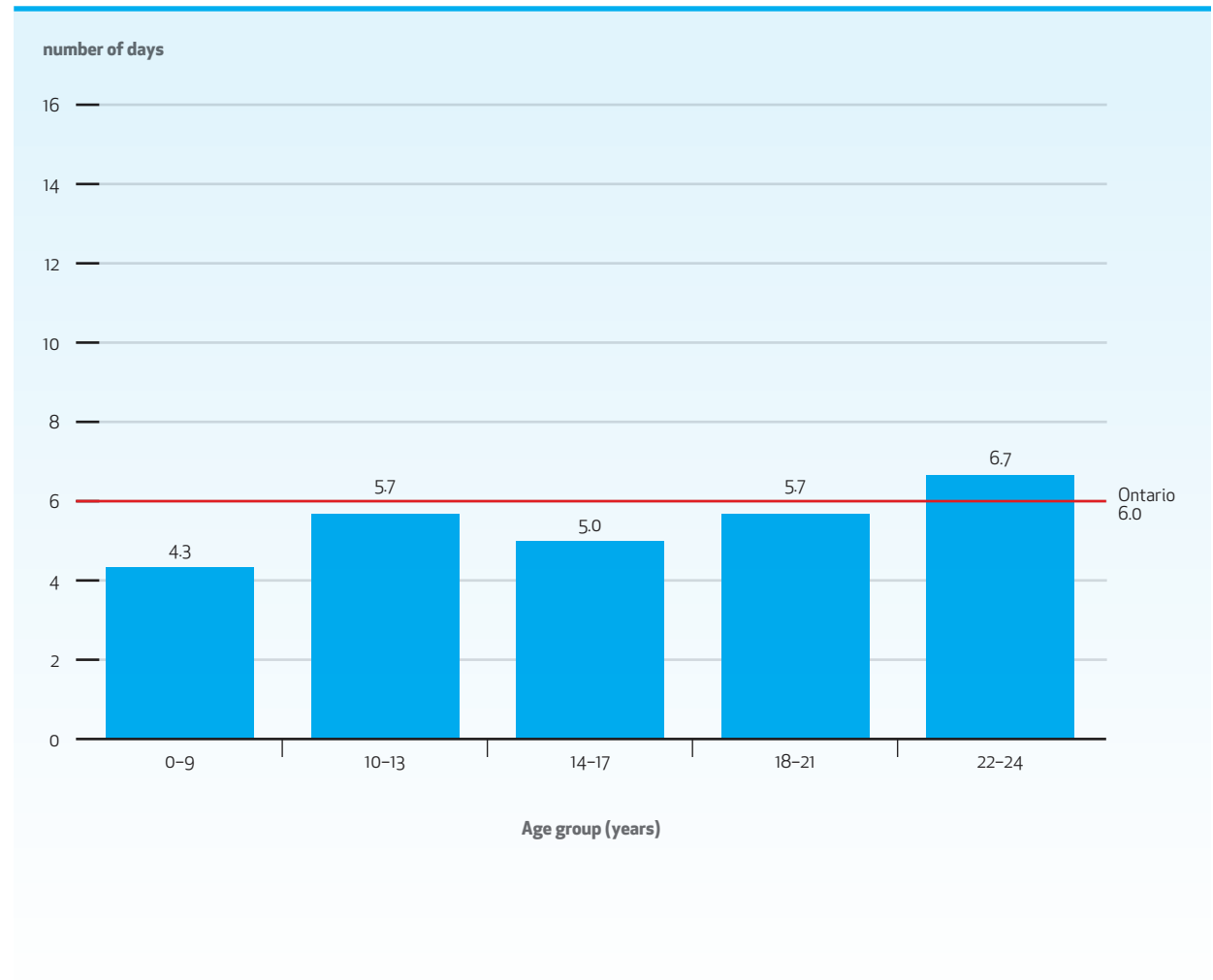




**EXHIBIT 2.5.6** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

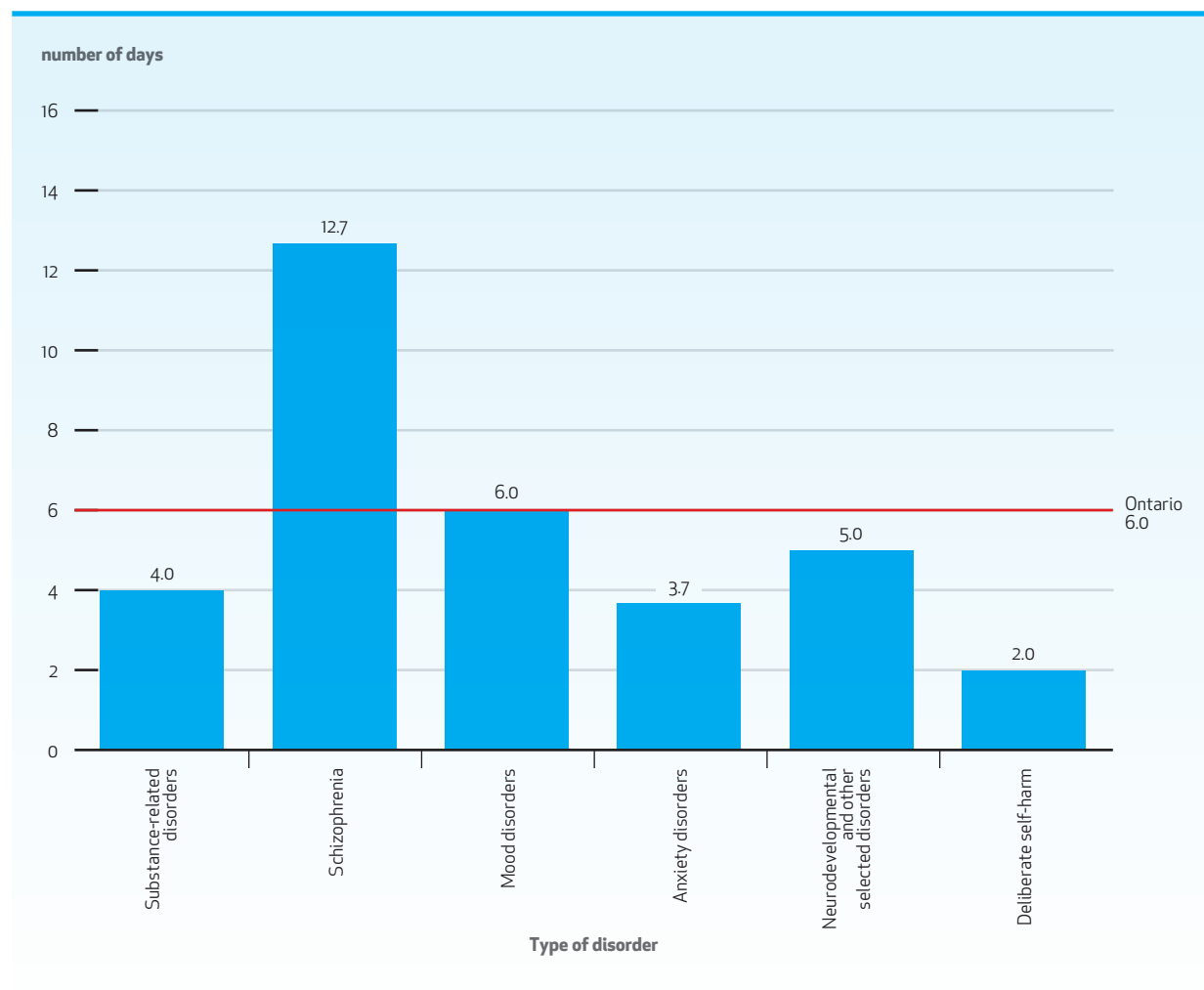
- Between 2012 and 2014, the median length of stay for psychiatric hospitalizations was longest for youth aged 22 to 24 and shortest for children aged 0 to 9.



**EXHIBIT 2.5.7** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Finding

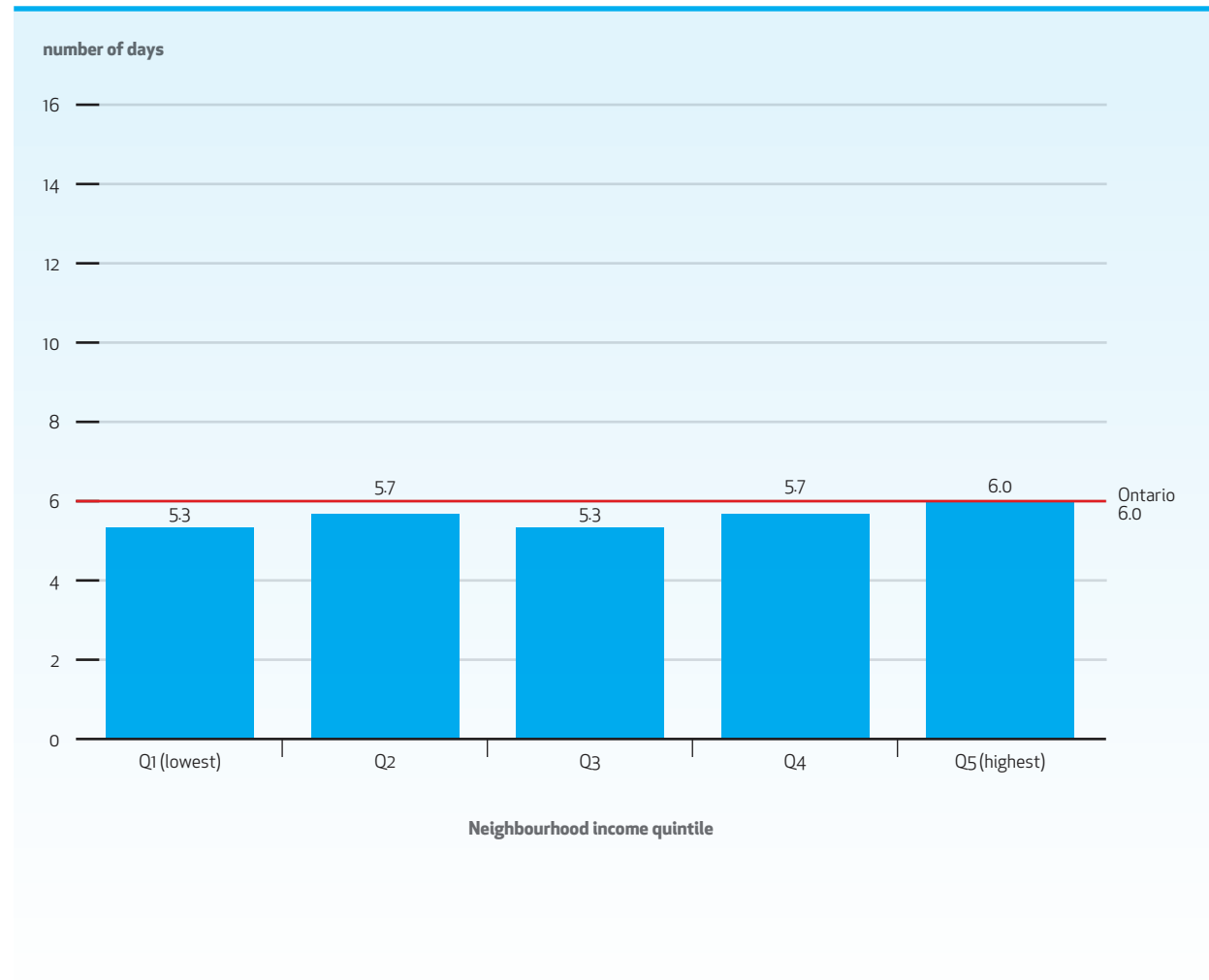
- Between 2012 and 2014, the median length of stay was longest among children and youth hospitalized for schizophrenia and shortest among those hospitalized for deliberate self-harm.



**EXHIBIT 2.5.8** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

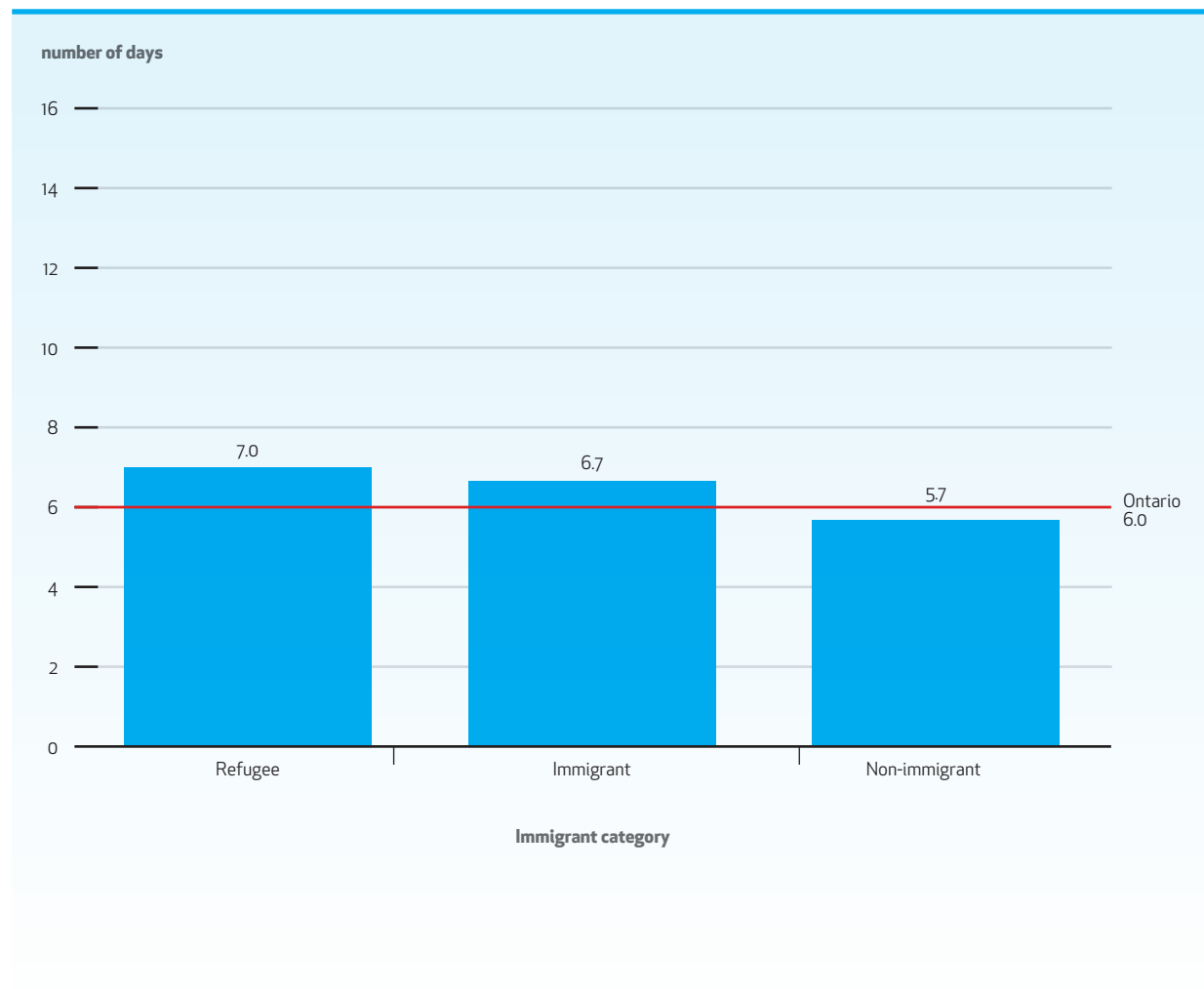
- From 2012 to 2014, the median length of stay for psychiatric hospitalizations was consistent among children and youth living in neighbourhoods with different income levels.



**EXHIBIT 2.5.9** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

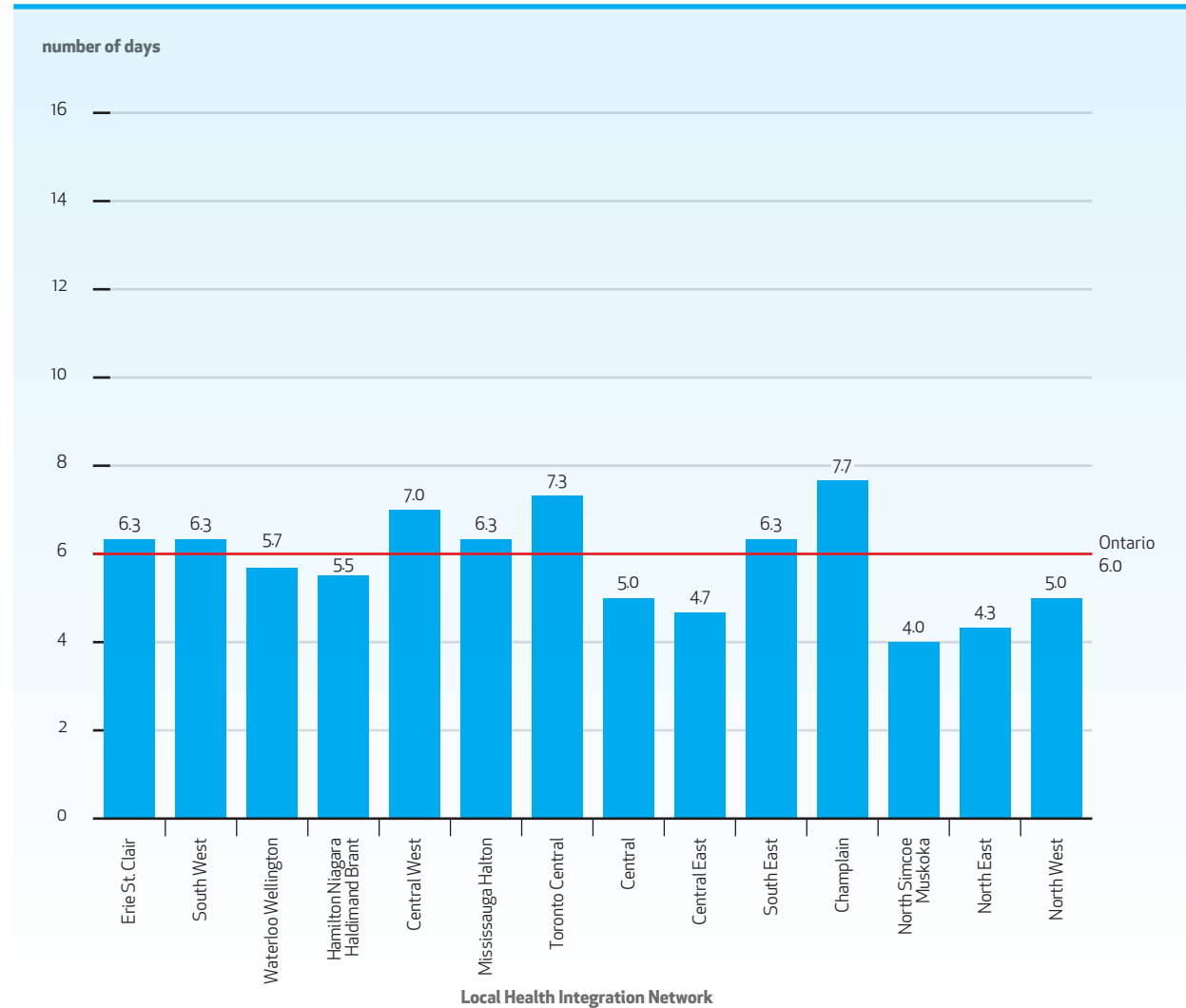
- Between 2010 and 2012, the median length of stay for psychiatric hospitalizations was longer among children and youth who were refugees and immigrants.



**EXHIBIT 2.5.10** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

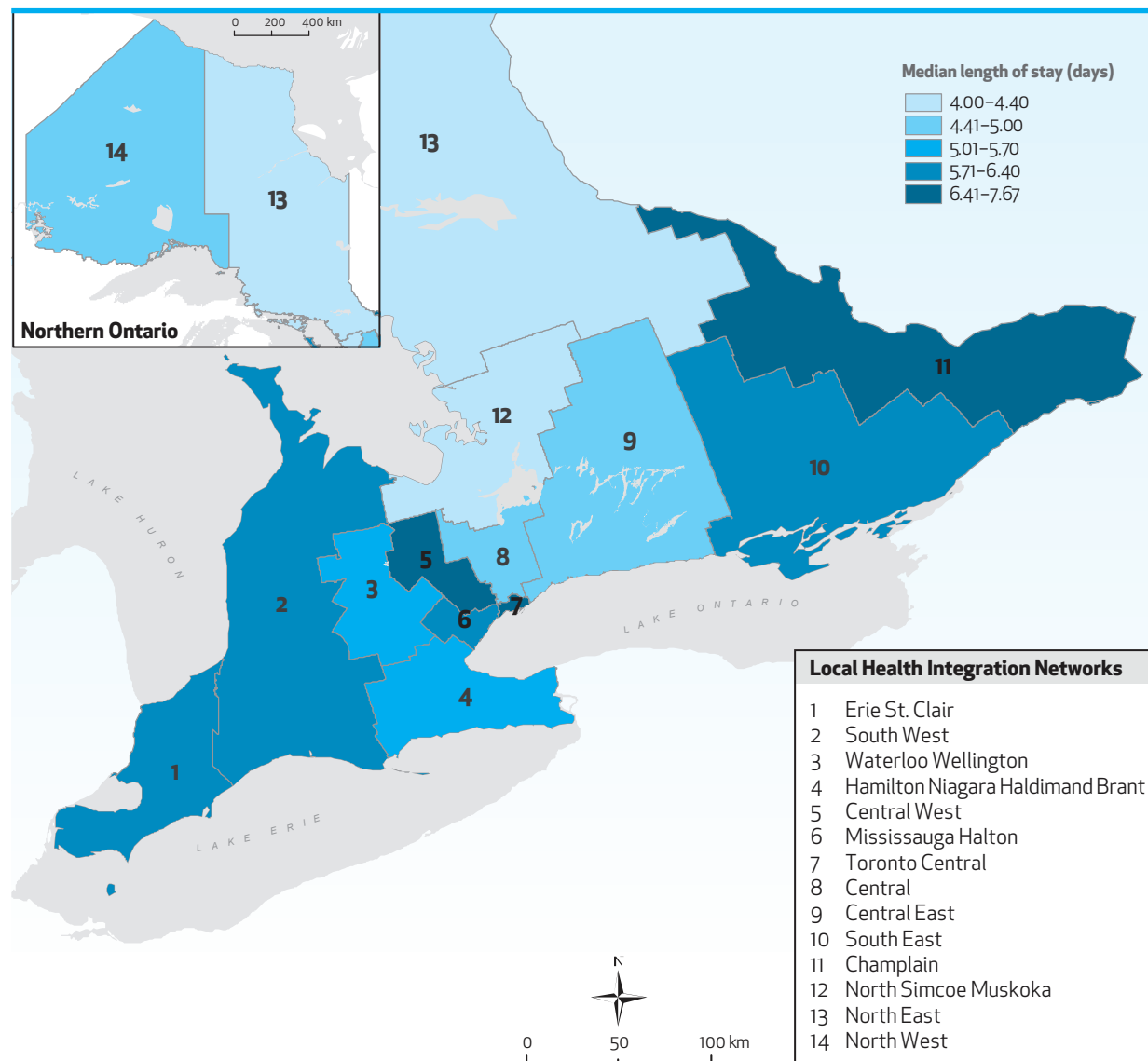
- Between 2012 and 2014, the median length of stay for psychiatric hospitalizations was longest among children and youth living in the Champlain, Toronto Central and Central West LHINs.



**EXHIBIT 2.5.11** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

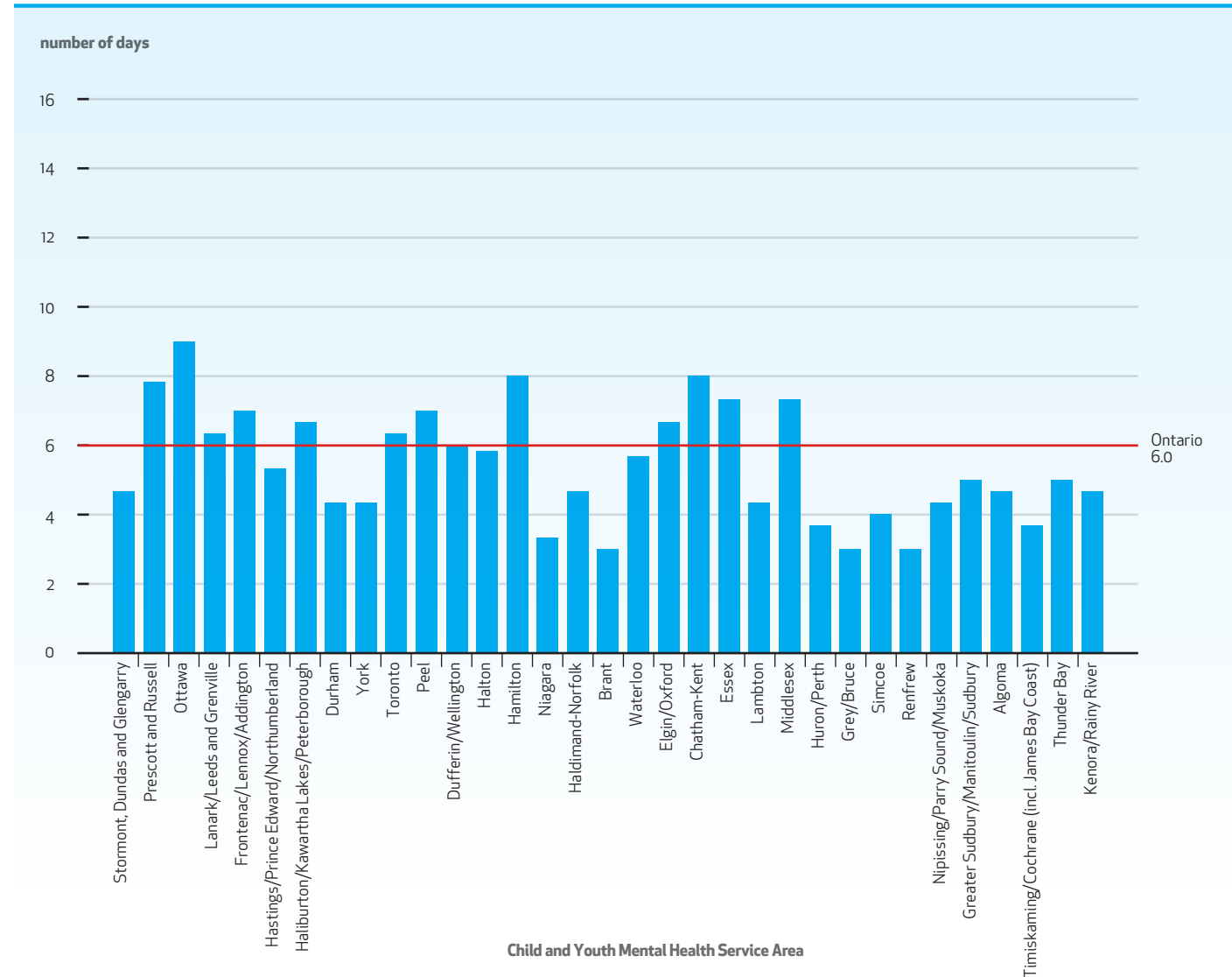
- Between 2012 and 2014, the median length of stay for psychiatric hospitalizations was longest among children and youth living in the Champlain, Toronto Central and Central West LHINs.



**EXHIBIT 2.5.12** Median length of stay for psychiatric hospitalizations among children and youth aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

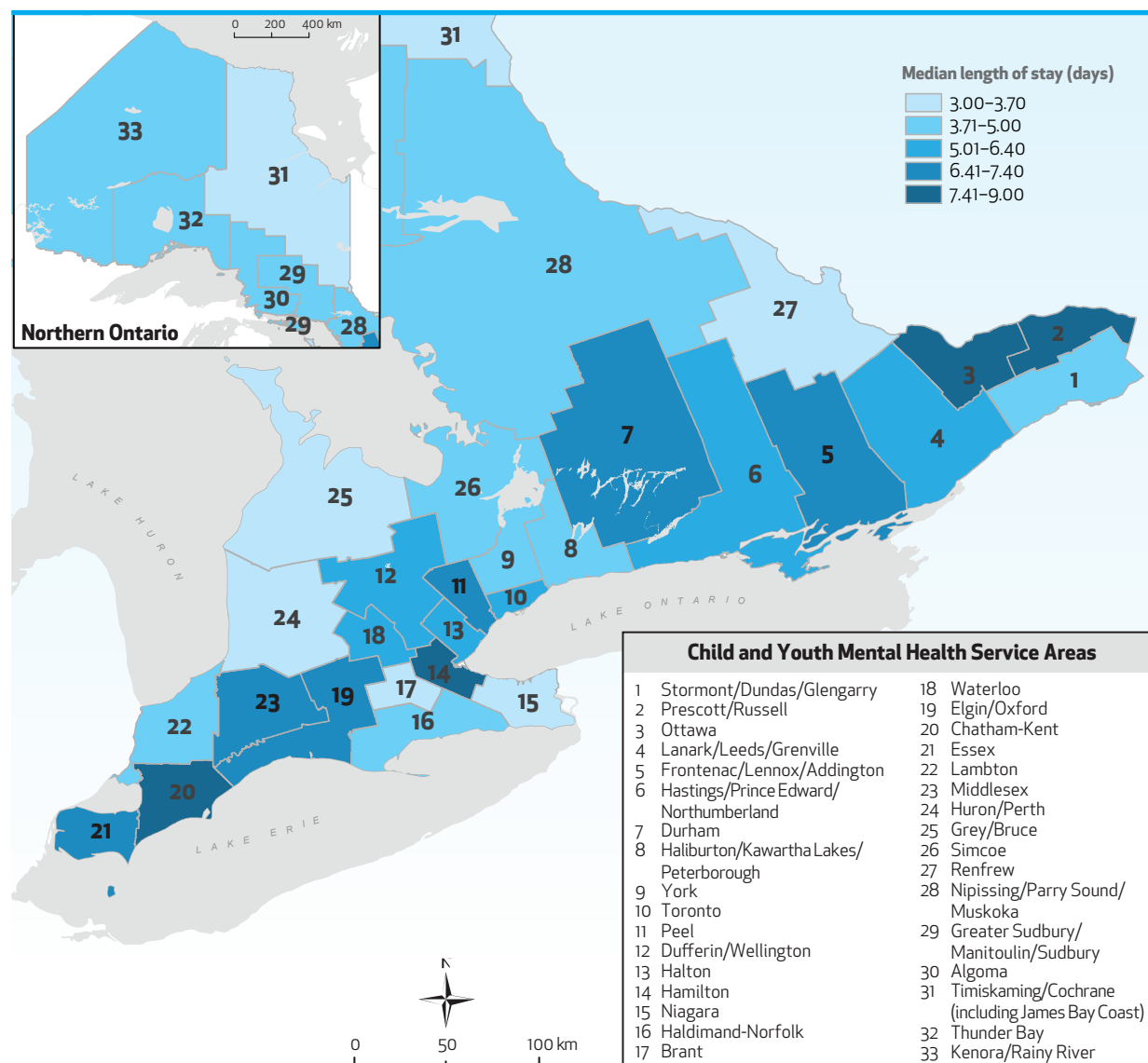
- Among Child and Youth Mental Health Service Areas, the average median length of stay for psychiatric hospitalizations between 2012 and 2014 was longest in Ottawa and shortest in Brant, Grey/Bruce, and Renfrew.



**EXHIBIT 2.5.13** Median length of stay for psychiatric hospitalizations of 0-to-24-year-olds, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Among Child and Youth Mental Health Service Areas, the average median length of stay for psychiatric hospitalizations between 2012 and 2014 was longest in Ottawa and shortest in Brant, Grey/Bruce, and Renfrew.





---

# Contextual Indicators: Outcomes

---

**2.6** Prevalence of neonatal abstinence syndrome

**2.7** Rate of deaths by suicide among children and youth

**2.8** Rate of emergency department visits for deliberate self-harm among children and youth

**2.9** Rate of emergency department visits related to mental health and addictions among children and youth

**2.10** Rate of hospitalizations related to mental health and addictions among children and youth

## 2.6 Prevalence of neonatal abstinence syndrome

### Rationale

Neonatal abstinence syndrome (NAS) is a withdrawal syndrome observed in the babies of mothers who are either using opioids or being treated for opioid dependence with methadone. Rates of NAS are a proxy for maternal substance-use problems.

### Results

The prevalence of infants with NAS increased dramatically, with rates nearly six times higher in 2014 than in 2002. NAS was more common among women who had their first child during their teenage years, compared to women giving birth after age 20. By equity lens, an income gradient was seen such that rates of NAS were higher in poorer neighbourhoods. Across immigrant categories, rates of NAS were more than six times higher for infants whose mothers were non-immigrants compared to mothers who were refugees or immigrants. Among Local Health Integration Networks, NAS prevalence was significantly higher in the North West LHIN and lowest in the Central West LHIN.

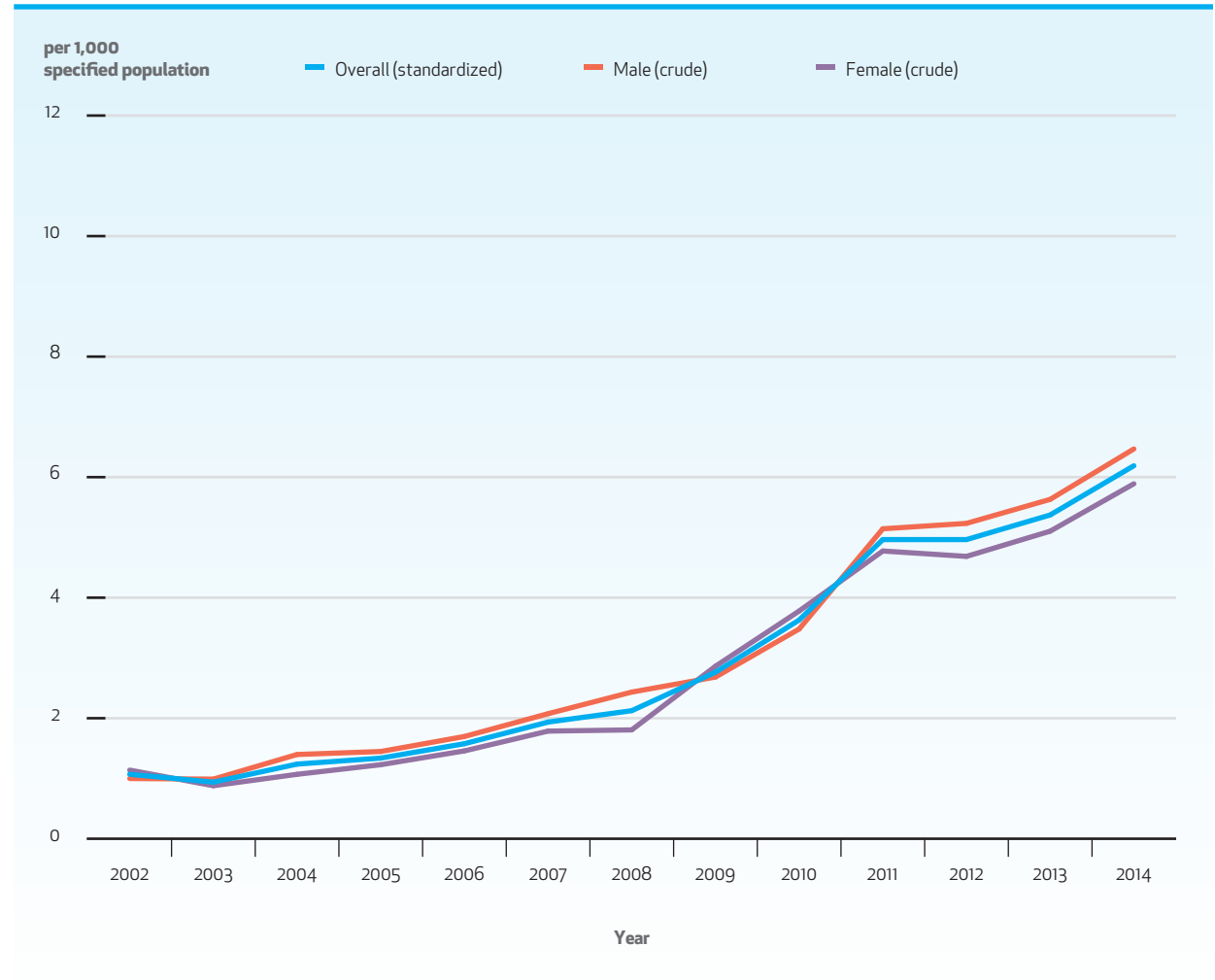
### Interpretation

The increase in rates of NAS may be due to a combination of factors, including (1) an increase in maternal use of illicit and prescription drugs, (2) an increase in women receiving methadone for opioid dependence treatment, and (3) an improvement in the detection of NAS at the time of birth, which may be evidenced by the sharp increase in prevalence since 2008. The substantially higher rate of NAS in the North West LHIN coincides with previous evidence indicating higher rates of opioid users and opioid-related hospital admissions and emergency department visits among residents in the LHIN.<sup>4</sup> The rise in NAS prevalence should be used as evidence to support prevention strategies around managing opioid prescribing practices, particularly for women of childbearing age and those living in northern Ontario.

<sup>4</sup> Ontario Drug Policy Research Network. *Opioid Use and Related Adverse Events in Ontario*. Toronto, ON: ODPRN; 2016. Accessed March 7, 2017 at <http://odprn.ca/wp-content/uploads/2016/11/ODPRN-Opioid-Use-and-Related-Adverse-Events-Nov-2016.pdf>.

**EXHIBIT 2.6.1** Prevalence of neonatal abstinence syndrome per 1,000 hospital births, overall and by sex, in Ontario, 2002 to 2014**Key Finding**

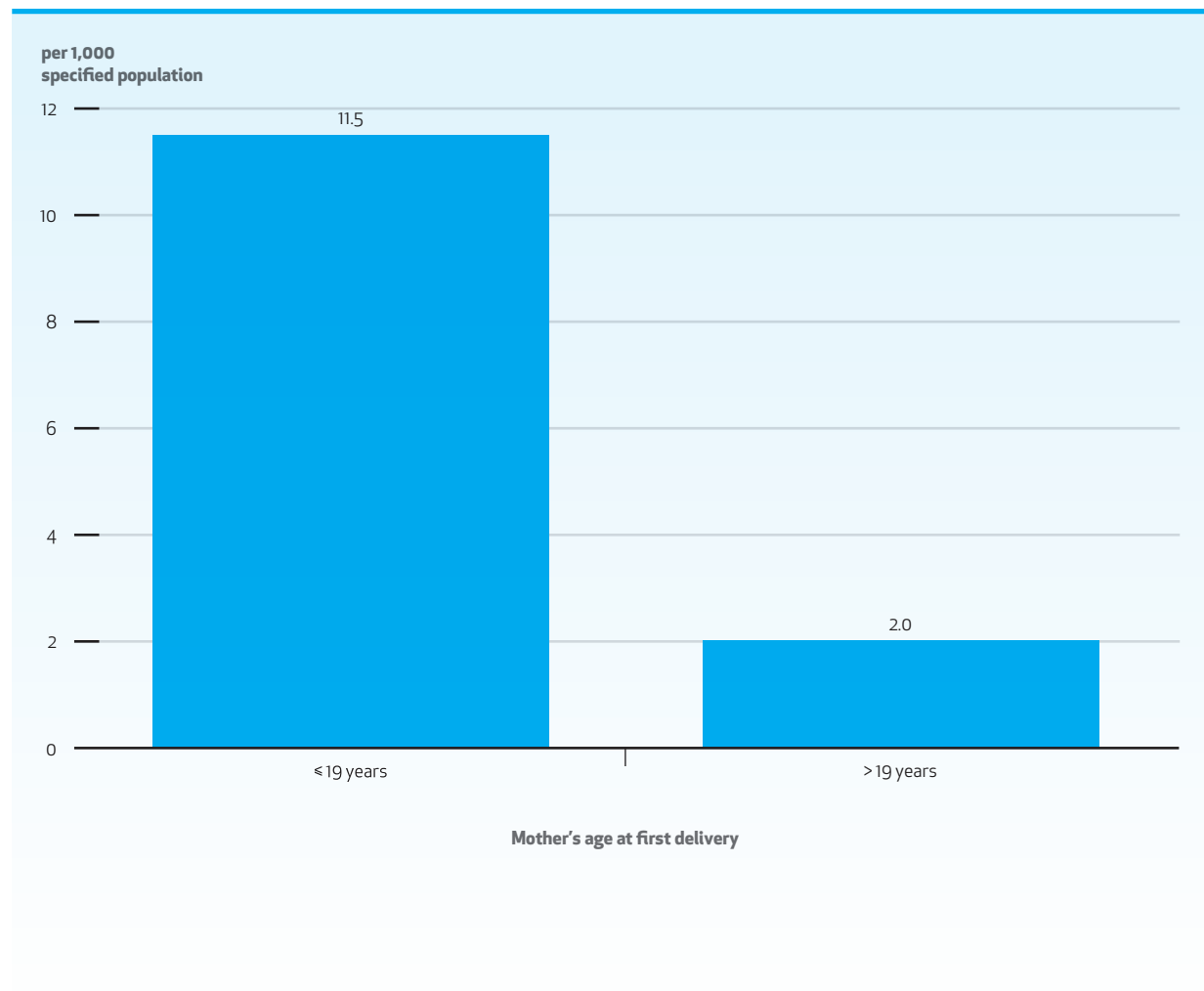
- From 2002 to 2014, the prevalence of neonatal abstinence syndrome increased substantially, with the largest increase occurring after 2007.



**EXHIBIT 2.6.2** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by maternal age at first delivery, in Ontario, 2002 to 2014 combined

## Key Finding

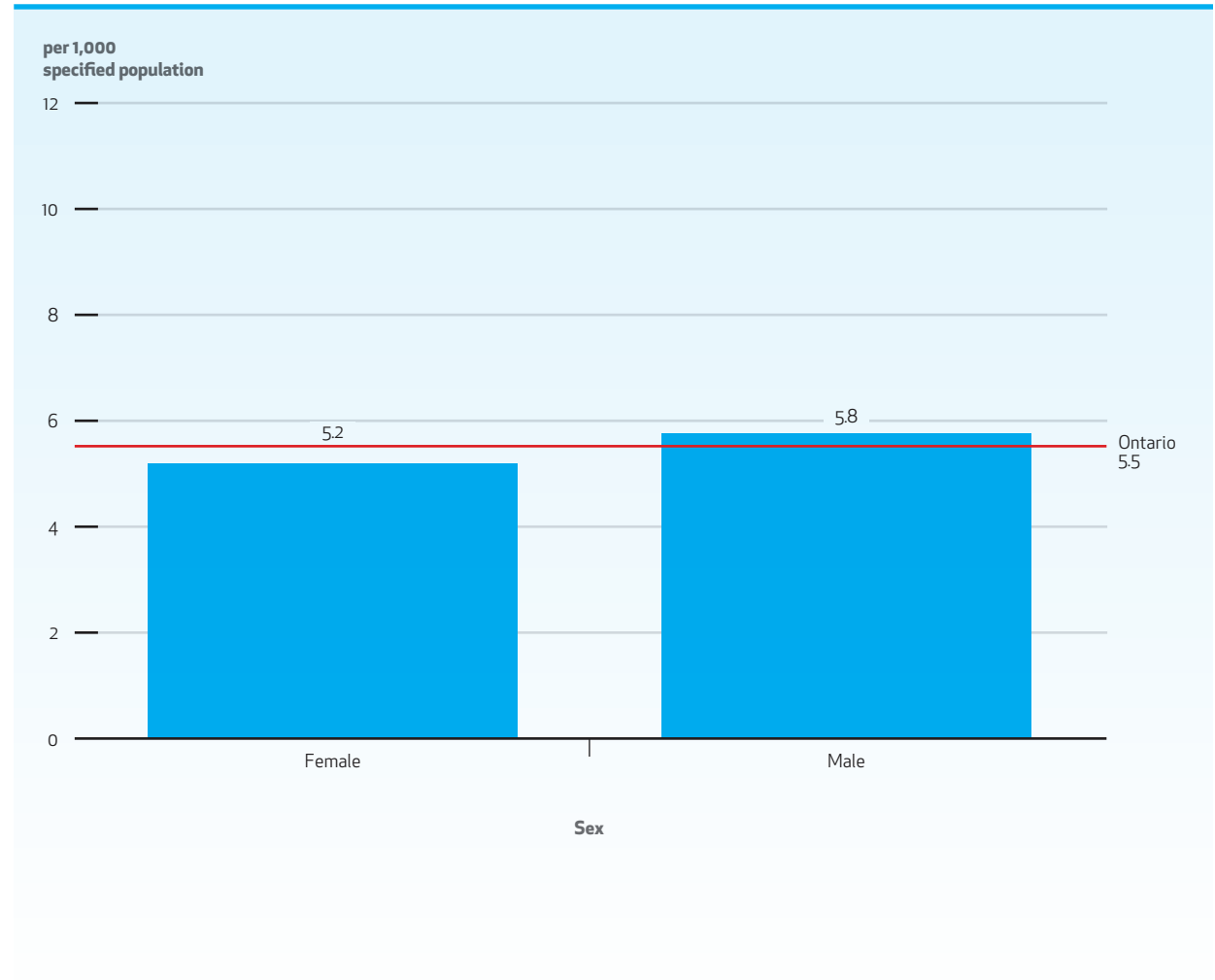
- The rate of neonatal abstinence syndrome was nearly six times higher among infants whose mothers had their first child at age 19 or younger (i.e., the teenage years) compared to those whose mothers were age 20 or older at first delivery.



**EXHIBIT 2.6.3** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

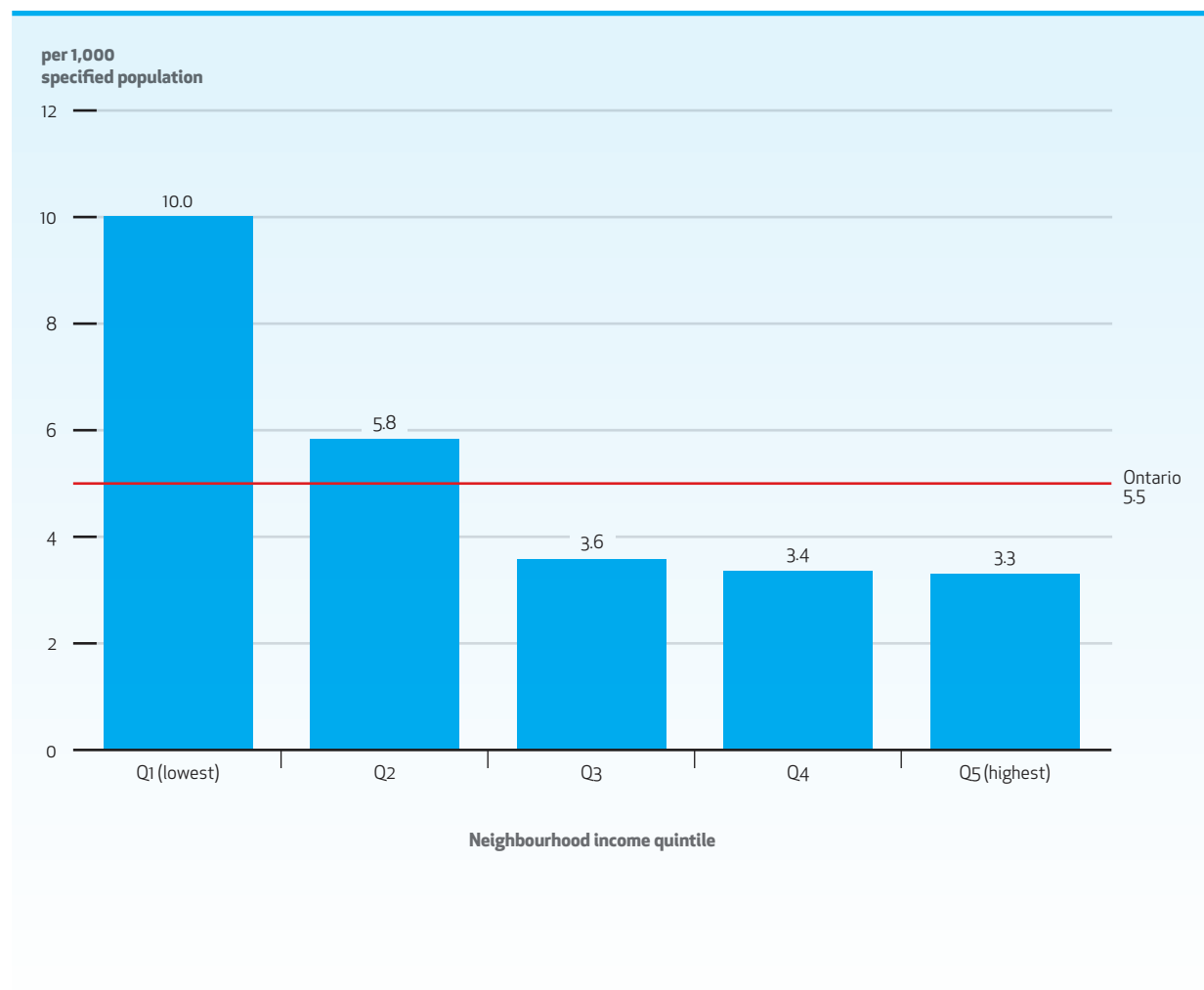
- From 2012 to 2014, the average prevalence of neonatal abstinence syndrome was similar for male and female infants.



**EXHIBIT 2.6.4** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

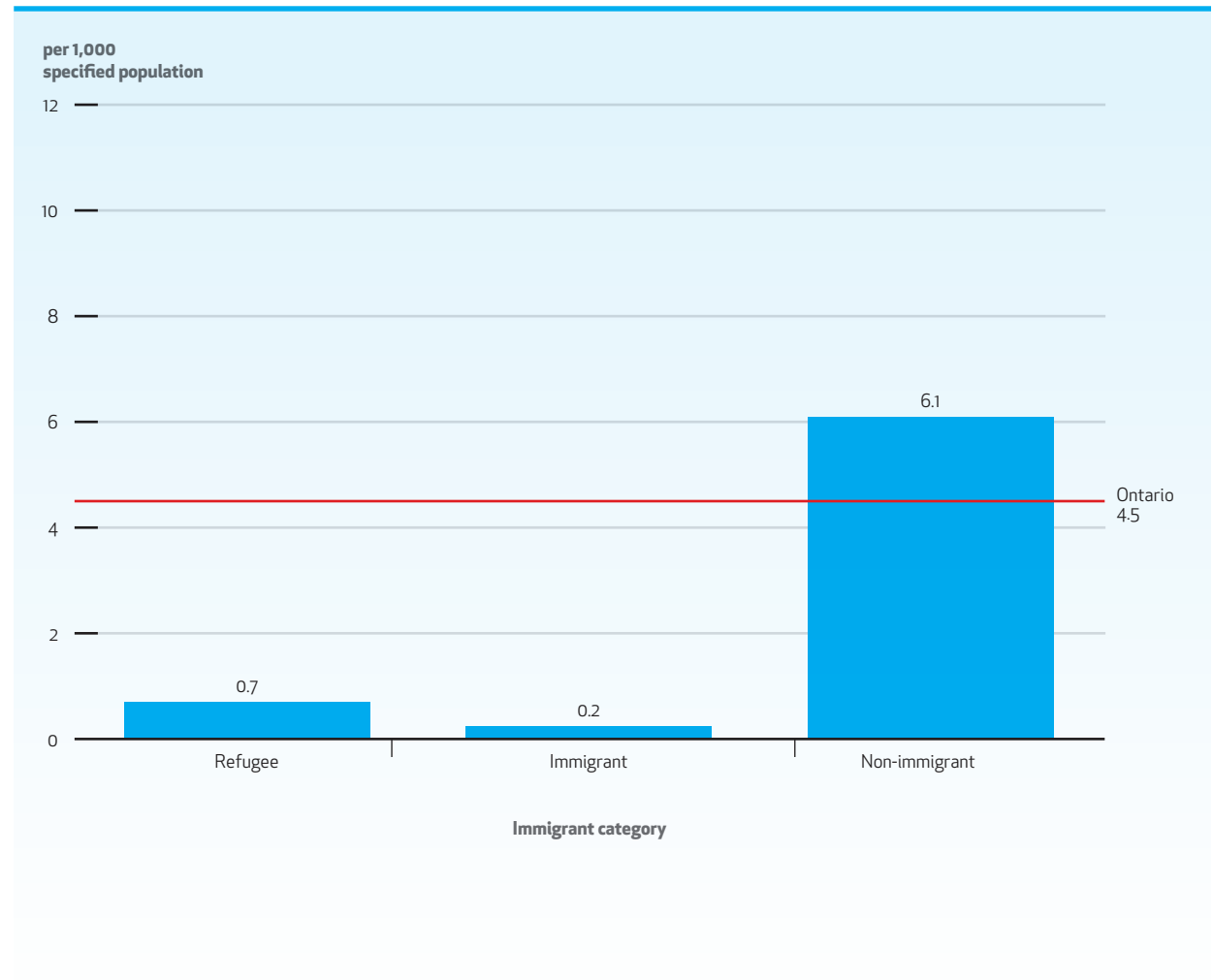
- Between 2012 and 2014, the average rate of neonatal abstinence syndrome was higher among infants living in lower-income neighbourhoods.



**EXHIBIT 2.6.5** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (crude), by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

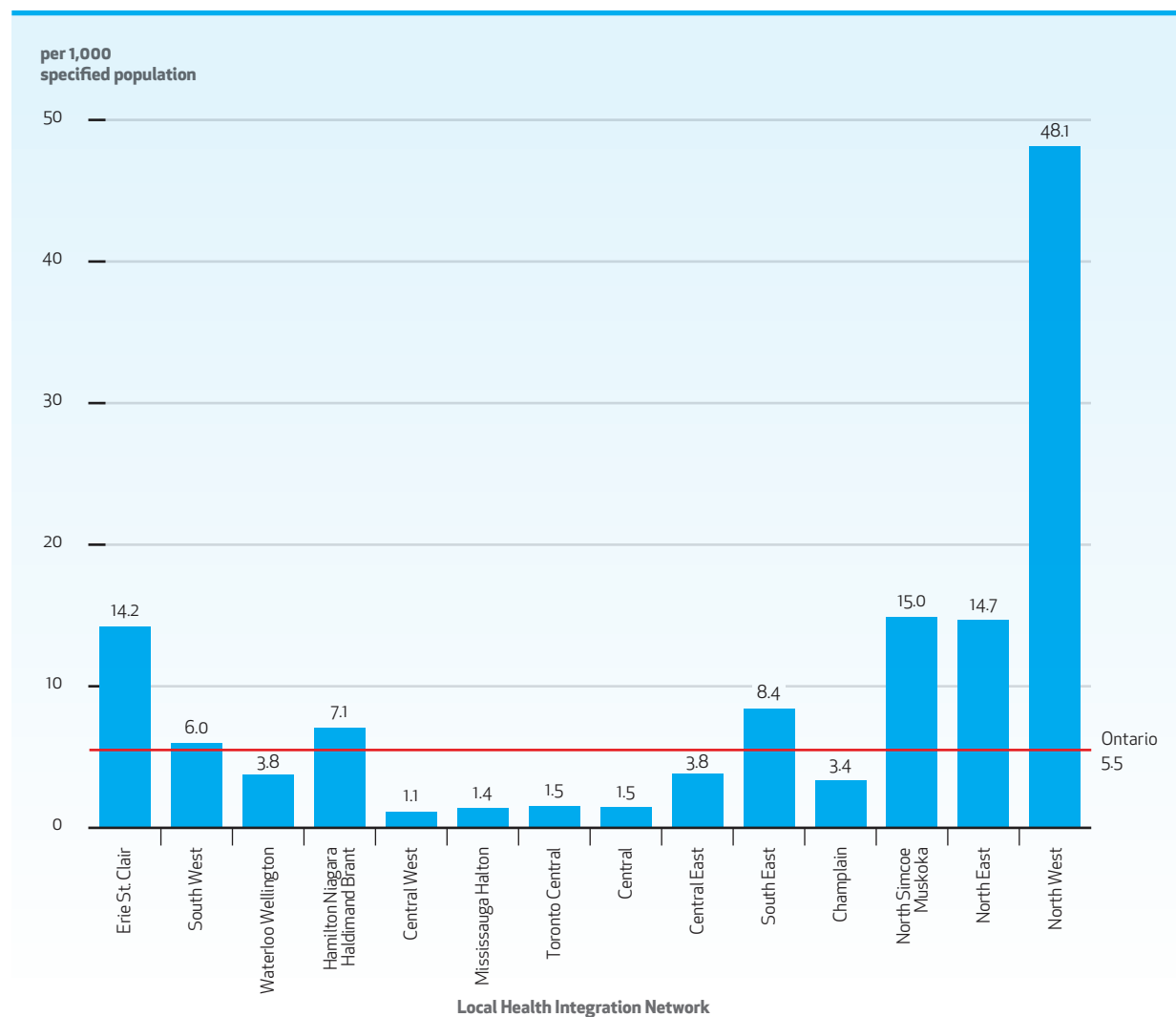
- Between 2010 and 2012, the prevalence of neonatal abstinence syndrome was much higher among infants whose mothers were non-immigrants.



**EXHIBIT 2.6.6** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (standardized), by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average rate of neonatal abstinence syndrome was highest in the North West LHIN, where it was considerably higher than the Ontario average. The lowest rate was found in the Central West LHIN.

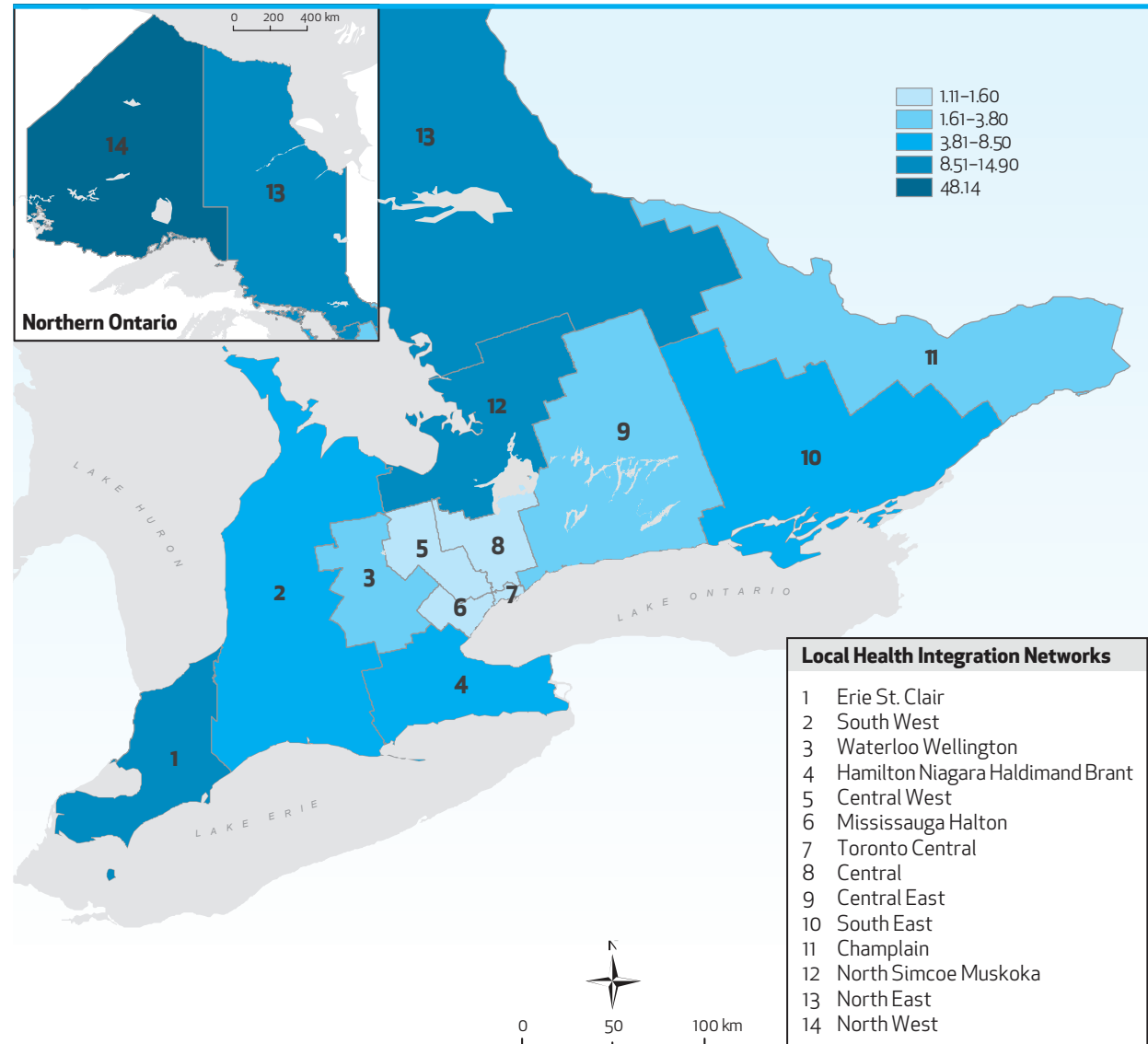




**EXHIBIT 2.6.7** Prevalence of neonatal abstinence syndrome per 1,000 hospital births (standardized), by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average rate of neonatal abstinence syndrome was highest in the North West LHIN, where it was considerably higher than the Ontario average. The lowest rate was found in the Central West LHIN.



## 2.7 Rate of deaths by suicide among children and youth

### Rationale

Suicide is one of the most common causes of death during adolescence. Understanding variations and trends in suicide rates may assist in identifying high-risk groups and designing appropriate interventions to reduce suicidal behaviours.

### Results

Rates of death by suicide were low among Ontario children and youth, and remained consistently low over time. Rates were about 2.5 times higher for males than for females and by age group, the highest rates of death by suicide were among those aged 20 to 24 years, while the lowest rates were found for those aged 10 to 14 years. Irrespective of age and sex, the most common method of suicide used was hanging and this was consistent over time. Rates of death by suicide were slightly higher among children and youth living in lower income neighbourhoods. Across immigrant categories, non-immigrants had the highest rates while the lowest rates were found among immigrants. By geography, the highest rates of death by suicide were found in northern Ontario, specifically the North West Local Health Integration Network and the Kenora/Rainy River Child and Youth Mental Health Service Area.

### Interpretation

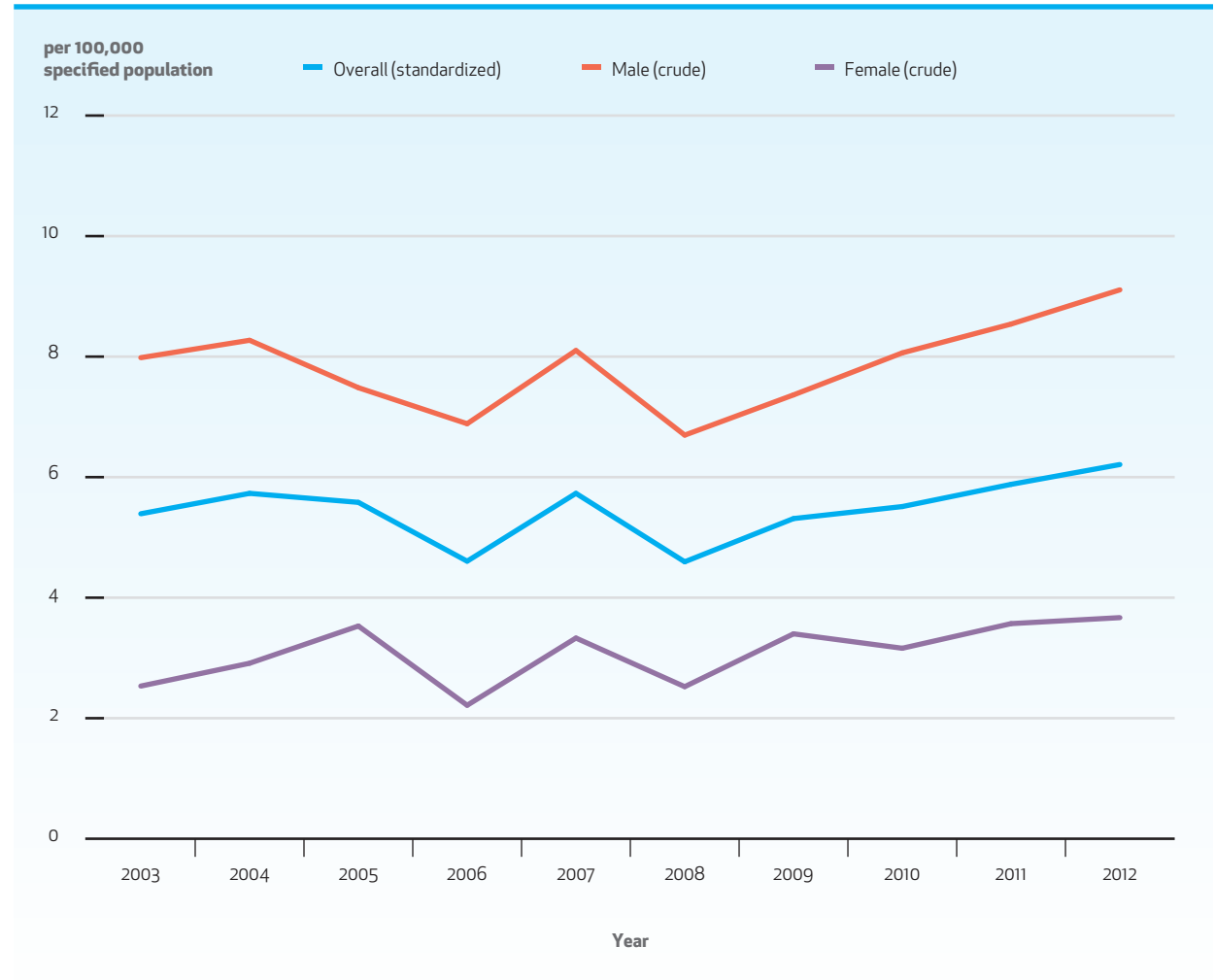
Suicide rates among children and youth were low and remained relatively stable between 2003 and 2012. However, geographic variation existed across the Local Health Integration Networks and Child and Youth Mental Health Service Areas. Rates were substantially higher in the northern regions, specifically, the North West LHIN and the Kenora/Rainy River Child and Youth Mental Health Service Area. Furthermore, while it appears that the suicide rate in the North West LHIN remained unchanged from our 2015 report,<sup>5</sup> the rate in the North East LHIN almost doubled. These findings indicate that children and youth living in northern Ontario are at a particularly high risk of suicide and that greater efforts surrounding prevention initiatives are required for this population.

<sup>5</sup> MHASEF Research Team. *The Mental Health of Children and Youth in Ontario: A Baseline Scorecard*. Toronto, ON: Institute for Clinical Evaluative Sciences; 2015.

**EXHIBIT 2.7.1** Number of deaths by suicide per 100,000 population aged 10 to 24 years, overall and by sex, in Ontario, 2003 to 2012

## Key Finding

- From 2003 to 2012, the rate of deaths by suicide remained consistent and was higher among males than females.



**EXHIBIT 2.7.2** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by age group, in Ontario, 2003 to 2012

## Key Findings

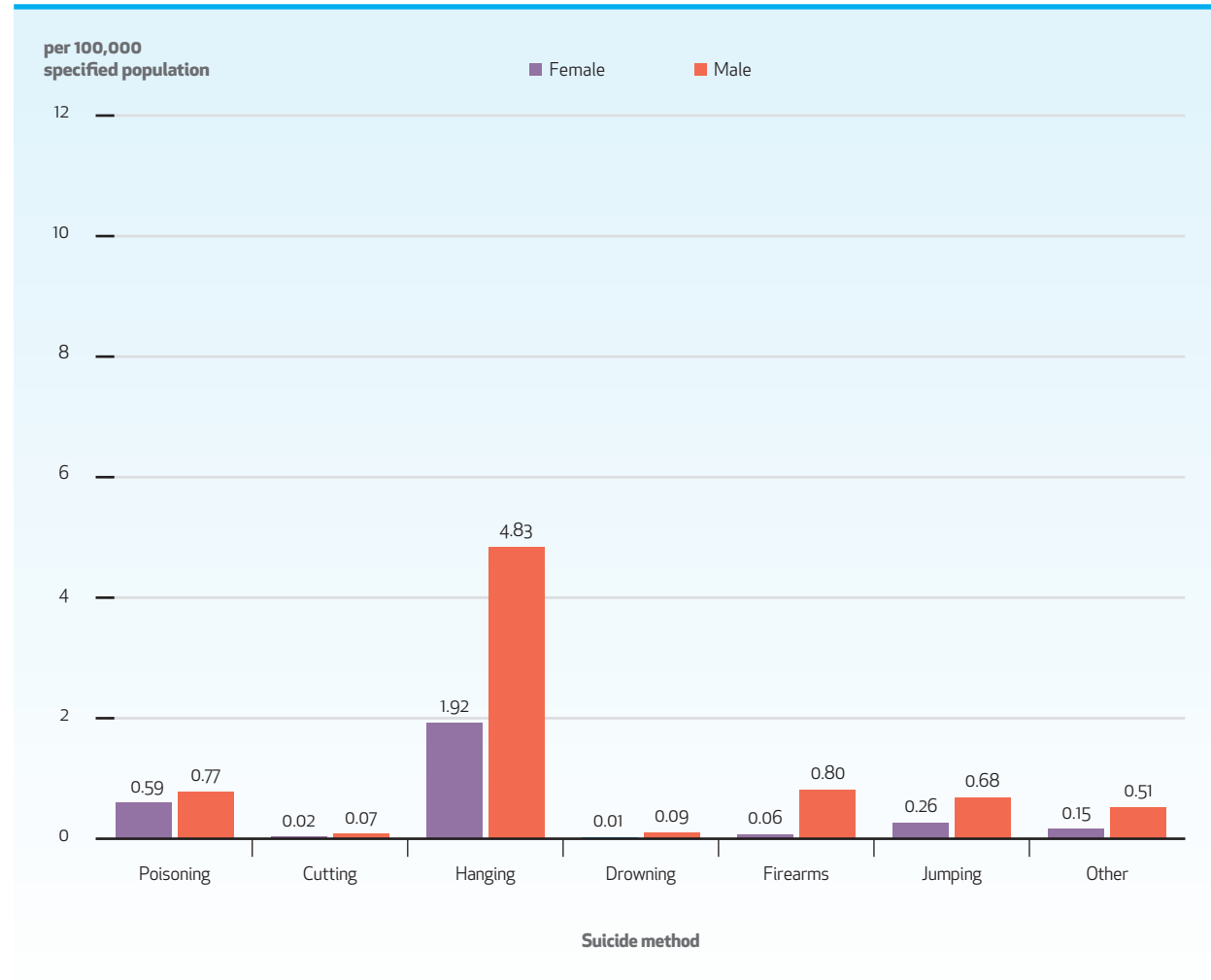
- From 2003 to 2012, the rate of deaths by suicide did not change across age groups.
- The rate was highest among individuals aged 20 to 24 and lowest among those aged 10 to 14.



**EXHIBIT 2.7.3** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by suicide method and sex, in Ontario, 2003 to 2012 combined

## Key Finding

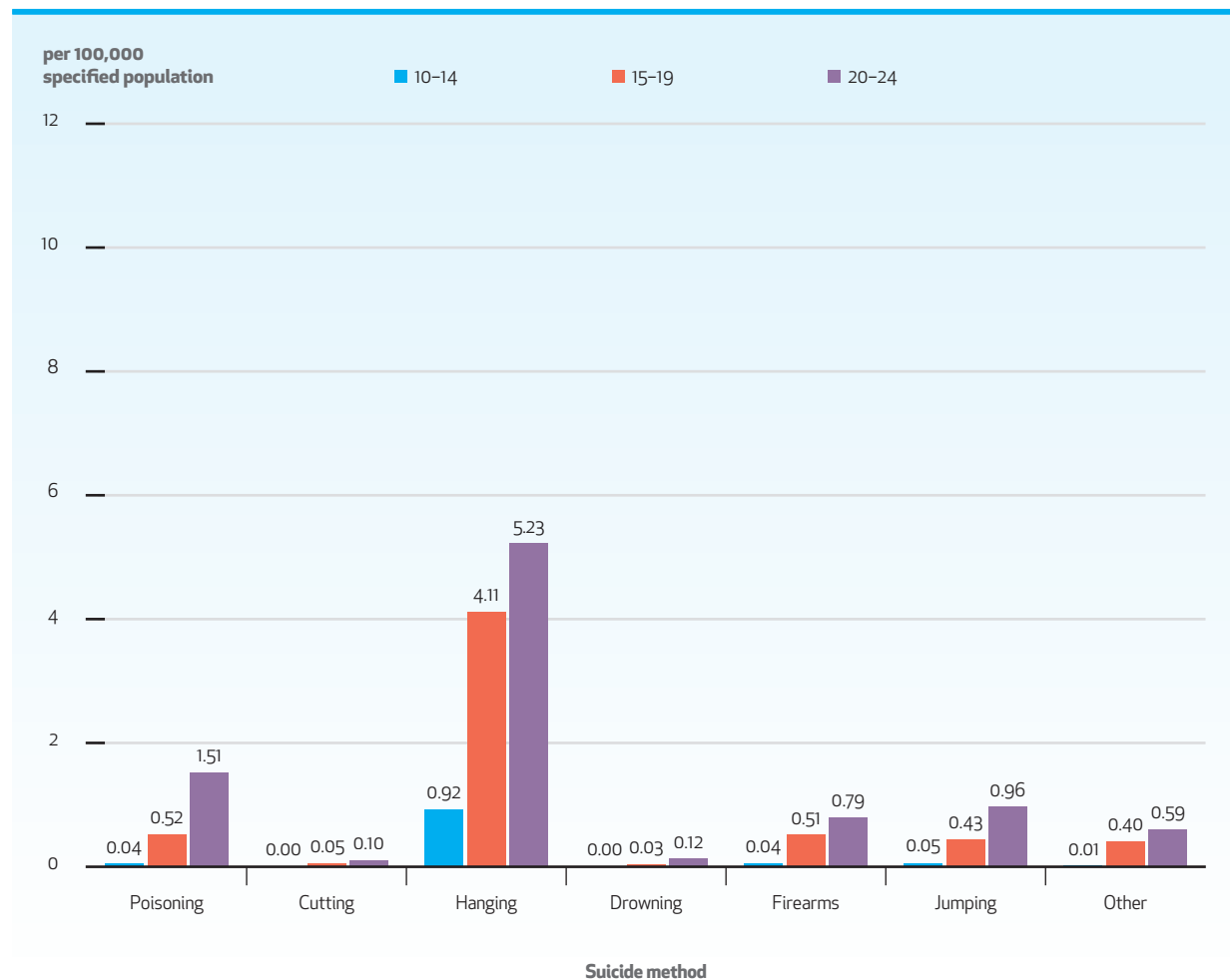
- Among children and youth, the most common method of suicide was hanging. This was consistent for both males and females.



**EXHIBIT 2.7.4** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by suicide method and age group, in Ontario, 2003 to 2012 combined

## Key Finding

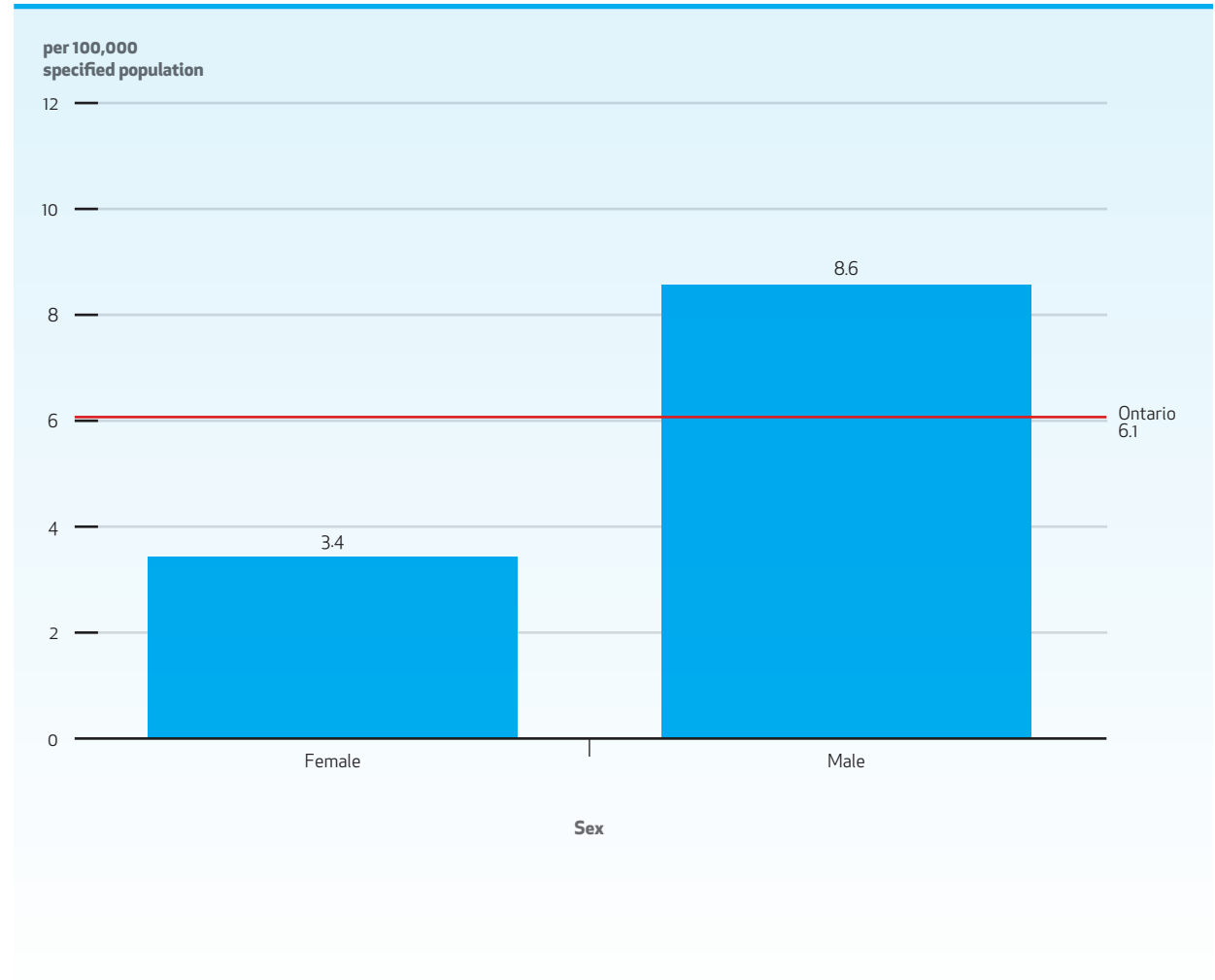
- Across age groups, the most common method of suicide was by hanging. This was followed by poisoning for those aged 20 to 24 and by either poisoning or firearms for those aged 15 to 19.



**EXHIBIT 2.7.5** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by sex, in Ontario, three-year average for 2010 to 2012

## Key Finding

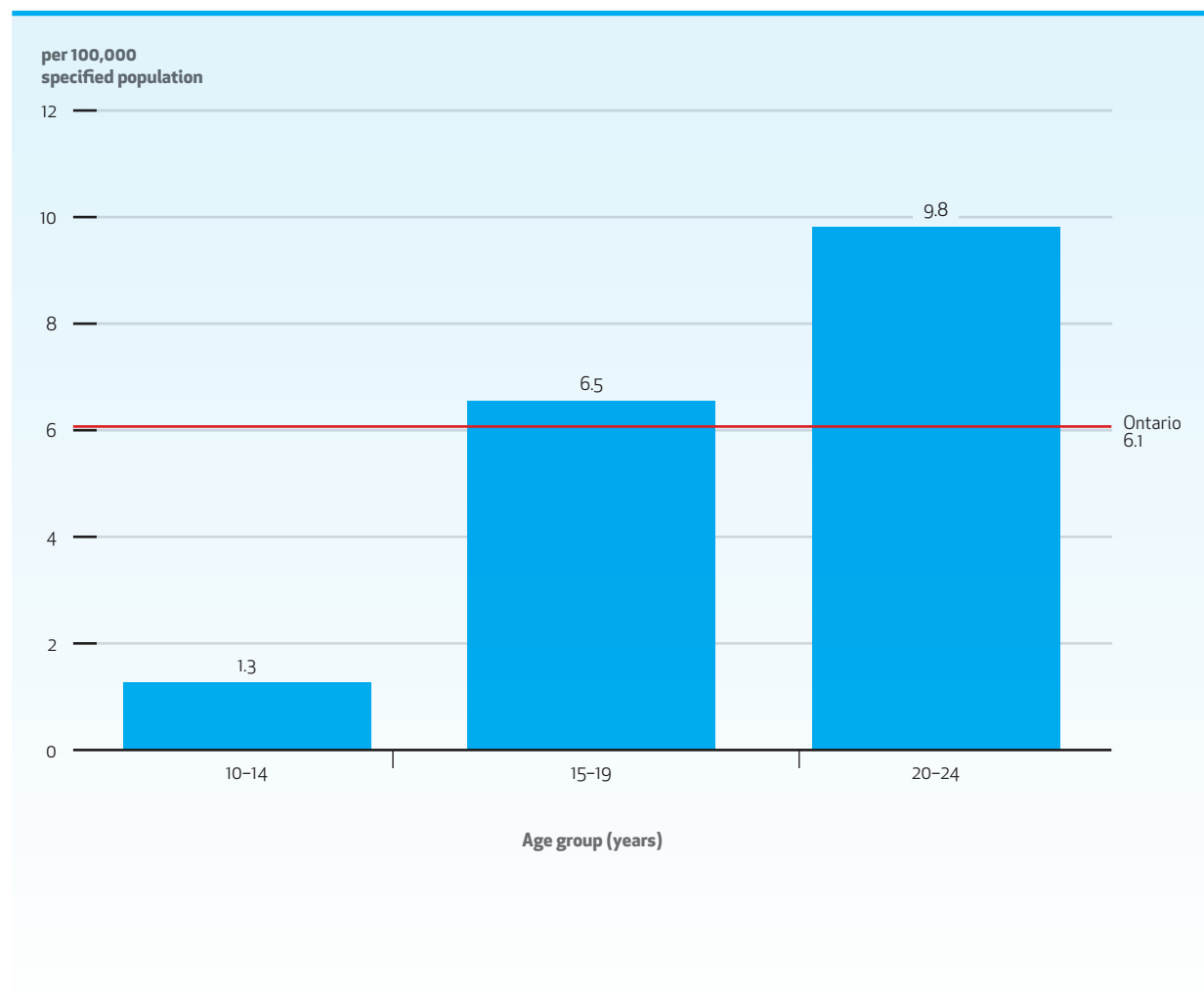
- Between 2010 and 2012, the average rate of death by suicide was approximately 2.5 times higher for males.



**EXHIBIT 2.7.6** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by age group, in Ontario, three-year average for 2010 to 2012

## Key Finding

- From 2010 to 2012, the average rates of death by suicide were higher among older children and youth, with the highest rate being among those aged 20 to 24.

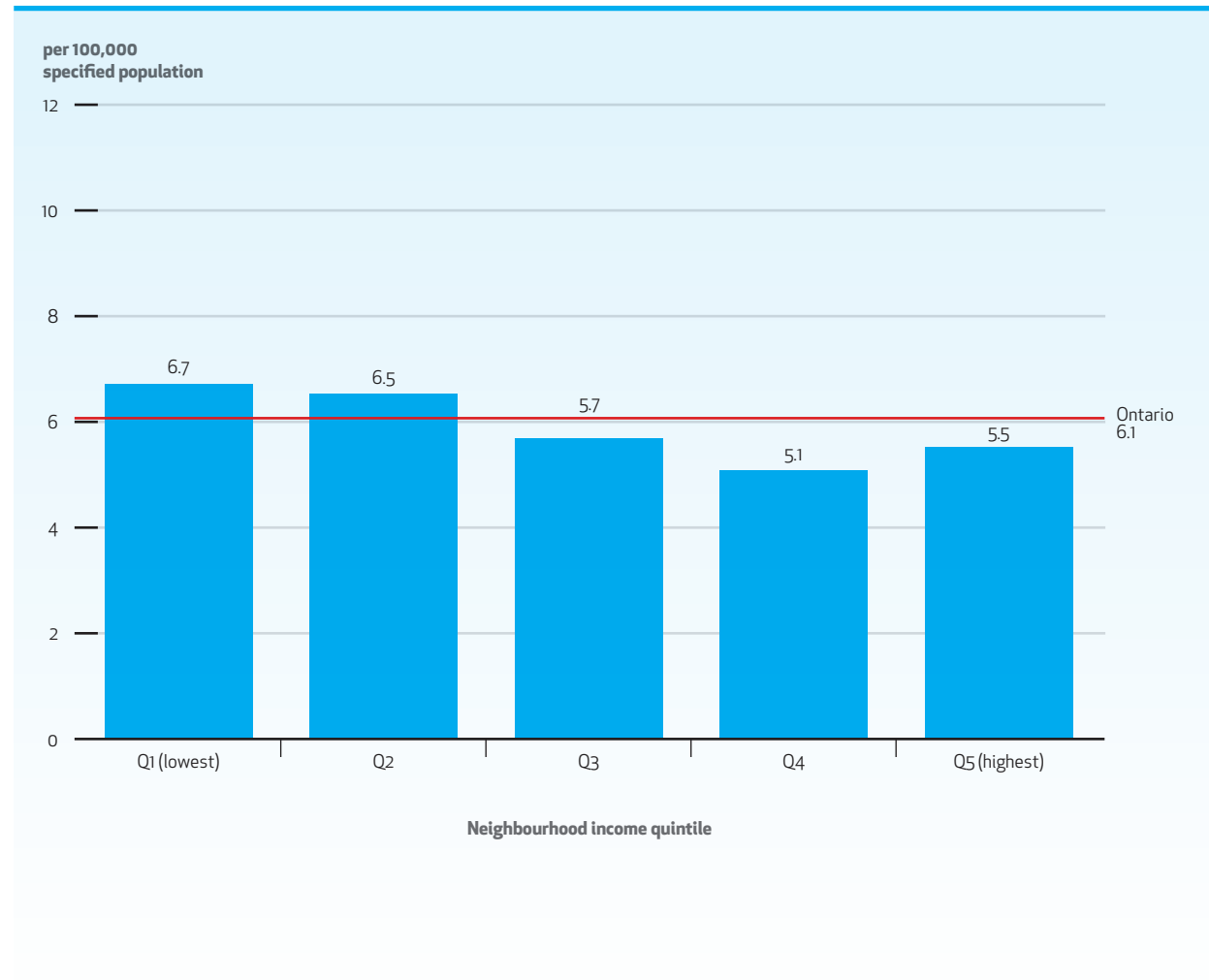




**EXHIBIT 2.7.7** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2010 to 2012

## Key Finding

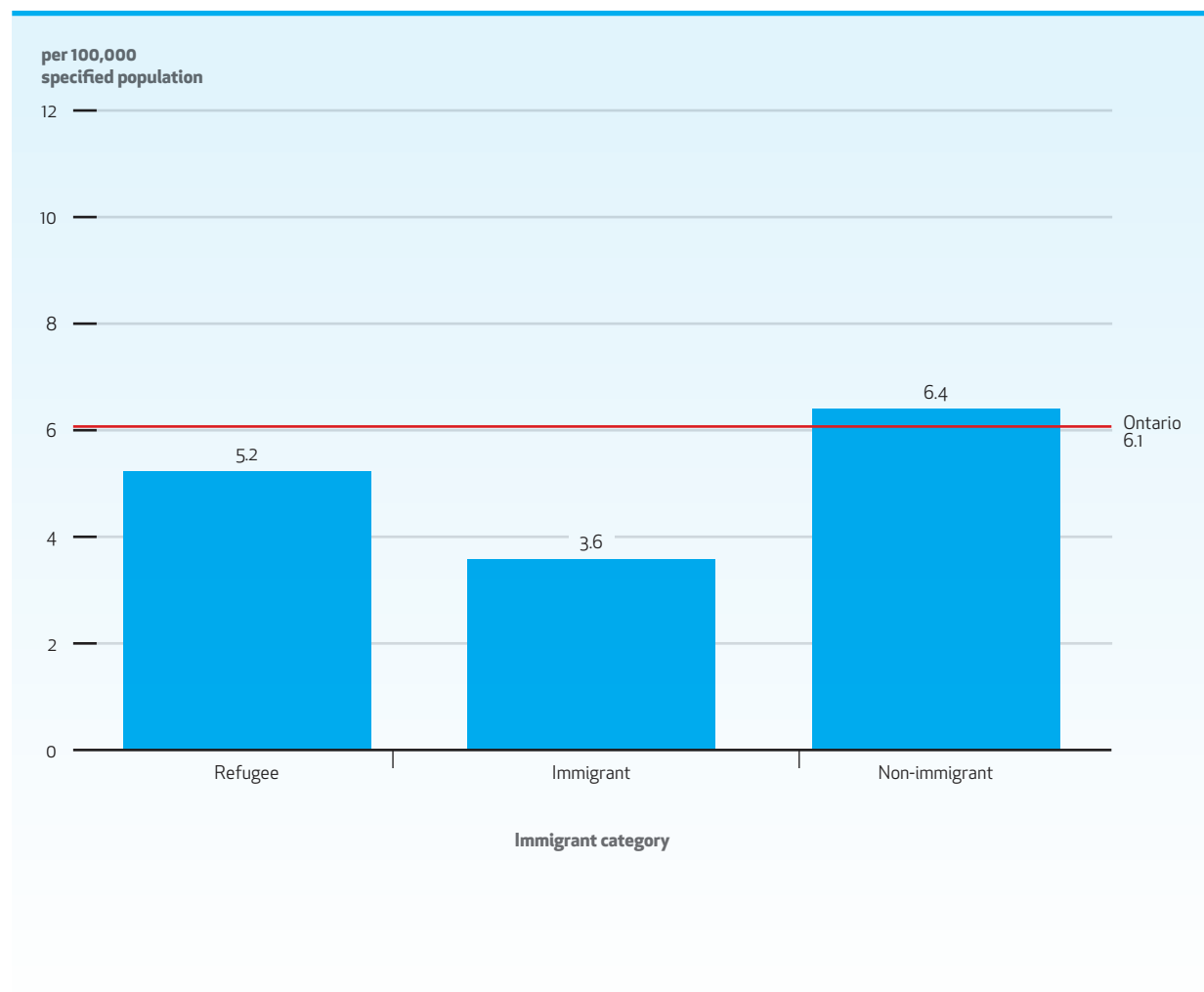
- Between 2010 and 2012, the average rate of death by suicide was higher among children and youth who lived in poorer neighbourhoods.



**EXHIBIT 2.7.8** Number of deaths by suicide per 100,000 crude population aged 10 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

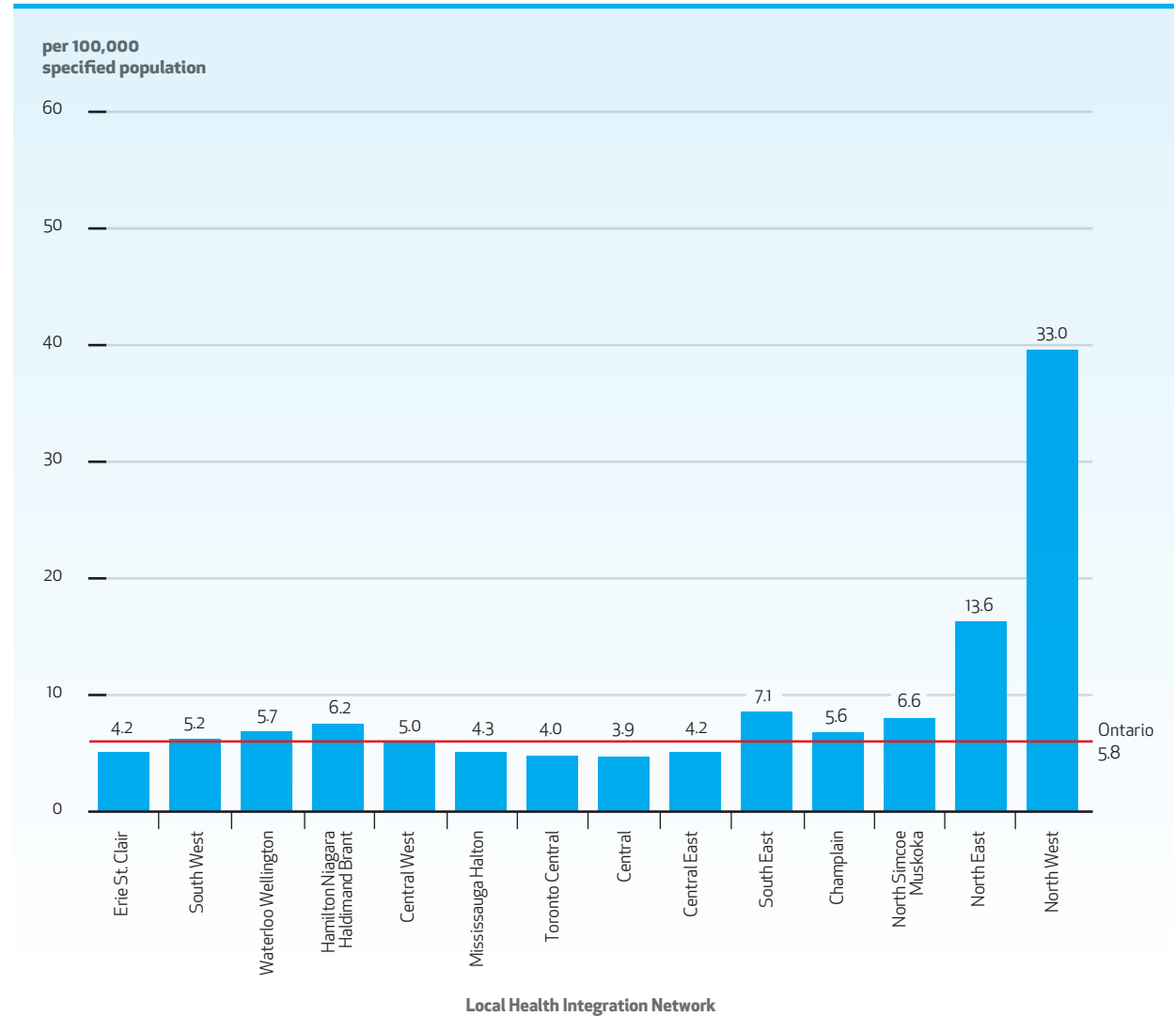
- Between 2010 and 2012, the average rate of death by suicide among children and youth was higher for non-immigrants and lower for immigrants.



**EXHIBIT 2.7.9** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012

## Key Finding

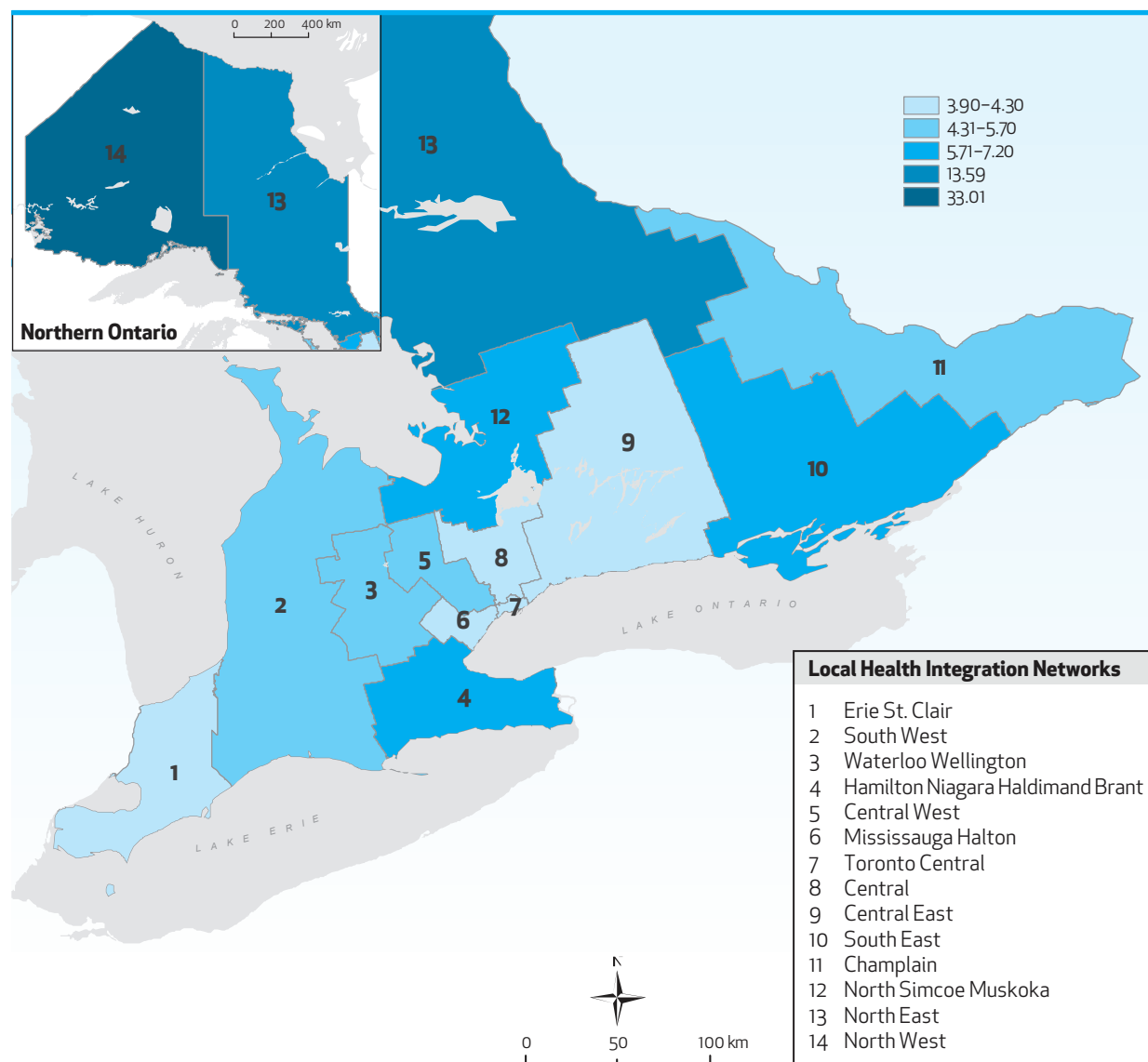
- From 2010 to 2012, the average rate of death by suicide was highest in the North West LHIN, which was considerably higher than the Ontario average.



**EXHIBIT 2.7.10** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2010 to 2012

## Key Finding

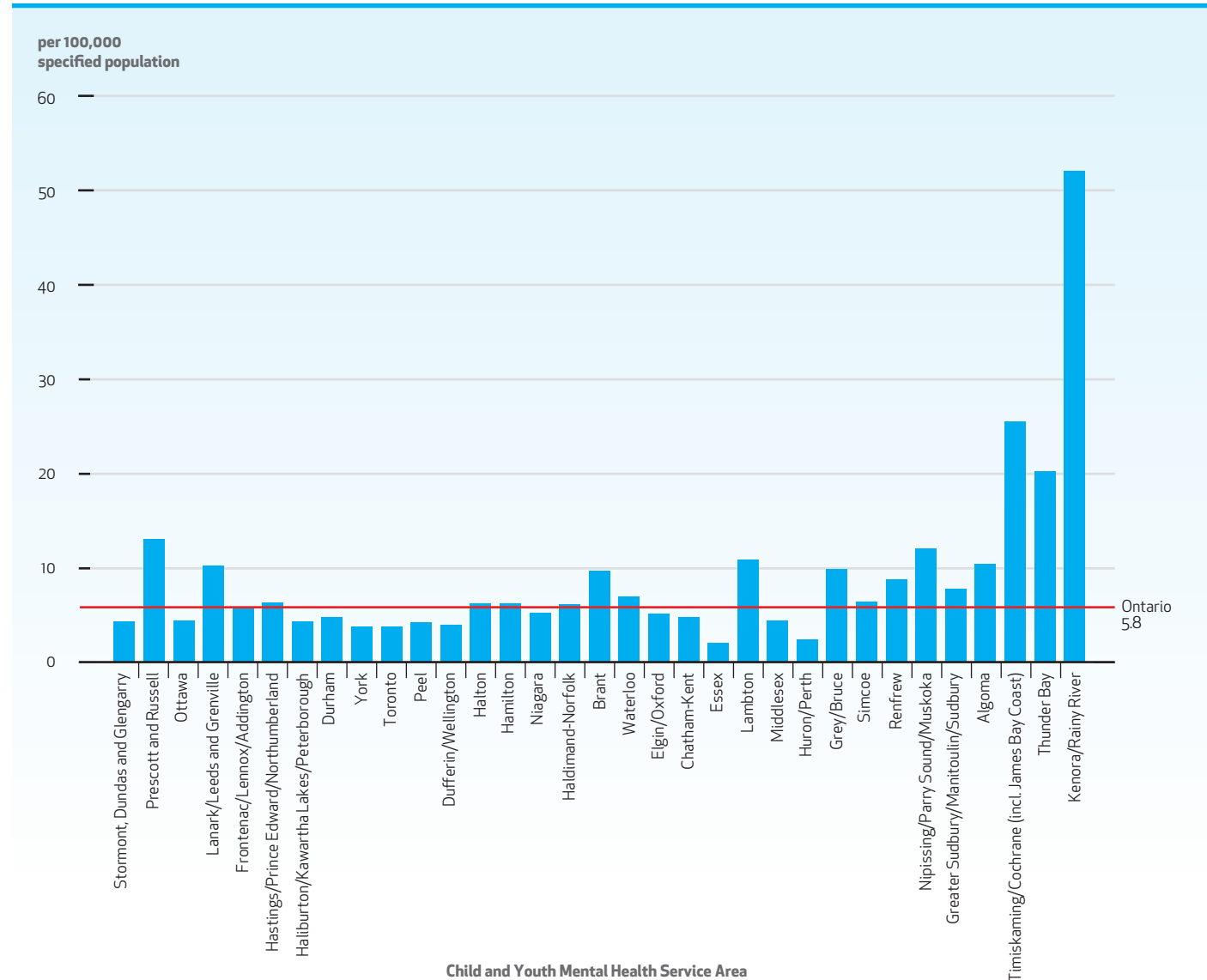
- From 2010 to 2012, the average rate of death by suicide was highest in the North West LHIN, which was considerably higher than the Ontario average.



**EXHIBIT 2.7.11** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2010 to 2012

## Key Finding

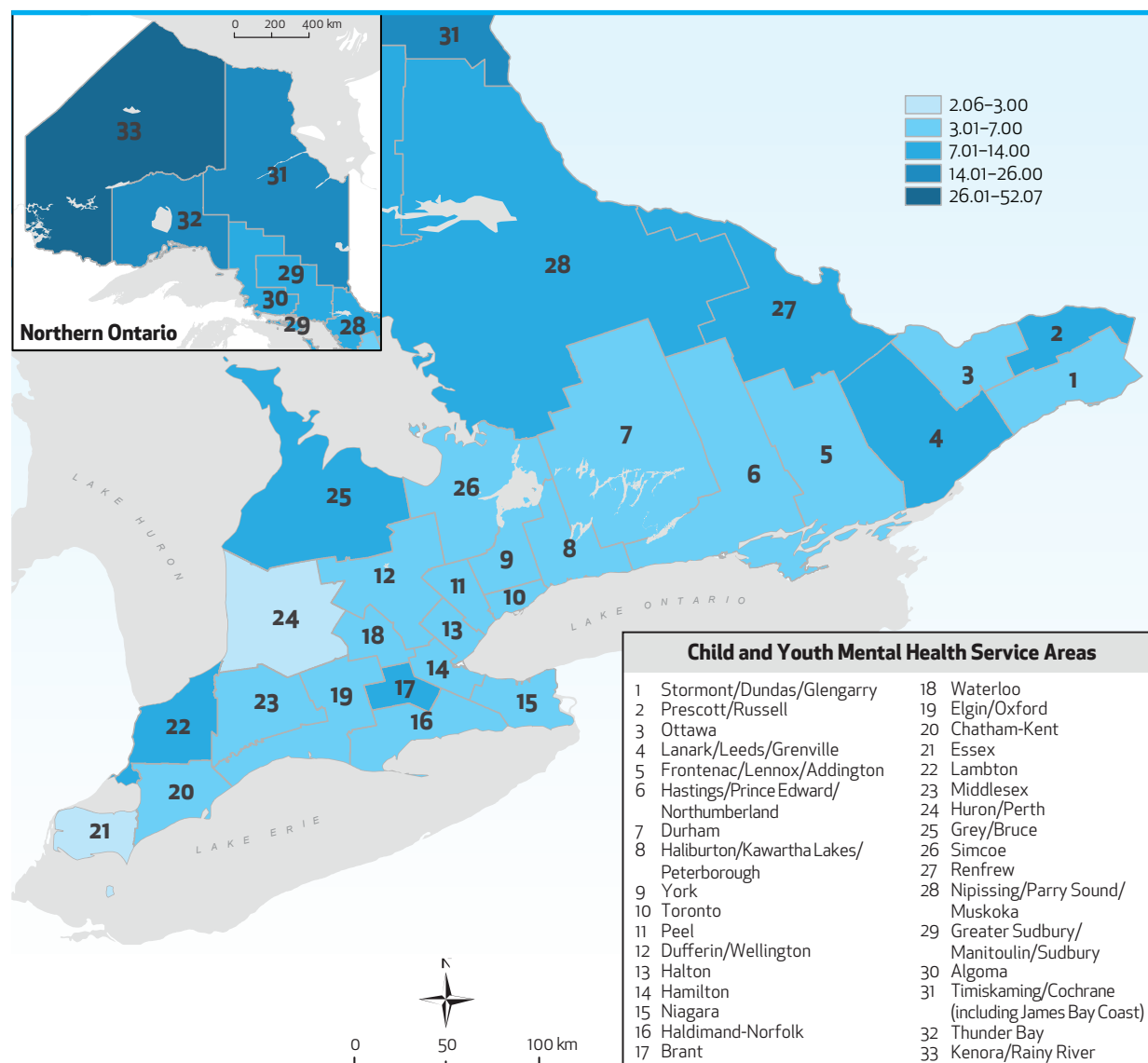
- Between 2010 and 2012, the average rate of death by suicide was highest among children and youth living in the northern Child and Youth Mental Health Service Areas, particularly Kenora/Rainy River, Timiskaming/Cochrane, and Thunder Bay.



**EXHIBIT 2.7.12** Number of deaths by suicide per 100,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2010 to 2012

## Key Finding

- Between 2010 and 2012, the average rate of death by suicide was highest among children and youth living in the northern Child and Youth Mental Health Service Areas, particularly Kenora/Rainy River, Timiskaming/Cochrane, and Thunder Bay.



## 2.8 Rate of emergency department visits for deliberate self-harm among children and youth

### Rationale

Deliberate self-harm refers to non-fatal self-poisoning or self-injury and encompasses a wide range of behaviours, from non-suicidal acts to attempted suicide (carried out with at least some intent to end one's life). These behaviours are important markers of mental health and may reflect unrecognized or under-treated disease, or a lack of access to mental health services.

### Results

Emergency department visits for deliberate self-harm have increased since 2011; this rise is largely driven by females and those aged 14 to 17 and 18 to 21 years. Emergency department visits for deliberate self-harm were approximately 2.5 times higher for females than for males. The most common method of self-harm among children and youth was self-poisoning, and this was consistent over time.

Children and youth living in poorer neighbourhoods had a higher rate of visits than those living in wealthier neighbourhoods. Across immigrant categories, non-immigrants had a higher rate of visits compared to refugees and immigrants. By geography, children and youth living in the North West LHIN and the Kenora/Rainy River Child and Youth Mental Health Service Area had the highest rates of emergency department visits for deliberate self-harm, compared to other LHINs and Service Areas, respectively.

### Interpretation

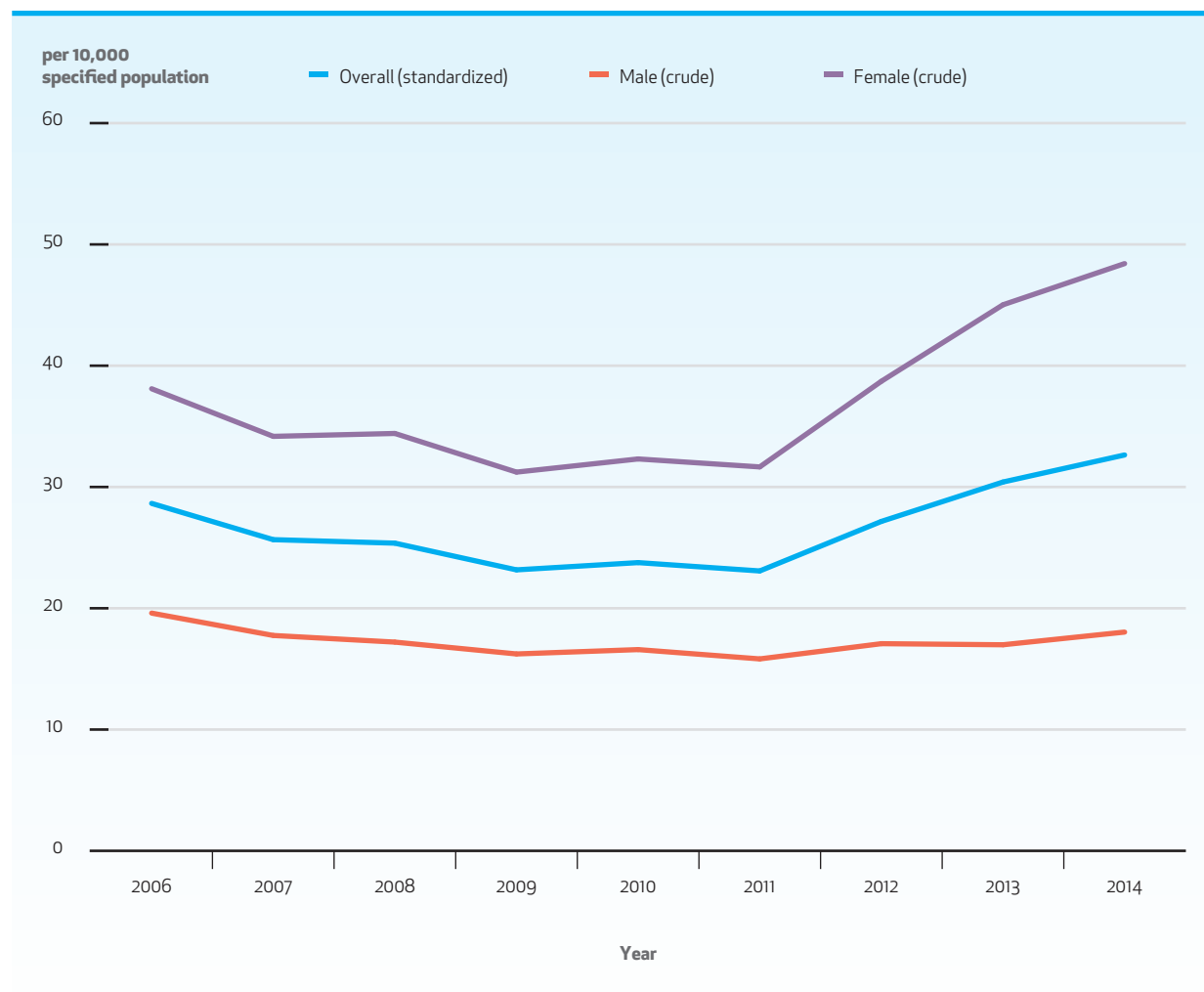
While rates of emergency department visits for deliberate self-harm were trending downward from 2006 to 2011, rates have increased since 2011. This may indicate increasing rates of untreated or inadequately treated mental health conditions among children and youth. The higher rates of emergency department visits for deliberate self-harm among females is consistent with previous evidence that indicates self-harm is more common among females while suicide deaths are more common among males.<sup>6</sup> Similar to our result for rates of death by suicide, emergency department visits for deliberate self-harm were more prevalent among children and youth living in lower-income neighbourhoods and in the northern Local Health Integration Networks and Child and Youth Mental Health Service Areas. A cause for concern, these findings indicate that social factors may be at play and that inequities in accessing timely services may also exist, particularly among those experiencing severe distress.

<sup>6</sup> Harrington R. Depression, suicide and deliberate self-harm in adolescence. *Br Med Bull.* 2001; 57:47–60.

**EXHIBIT 2.8.1** Number of emergency department visits for deliberate self-harm per 10,000 population aged 10 to 24 years, overall and by sex, in Ontario, 2006 to 2014

## Key Finding

- The overall rate of ED visits for deliberate self-harm was highest in 2014 and had been increasing since 2011. The rate was higher among females than males.

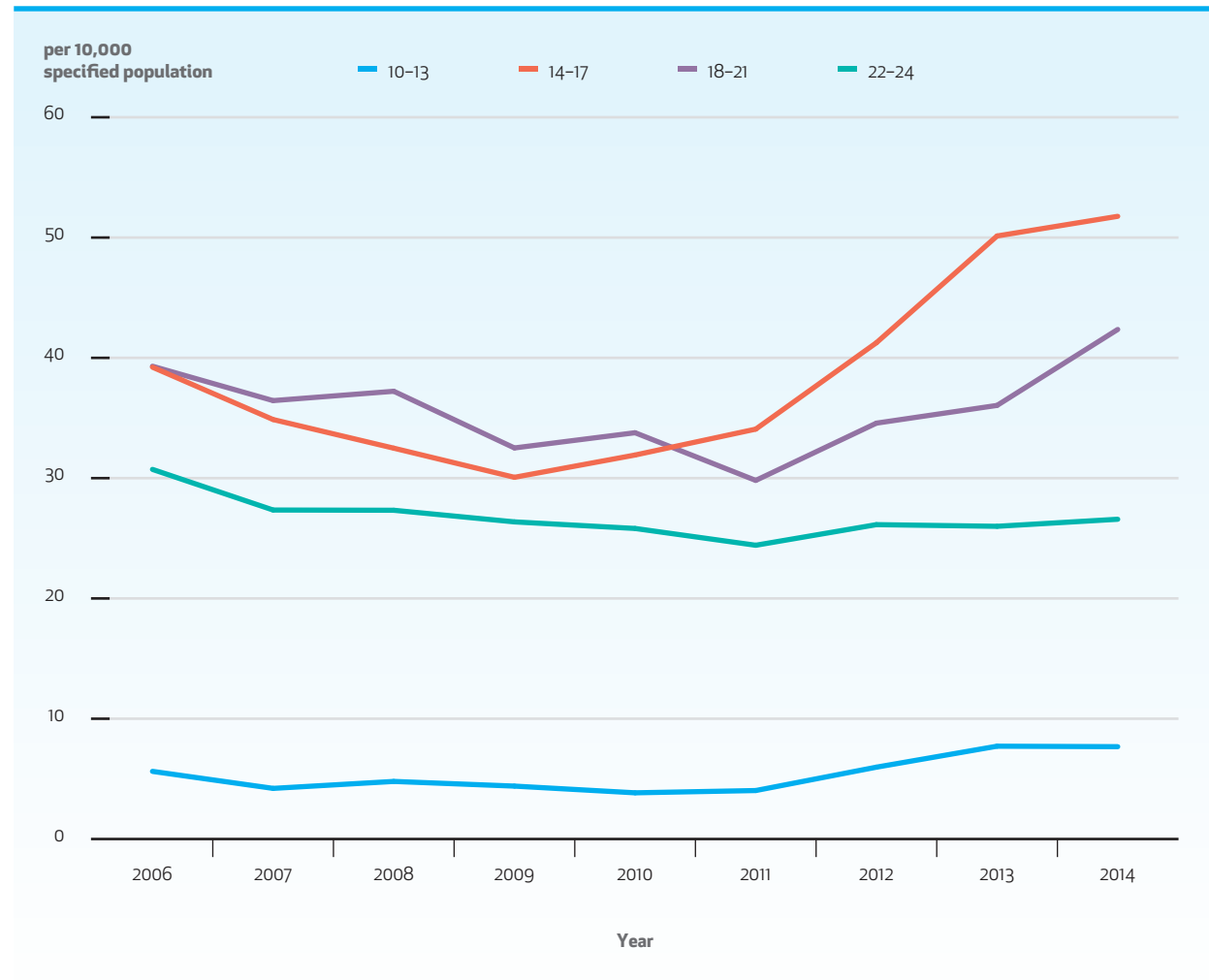




**EXHIBIT 2.8.2** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by age group, in Ontario, 2006 to 2014

## Key Finding

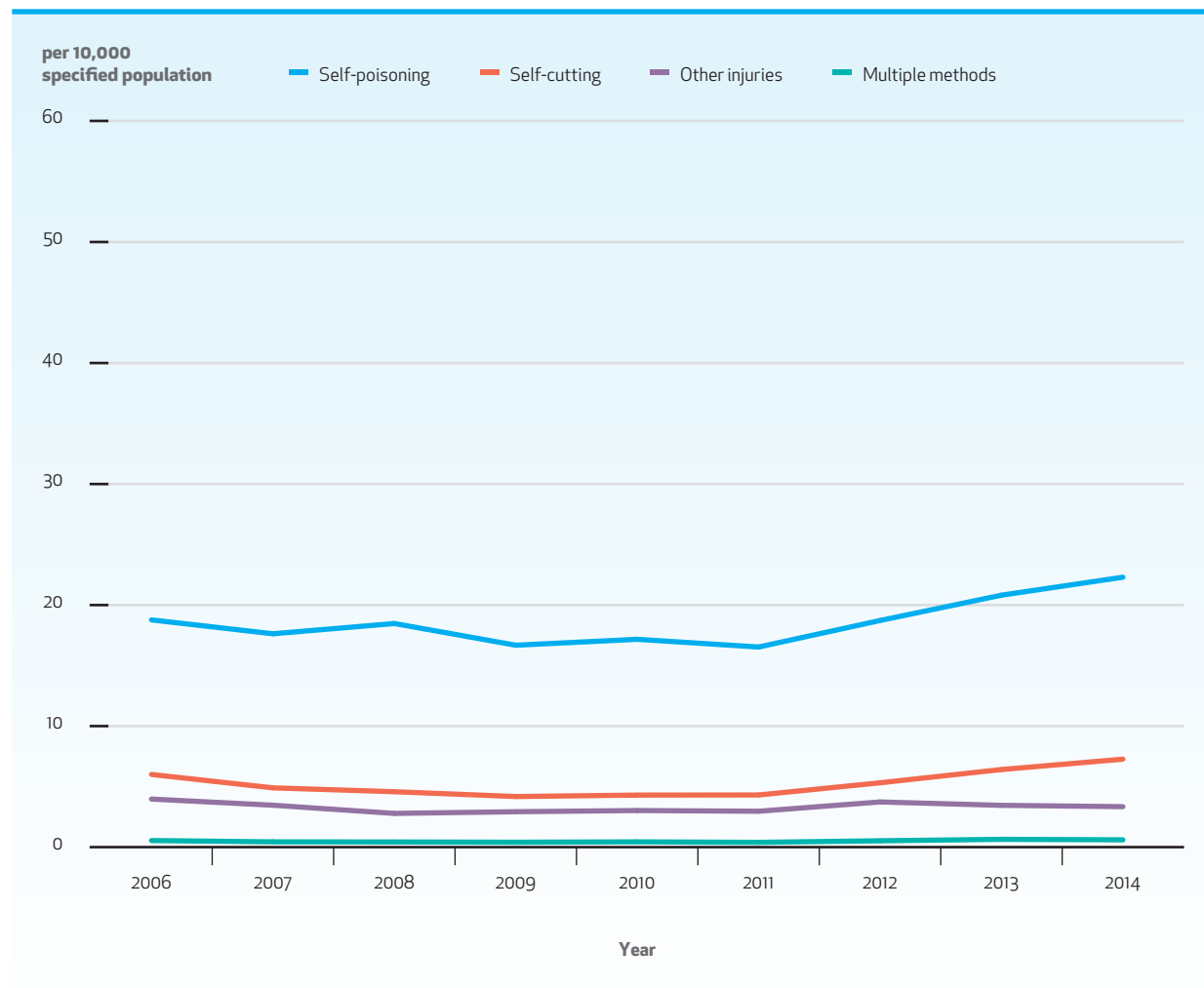
- Between 2006 and 2014, the ED visit rate for deliberate self-harm increased among youth aged 14 to 21, and was highest among those aged 14 to 17.



**EXHIBIT 2.8.3** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by method of self-harm, in Ontario, 2006 to 2014

## Key Finding

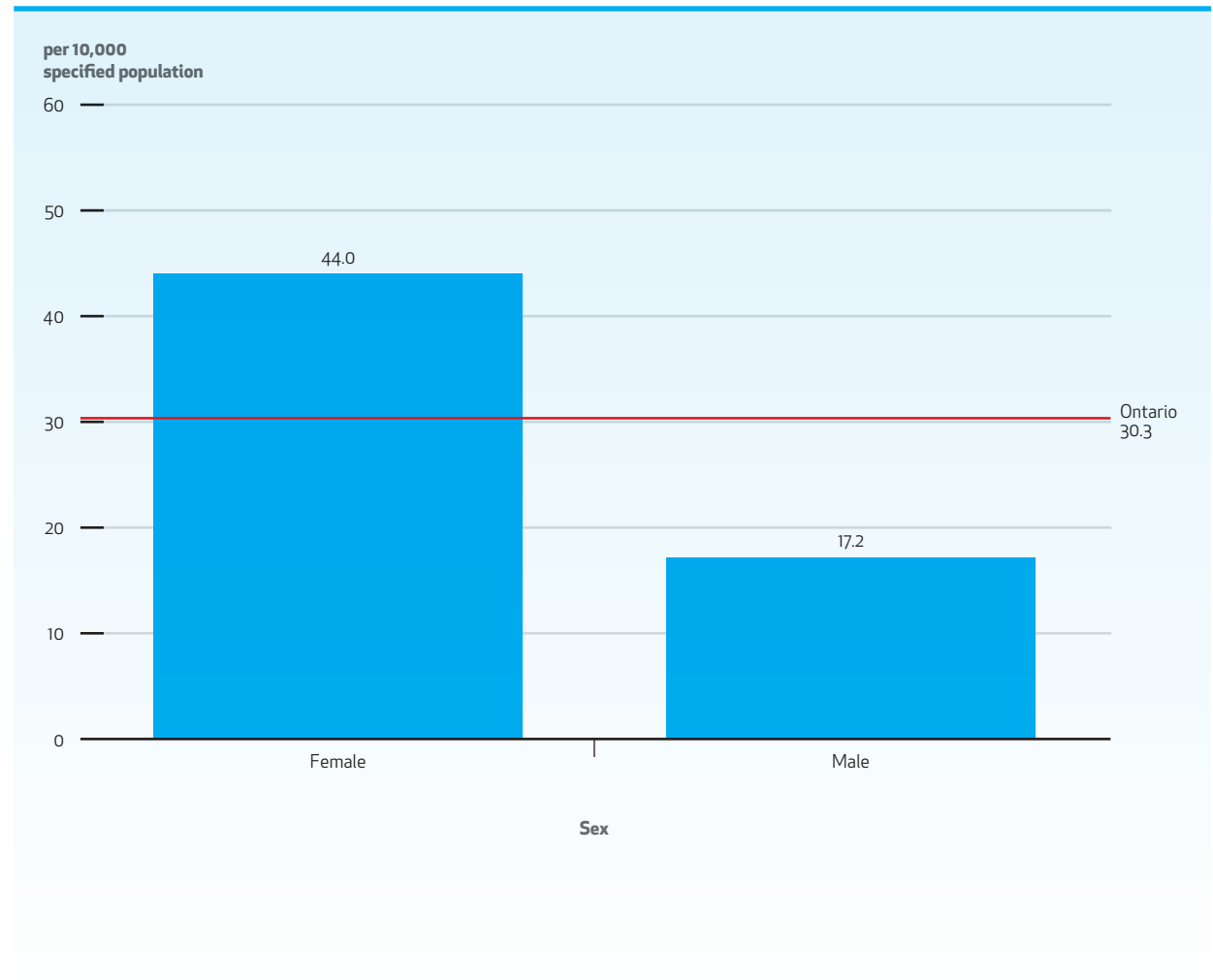
- Between 2006 and 2014, the most common method used for deliberate self-harm among children and youth was self-poisoning, and this was consistent over time.



**EXHIBIT 2.8.4** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

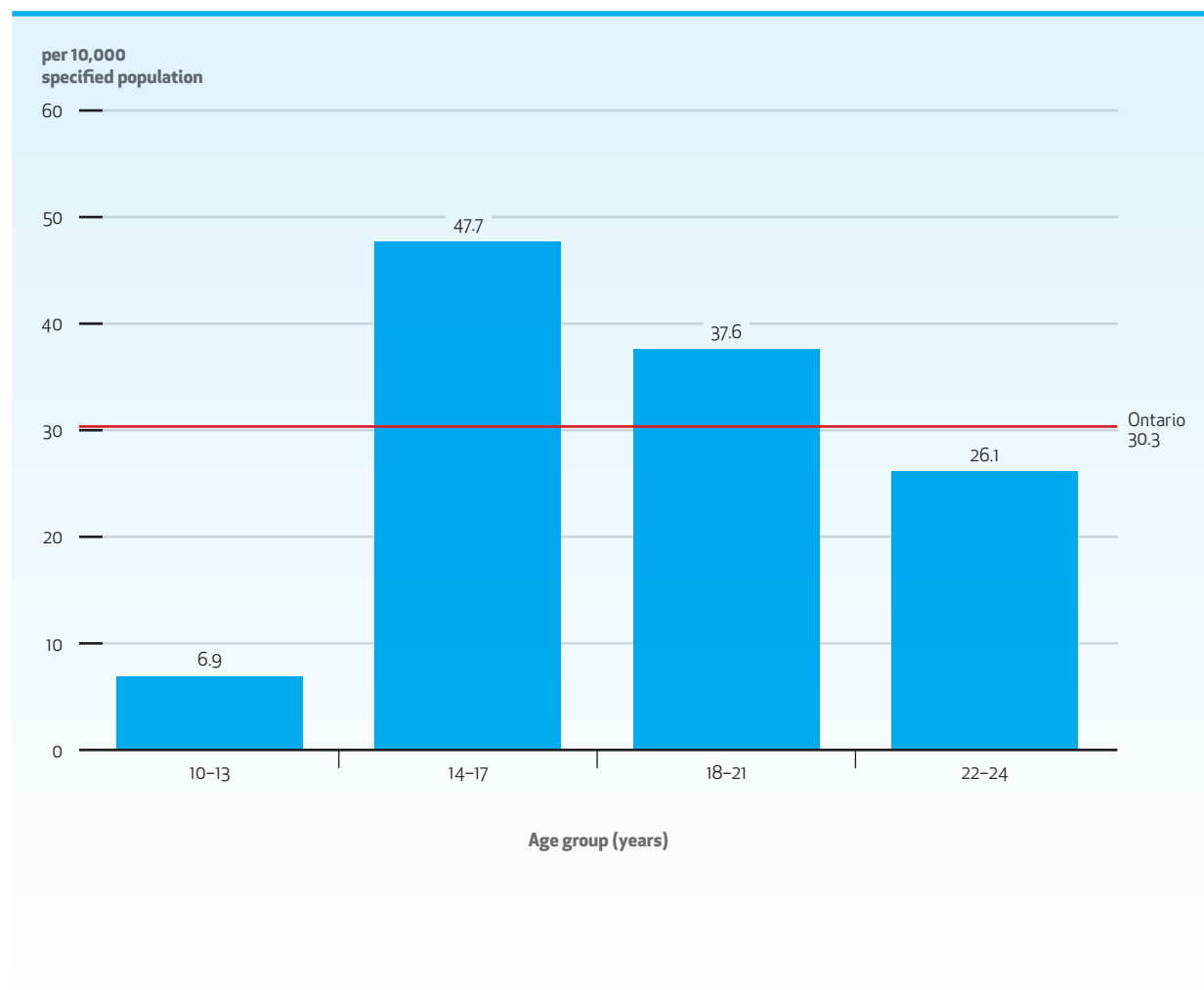
- Between 2012 and 2014, the average rate of ED visits for deliberate self-harm was approximately 2.5 times higher for females.



**EXHIBIT 2.8.5** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

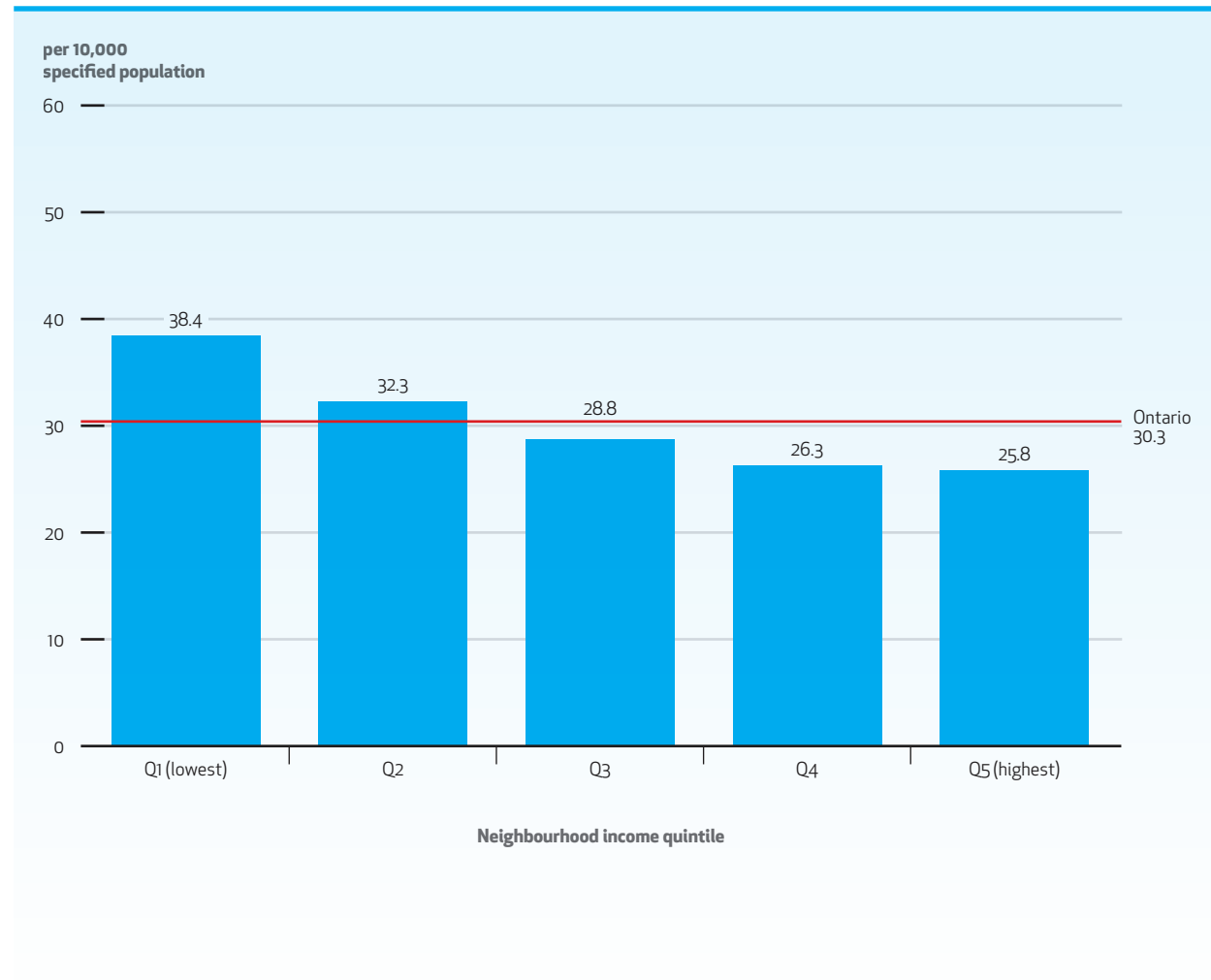
- From 2012 to 2014, the average rate of ED visits for deliberate self-harm was highest among youth aged 14 to 17 and lowest among children aged 10 to 13.



**EXHIBIT 2.8.6** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

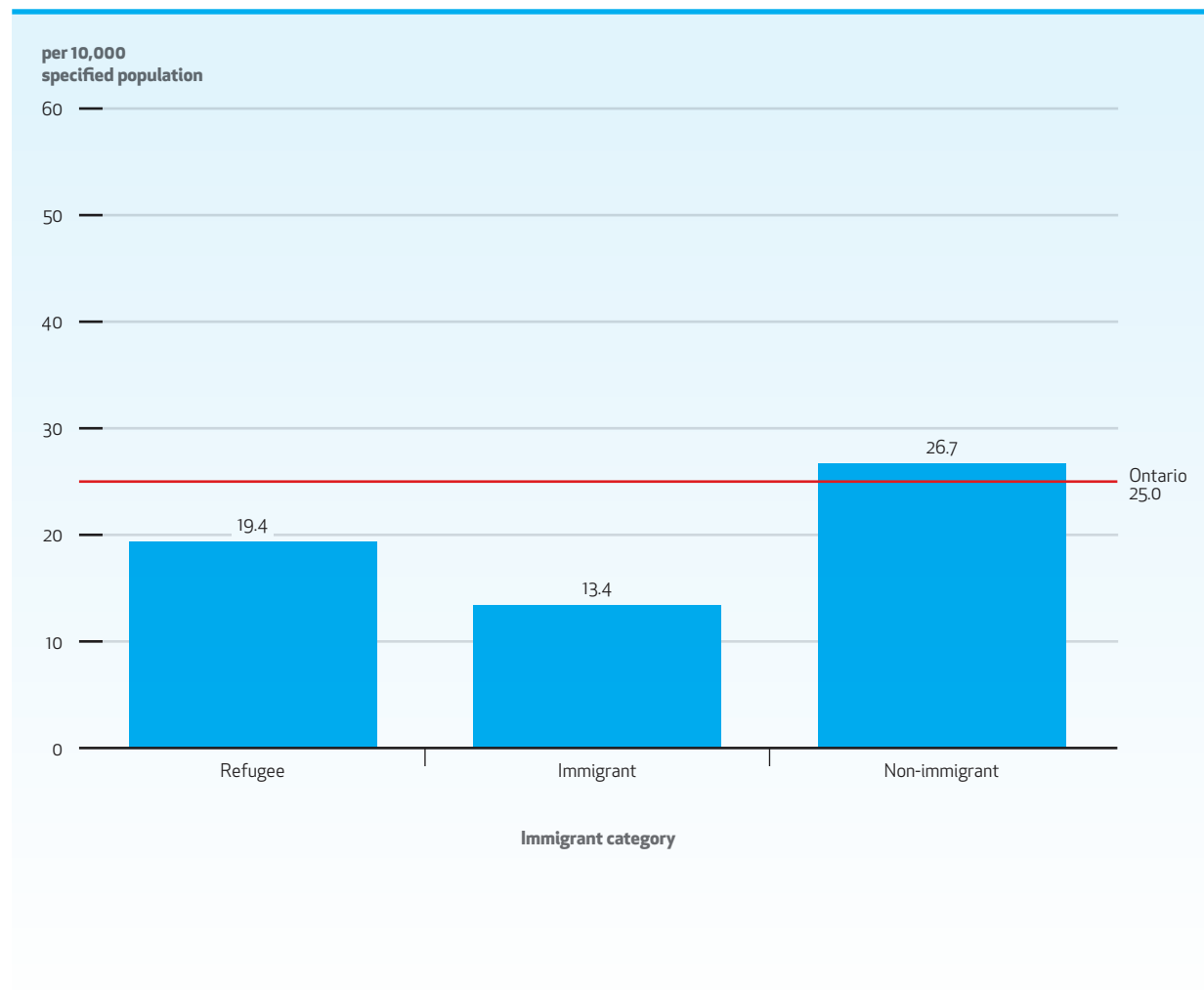
- Between 2012 and 2014, the average rate of ED visits for deliberate self-harm was higher among children and youth living in poorer neighbourhoods.



**EXHIBIT 2.8.7** Number of emergency department visits for deliberate self-harm per 10,000 crude population aged 10 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

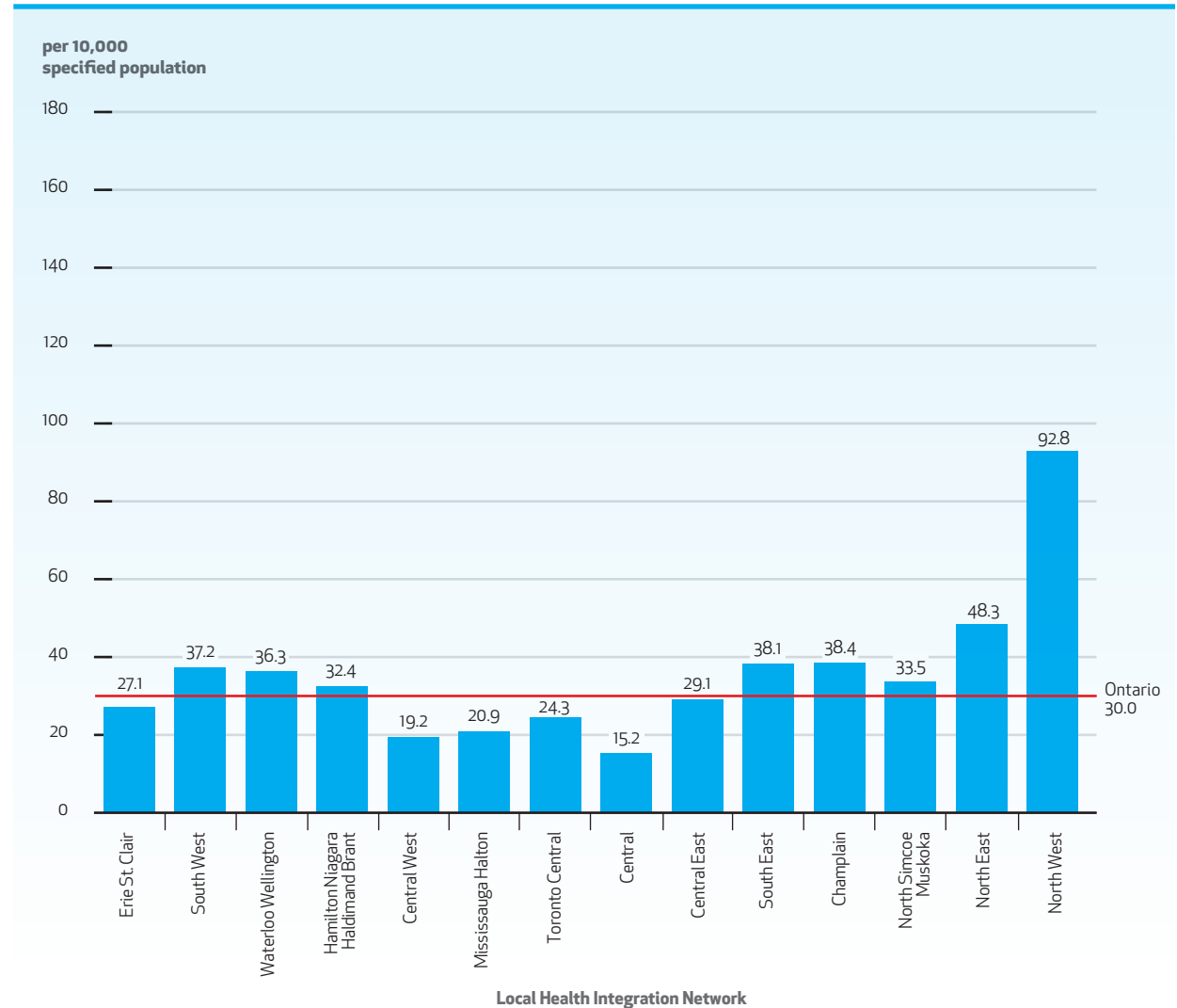
- Between 2010 and 2012, the average rate of ED visits for deliberate self-harm among children and youth was highest for non-immigrants.



**EXHIBIT 2.8.8** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Local Integration Health Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

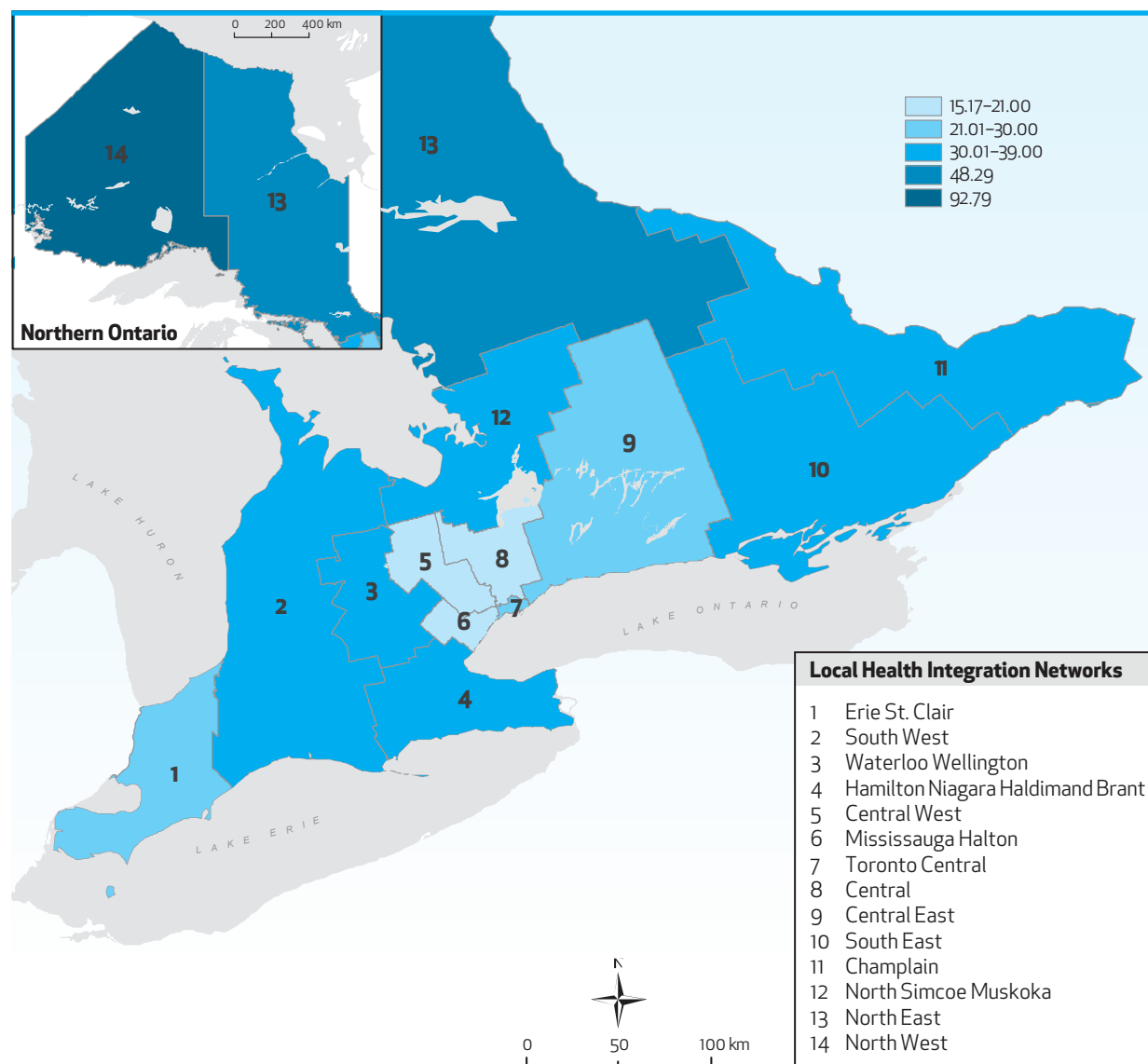
- From 2012 to 2014, the average rate of ED visits for deliberate self-harm was highest in the North West LHIN. This rate was considerably higher than the Ontario average.



**EXHIBIT 2.8.9** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average rate of ED visits for deliberate self-harm was highest in the North West LHIN. This rate was considerably higher than the Ontario average.

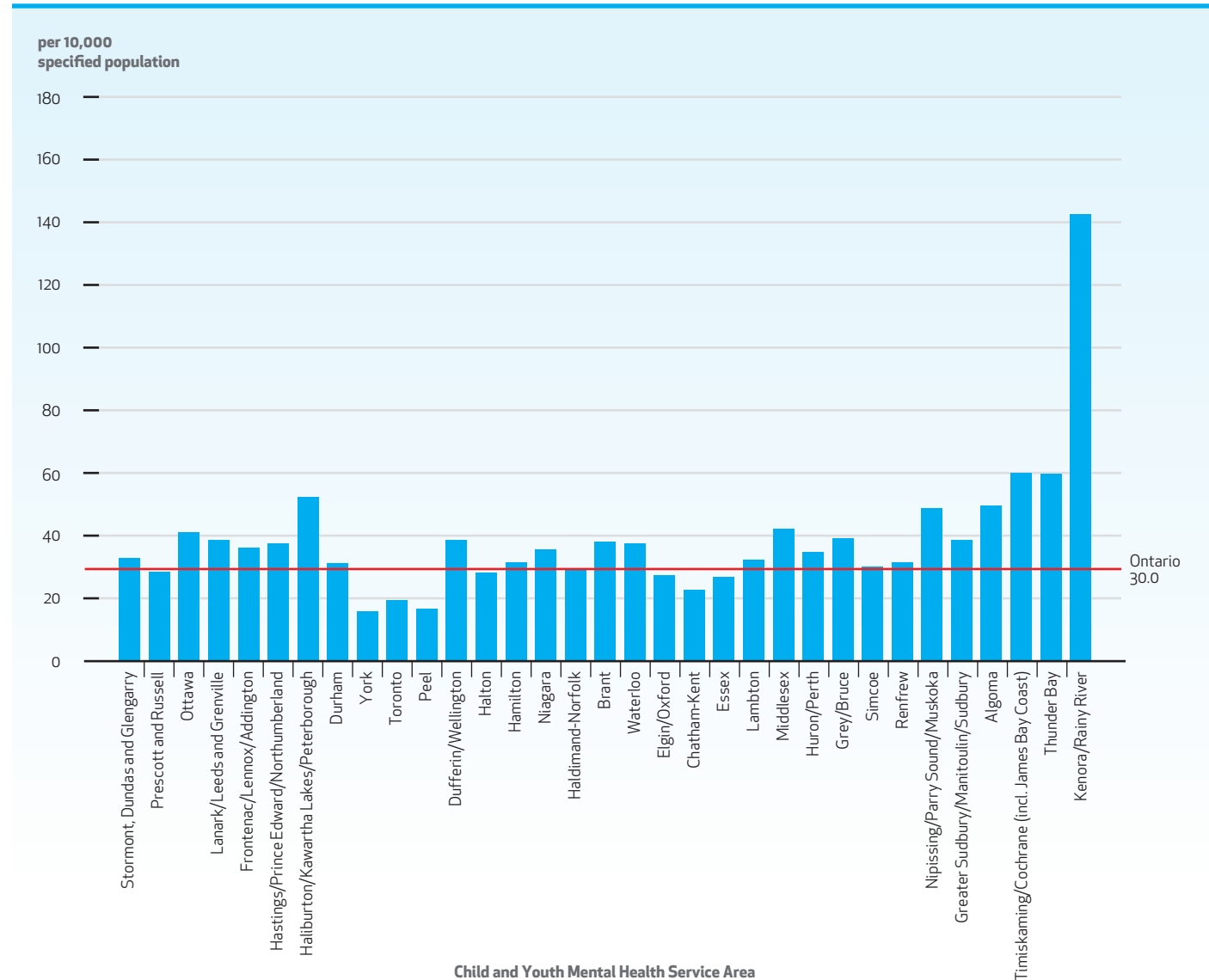




**EXHIBIT 2.8.10** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

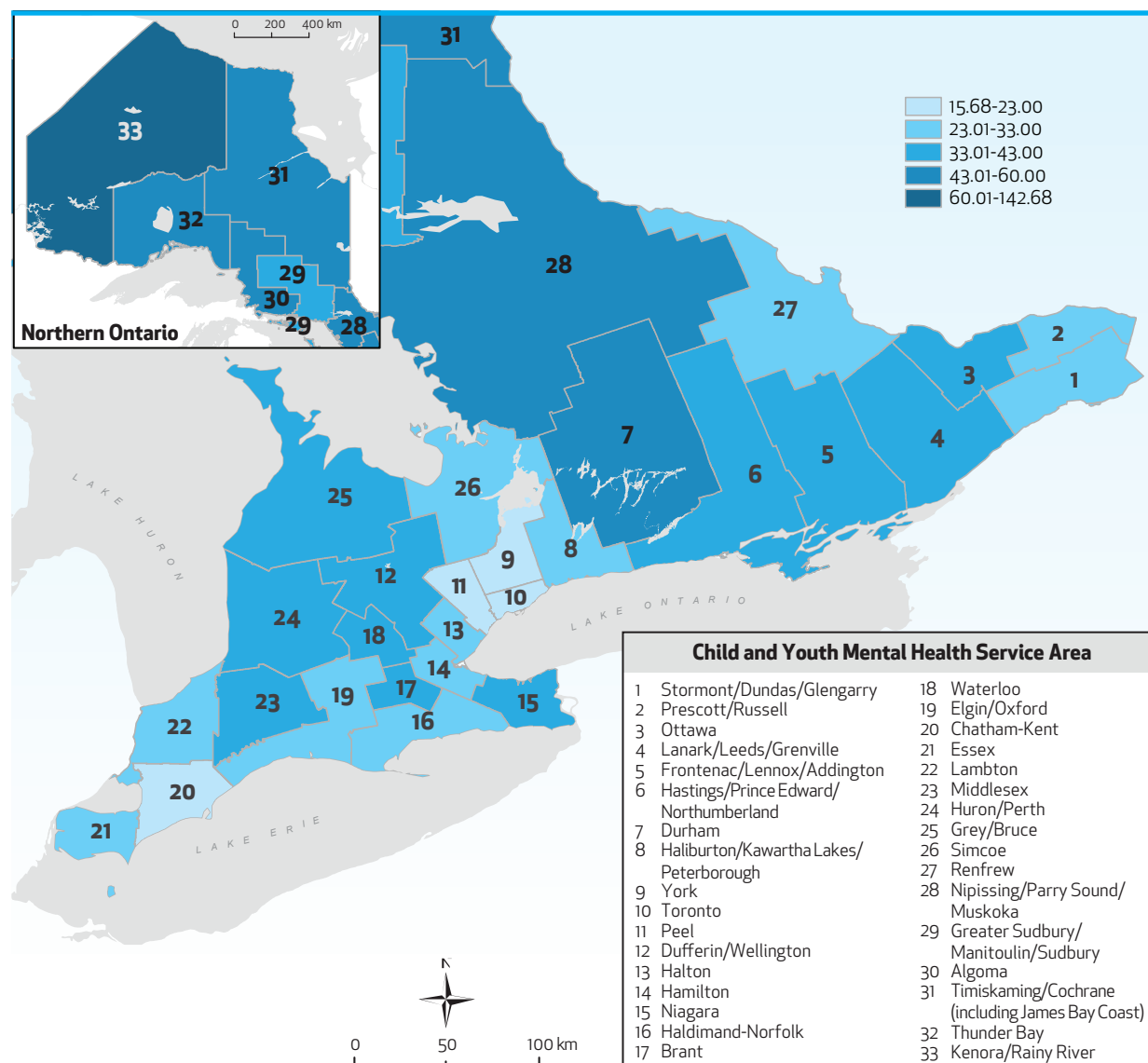
- Between 2012 and 2014, the average rate of ED visits for deliberate self-harm among Child and Youth Mental Health Service Areas was highest in Timiskaming/Cochrane and lowest in Kenora/Rainy River.



**EXHIBIT 2.8.11** Number of emergency department visits for deliberate self-harm per 10,000 standard population aged 10 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average rate of emergency department visits for deliberate self-harm among Child and Youth Mental Health Service Areas was highest in Timiskaming/Cochrane and lowest in Kenora/Rainy River.



## 2.9 Rate of emergency department visits related to mental health and addictions among children and youth

### Rationale

The use of emergency departments for mental health and addictions problems may signal a lack of early identification of mental health and addictions needs, as well as gaps in services available and accessible at the primary care and community levels.

### Results

Emergency department visits related to mental health and addictions problems have been increasing over time from 2006 to 2014 for both sexes and across most age groups. Rates of emergency department visits were highest among females and those aged 18 to 21 years. Irrespective of age, the most common reason for an emergency department visit was for anxiety disorder and rates have been steadily increasing. Rates of ED visits for mood disorders and substance-related disorders also increased, while rates of emergency department visits for schizophrenia, neurodevelopmental and other selected disorders, and for deliberate self-harm showed smaller increases over time.

Children and youth living in lower income neighbourhoods had higher rates of emergency department visits for mental health and addictions problems compared to those living in higher income neighbourhoods. Across immigrant categories, rates of visits were higher among refugees and non-immigrant children and youth compared to immigrants. By geography, the highest rates of visits for mental health and addictions problems were in the North West LHIN and the Kenora/Rainy River Child and Youth Mental Health Service Area, with the lowest rates found in the Central LHIN and the York Child and Youth Mental Health Service Area.

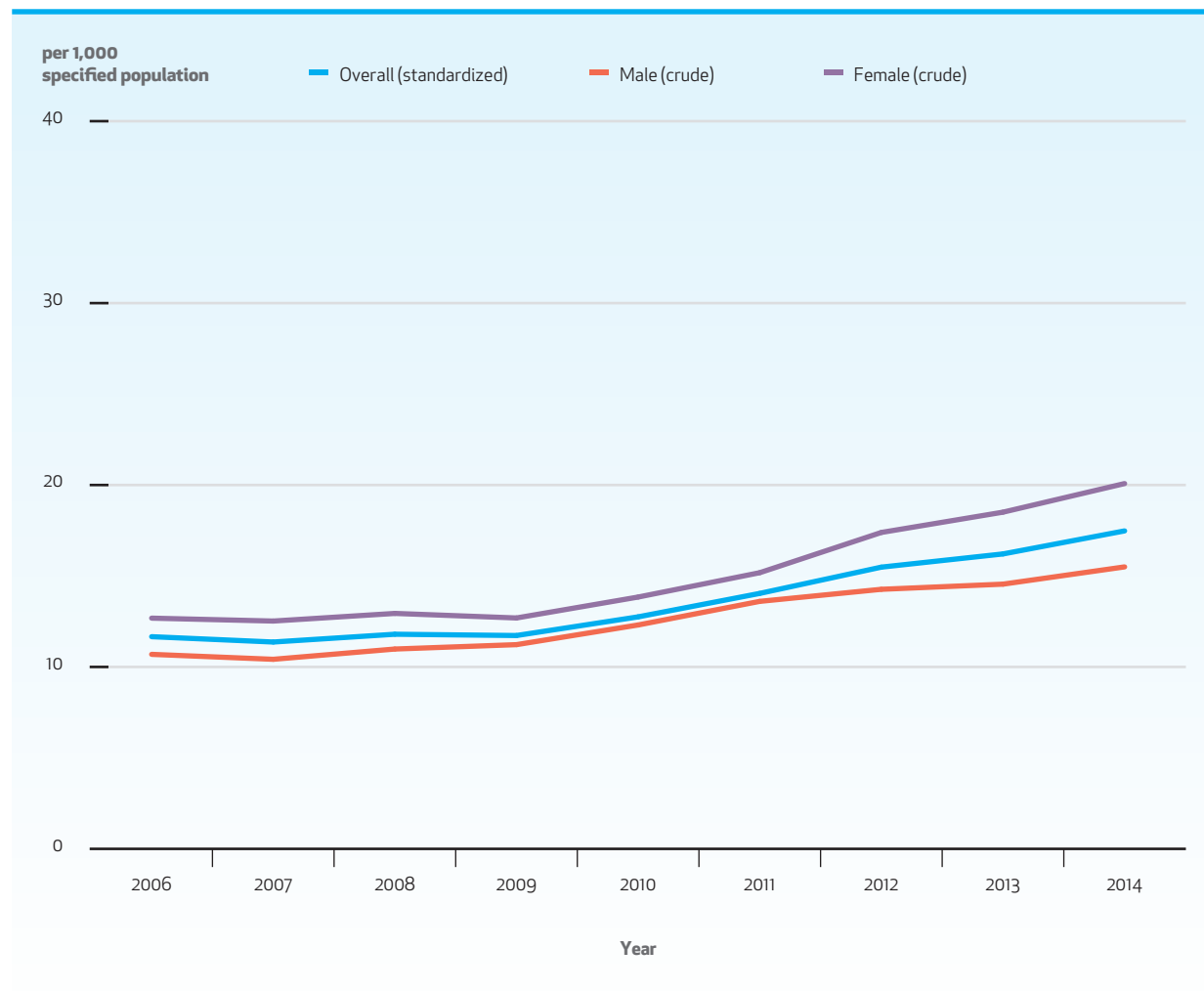
### Interpretation

The steady rise in emergency department visits for mental health and addictions may reflect reduced mental health stigma, and in turn, an increase in the number of individuals seeking help. It may also reflect a true increase in the burden of mental health and addictions problems among children and youth. The increase over time in emergency department visits indicate that greater efforts are needed to manage individuals suffering from mental health problems in the community; specifically, through community-based mental health and addictions services or primary care services. A greater volume of care received from these services may help lessen the burden on the acute care system. Lastly, higher rates in northern Ontario and among those living in lower income neighbourhoods indicate areas in which targeted interventions should be a priority.

**EXHIBIT 2.9.1** Number of emergency department visits related to mental health and addictions per 1,000 population aged 0 to 24 years, overall and by sex, 2006 to 2014

## Key Finding

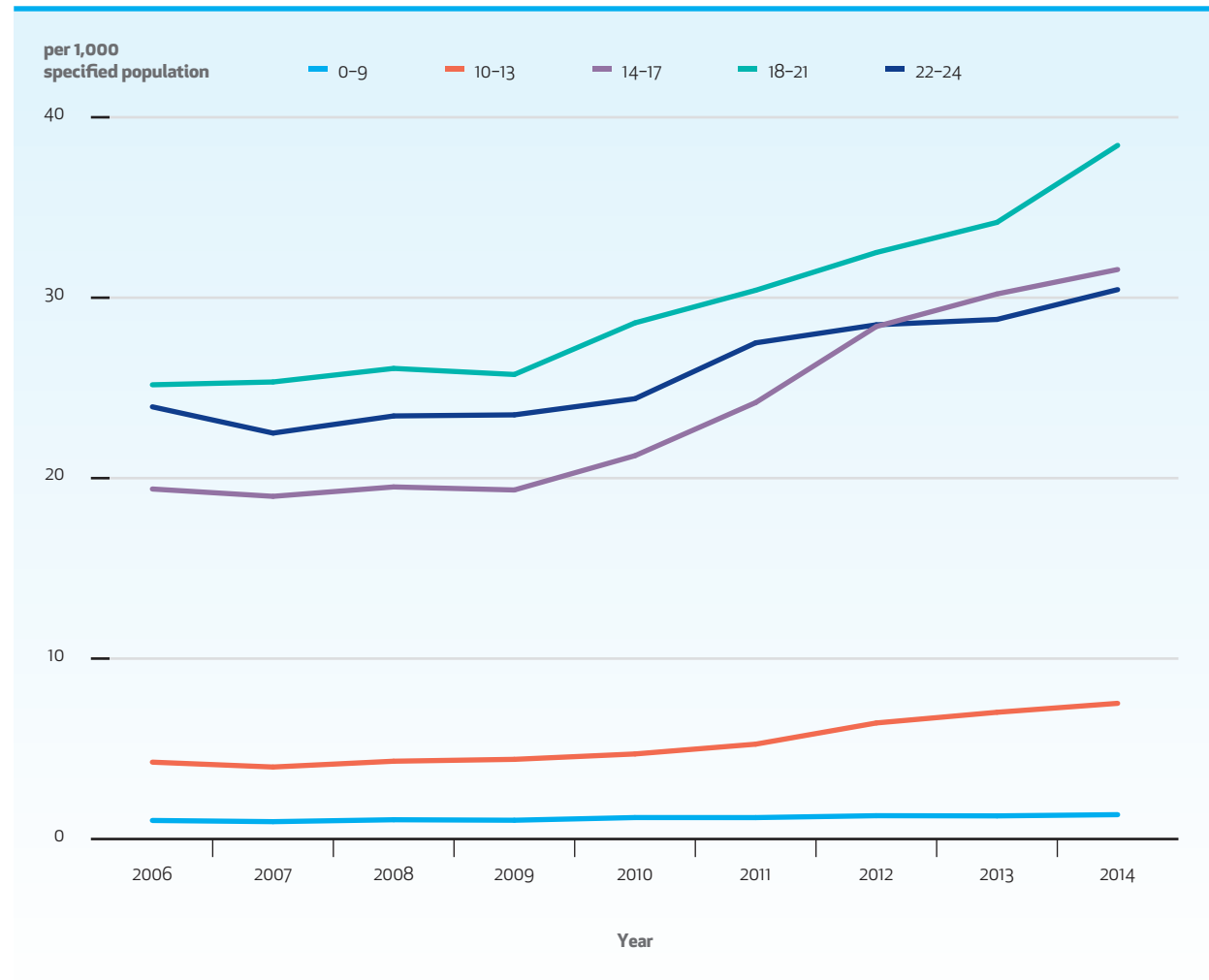
- From 2006 to 2014, the rate of ED visits related to mental health and addictions increased, and was higher for females across all years.



**EXHIBIT 2.9.2** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, 2006 to 2014

## Key Findings

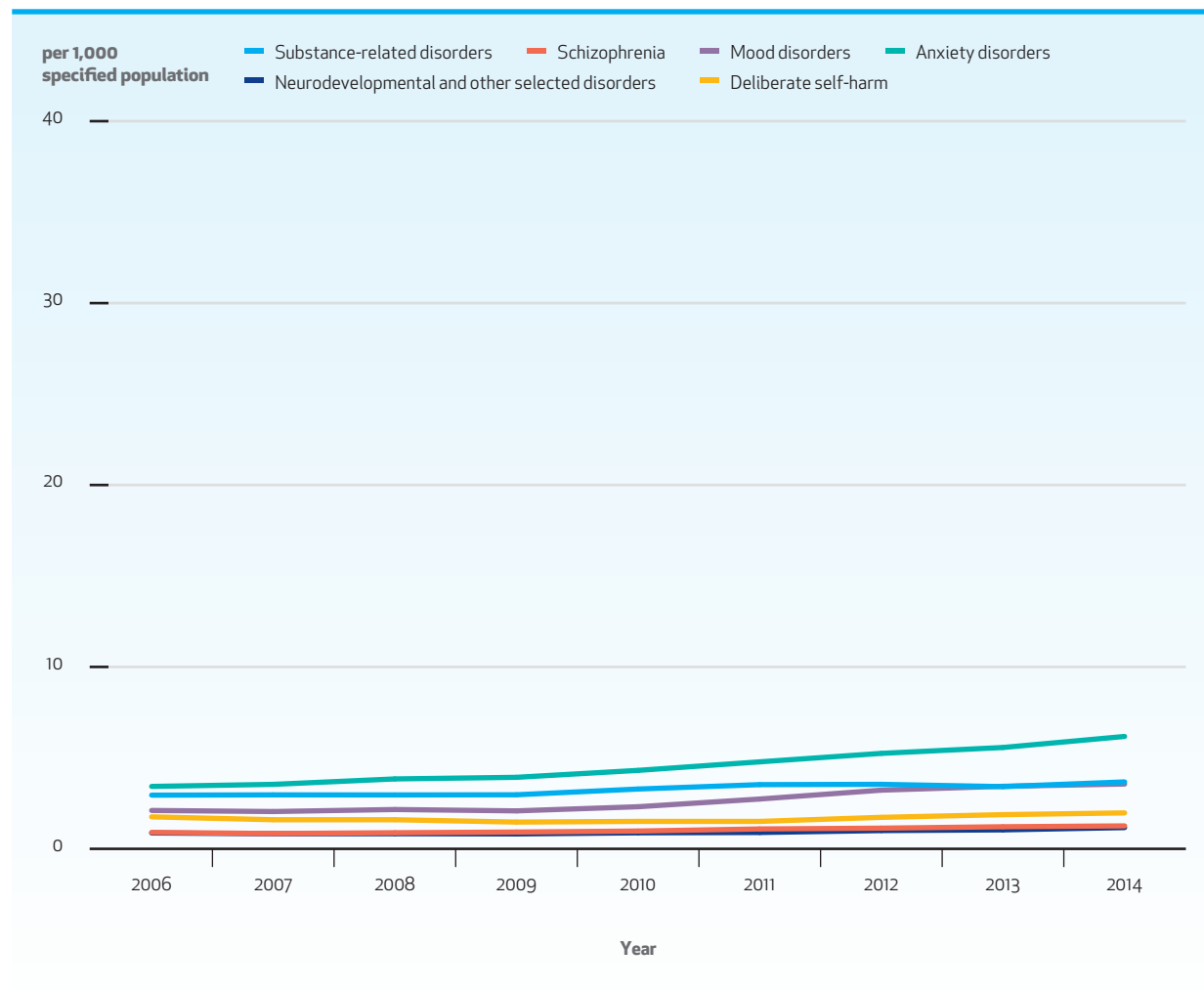
- Between 2006 and 2014, the rate of ED visits related to mental health and addictions increased for most age groups.
- The highest rate and the largest increase in rates were observed among youth aged 18 to 21.



**EXHIBIT 2.9.3** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, 2006 to 2014

## Key Findings

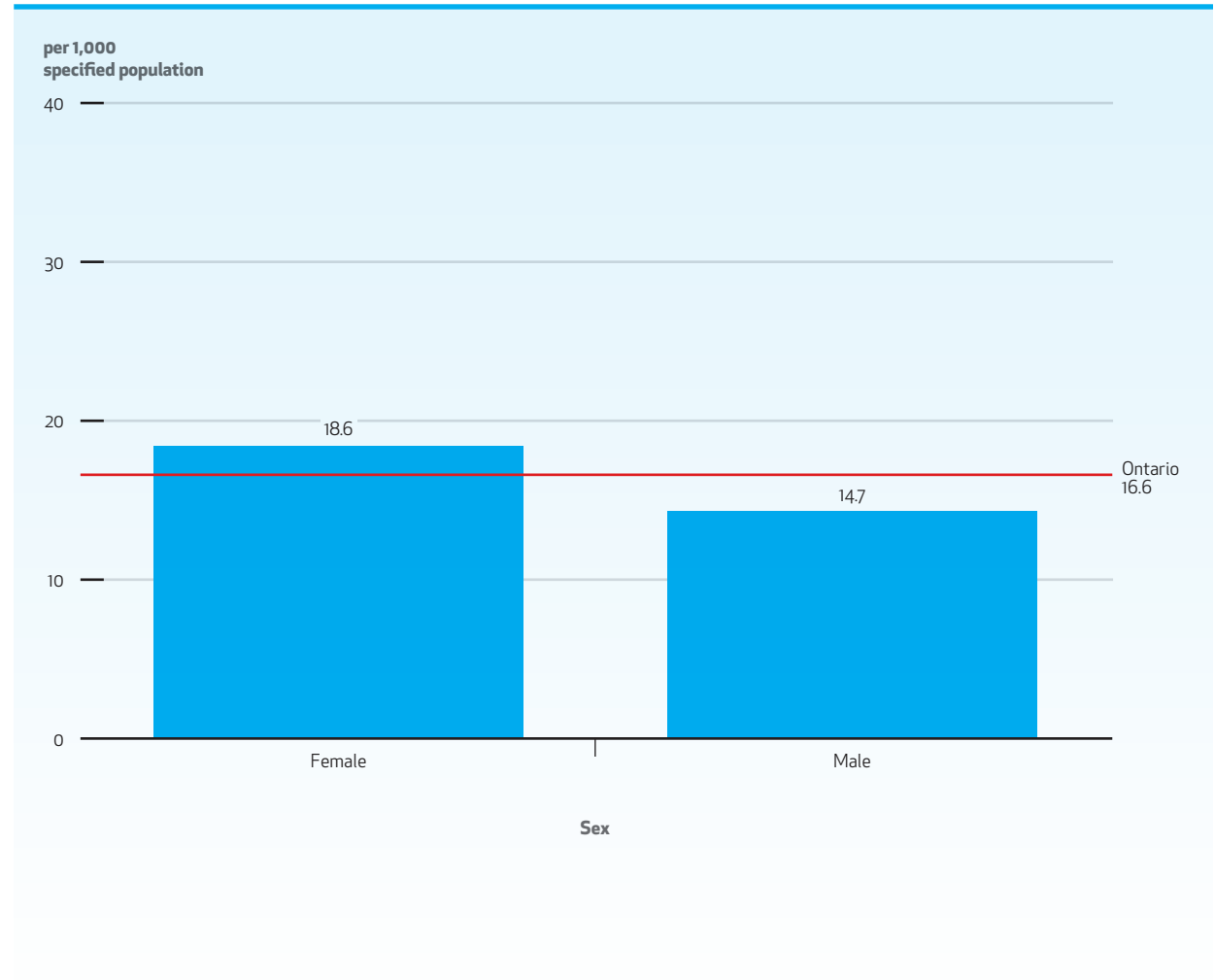
- From 2006 to 2014, anxiety disorders were the most common reason for an ED visit.
- Visit rates increased across all mental health conditions, particularly for anxiety, mood and substance-related disorders.



**EXHIBIT 2.9.4** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

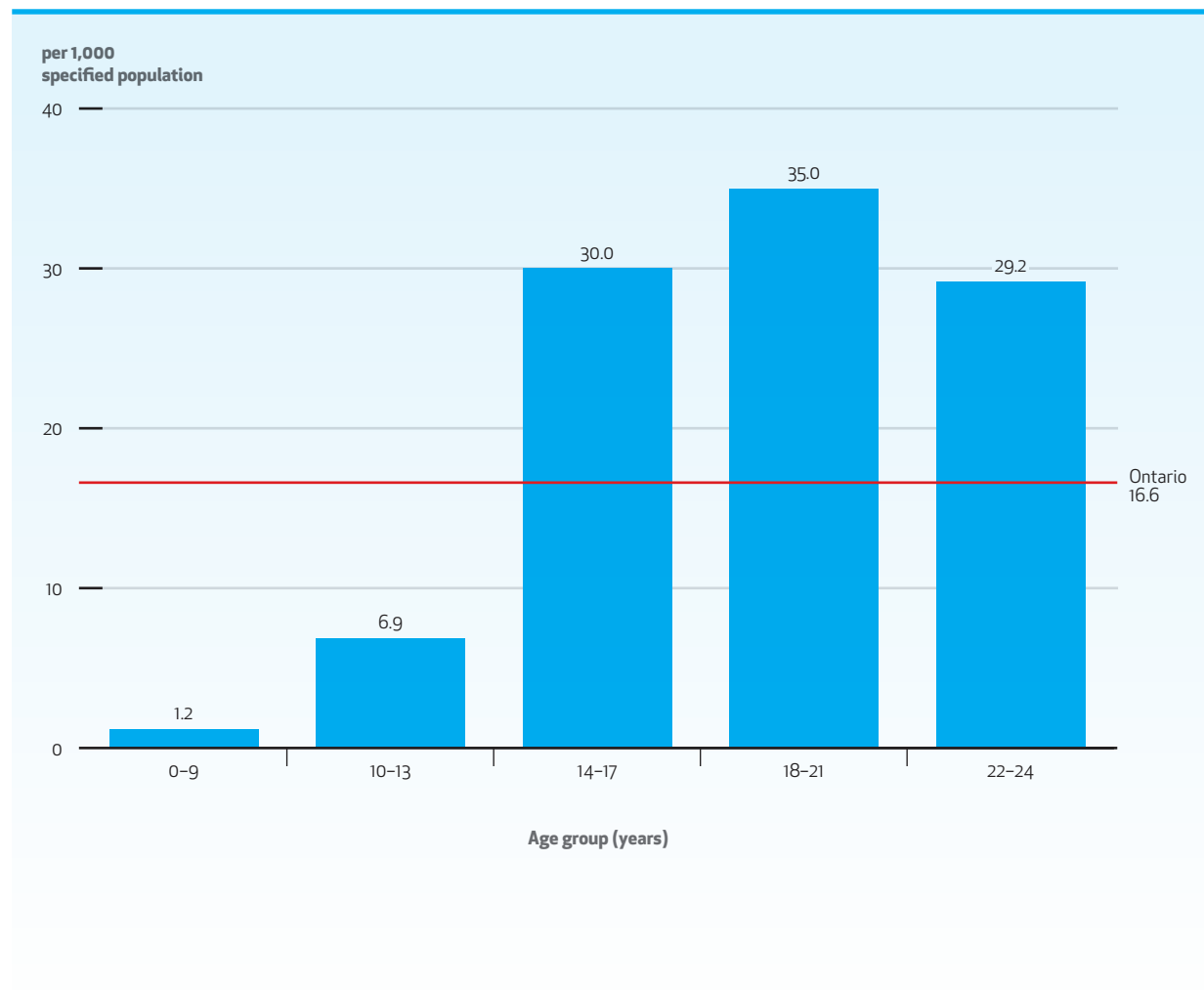
- Between 2012 and 2014, the average rate of ED visits for mental health and addictions was higher for females.



**EXHIBIT 2.9.5** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average rate of ED visits related to mental health and addictions were highest among youth aged 18 to 21 and lowest among children younger than age 14.

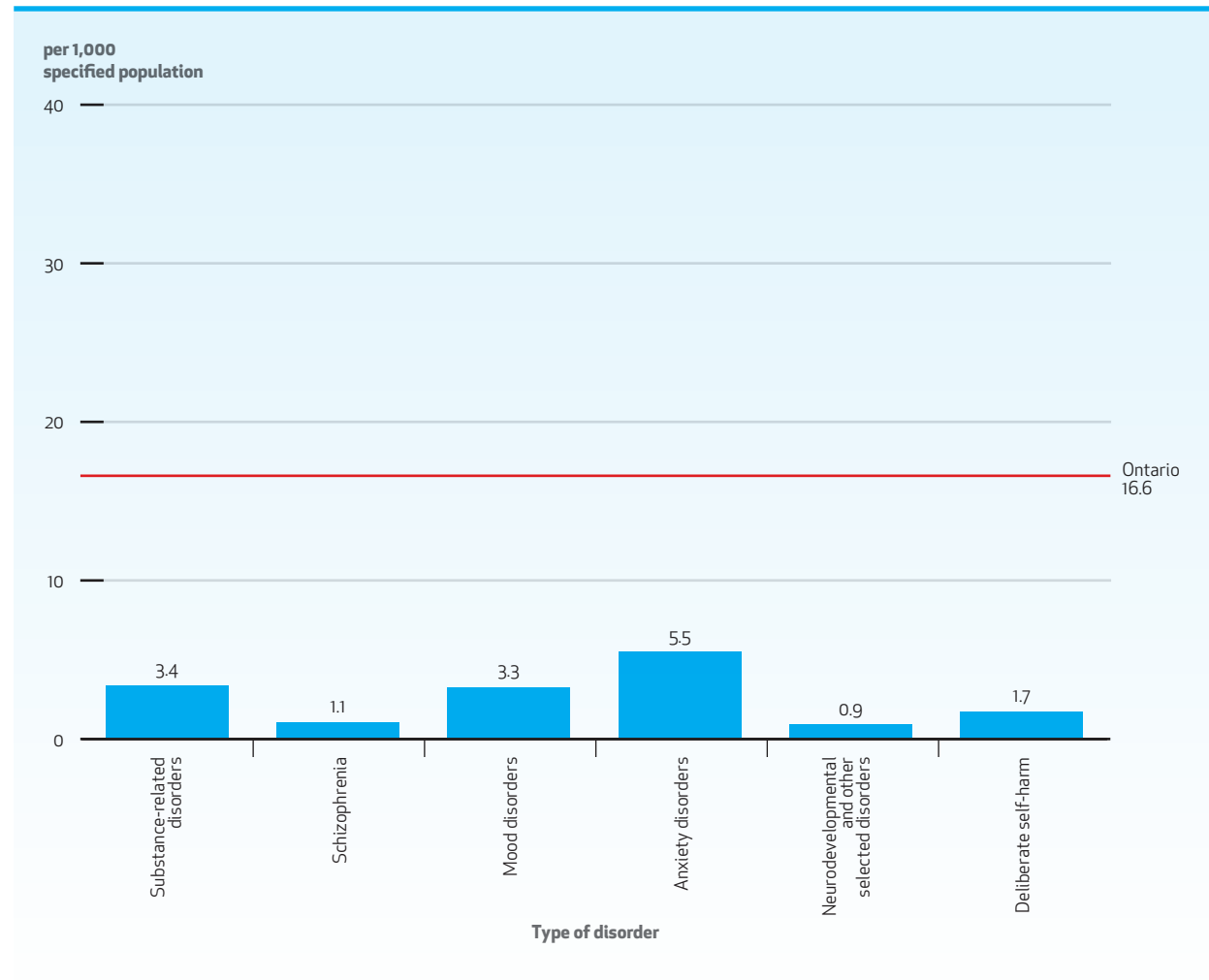




**EXHIBIT 2.9.6** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Finding

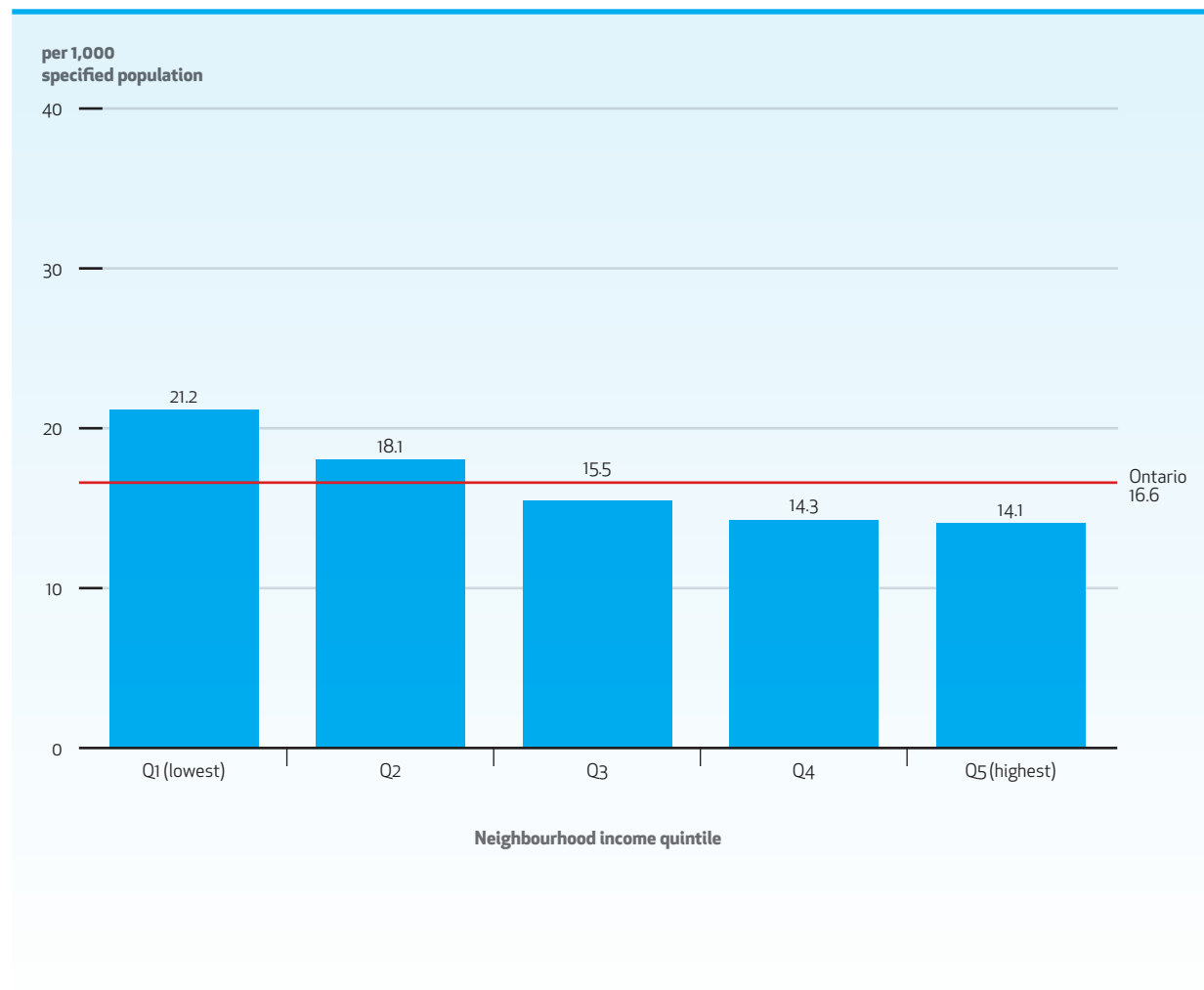
- Between 2012 and 2014, anxiety disorders were the most common reason for a child or youth to present to the ED for a mental health and addictions concern.



**EXHIBIT 2.9.7** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

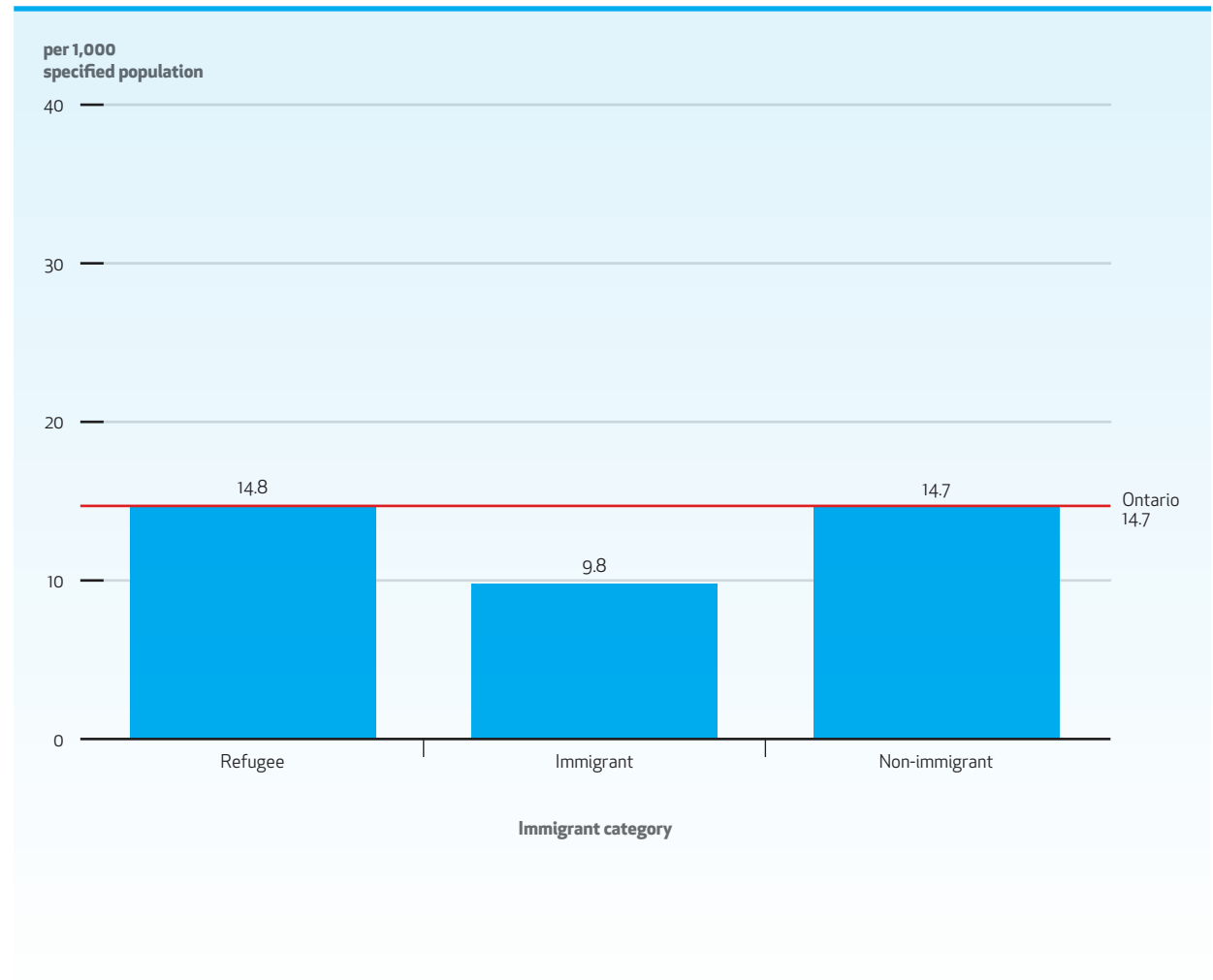
- Between 2012 and 2014, the average rate of ED visits for mental health and addictions was higher among children and youth living in low-income neighbourhoods.



**EXHIBIT 2.9.8** Number of emergency department visits related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

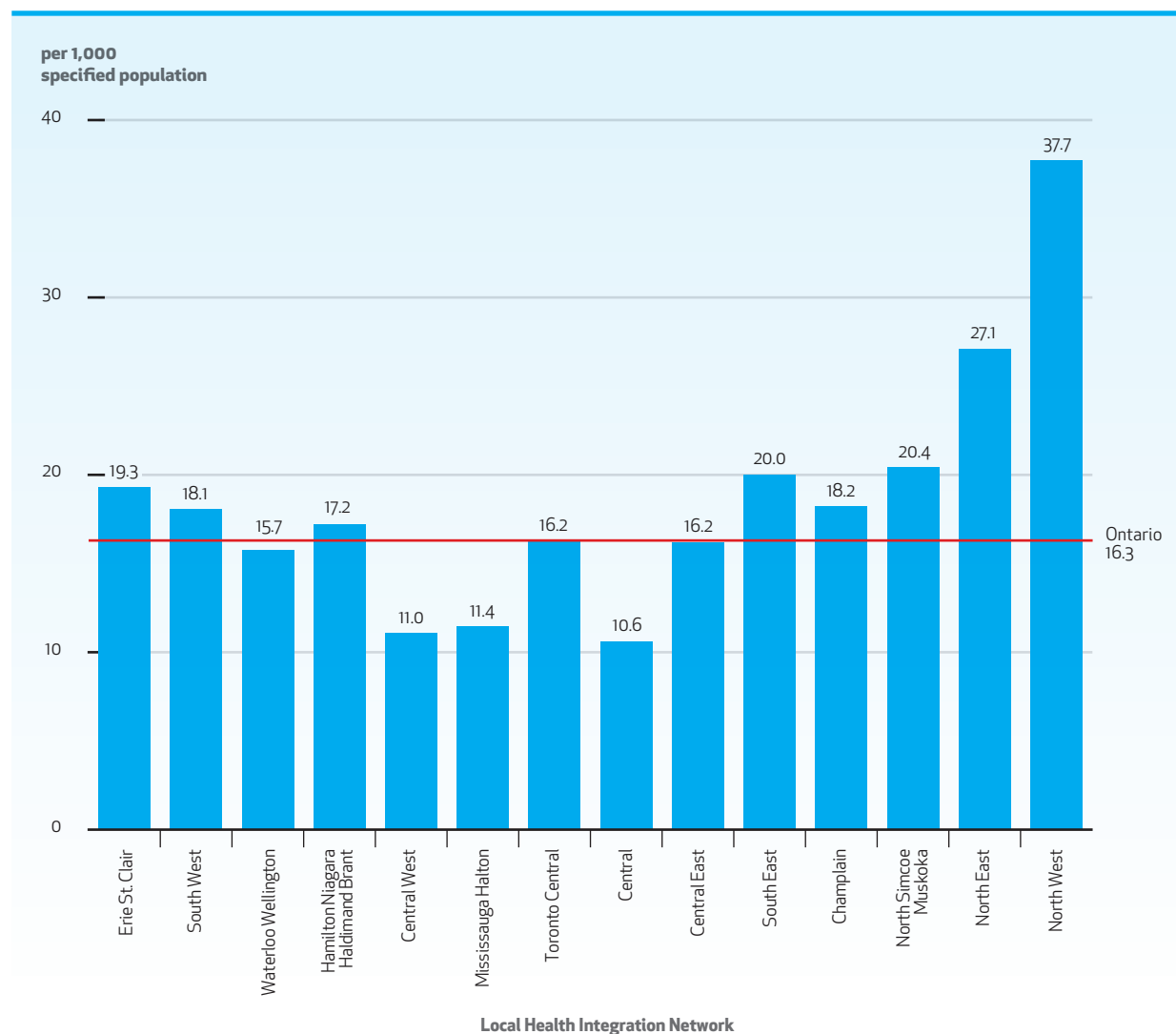
- Between 2010 and 2012, the average rate of ED visits related to mental health and addictions was highest among refugees and non-immigrants.



**EXHIBIT 2.9.9** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

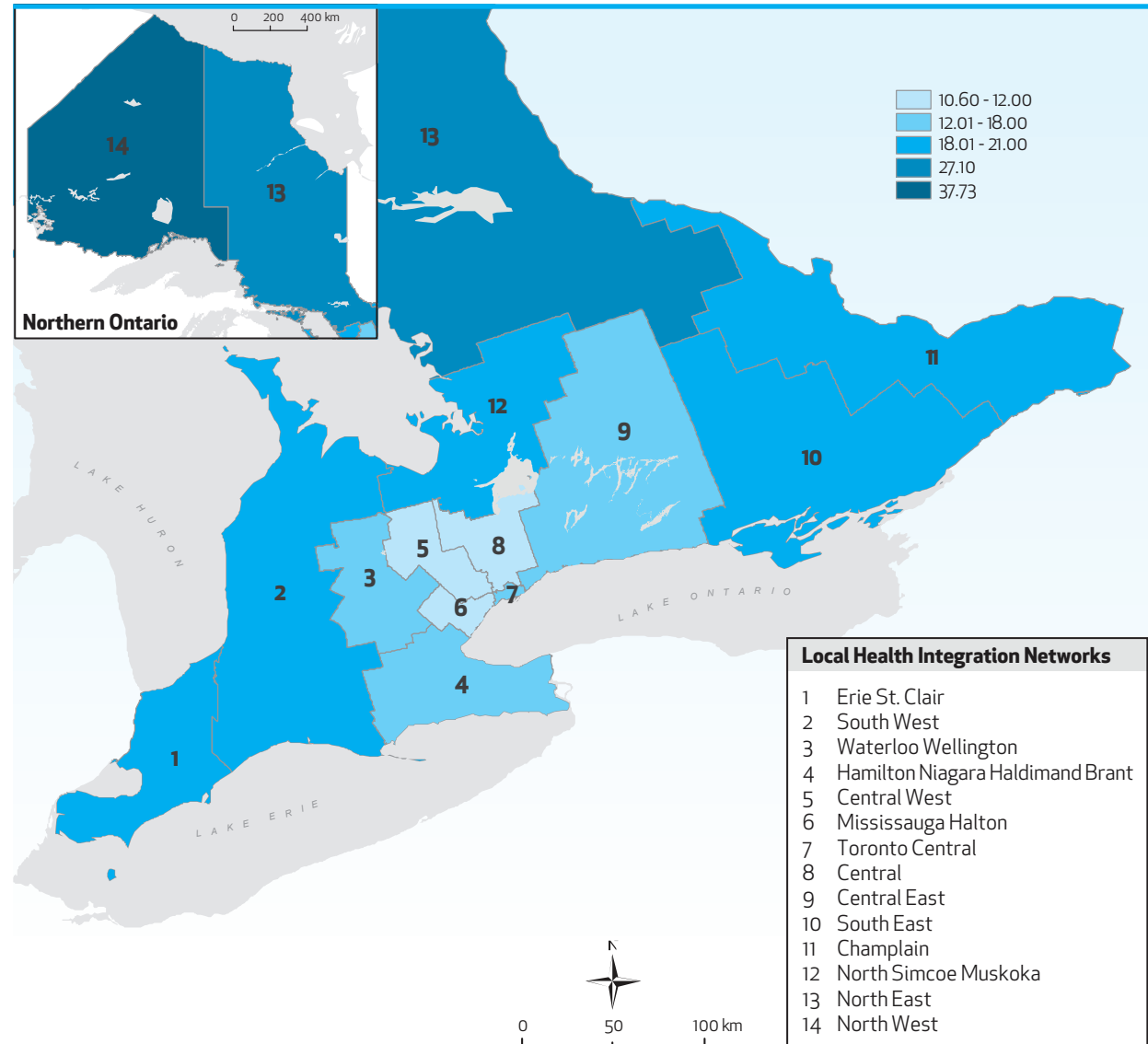
- Between 2012 and 2014, the average age- and sex-standard rate of ED visits for mental health and addictions was highest among children and youth in the North West LHIN and lowest among those in the Central LHIN.



**EXHIBIT 2.9.10** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

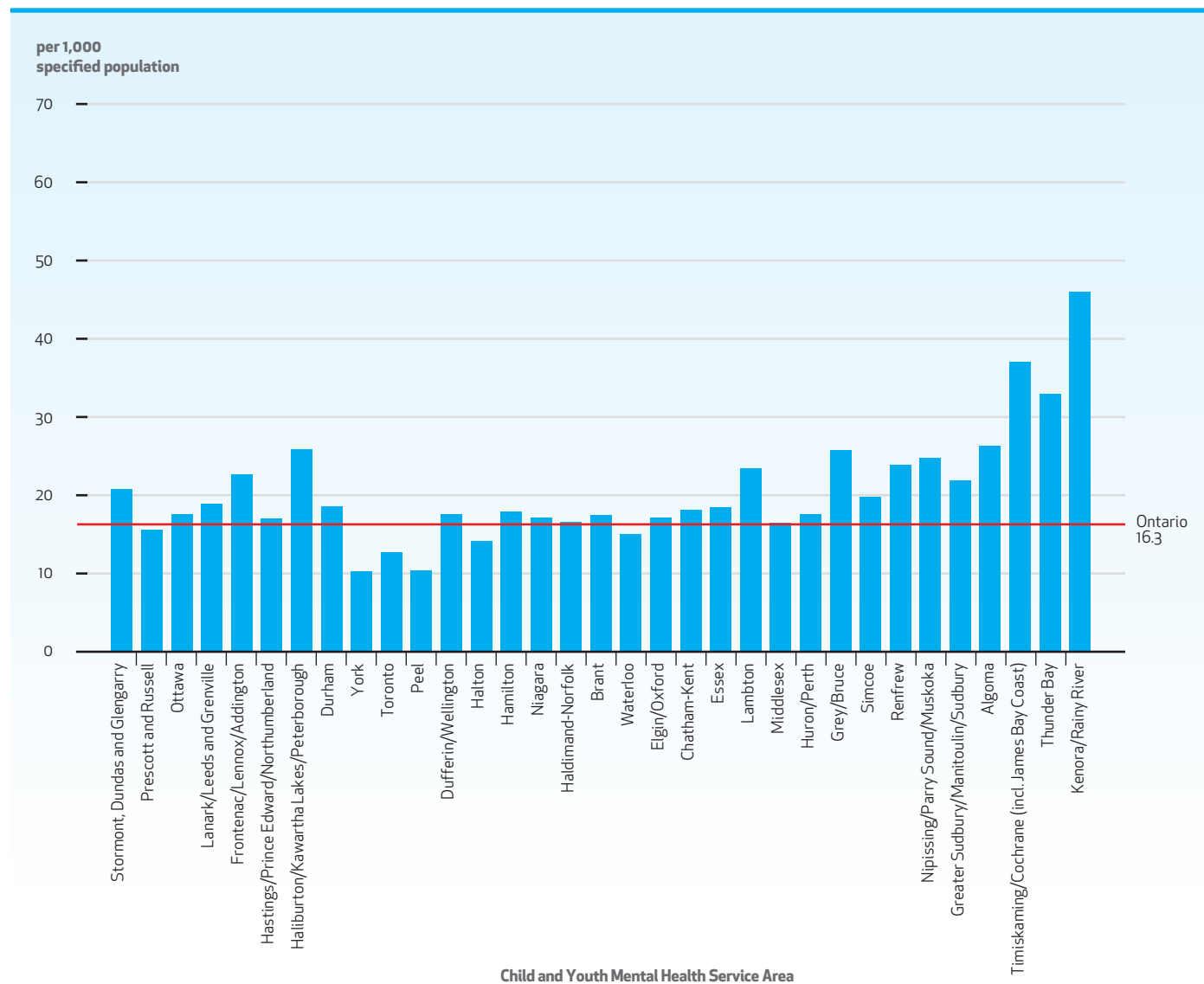
- Between 2012 and 2014, the average age- and sex-standard rate of ED visits for mental health and addictions was highest among children and youth in the North West LHIN and lowest among those in the Central LHIN.



**EXHIBIT 2.9.11** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

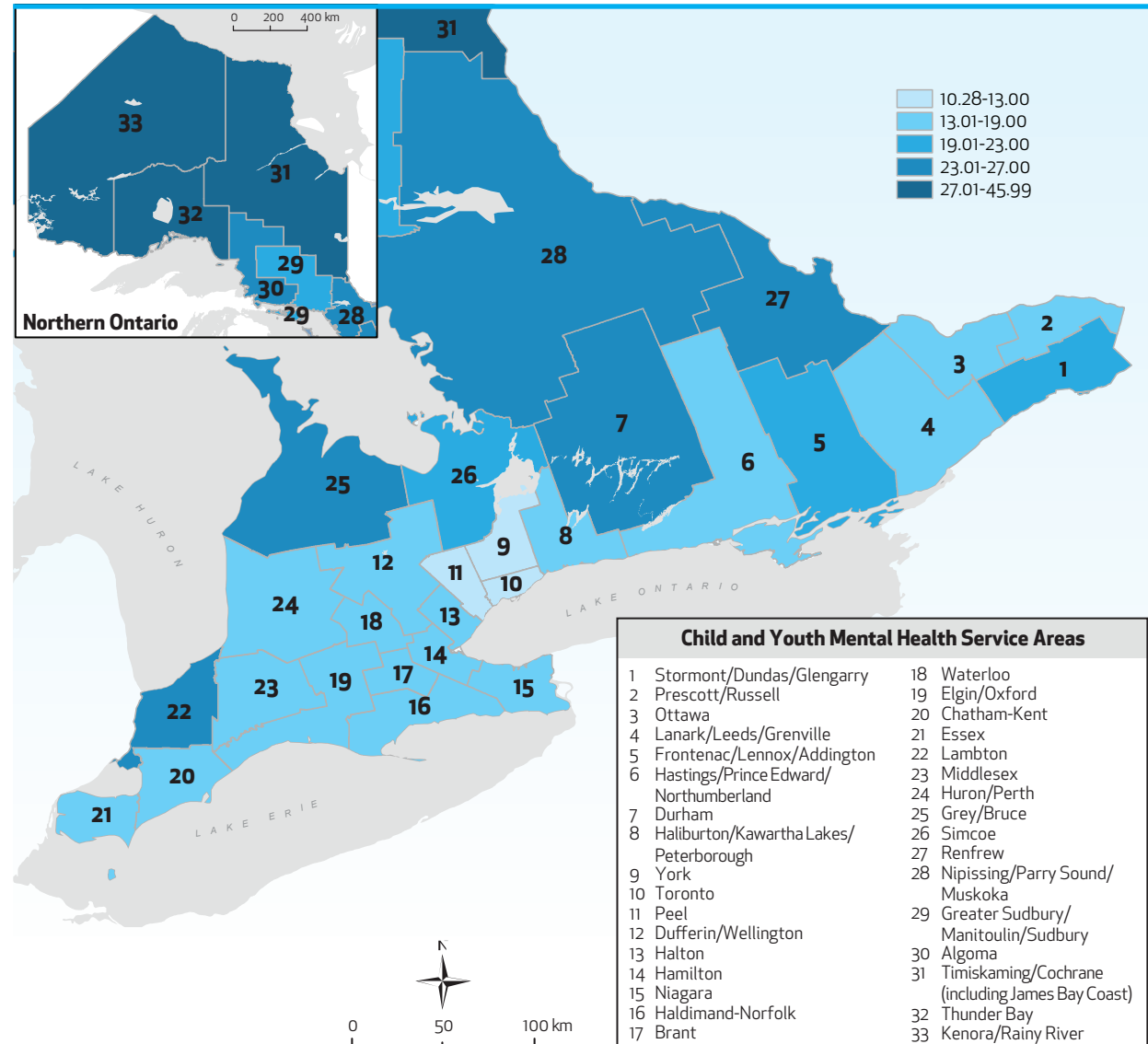
- From 2012 to 2014, the average age- and sex-standardized rate of ED visits among Child and Youth Mental Health Service Areas was highest in Kenora/Rainy River. That rate was more than four times the Ontario average.



**EXHIBIT 2.9.12** Number of emergency department visits related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- From 2012 to 2014, the average age- and sex-standardized rate of ED visits among Child and Youth Mental Health Service Areas was highest in Kenora/Rainy River. That rate was more than four times the Ontario average.



## 2.10 Rate of hospitalizations related to mental health and addictions among children and youth

### Rationale

Hospitalizations related to mental health and addictions may reflect the burden of severe disease or may be the result of inadequate early identification and treatment of mental illnesses and addictions. It may also be a marker of the need for alternative models of accessible mental health care delivery to support children and youth in community settings.

### Results

The rate of hospitalizations for mental health and addictions was more than 1.5 times higher in 2014 compared to 2006. Hospitalizations were more common among females and youth aged 14 to 17. Most mental health and addictions-related hospitalizations were for mood disorders; this was consistent across most age groups, with the exception of those under age 14, for whom anxiety disorders and neurodevelopmental and other selected disorders were more common.

Rates of hospitalization were highest among individuals in poorer neighbourhoods, and among refugees and non-immigrants. Rates of hospitalization were highest in the North West and North East LHINs, as well as in the Lambton and northern Child and Youth Mental Health Service Areas, particularly Algoma and Thunder Bay.

### Interpretation

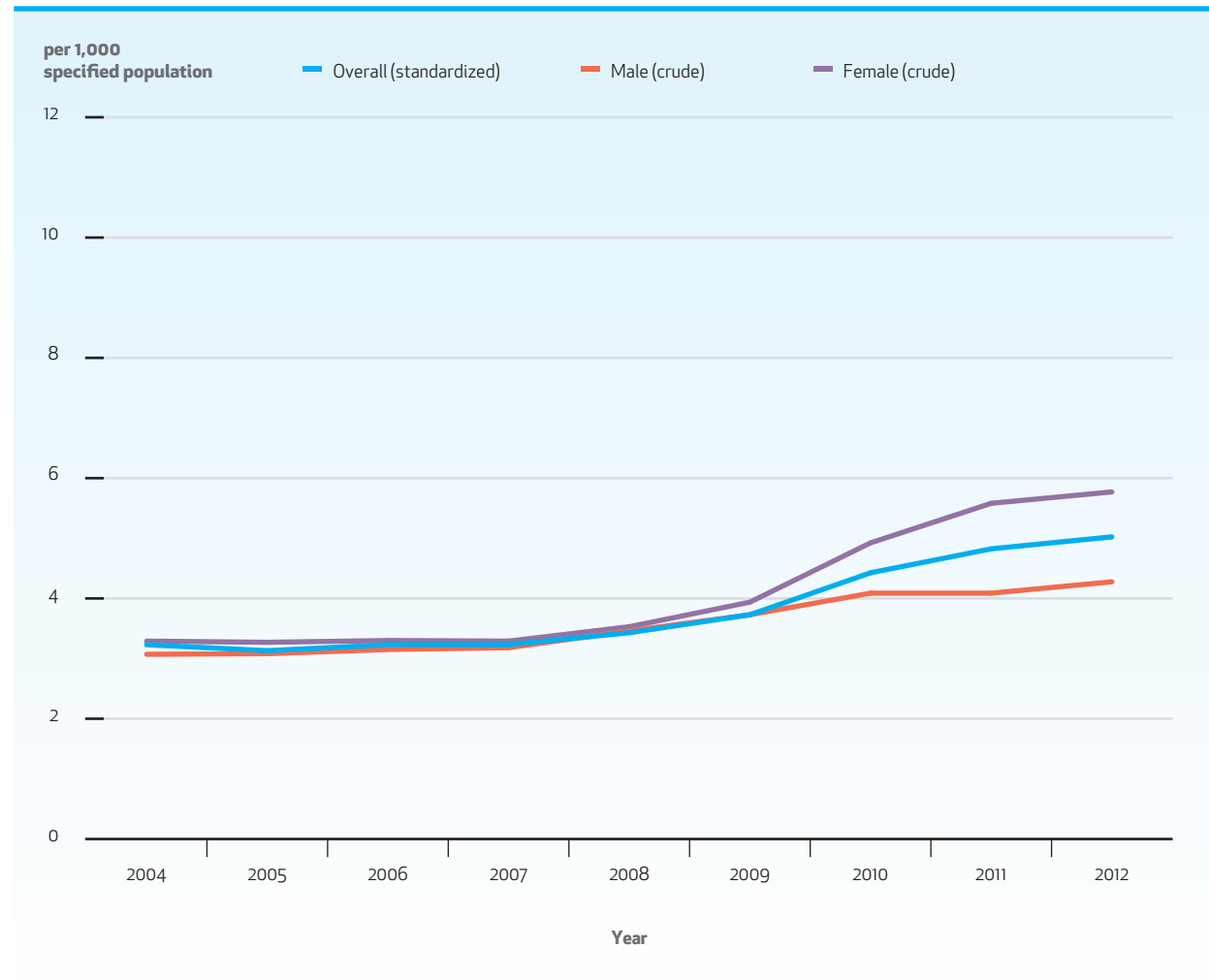
The rate of hospitalizations for mental health and addictions was relatively low, especially in comparison to the rate of psychiatric emergency department visits. However, rates of hospitalizations are increasing over time. Rates are highest among children and youth in lower-income neighbourhoods and those in the more remote northern LHINs and Child and Youth Mental Health Service Areas. This may be the result of a greater burden of mental illness and less access to alternative community-based services in these communities.



**EXHIBIT 2.10.1** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, overall and by sex, in Ontario, 2006 to 2014

## Key Finding

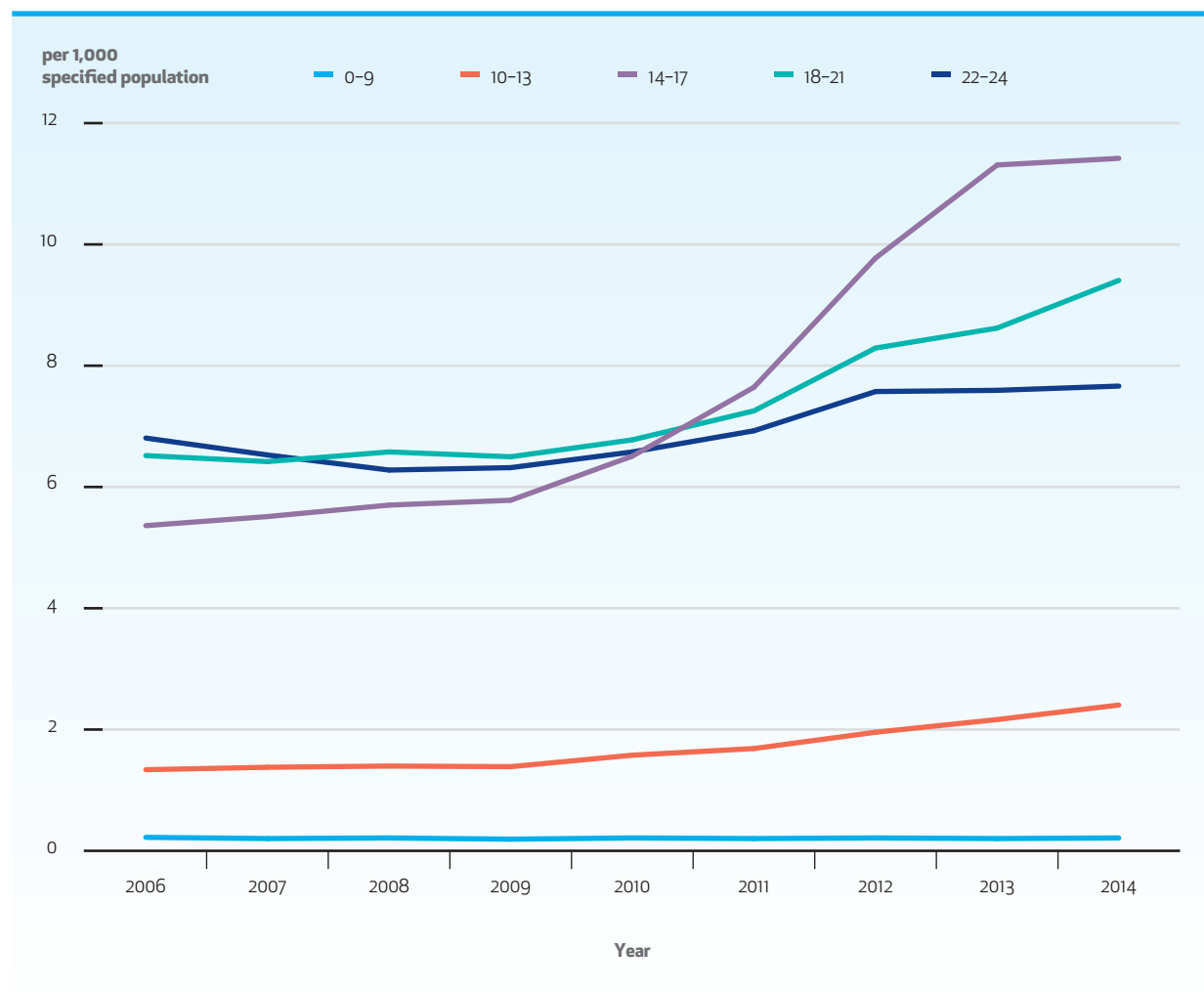
- From 2006 to 2014, the overall rate of MHA-related hospitalizations increased. The increase in hospitalizations was greater for females.



**EXHIBIT 2.10.2** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, 2006 to 2014

## Key Finding

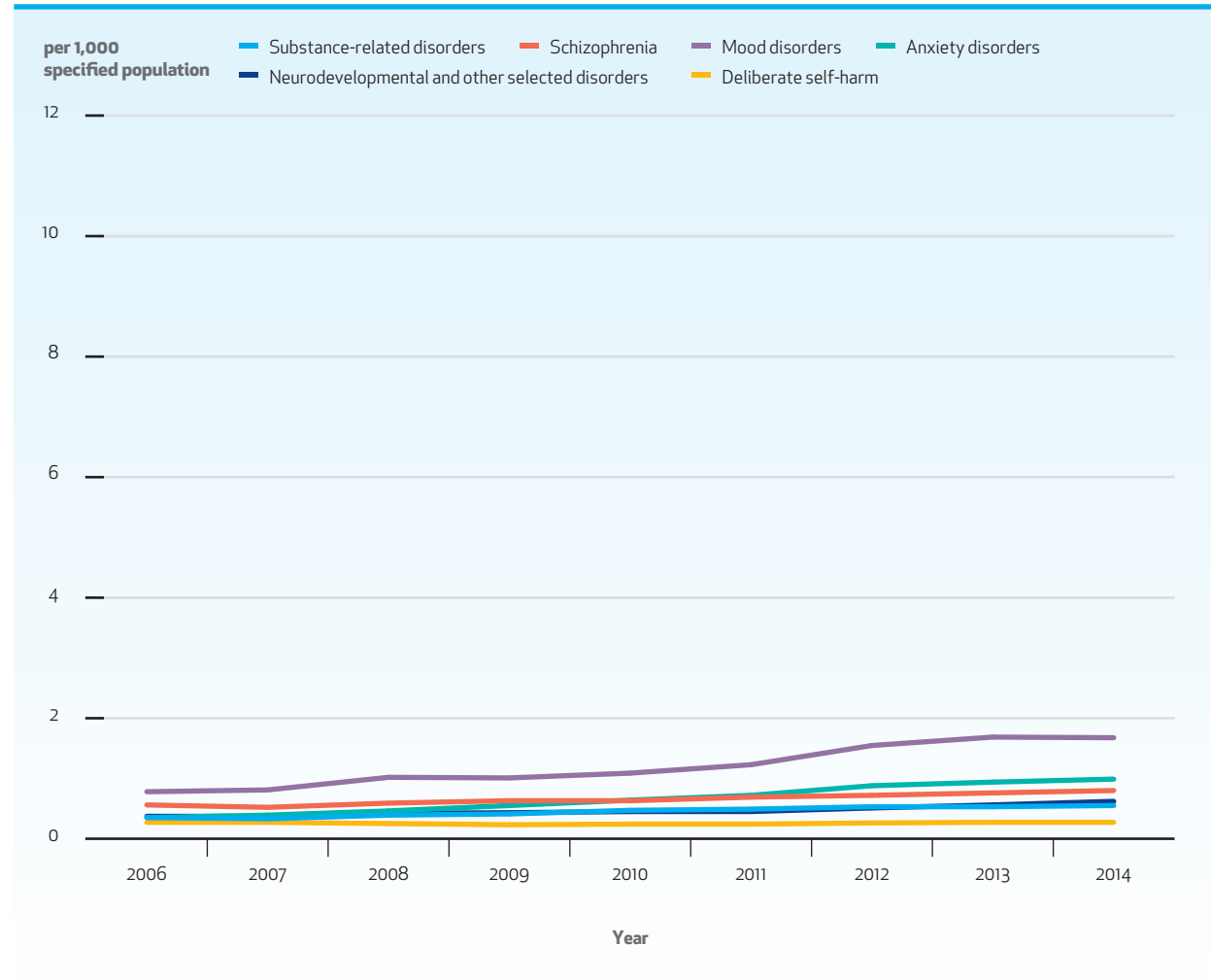
- Rates of MHA-related hospitalizations increased over time across most age groups, with the highest rate and the largest rate of increase being among those aged 14 to 17.



**EXHIBIT 2.10.3** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, 2006 to 2014

## Key Findings

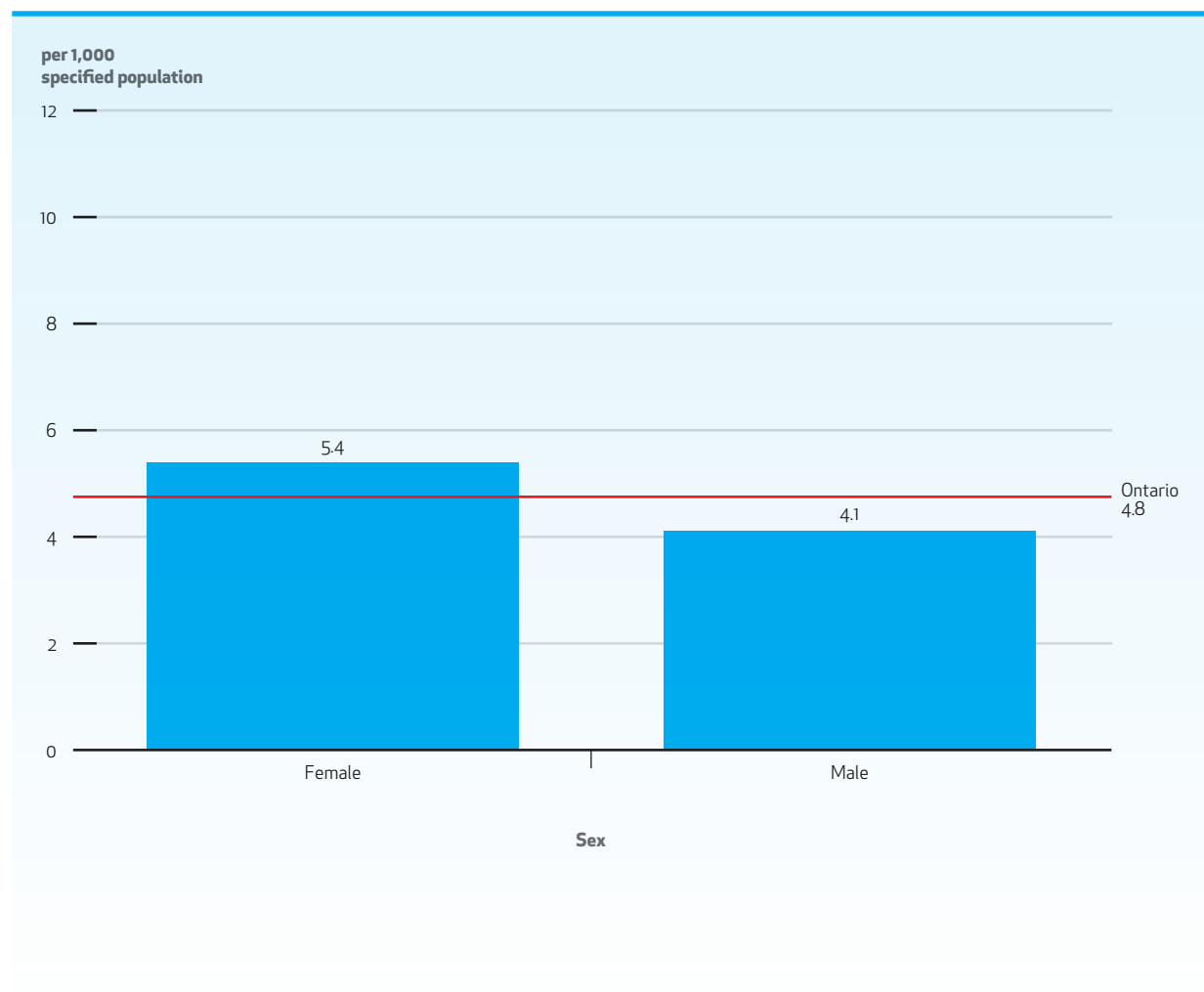
- Mood disorders were the most common reason for MHA-related hospitalizations, followed by anxiety disorders and schizophrenia.
- Rates of hospitalization increased for all conditions except deliberate self-harm.



**EXHIBIT 2.10.4** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

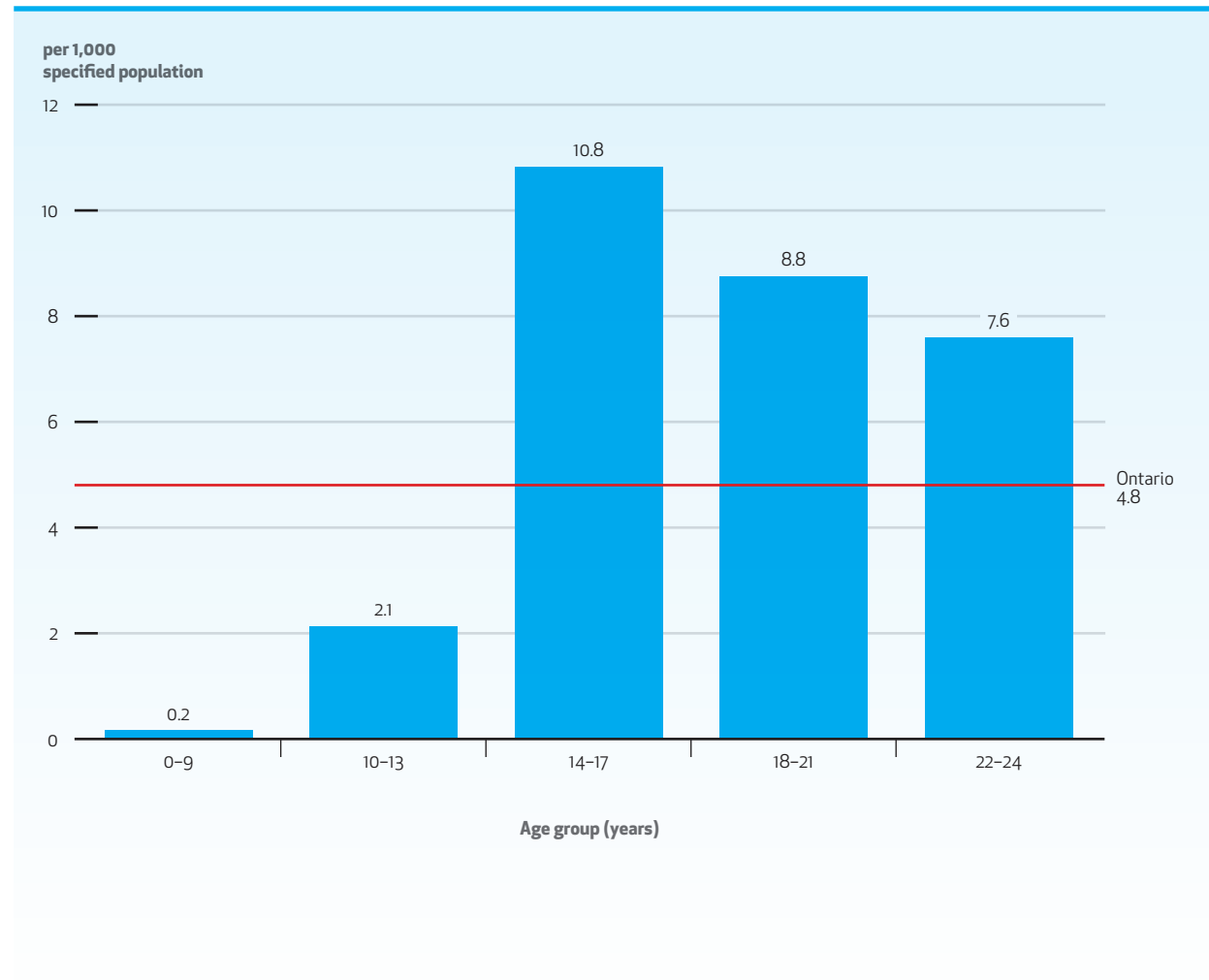
- Between 2012 and 2014, the average rate of MHA-related hospitalizations was higher among females.



**EXHIBIT 2.10.5** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

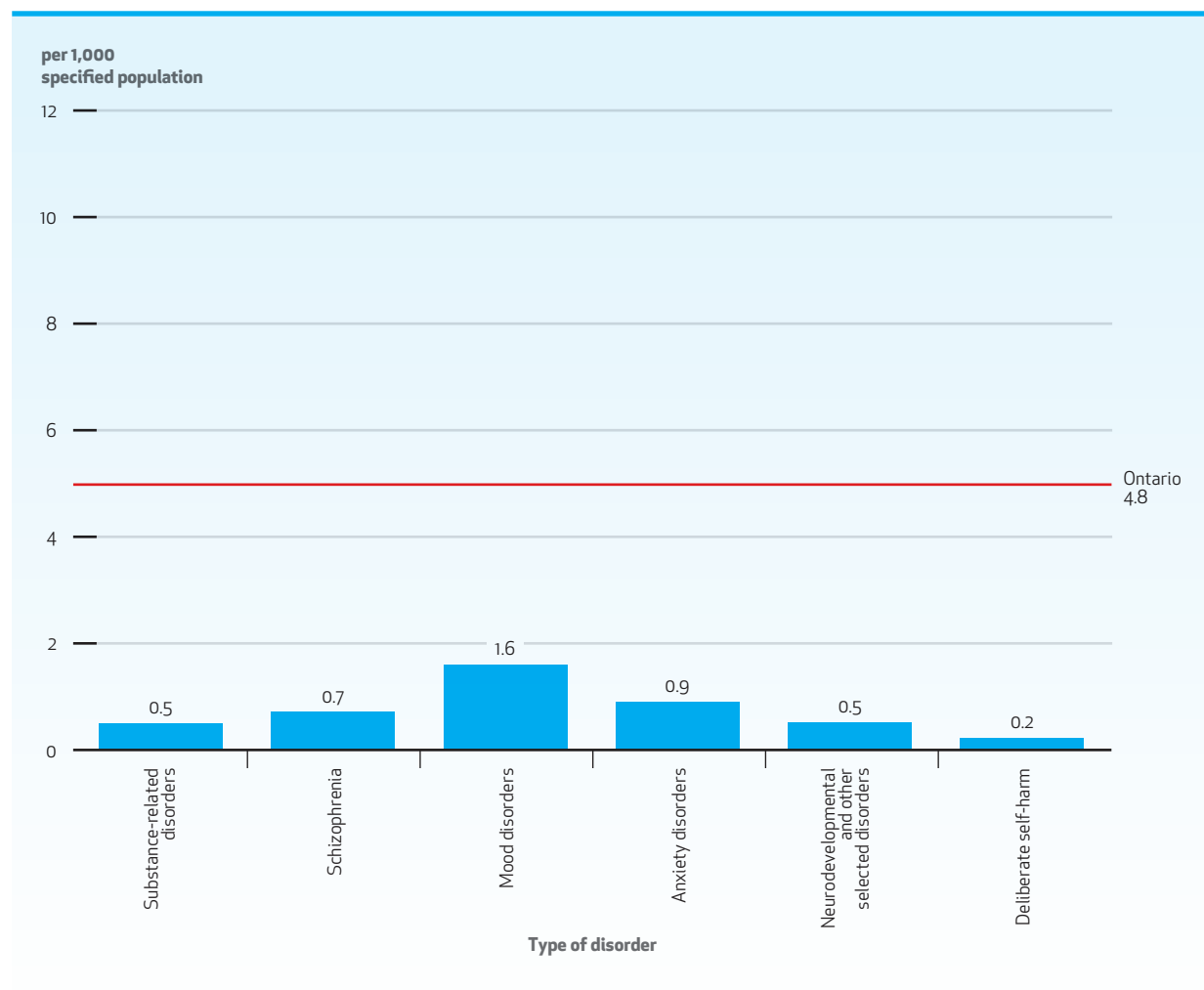
- From 2012 to 2014, the average rate of MHA-related hospitalizations was highest among youth aged 14 to 17 and lowest among children aged 0 to 13.



**EXHIBIT 2.10.6** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Finding

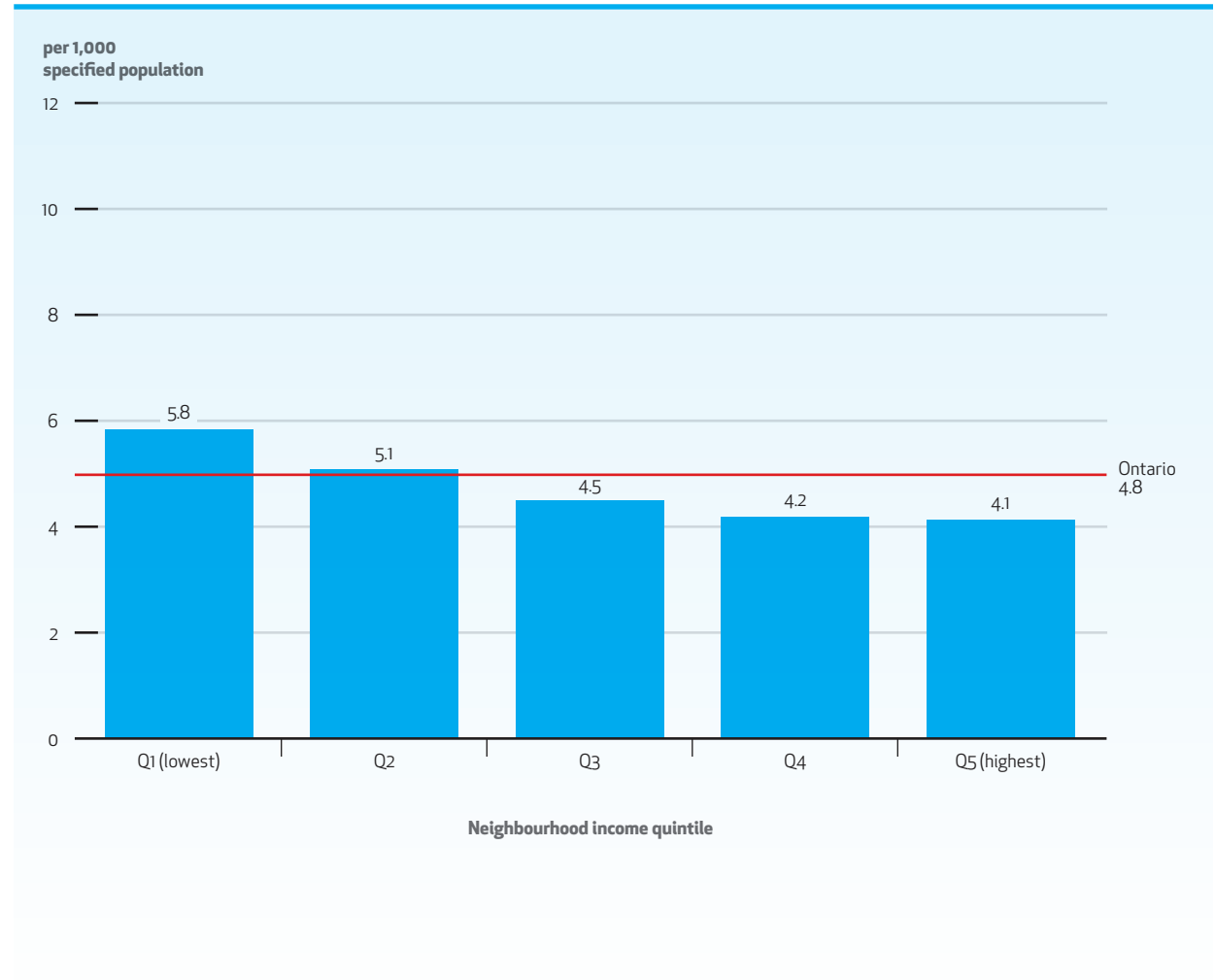
- Between 2012 and 2014, mood disorders were the most common reason for an MHA-related hospitalization among children and youth, followed by anxiety disorders.



**EXHIBIT 2.10.7** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

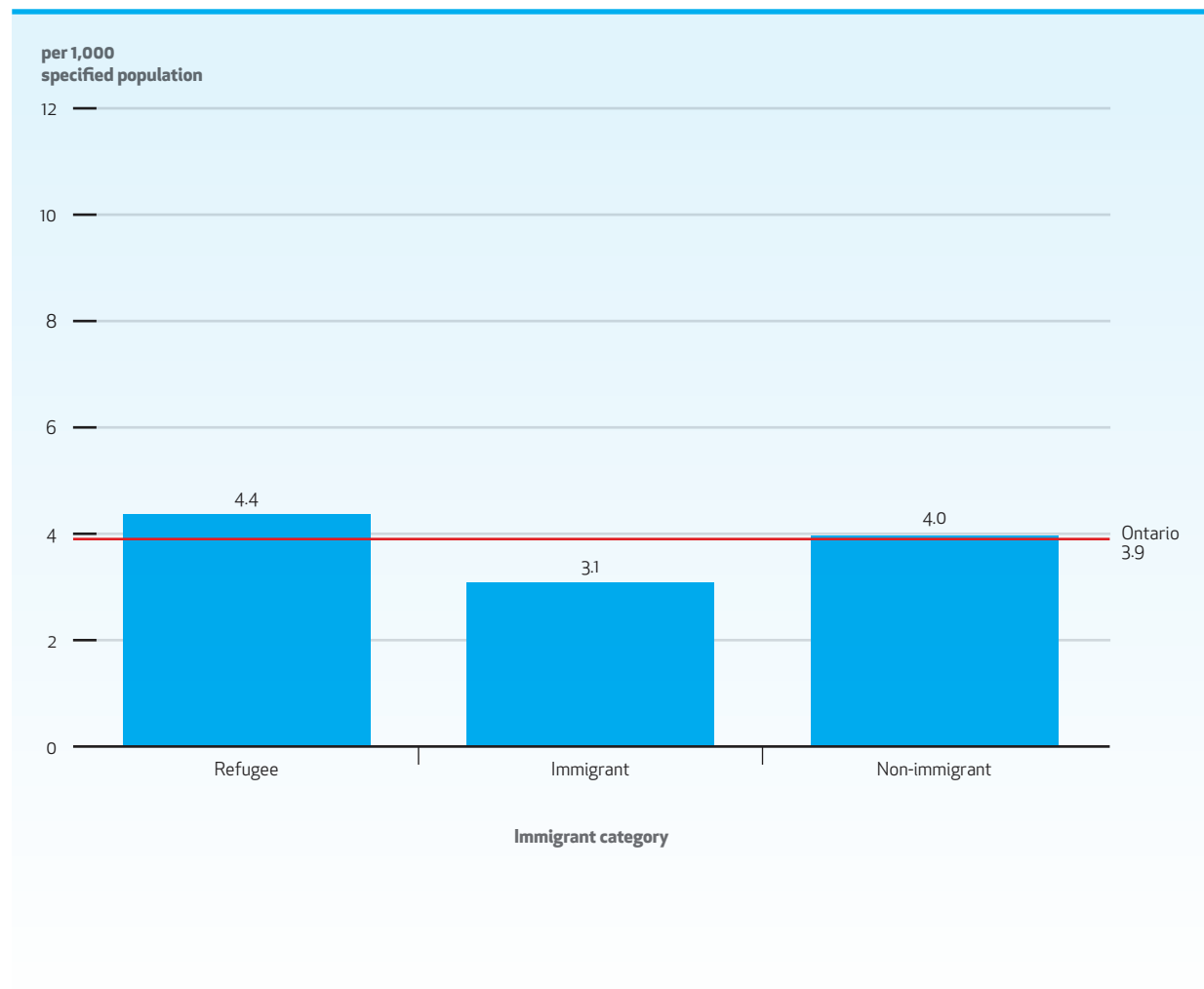
- Between 2012 and 2014, the average rate of MHA-related hospitalizations was highest among children and youth living in the lowest-income neighbourhoods.



**EXHIBIT 2.10.8** Number of hospitalizations related to mental health and addictions per 1,000 crude population aged 0 to 24 years, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

- From 2010 to 2012, the average rate of MHA-related hospitalizations was highest among refugees and non-immigrants and lowest among immigrants.

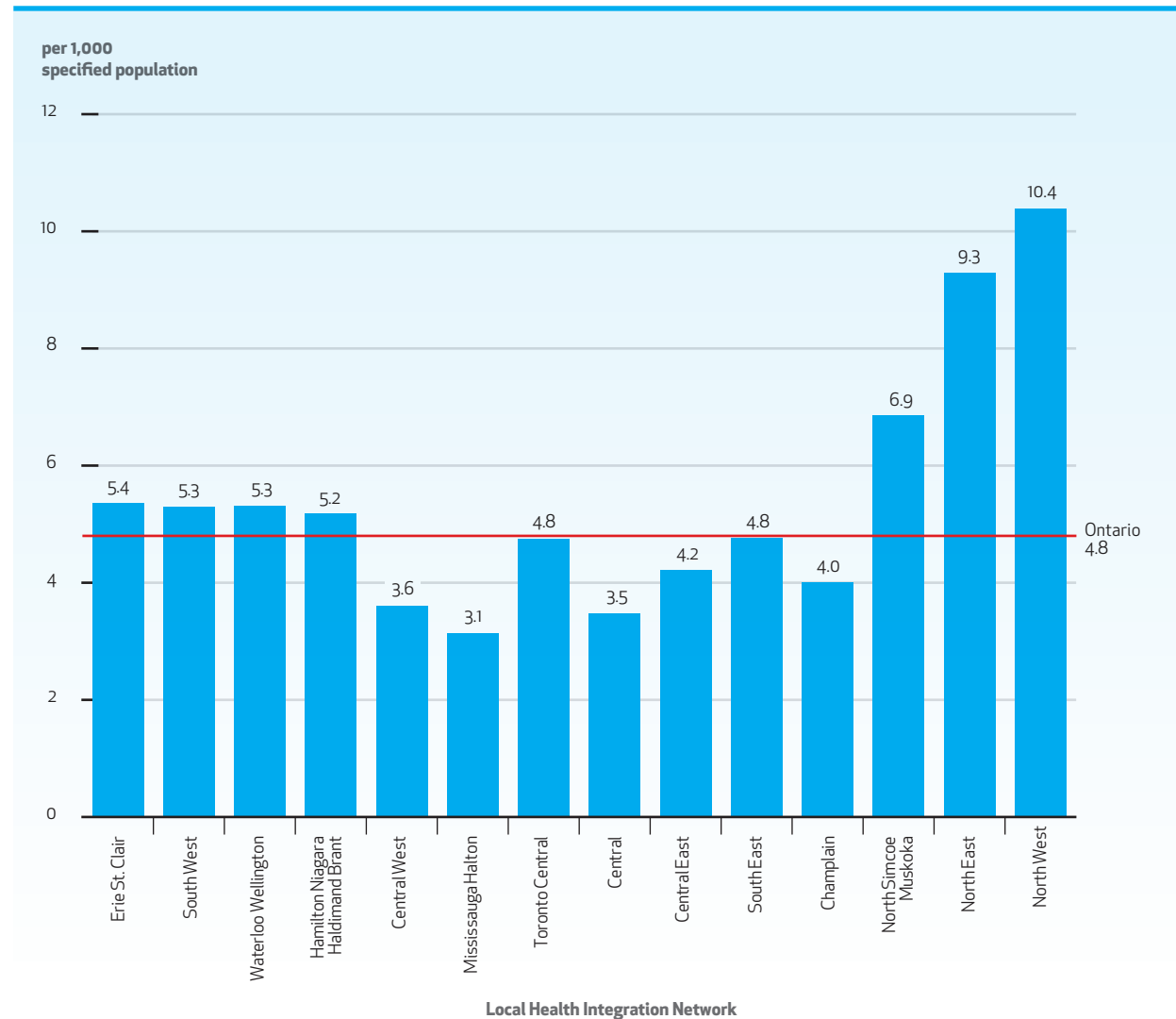




**EXHIBIT 2.10.9** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

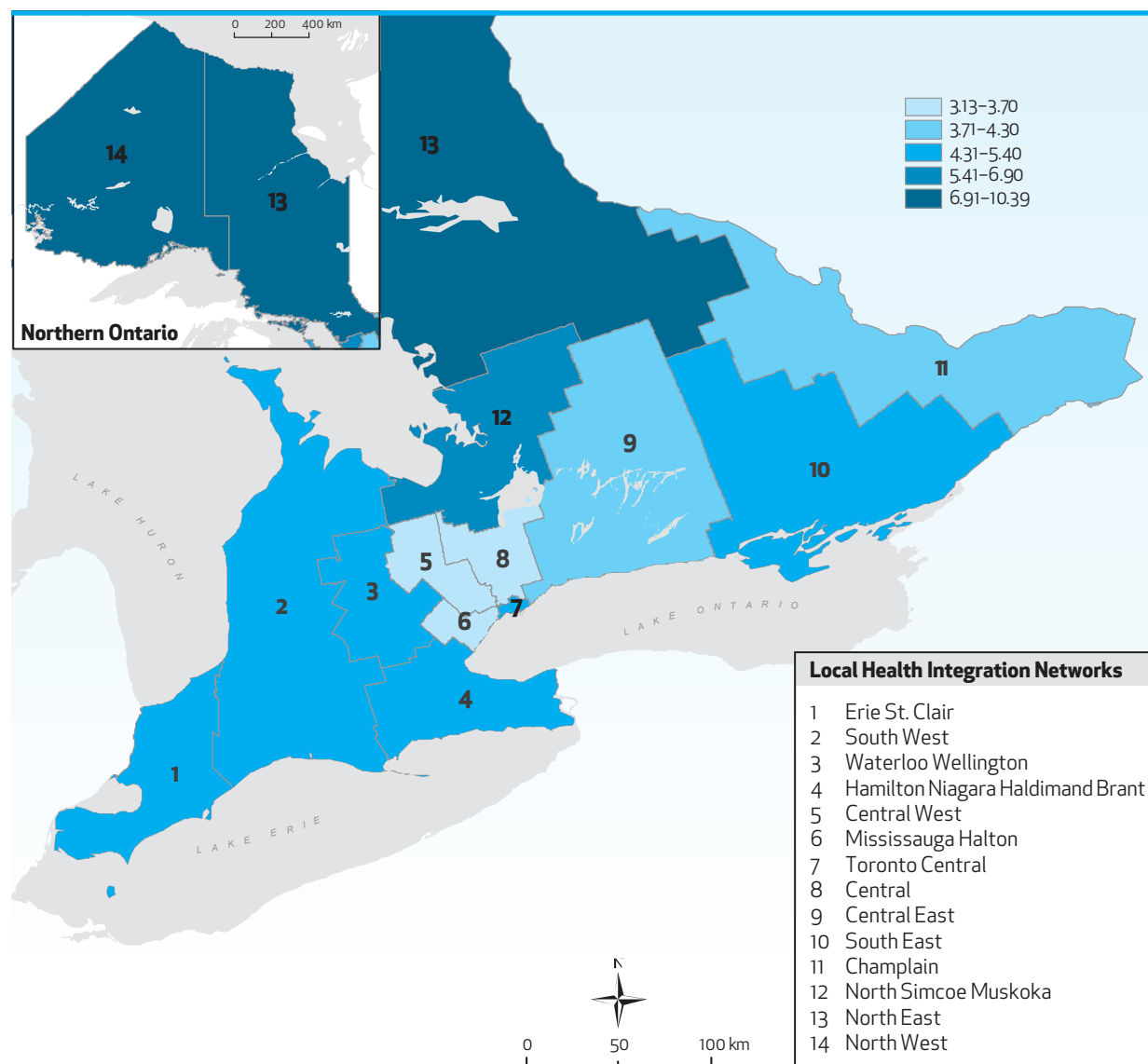
- Between 2012 and 2014, hospitalizations for mental health and addictions were more common in the northern LHINs, specifically the North West, North East, and North Simcoe Muskoka LHINs.



**EXHIBIT 2.10.10** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

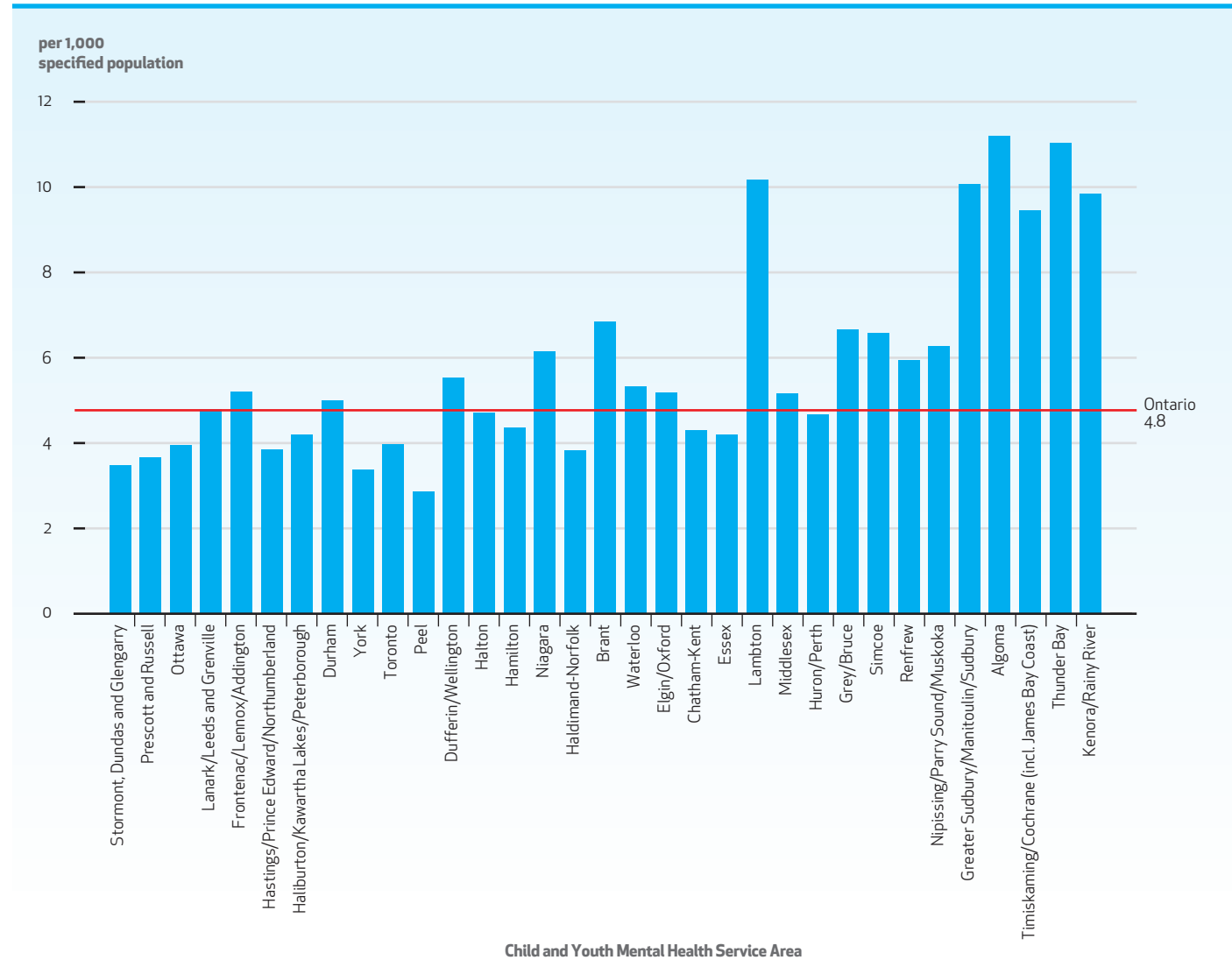
- Between 2012 and 2014, hospitalizations for mental health and addictions were more common in the northern LHINs, specifically the North West, North East, and North Simcoe Muskoka LHINs.



**EXHIBIT 2.10.11** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

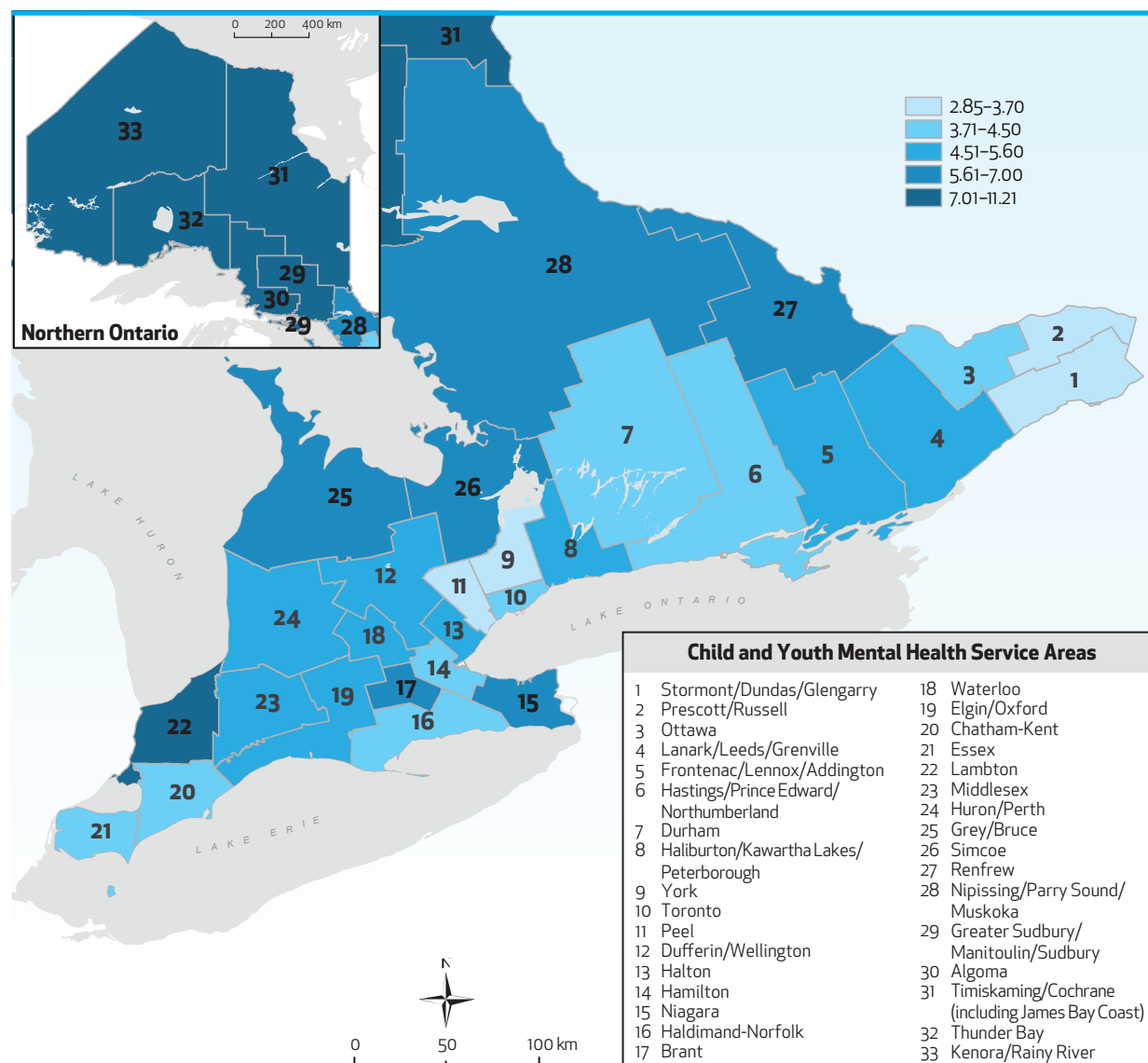
- Between 2012 and 2014, the average MHA-related hospitalization rate among children and youth was highest in the northern Child and Youth Mental Health Service Areas, particularly Algoma and Thunder Bay, and in Lambton.



**EXHIBIT 2.10.12** Number of hospitalizations related to mental health and addictions per 1,000 standard population aged 0 to 24 years, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average MHA-related hospitalization rate among children and youth was highest in the northern Child and Youth Mental Health Service Areas, particularly Algoma and Thunder Bay, and in Lambton in the south.



---

# System Performance Indicators: Access

---

**2.11** Rate of outpatient visits within 7 days of leaving the hospital after treatment for mental health and addictions

## 2.11 Rate of outpatient visits within 7 days of leaving the hospital after treatment for mental health and addictions

### Rationale

Examining whether children and youth were seen in an outpatient setting within one week following a mental health and addictions-related hospital discharge helps identify smooth transitions between in- and outpatient settings, which, in turn, may encourage adherence to treatment, improve communication between care providers and patients, and may prevent hospital readmissions.

### Results

Rates of psychiatrist and paediatrician visits within one week of leaving the hospital after treatment for mental health and addictions have slightly increased over time, while visits to GP/FPs experienced a minor decline. Females had higher rates of post-discharge follow-up than males. An age gradient of higher rates

in younger age groups was observed for psychiatrists and paediatricians, as well as an increase over time in paediatrician follow-up for children aged 0 to 13. The opposite gradient was observed for GP/FPs. The younger age groups were more likely to visit paediatricians and to receive combined care, while the older age groups were more likely to visit GP/FPs.

There was an increase over time in psychiatrist visits within 7 days following deliberate self-harm, anxiety, and substance-related hospital discharges. By contrast, follow-up by GP/FPs for those discharged with a diagnosis of substance-related disorders and deliberate self-harm declined over time. Paediatrician and combined care follow-up was also most common for deliberate self-harm. An income gradient, with higher rates of follow-up in wealthier neighbourhoods, was largely driven by psychiatrist care, while other physician specialties had fairly equal follow-up rates across income groups. Immigrants and refugees received more psychiatrist follow-up than GP/FP follow-up, while the opposite was observed for non-immigrants.

Psychiatrists provided the most post-discharge follow-up in the Toronto Central LHINs, while GP/FPs had the highest rates in the Central East LHIN. In most LHINs, psychiatrists provided more follow-up than GP/FPs, with the exception of the Central, North Simcoe Muskoka, and North West LHINs. The highest rates of combined care were observed in Central

LHIN. Outpatient follow-up also varied across the types of hospitals from which children and youth were discharged.

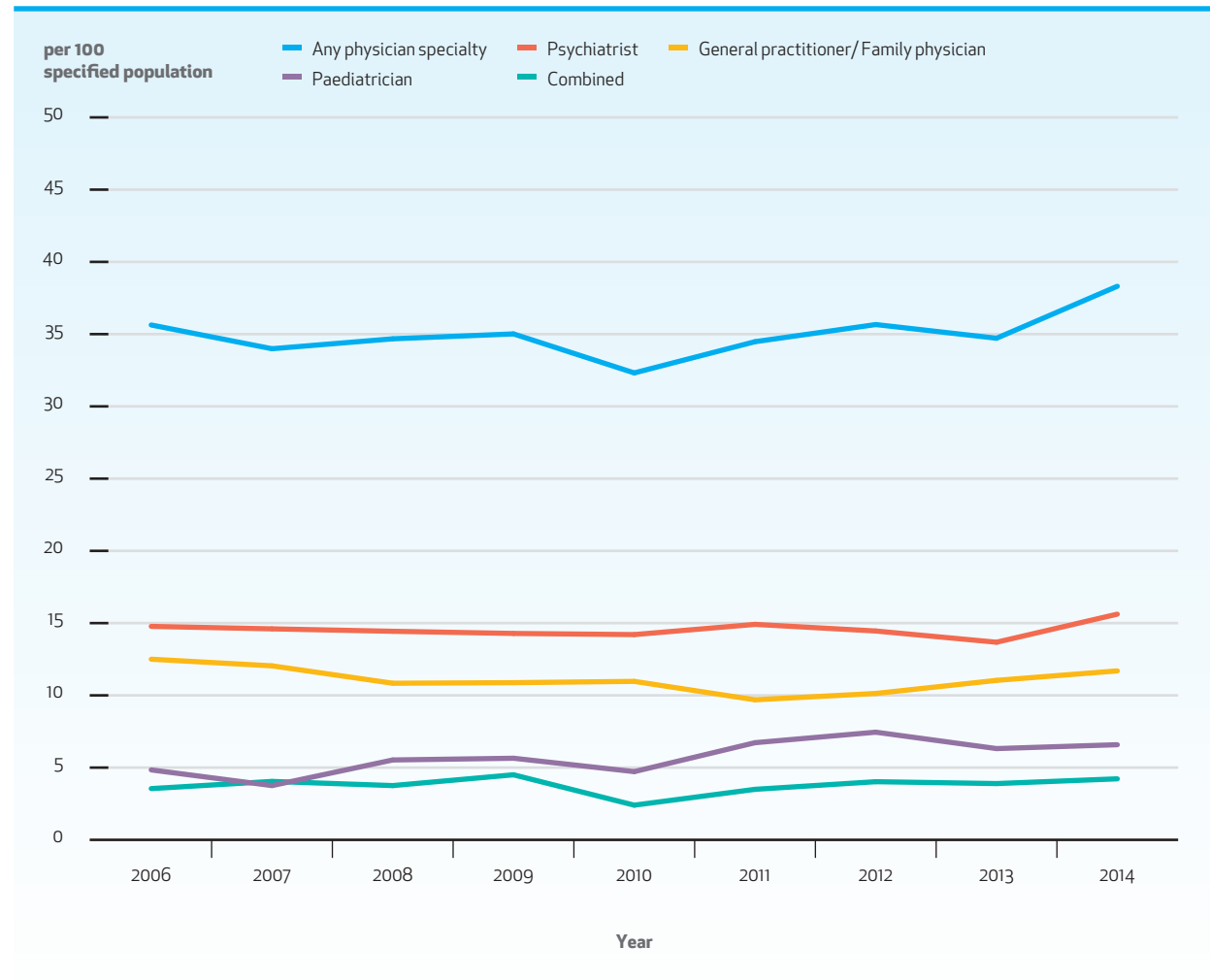
### Interpretation

Following a psychiatric hospital discharge, approximately one in three children was seen by either a psychiatrist, a GP/FP or a paediatrician for a mental health and addictions problem. Although the variation in follow-up rates by physician specialty for the different age groups and diagnoses suggests that certain groups are being targeted, overall rates have not increased substantially over time.

**EXHIBIT 2.11.1** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by physician specialty, in Ontario, 2006 to 2014

## Key Finding

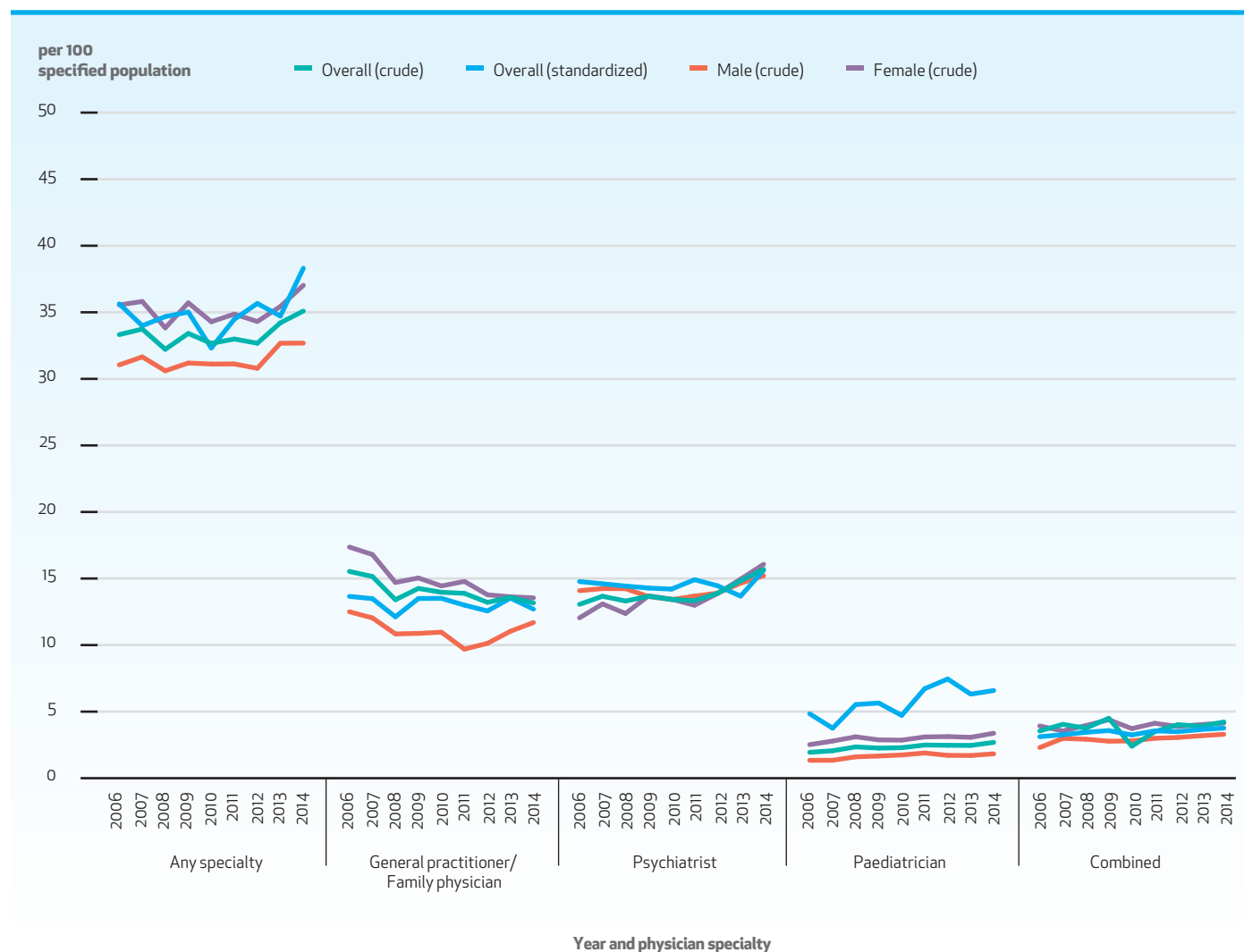
- Between 2006 and 2014, the rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge increased slightly. There was also a slight increase for psychiatrist follow-up and a decrease for GP/FP follow-up. Rates of paediatrician and combined care follow-up remained stable.



**EXHIBIT 2.11.2** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge, by physician specialty and sex, in Ontario, 2006 to 2014

## Key Findings

- Between 2006 and 2014, the rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge increased slightly.
- There was also a slight increase in psychiatrist follow-up and a decrease for GP/FP follow-up.
- Rates of paediatrician and combined care follow-up remained relatively stable.
- Females received more GP/FP and paediatric follow-up, and males received more follow-up from psychiatrists.

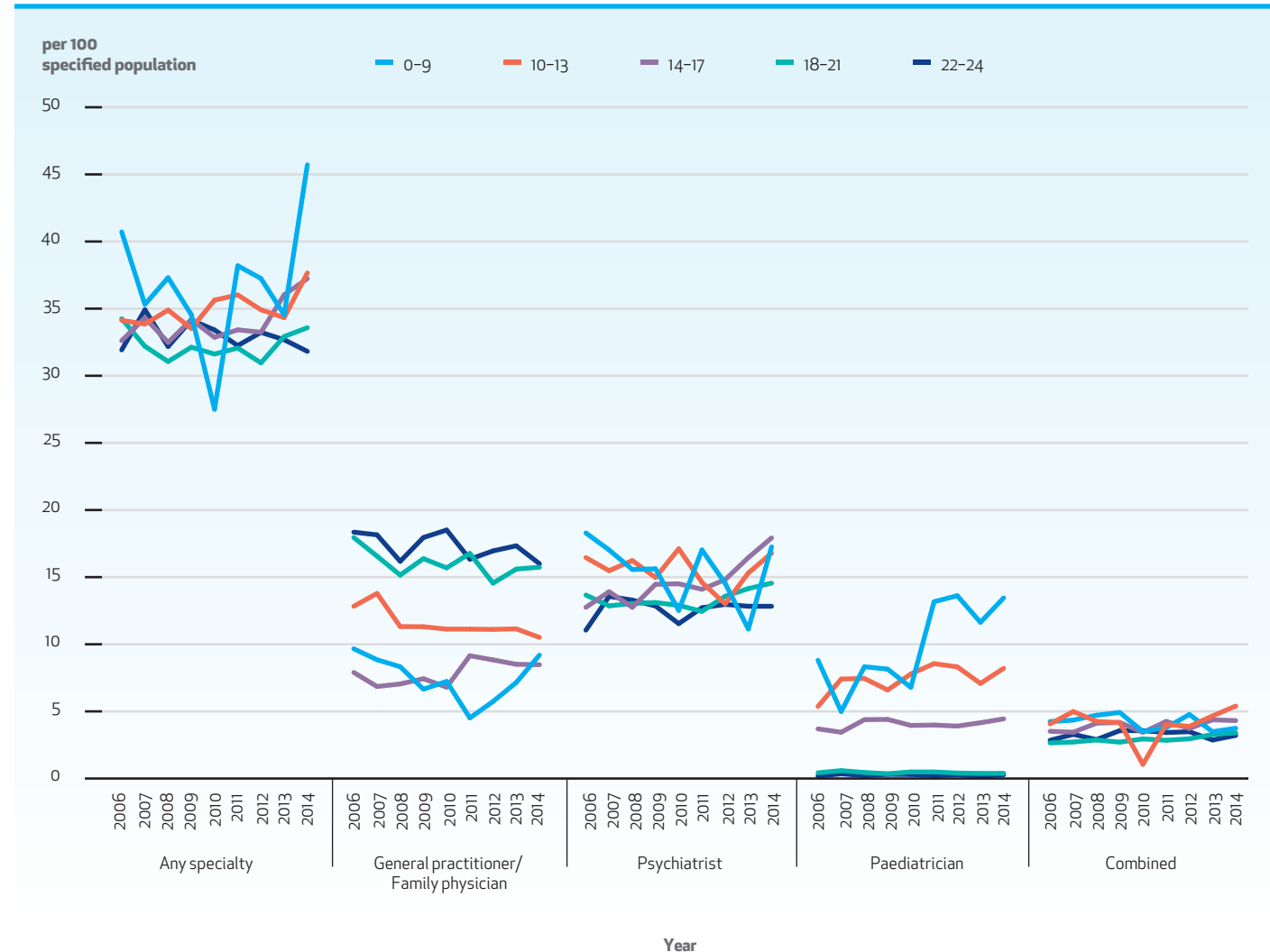




**EXHIBIT 2.11.3** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by age group and physician specialty, in Ontario, 2006 to 2014

## Key Findings

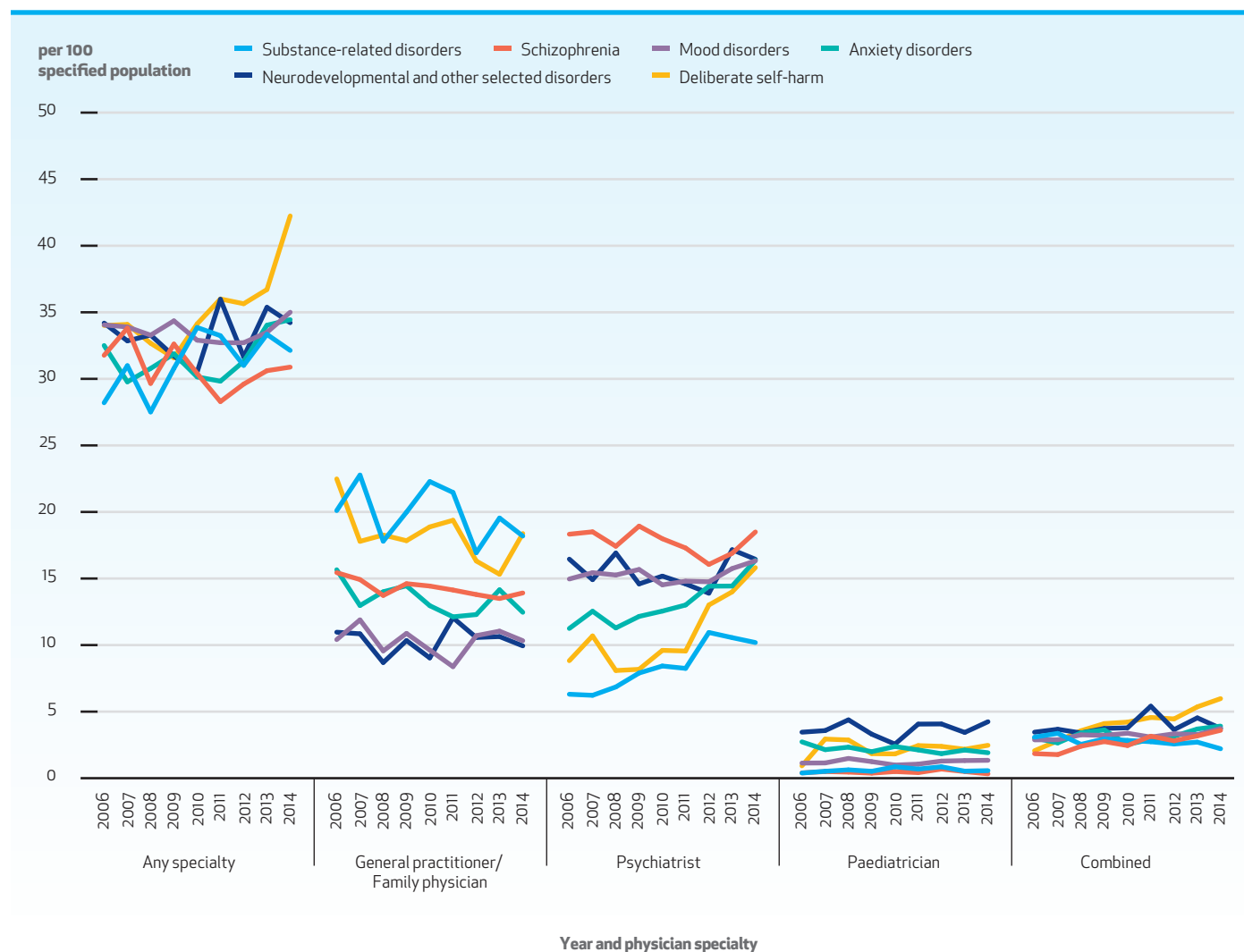
- Between 2006 and 2014, the rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge increased slightly among children aged 0 to 9; this was largely driven by an increase in paediatrician follow-up.
- For most physician specialties, an age gradient was observed, with higher outpatient visit rates among the younger age groups.
- For GP/FPs, the opposite gradient was observed.



**EXHIBIT 2.11.4** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by type of disorder and physician specialty, in Ontario, 2006 to 2014

## Key Findings

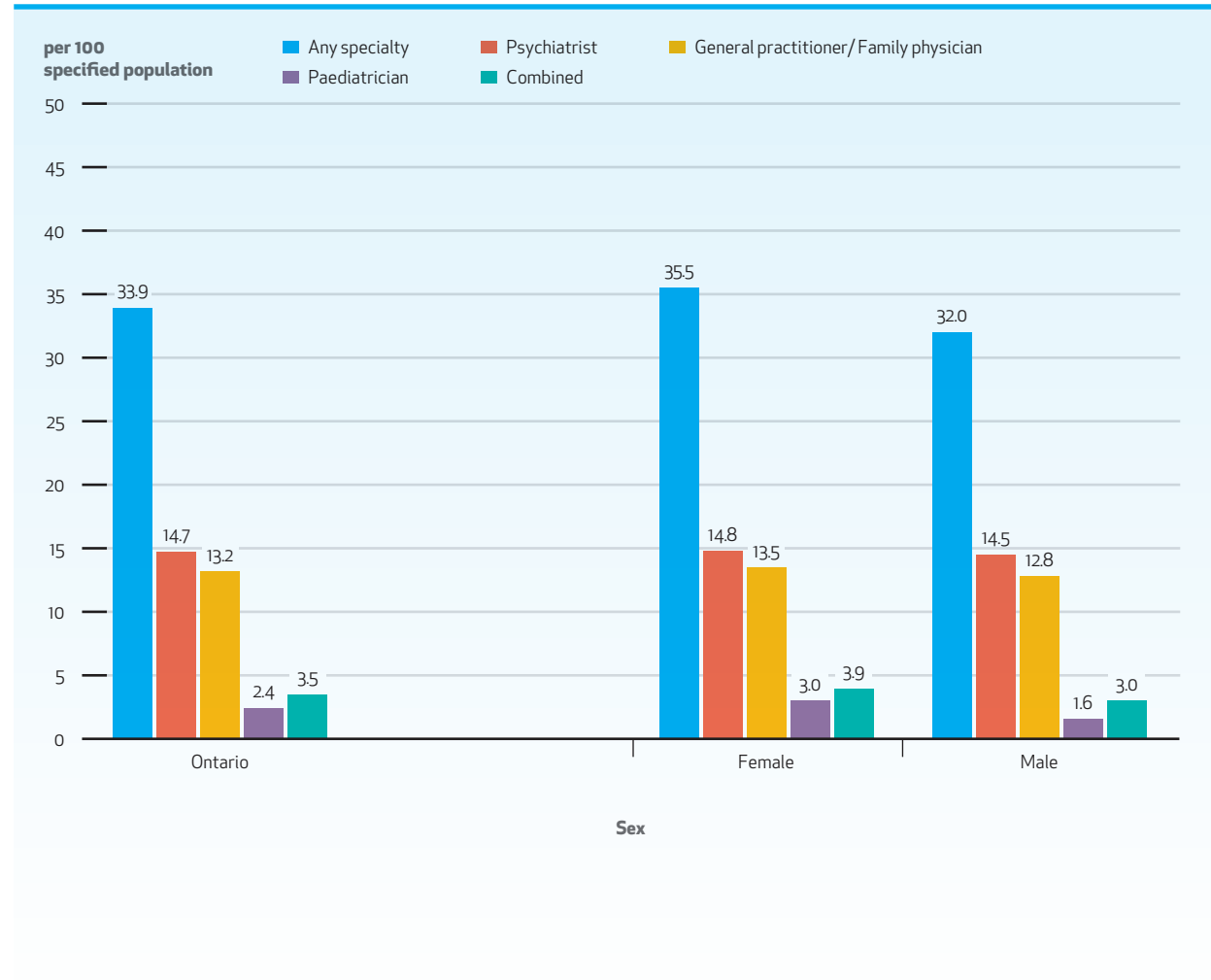
- Between 2006 and 2014, the rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge was highest among individuals discharged with a diagnosis of mood disorder or deliberate self-harm.
- Rates of outpatient follow-up for deliberate self-harm rapidly increased over time.
- Follow-up visit rates increased for substance-related disorders but decreased for schizophrenia.
- Psychiatrist follow-up rates increased over time for deliberate self-harm, anxiety disorders and substance-related disorders.
- Follow-up with GP/FPs was highest for substance-related disorders and deliberate self-harm, but these rates declined over time.



**EXHIBIT 2.11.5** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by sex and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Finding

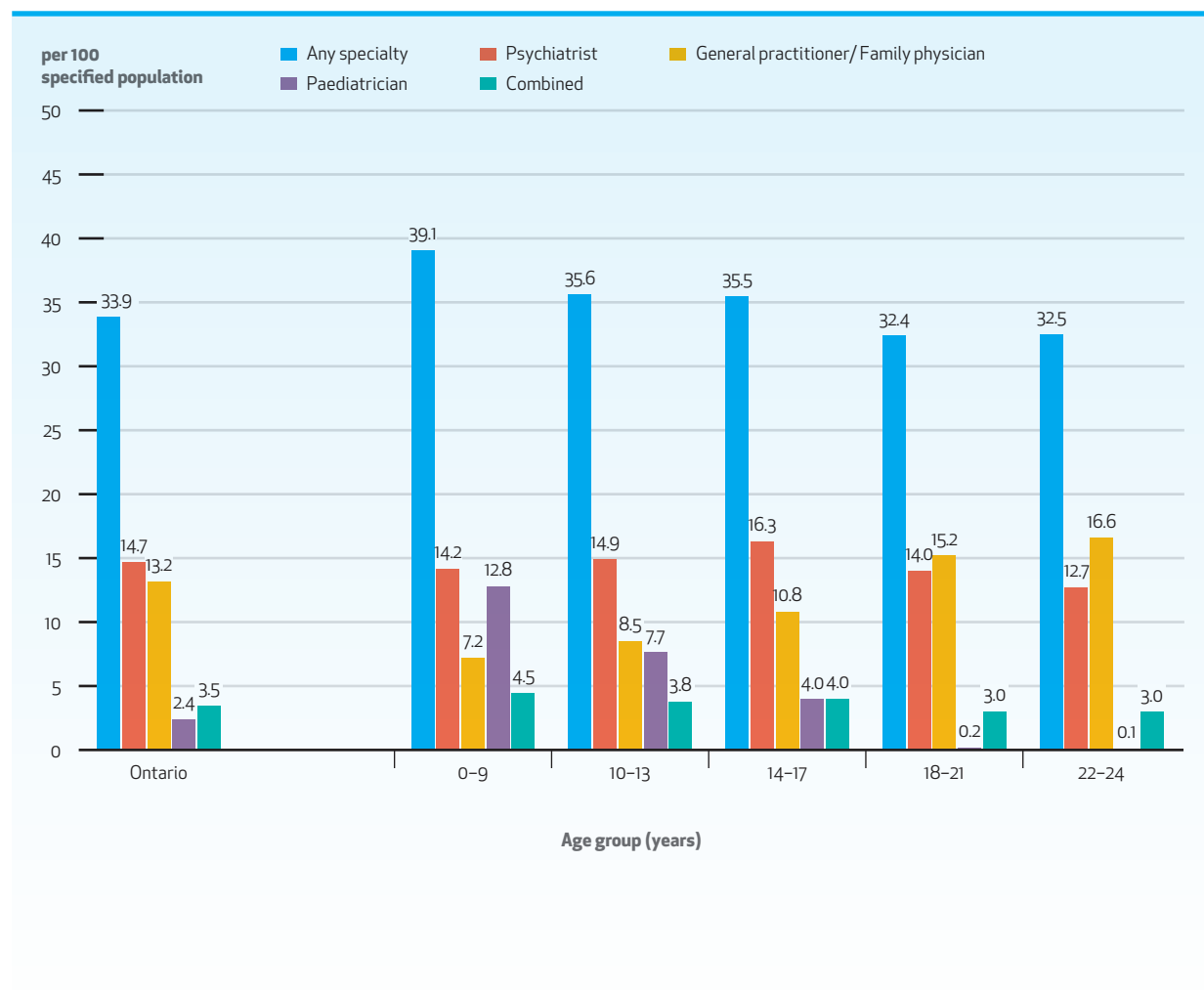
- Between 2012 and 2014, the average rate of outpatient visits within 7 days of an MHA-related hospital discharge was higher for females for all physician specialties.



**EXHIBIT 2.11.6** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by age group and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

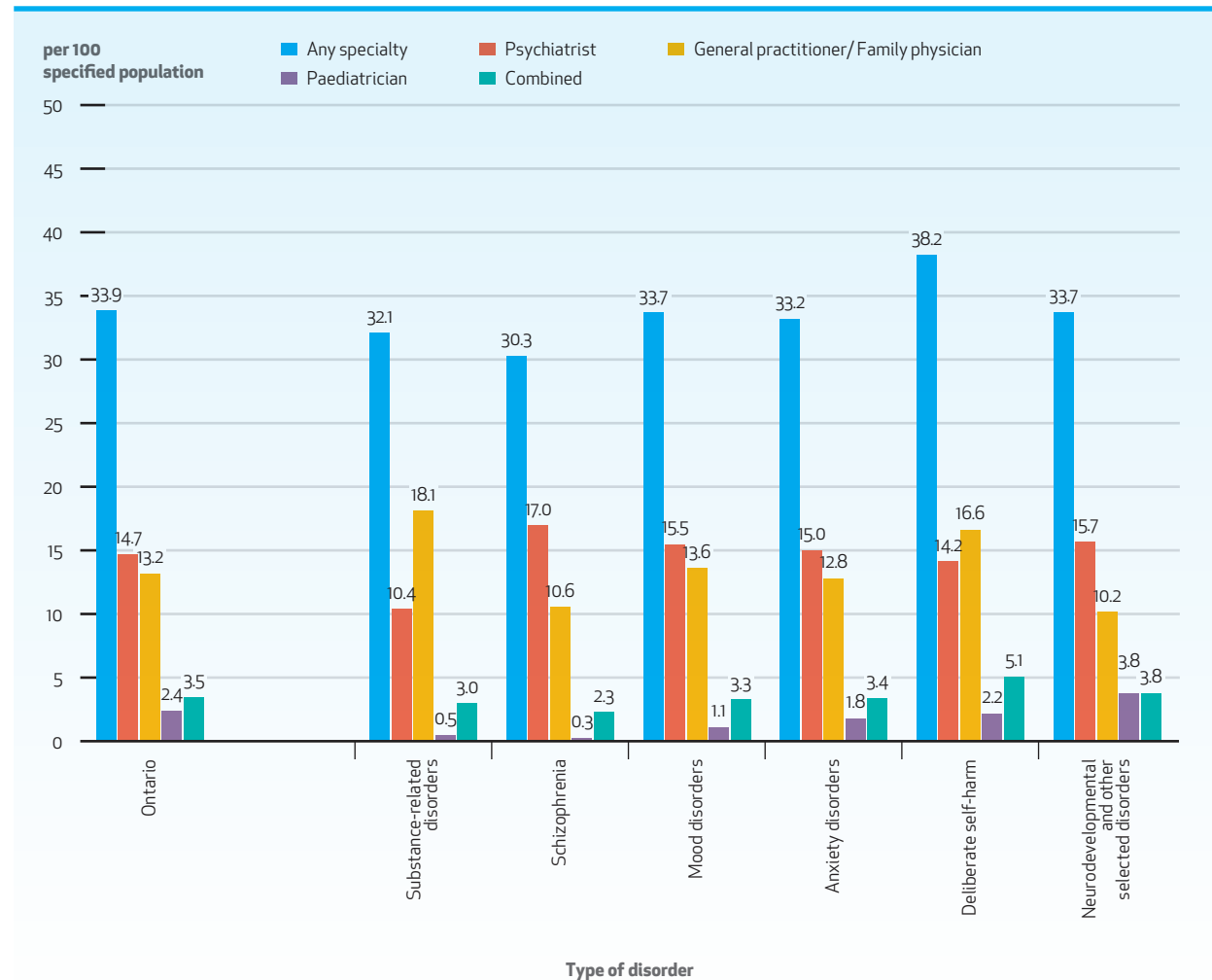
- Between 2012 and 2014, the average overall rate of physician follow-up within 7 days of an MHA-related hospital discharge was higher for younger age groups.
- Children aged 0 to 9 were most likely to visit paediatricians and to receive combined care from a psychiatrist and either a paediatrician or a GP/FP.
- Youths aged 18 and older were more likely to follow up with GP/FPs than with psychiatrists.
- Youths aged 14 to 17 had the highest psychiatrist follow-up rate within 7 days after a hospital discharge.



**EXHIBIT 2.11.7** Number of outpatient visits related to mental health and addictions (MHA) within 7 days of an incident MHA-related hospital discharge per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by type of disorder and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

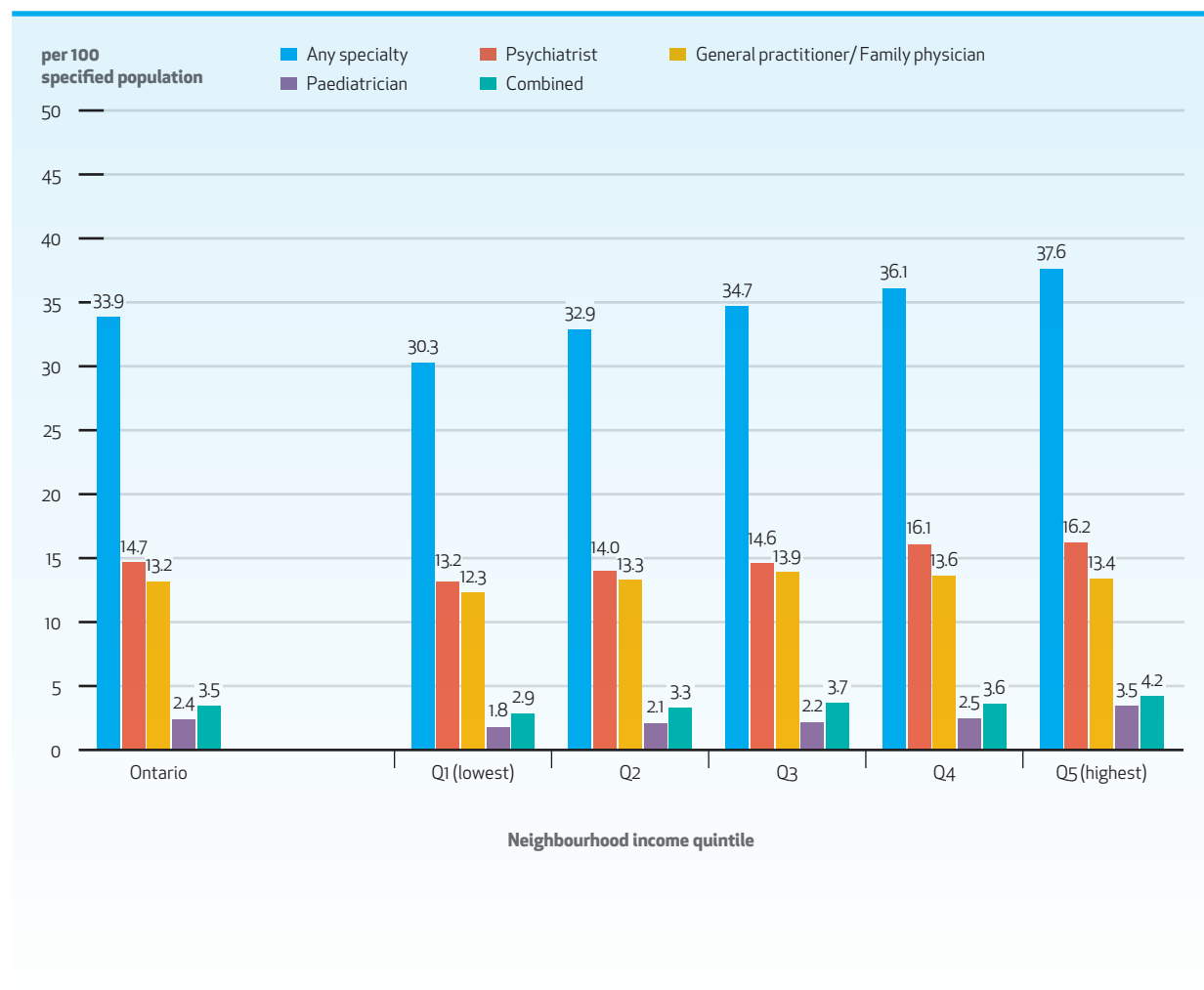
- Between 2012 and 2014, the average overall rate of physician follow-up within 7 days of an MHA-related hospital discharge was highest among children and youth discharged with a diagnosis of deliberate self-harm.
- GP/FP follow-up rates were highest among those with substance-related disorders.
- Psychiatrist follow-up rates were highest among those with schizophrenia.
- Paediatrician follow-up rates were highest among those with neurodevelopmental and other selected disorders.
- Combined care follow-up rates were highest among those with deliberate-self-harm.



**EXHIBIT 2.11.8** Number of outpatient visits related to mental health and addictions (MHA) within 7 days of an incident MHA-related hospital discharge per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by neighbourhood income quintile and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

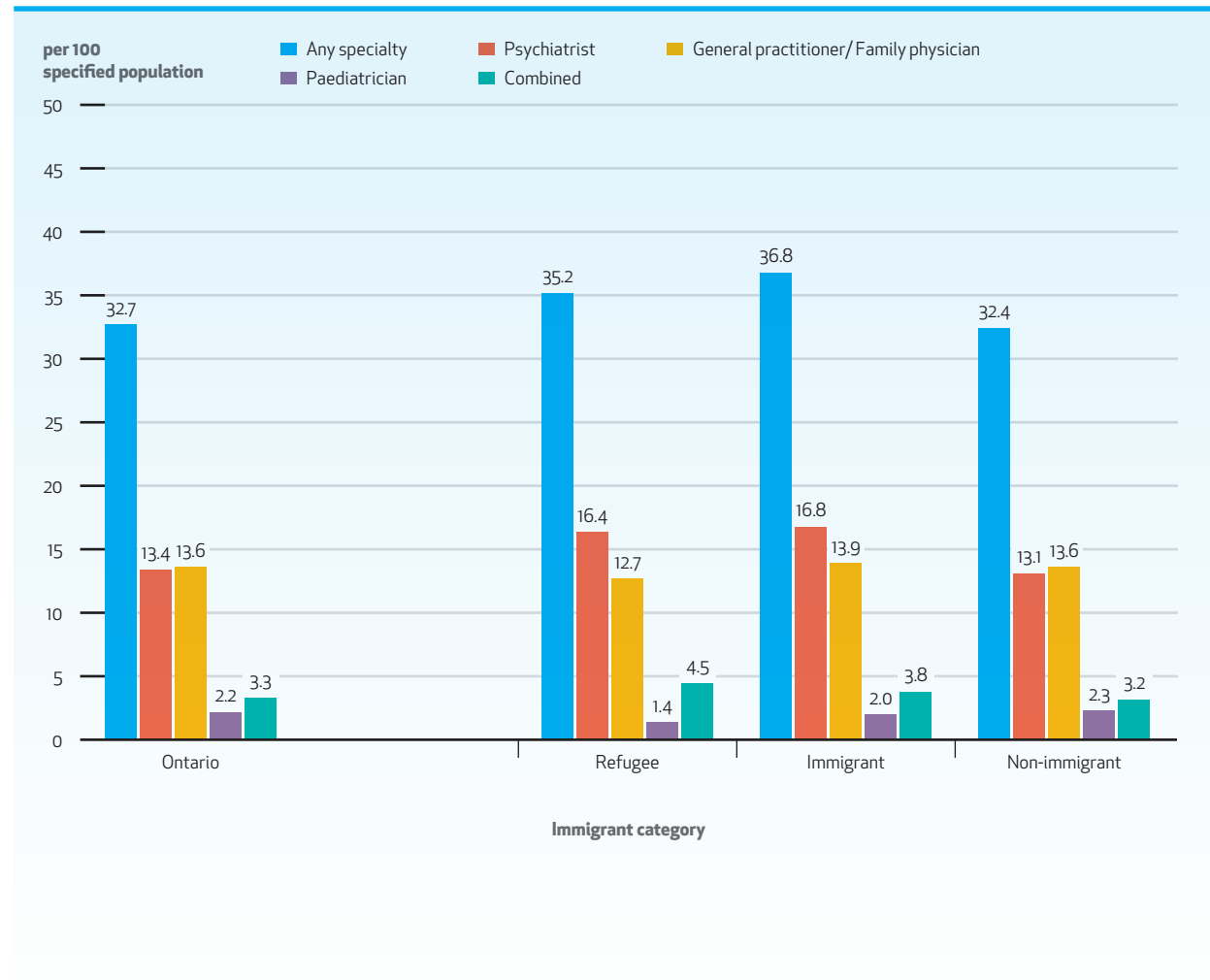
- Between 2012 and 2014, the average overall rate of physician follow-up within 7 days of an MHA-related hospital discharge was elevated in higher-income neighbourhoods, driven by psychiatrist follow-up visits.
- GP/FP follow-up rates were similar across neighbourhoods, while paediatrician and combined care follow-up rates were higher in the wealthiest neighbourhoods.



**EXHIBIT 2.11.9** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital discharge, by immigrant category and physician specialty, in Ontario, three-year average for 2010 to 2012

## Key Findings

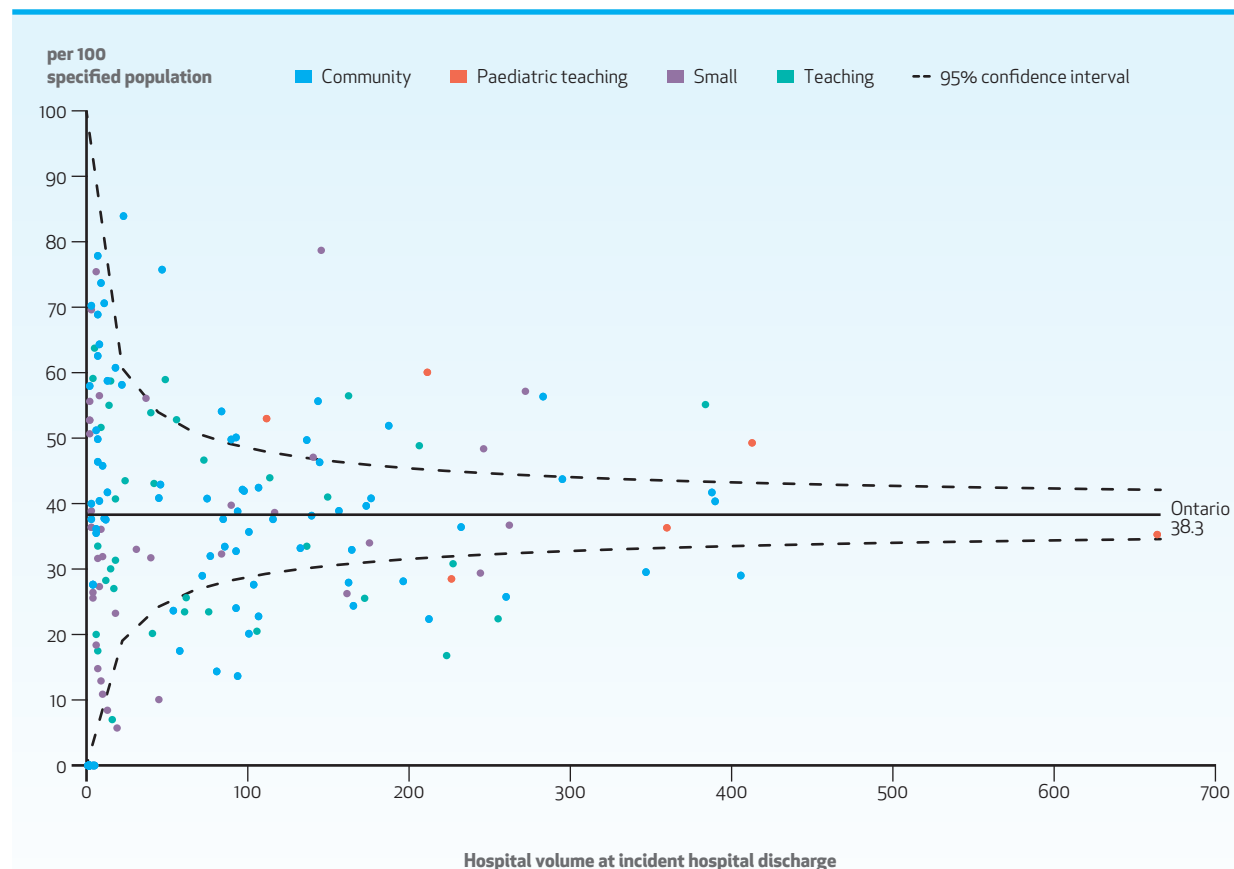
- Between 2010 and 2012, the average overall rate of physician follow-up within 7 days of an MHA-related hospital discharge was higher among immigrants.
- Immigrants and refugees received more psychiatrist follow-up than GP/FP follow-up, whereas non-immigrants received more GP/FP follow-up than psychiatrist follow-up.



**EXHIBIT 2.11.10** Number\* of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge, by hospital type, weighted by hospital discharge volume, in Ontario, 2014

## Key Findings

- In 2014, the age- and sex-adjusted rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge showed more variation by hospital type and volume than would be expected by chance.
- Several community hospitals showed both higher- and lower-than-average follow-up rates, given their volume.
- Two paediatric teaching hospitals had higher rates than would be expected by chance.



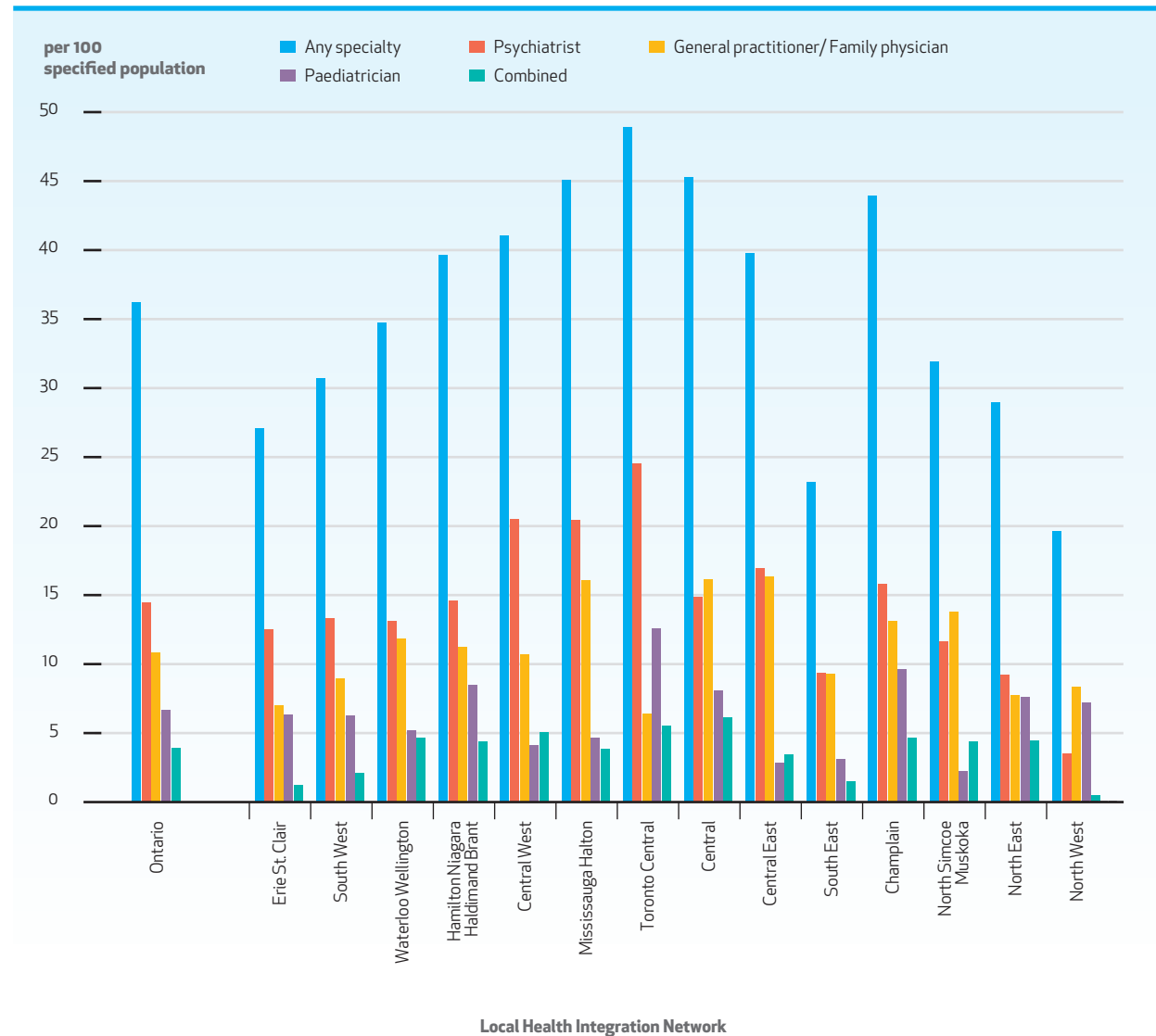
\*Adjusted for age and sex.



**EXHIBIT 2.11.11** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

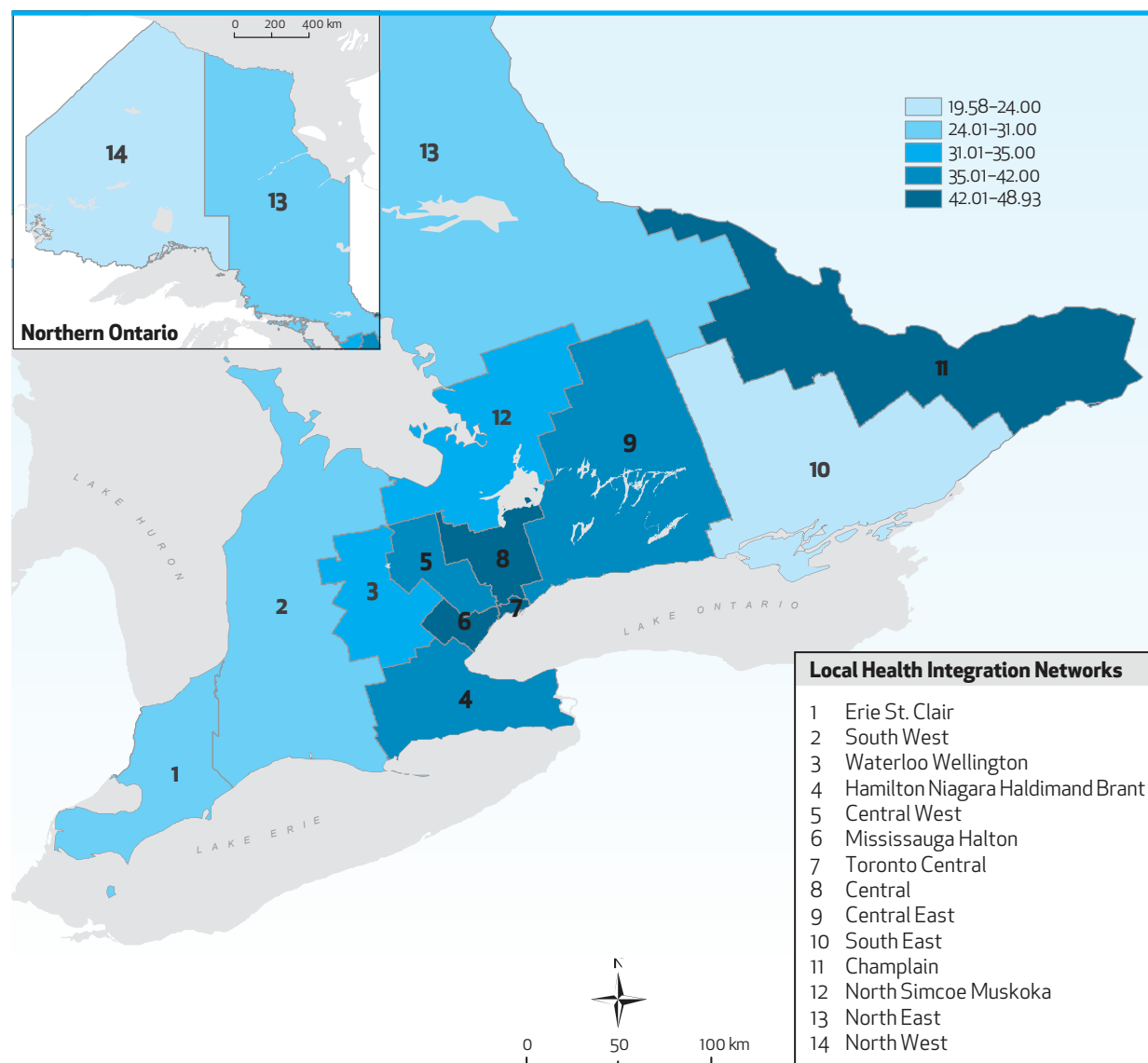
- Between 2012 and 2014, the average overall rate of physician follow-up within 7 days of an MHA-related hospital discharge was highest in the Toronto Central LHIN; this was driven largely by psychiatrist follow-up.
- The highest rate of GP/FP follow-up was observed in the Central East LHIN.
- In most LHINs, the rate of psychiatrist follow-up was higher than the rate of GP/FP or paediatrician follow-up, with the exception of the Central, North Simcoe Muskoka, and North West LHINs, where the highest rate of follow-up was with GP/FPs.
- Patients in the Toronto Central LHIN had more follow-up with paediatricians than with GP/FPs.
- The highest rate of combined care follow-up was observed in the Central LHIN.



**EXHIBIT 2.11.12** Number of outpatient visits to any physician specialty within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

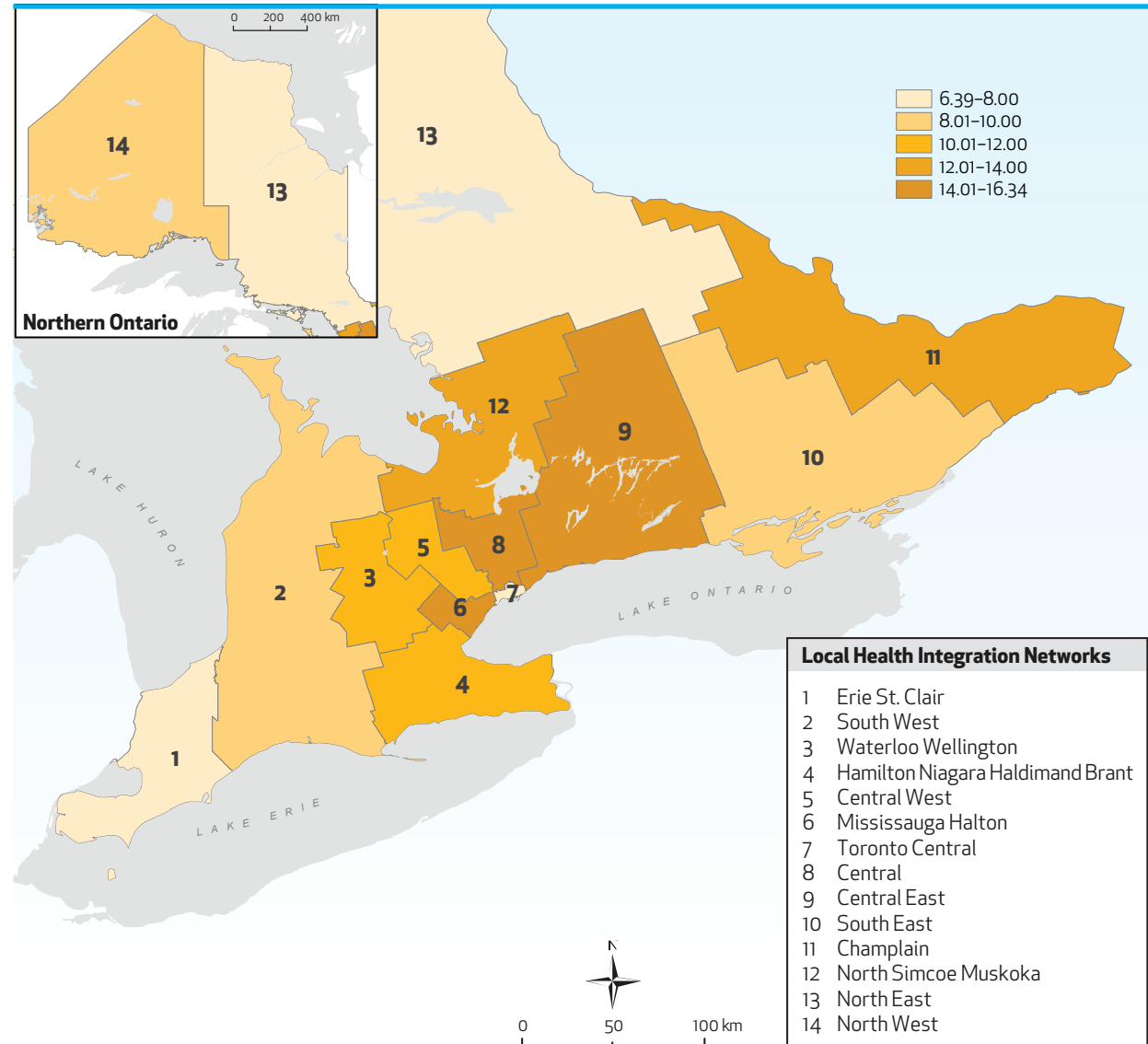
- Between 2012 and 2014, the average age- and sex-standardized rate of follow-up with any physician specialty within 7 days of an MHA-related hospital discharge was highest in the Toronto Central LHIN.



**EXHIBIT 2.11.13** Number of outpatient visits to a general practitioner or family physician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

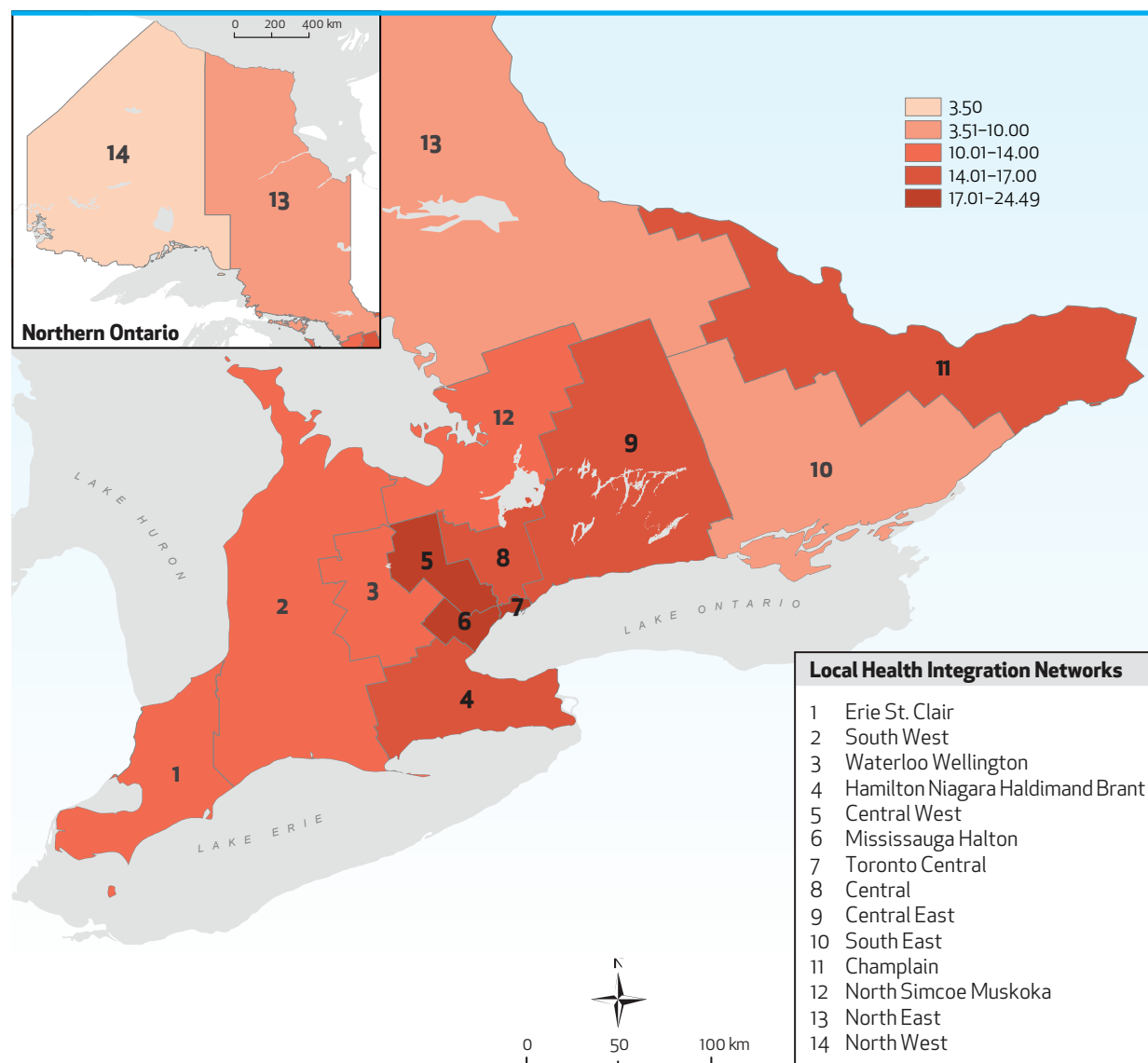
- Between 2012 and 2014, the average age- and sex-standardized rate of follow-up with a general practitioner or family physician within 7 days of an MHA-related hospital discharge was highest in the Central East LHIN.



**EXHIBIT 2.11.14** Number of outpatient visits to a psychiatrist within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

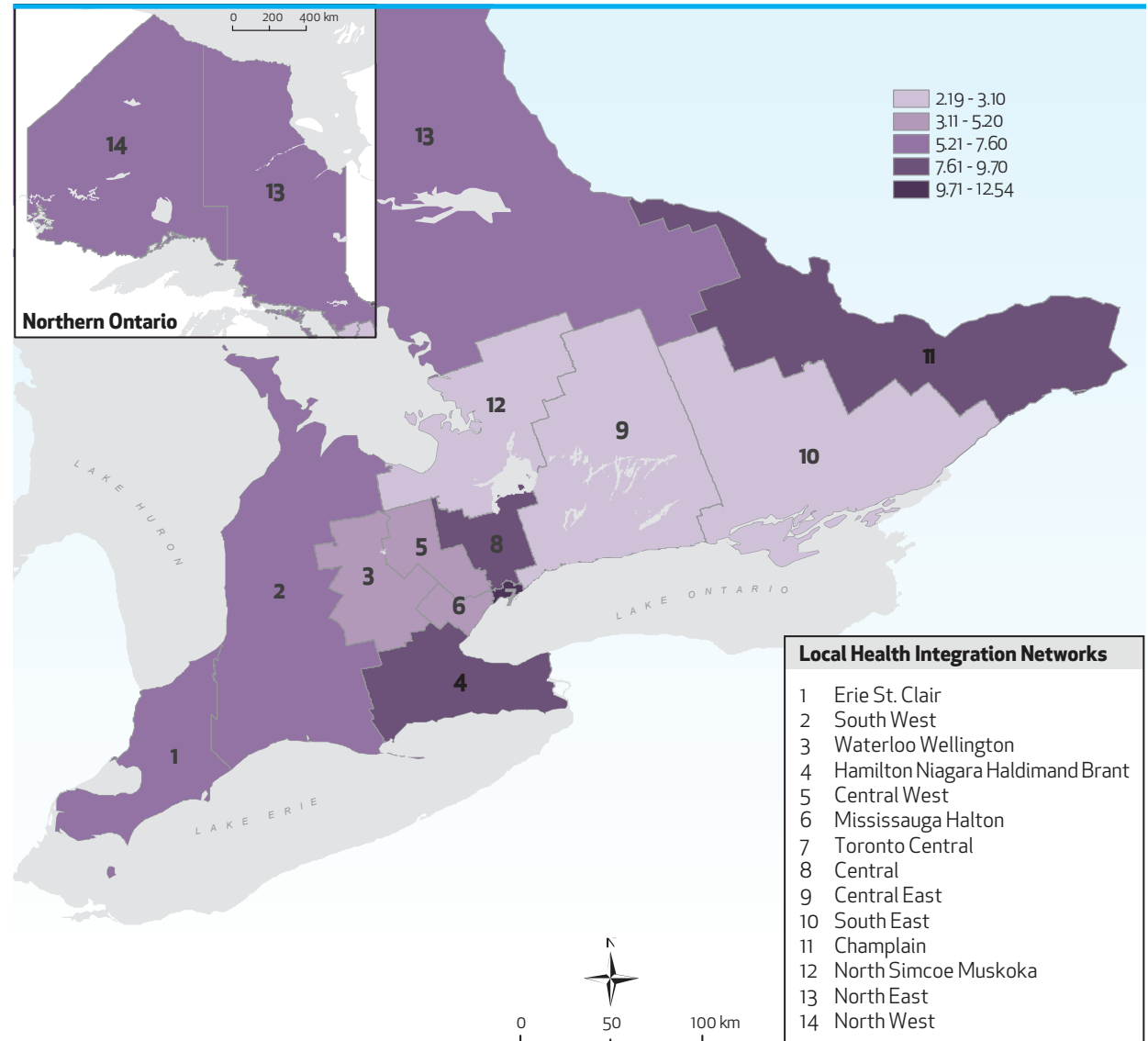
- Between 2012 and 2014, the average age- and sex-standardized rate of follow-up with a psychiatrist within 7 days of an MHA-related hospital discharge was highest in the Toronto Central LHIN.



**EXHIBIT 2.11.15** Number of outpatient visits to a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

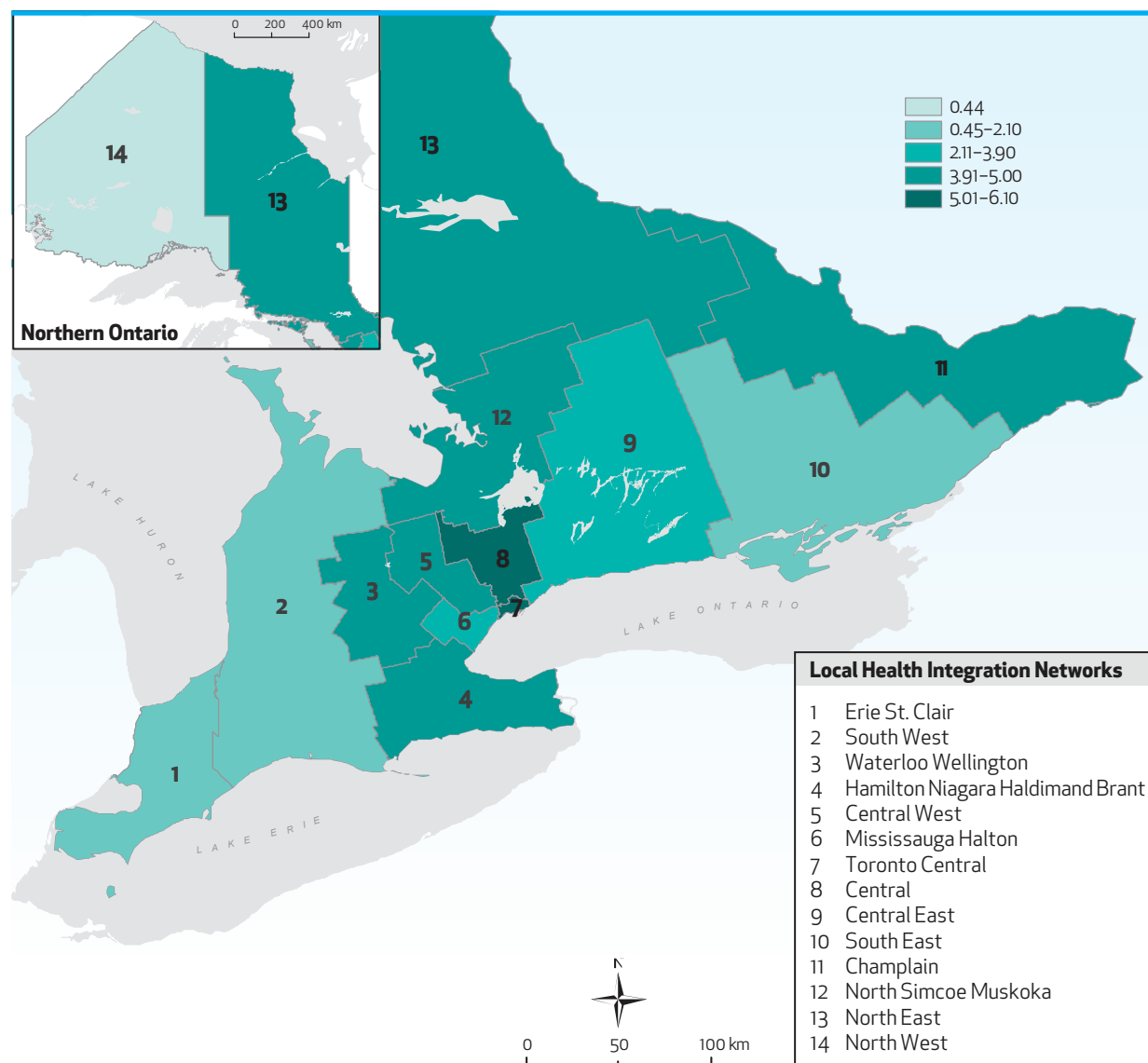
- Between 2012 and 2014, the average age- and sex-standardized rate of follow-up with a paediatrician within 7 days of an MHA-related hospital discharge was highest in the Toronto Central LHIN.



**EXHIBIT 2.11.16** Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Local Health Integration Network and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Finding

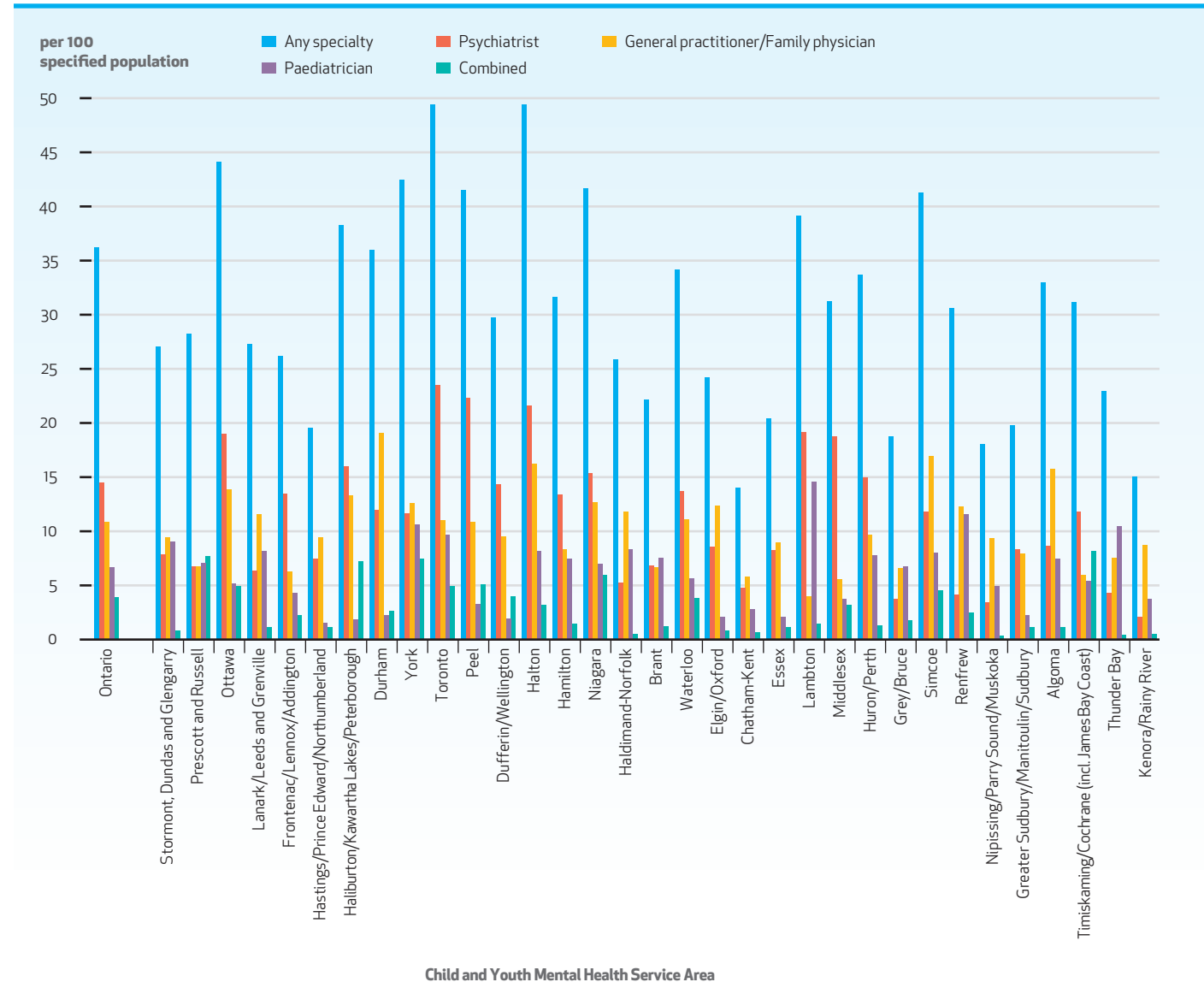
- Between 2012 and 2014, the average age- and sex-standardized rate of follow-up with a psychiatrist and either a paediatrician or a general practitioner/family physician within 7 days of an MHA-related hospital discharge was highest in the Central LHIN.



**EXHIBIT 2.11.17** Number of outpatient visits within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area and physician specialty, in Ontario, three-year average for 2012 to 2014

## Key Findings

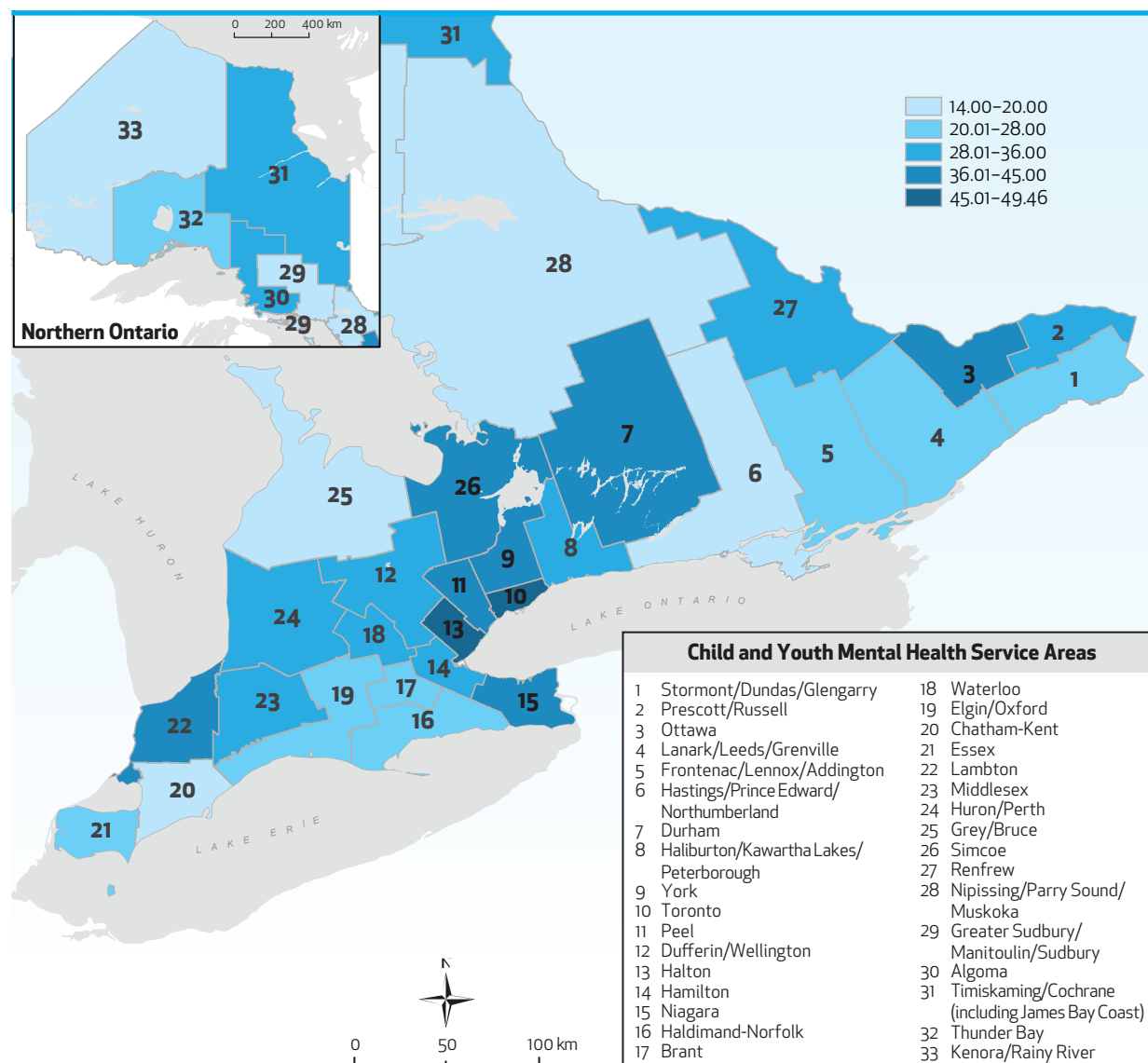
- Between 2012 and 2014, the average age- and sex-standardized rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge was highest in the Toronto and Halton Child and Youth Mental Health Service Areas.
- The highest rate of combined care was observed in Timiskaming/Cochrane.



**EXHIBIT 2.11.18** Number of outpatient visits to any physician specialty within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of outpatient visits to any physician specialty within 7 days of an MHA-related hospital discharge was highest in the Toronto and Halton Child and Youth Mental Health Service Areas.

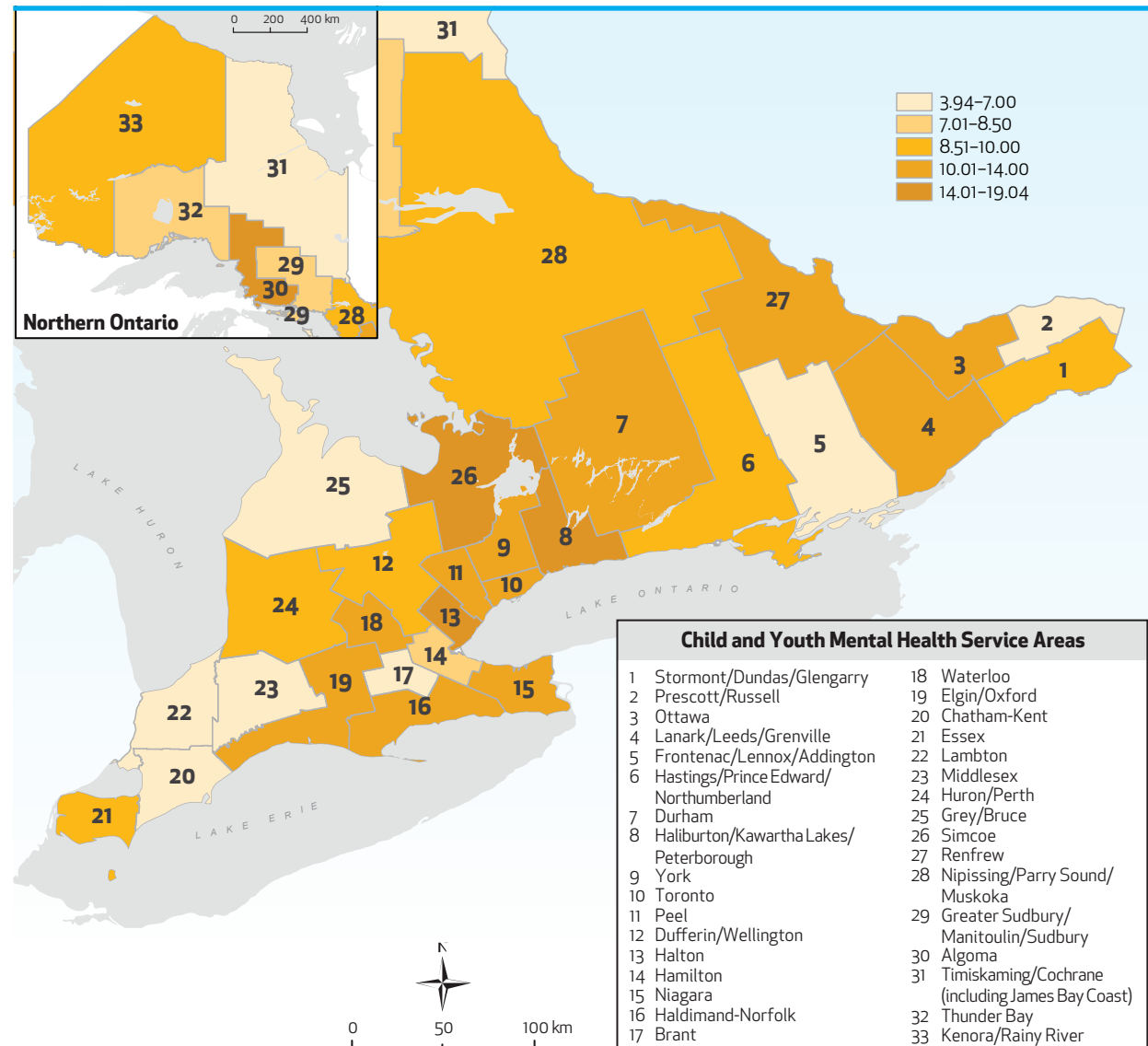




**EXHIBIT 2.11.19** Number of outpatient visits to a general practitioner or family physician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

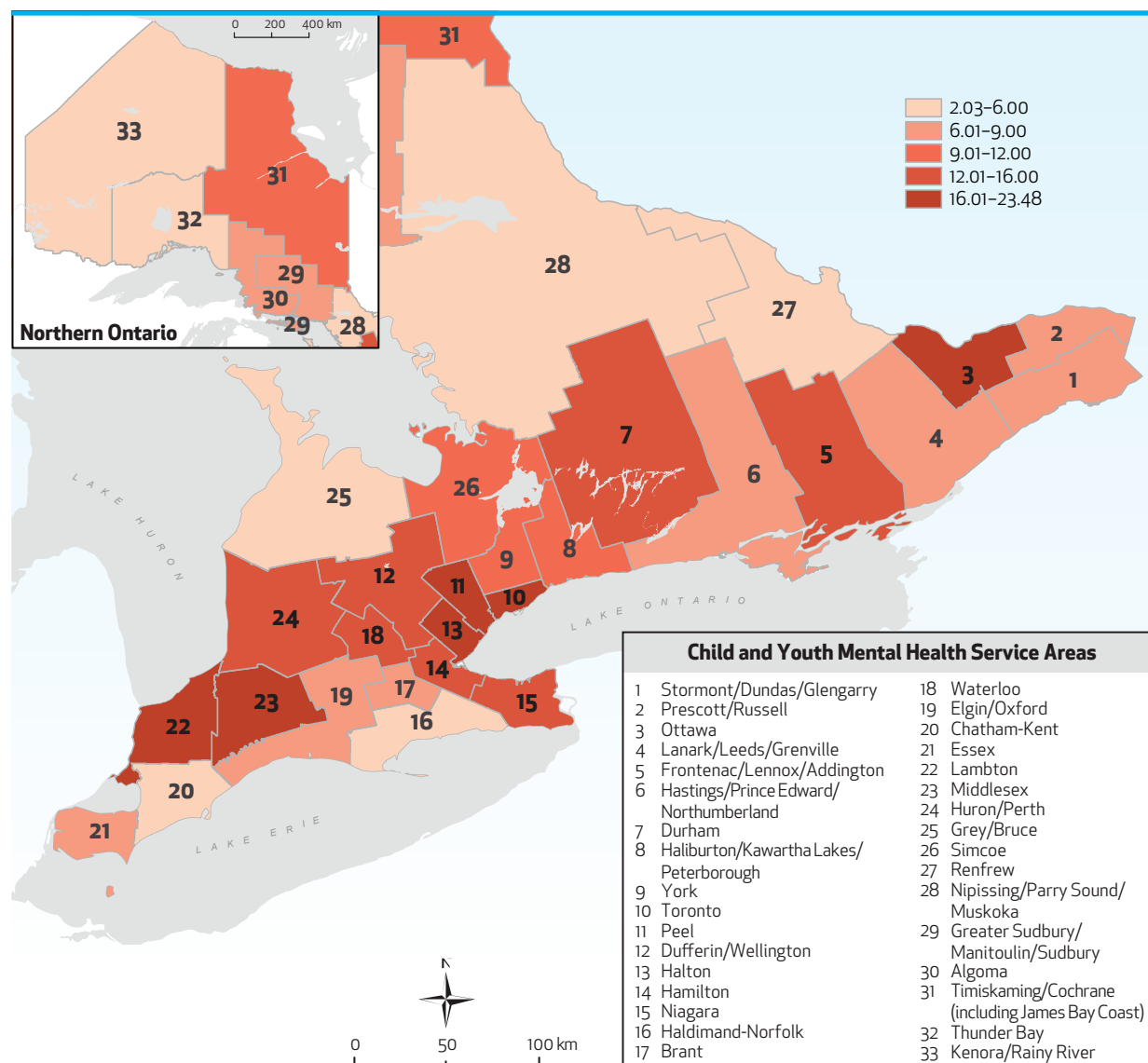
- Between 2012 and 2014, the average age- and sex-standardized rate of physician follow-up with a general practitioner or family physician within 7 days of an MHA-related hospital discharge was highest in the Durham Child and Youth Mental Health Service Area and lowest in Lambton.



**EXHIBIT 2.11.20** Number of outpatient visits to a psychiatrist within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

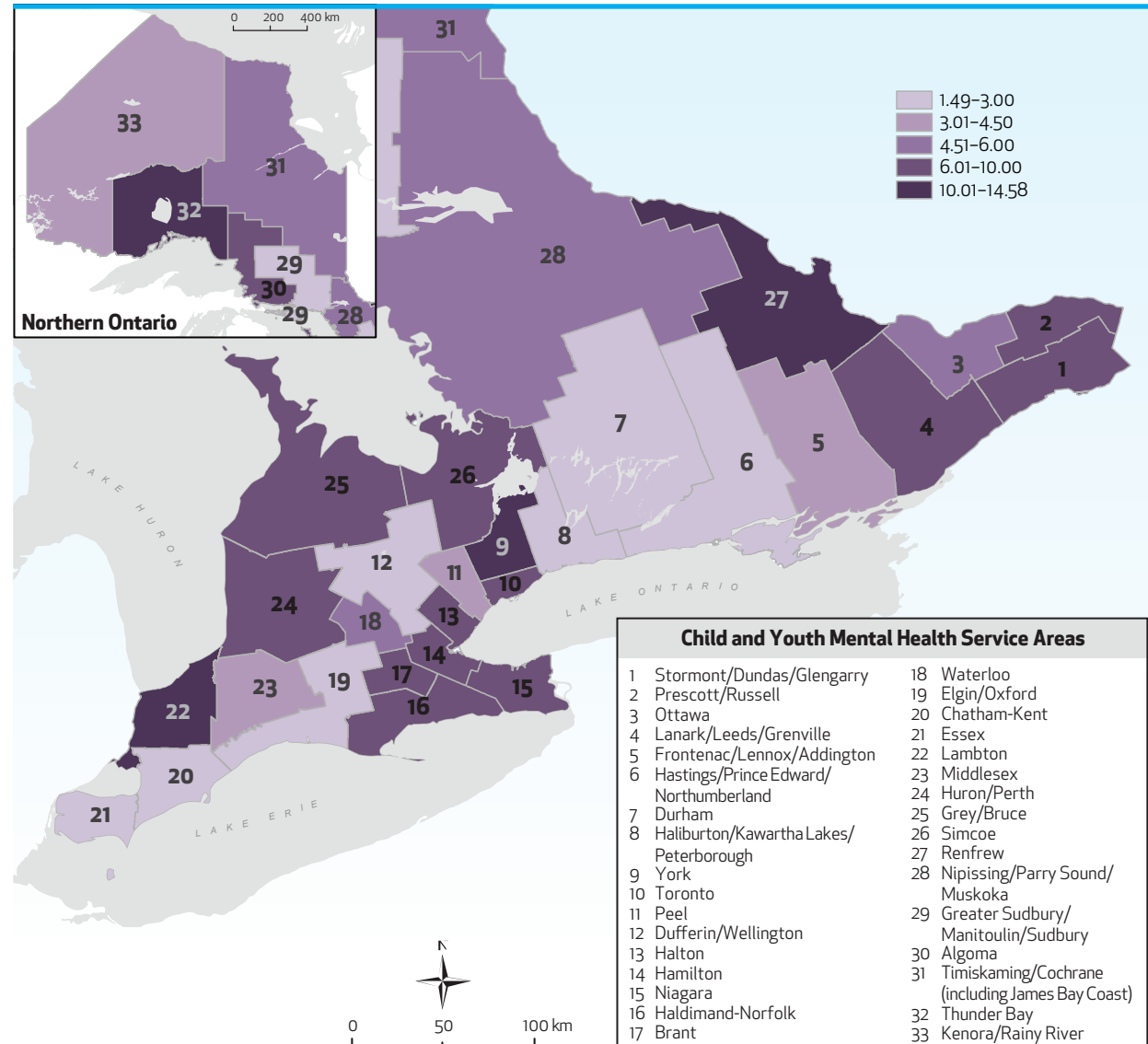
- Between 2012 and 2014 among Child and Youth Mental Health Service Areas, the average age- and sex-standardized rate of psychiatrist visits within 7 days of a mental health and addictions-related hospital discharge was highest in Toronto and Peel and lowest in Kenora/Rainy River.



**EXHIBIT 2.11.21** Number of outpatient visits to a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

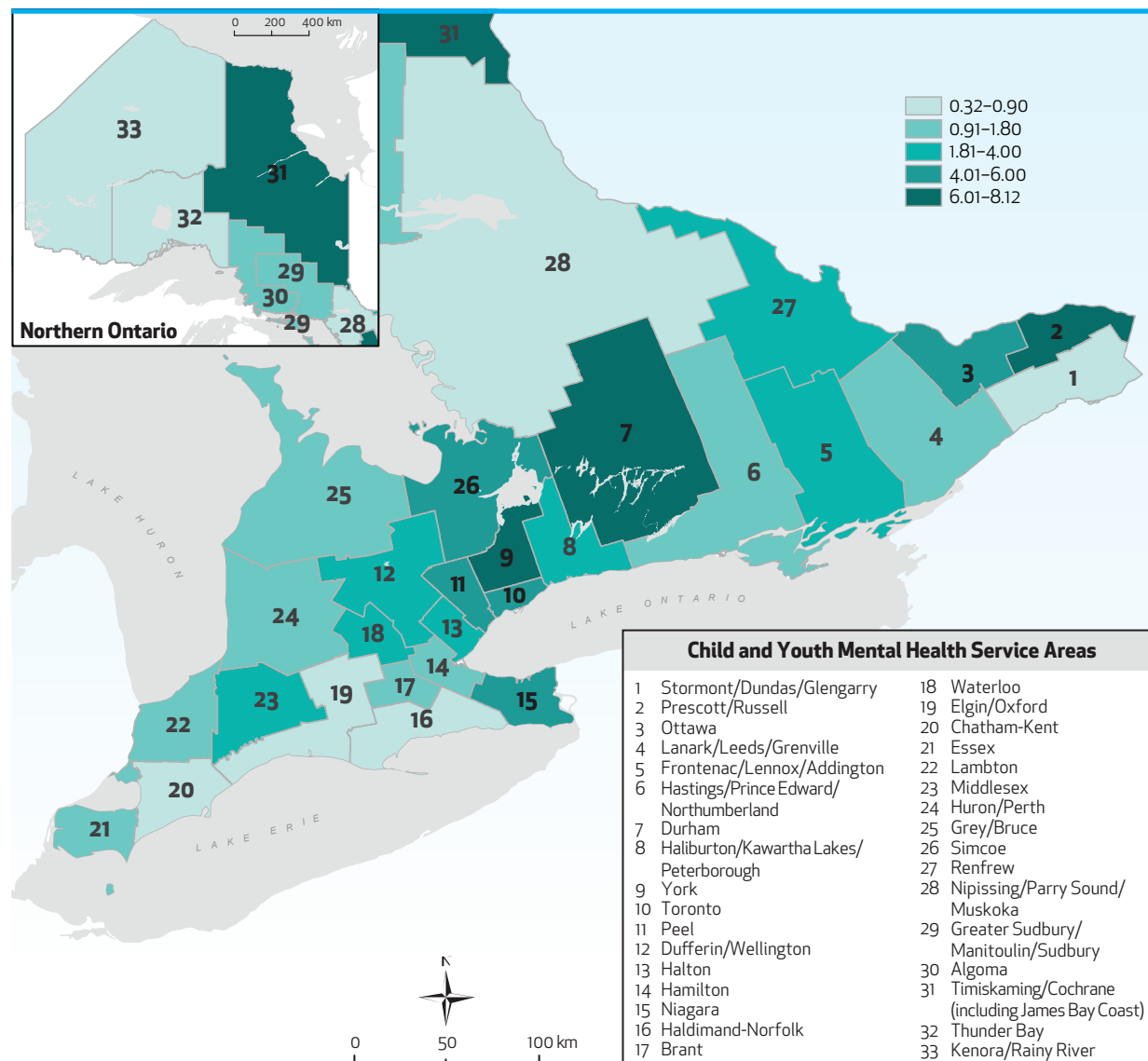
- Between 2012 and 2014, the average age- and sex-standardized rate of outpatient visits to a paediatrician for mental health and addictions within 7 days of a related hospital discharge was highest in the York, Lambton, Renfrew and Thunder Bay Child and Youth Mental Health Service Areas.



**EXHIBIT 2.11.22** Number of outpatient visits to a psychiatrist and either a general practitioner/family physician or a paediatrician within 7 days of an incident hospital discharge related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital discharge, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of combined physician follow-up with a psychiatrist and either a paediatrician or a general practitioner/family physician within 7 days of an MHA-related hospital discharge was highest in the Timiskaming/Cochrane Child and Youth Mental Health Service Area.



---

# System Performance Indicators: Quality

---

**2.12** Rate of 30-day repeat unscheduled emergency department (ED) visits after a mental health and addictions-related ED discharge for children and youth

**2.13** Rate of 30-day readmission after a mental health and addictions-related hospital discharge for children and youth

## 2.12 Rate of 30-day repeat unscheduled emergency department (ED) visits after a mental health and addictions-related ED discharge for children and youth

### Rationale

Unscheduled emergency department revisits following an incident emergency department discharge could signal inadequate support from community-based and outpatient mental health and addictions services.

### Results

Rates of unscheduled emergency department revisits within 30 days of an incident mental health and addictions-related ED visit increased slightly over time, particularly among children aged 13 and younger. Schizophrenia-related ED visits that resulted in a discharge home were the ones most often followed by an acute care revisit within 30 days. The highest rates of ED revisits were also found among males, 22- to 24-year-olds (with an age gradient whereby higher rates were observed in older age groups), non-immigrants, and those living in the lowest-income neighbourhoods. The North West LHIN and the Grey/Bruce Child and Youth Mental Health Service Area had the highest age- and sex-standardized rates of 30-day ED revisits for mental health and addictions. Lastly, there was significant variation in revisit rates between hospitals, especially those with moderate and high patient volumes.

### Interpretation

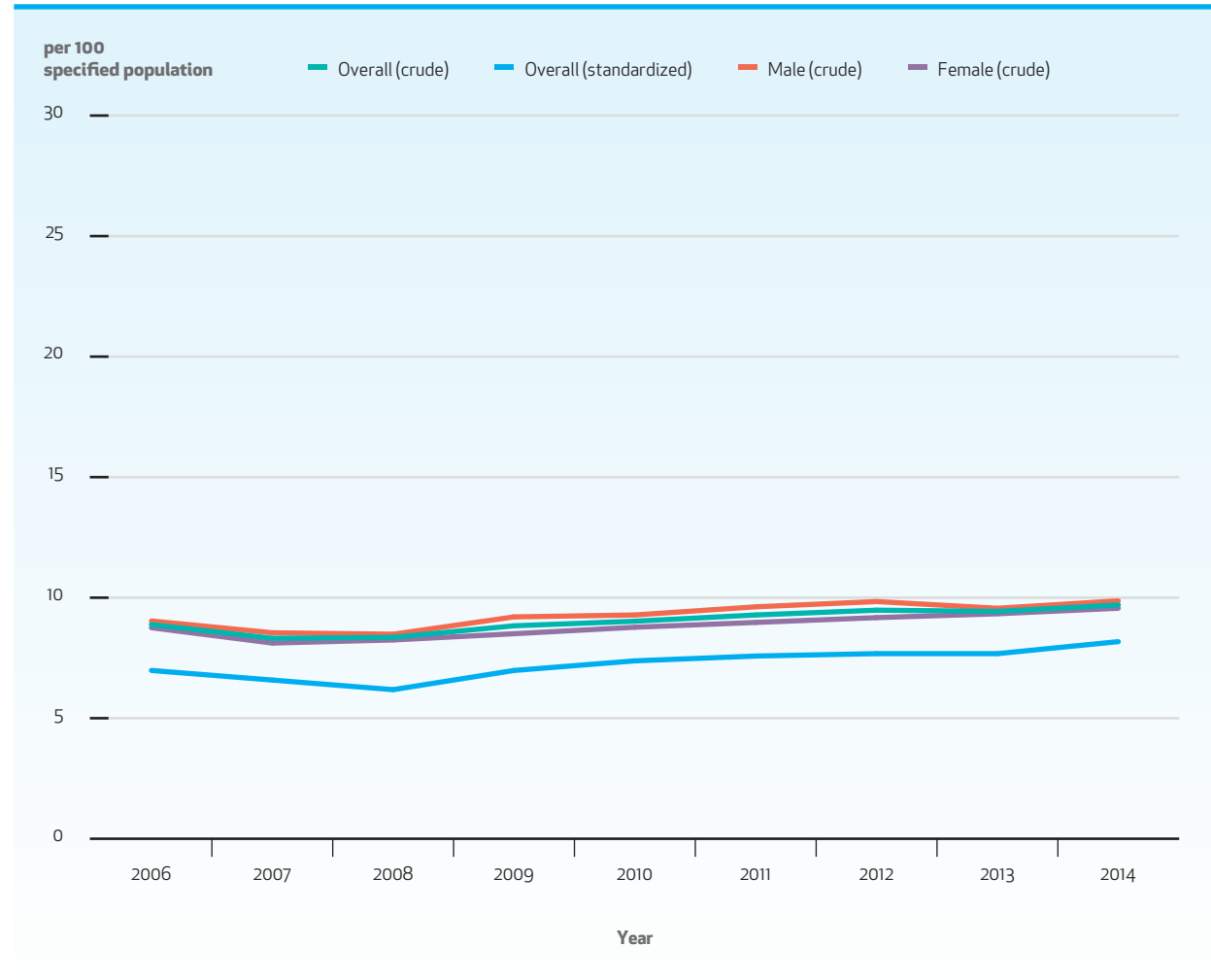
Approximately 8% of all children and youth return to the ED for mental health and addictions-related reasons within one month of an incident ED visit. These individuals may require considerable community-based resources to avoid acute care revisits, which increase the burden on the health care system. Repeated unscheduled ED visits may also be an indication of inadequate treatment plans. Consistent with findings in previous research<sup>1</sup>, we observed that acute care revisits following an incident emergency department visit were most common for children and youth with schizophrenia.

<sup>1</sup>Smith MW, Stocks C, Santora PB. Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Comm Ment Health J*. 2015; 51(2):190-7.

**EXHIBIT 2.12.1** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related ED visit, overall and by sex, in Ontario, 2006 to 2014

## Key Finding

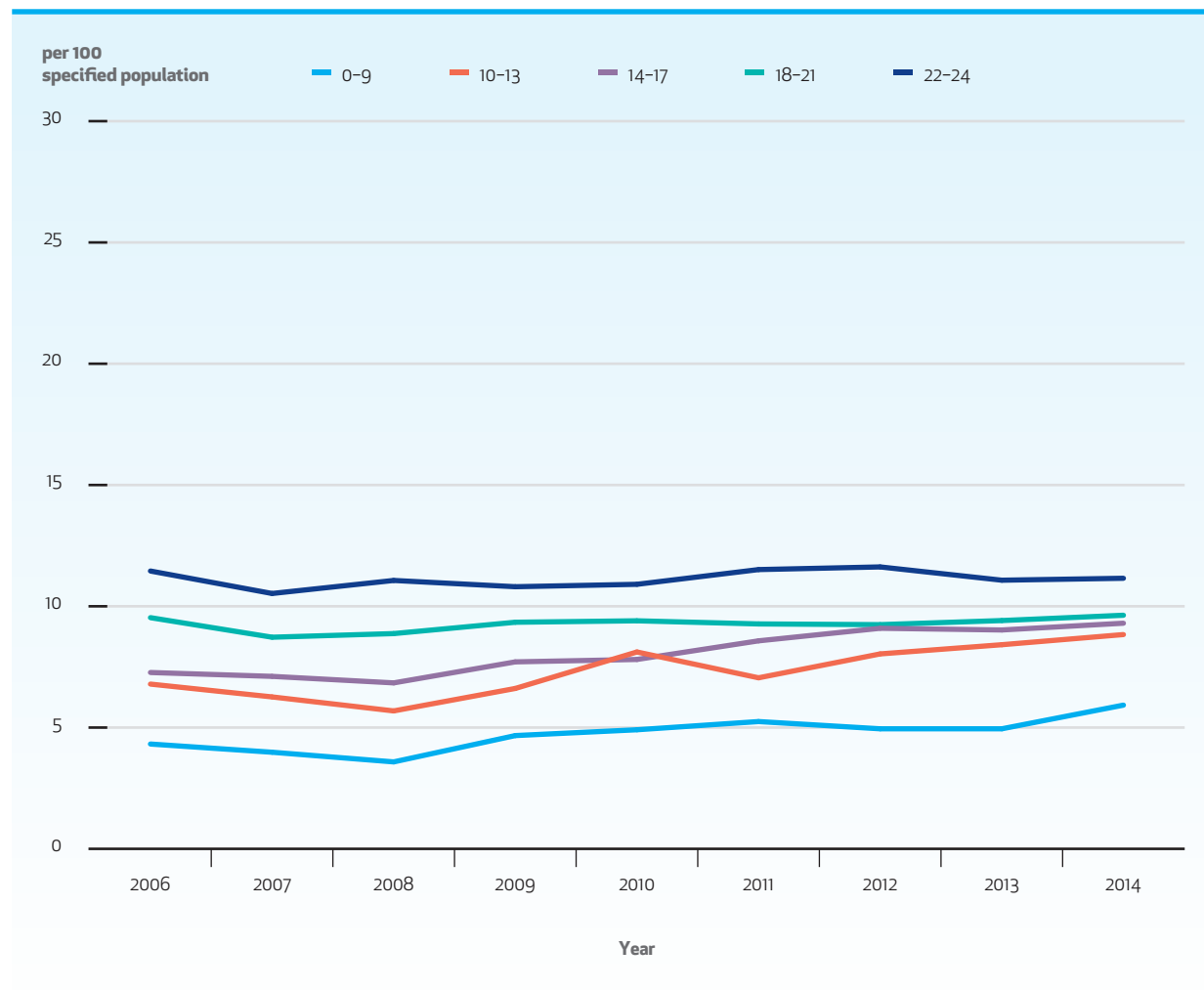
- Between 2006 and 2014, there was a slight increase in the overall rate of ED revisits within 30 days of an MHA-related ED. The revisit rate was higher in males.



**EXHIBIT 2.12.2** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by age group, in Ontario, 2006 to 2014

## Key Finding

- Between 2006 and 2014, the rate of ED revisits within 30 days of an MHA-related ED visit was higher among the older age groups. The rate of ED revisits increased for those aged 0 to 9, 10 to 13, and 14 to 17.

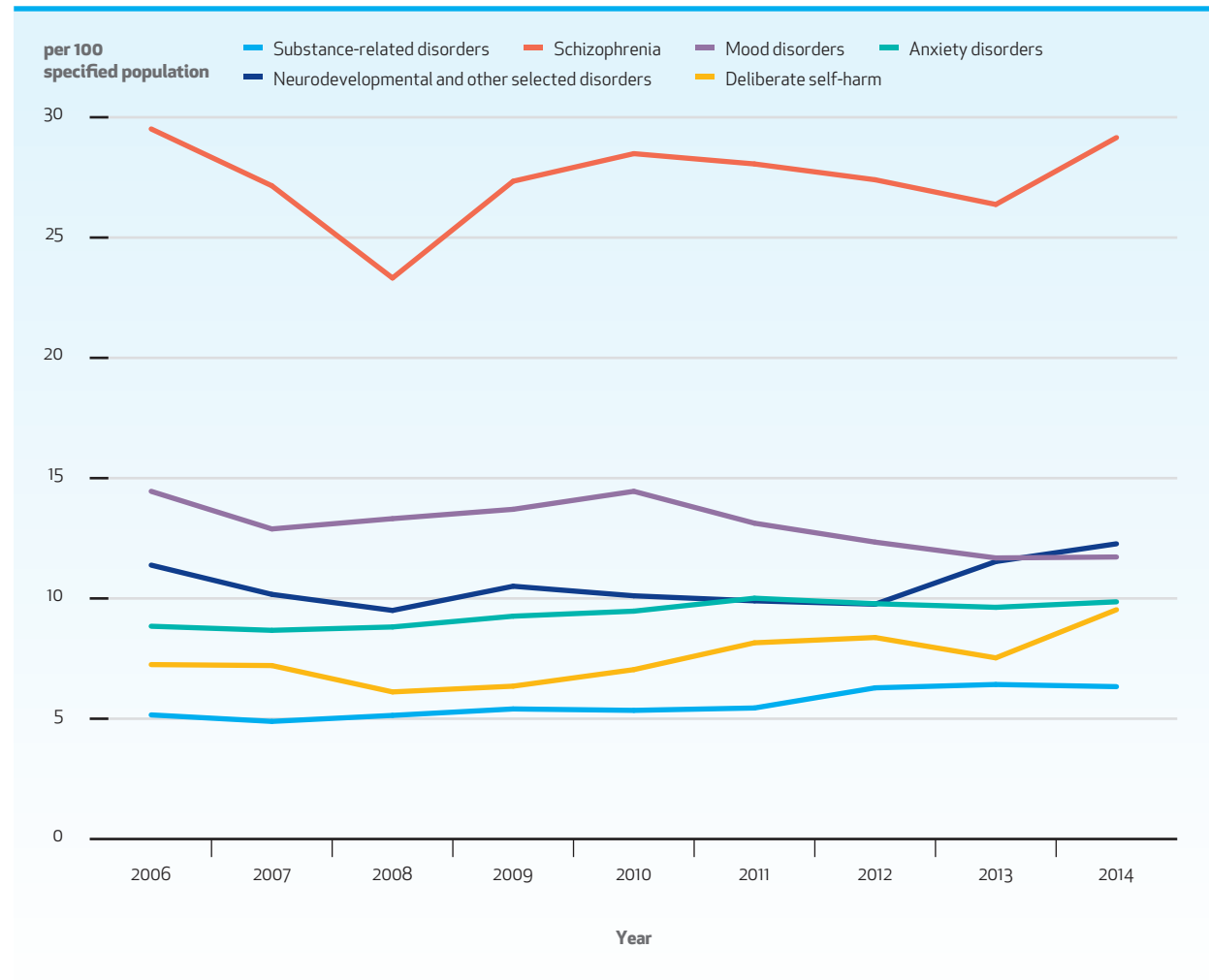




**EXHIBIT 2.12.3** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

## Key Findings

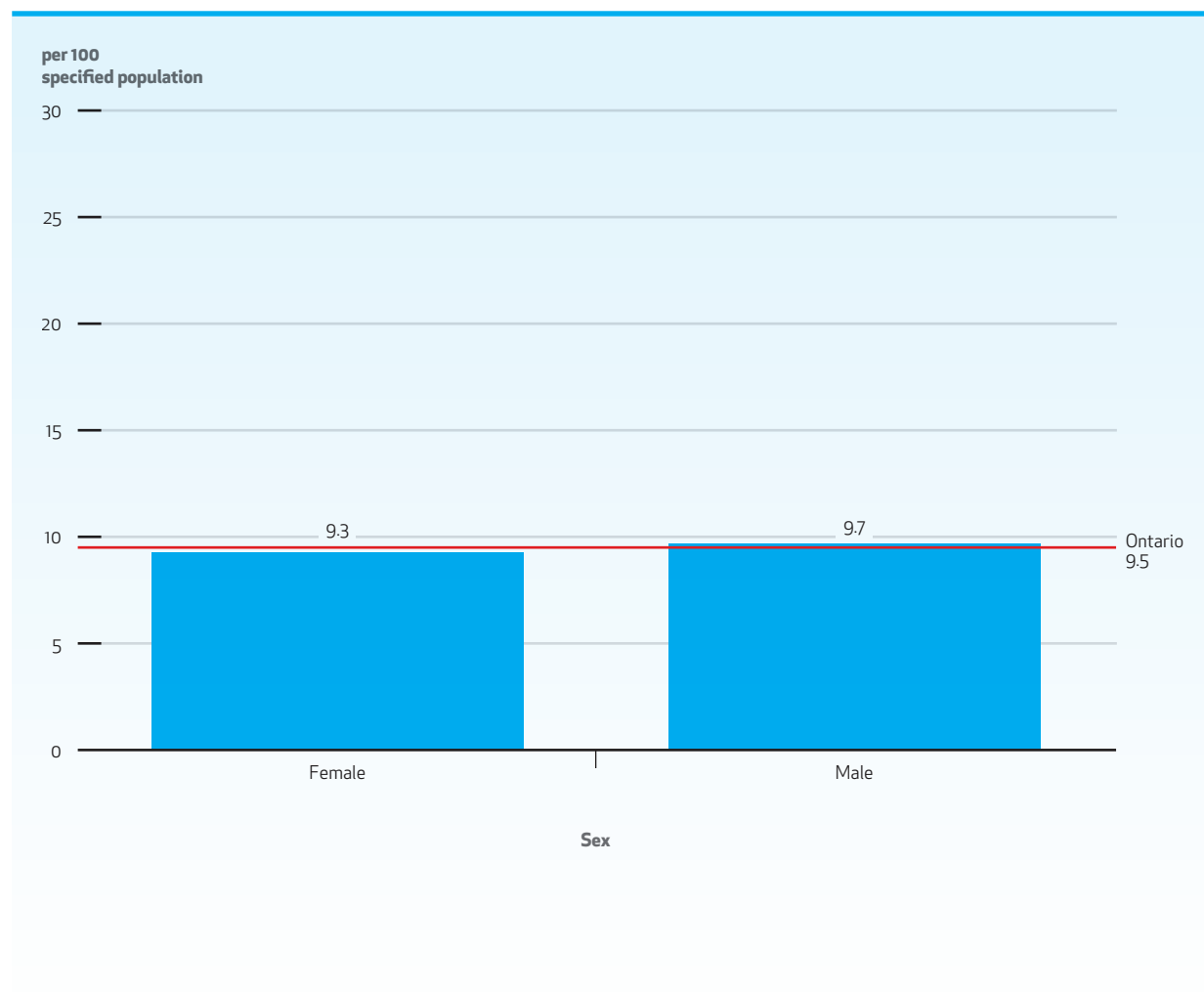
- Between 2006 and 2014, the rate of ED revisits within 30 days of an MHA-related ED visit was highest for children and youth discharged with a diagnosis of schizophrenia, followed by mood disorders.
- Revisit rates were lowest for those discharged with a diagnosis of substance-related disorders.



**EXHIBIT 2.12.4** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

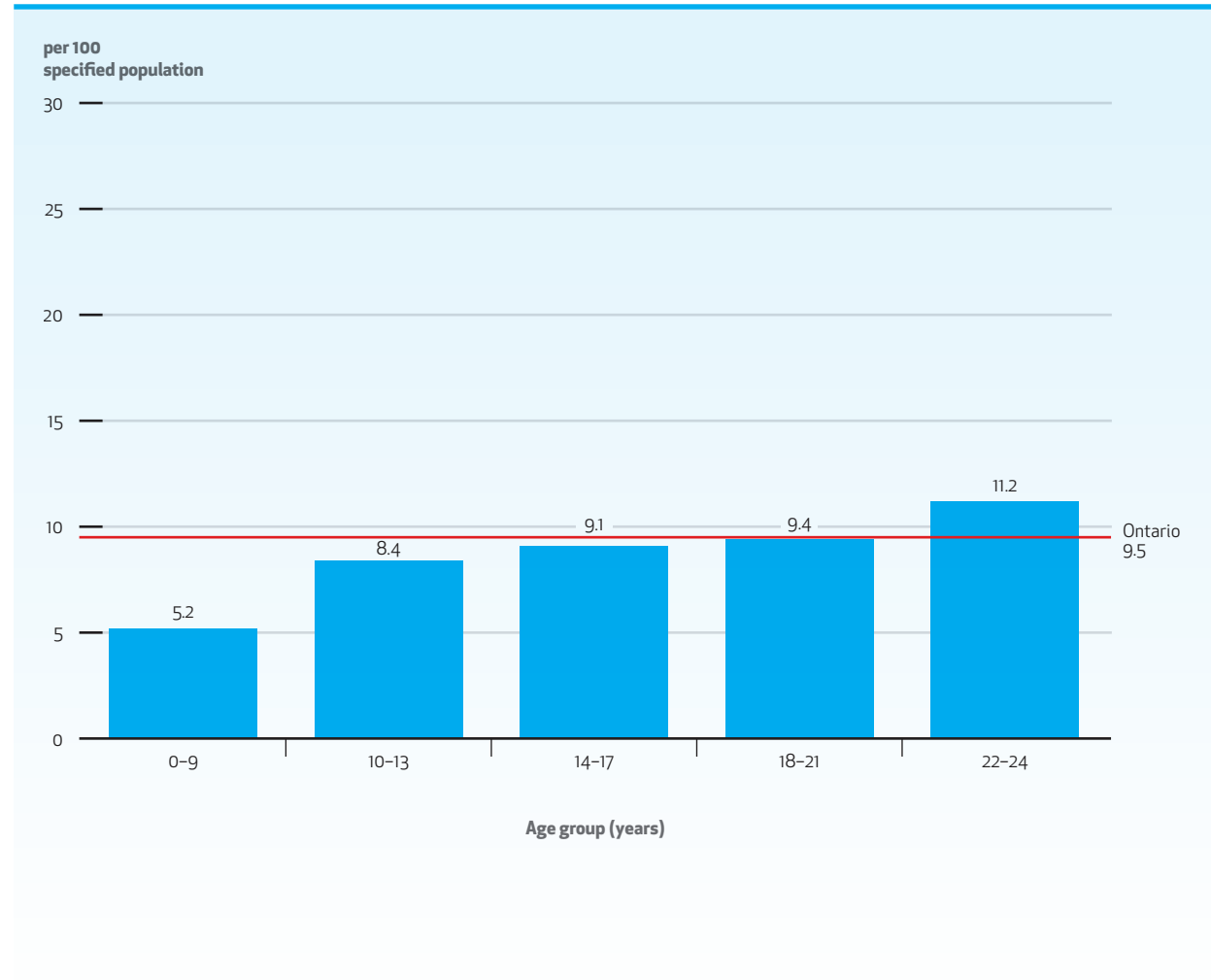
- Between 2012 and 2014, the average rate of ED revisits within 30 days of an MHA-related ED visit was similar for males and females.



**EXHIBIT 2.12.5** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

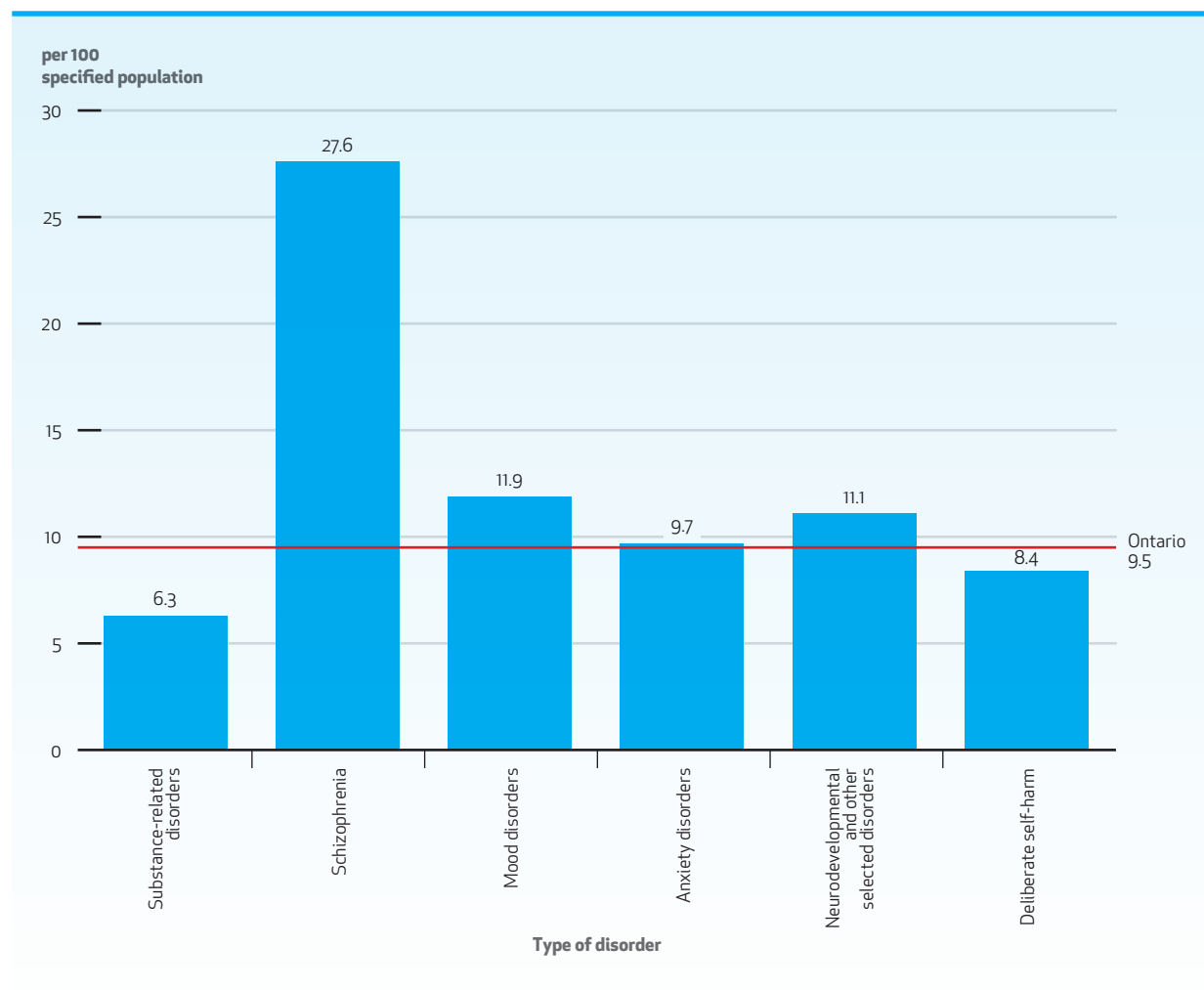
- Between 2012 and 2014, the average rate of ED revisits within 30 days of an MHA-related ED visit was higher among older age groups and highest in those aged 22 to 24.



**EXHIBIT 2.12.6** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Findings

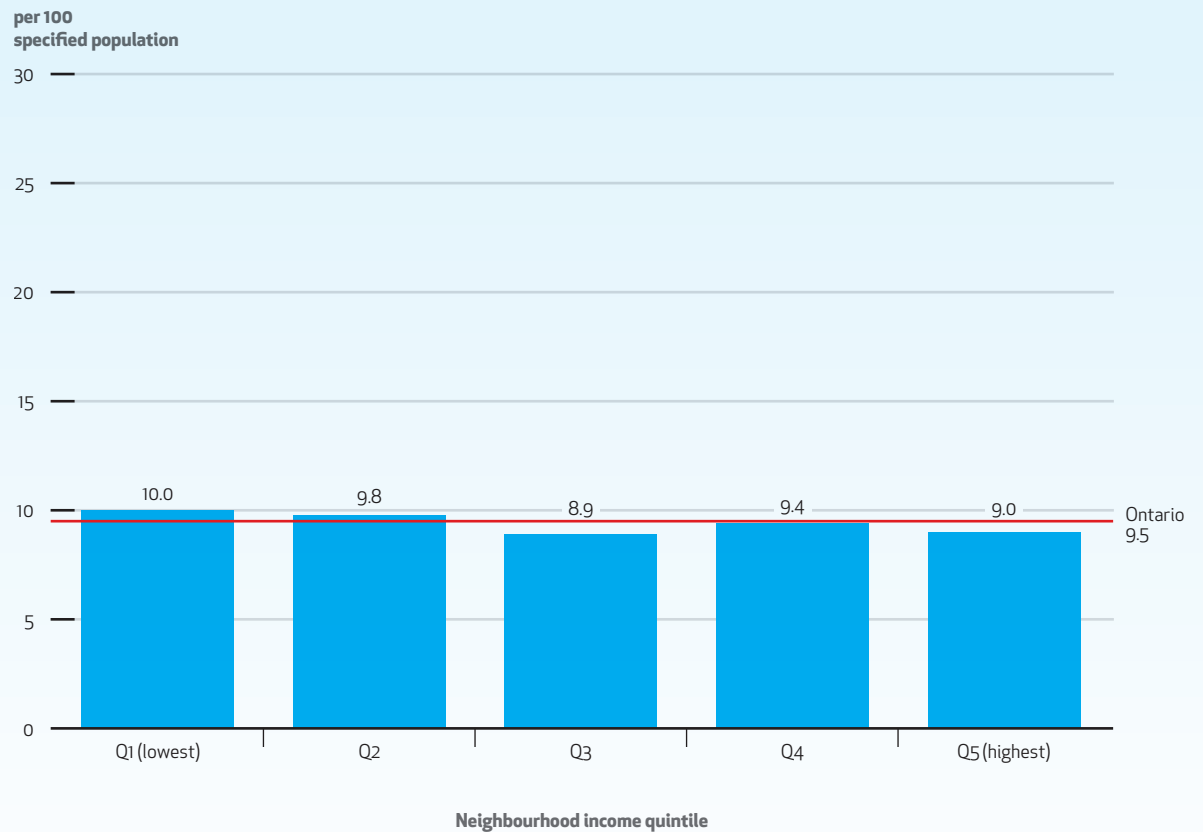
- Between 2012 and 2014, the average rates of ED revisits within 30 days of an MHA-related ED visit was highest among those discharged with a diagnosis of schizophrenia, followed by mood disorders.
- Revisit rates were lowest among those discharged with a diagnosis of substance-related disorders.



**EXHIBIT 2.12.7** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

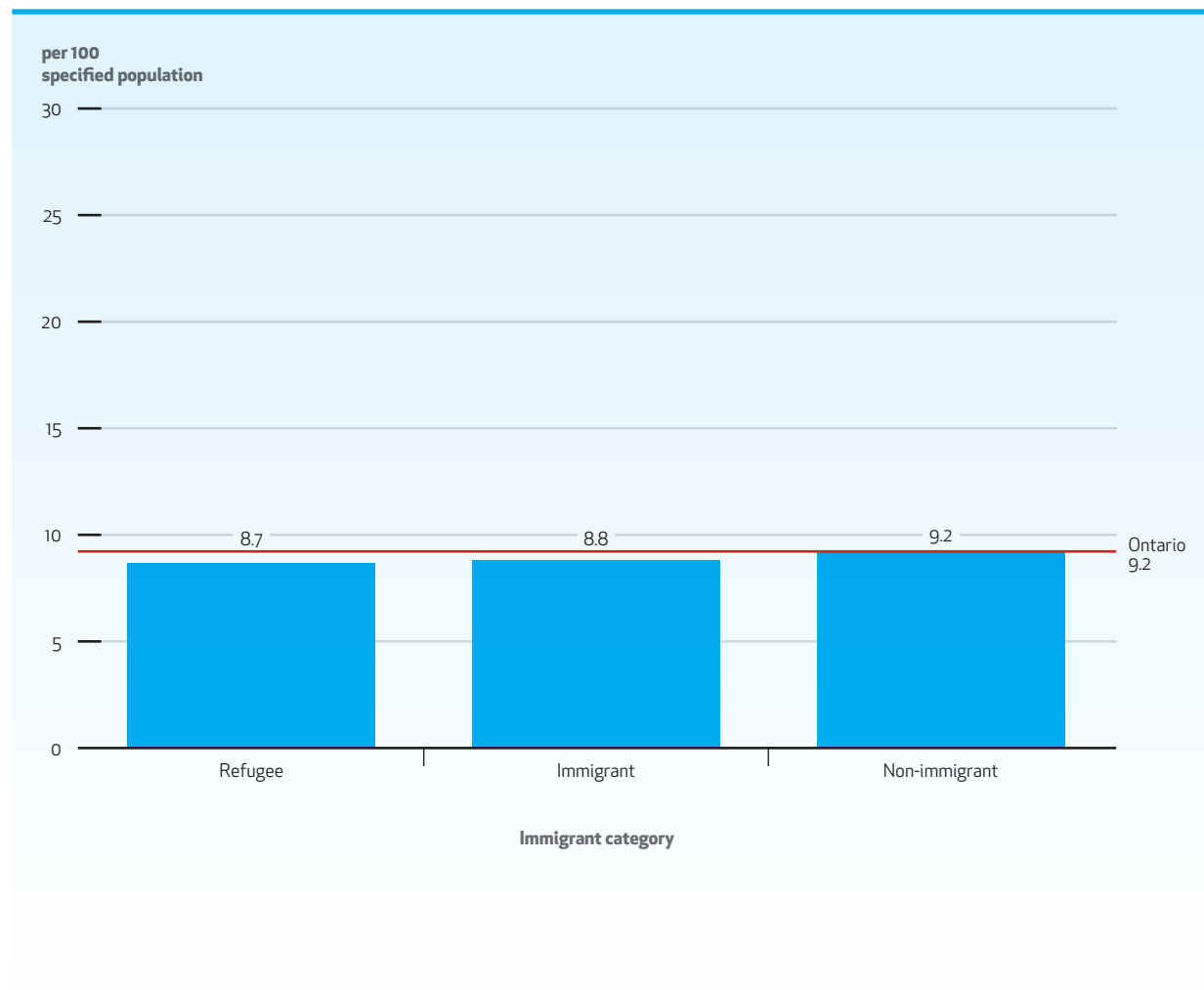
- Between 2012 and 2014, the average rate of ED revisits within 30 days of an MHA-related ED visit was slightly higher among children and youth in lower-income neighbourhoods.



**EXHIBIT 2.12.8** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

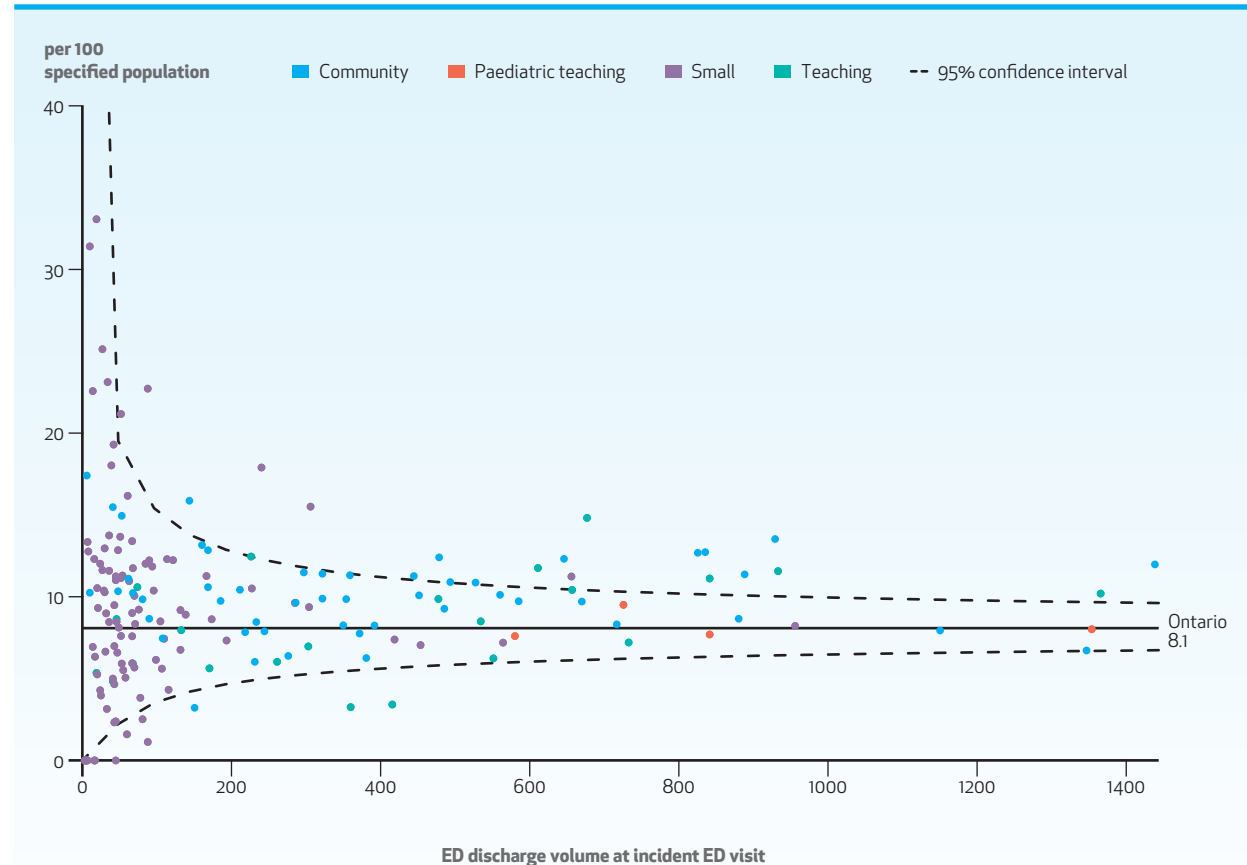
- Between 2010 and 2012, the average rate of ED revisits within 30 days of an MHA-related ED visit was slightly higher for non-immigrants.



**EXHIBIT 2.12.9** Number\* of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related ED visit, by hospital type, weighted by ED discharge volume, in Ontario, 2014

## Key Findings

- In 2014, the age- and sex-adjusted rate of ED revisits within 30 days of an MHA-related ED visit showed more variation than would be expected by chance, with some high-volume, high-revisit community hospitals and some small hospitals having high revisit rates.
- Some teaching hospitals showed variation, with both high and low rates, relative to their volume.

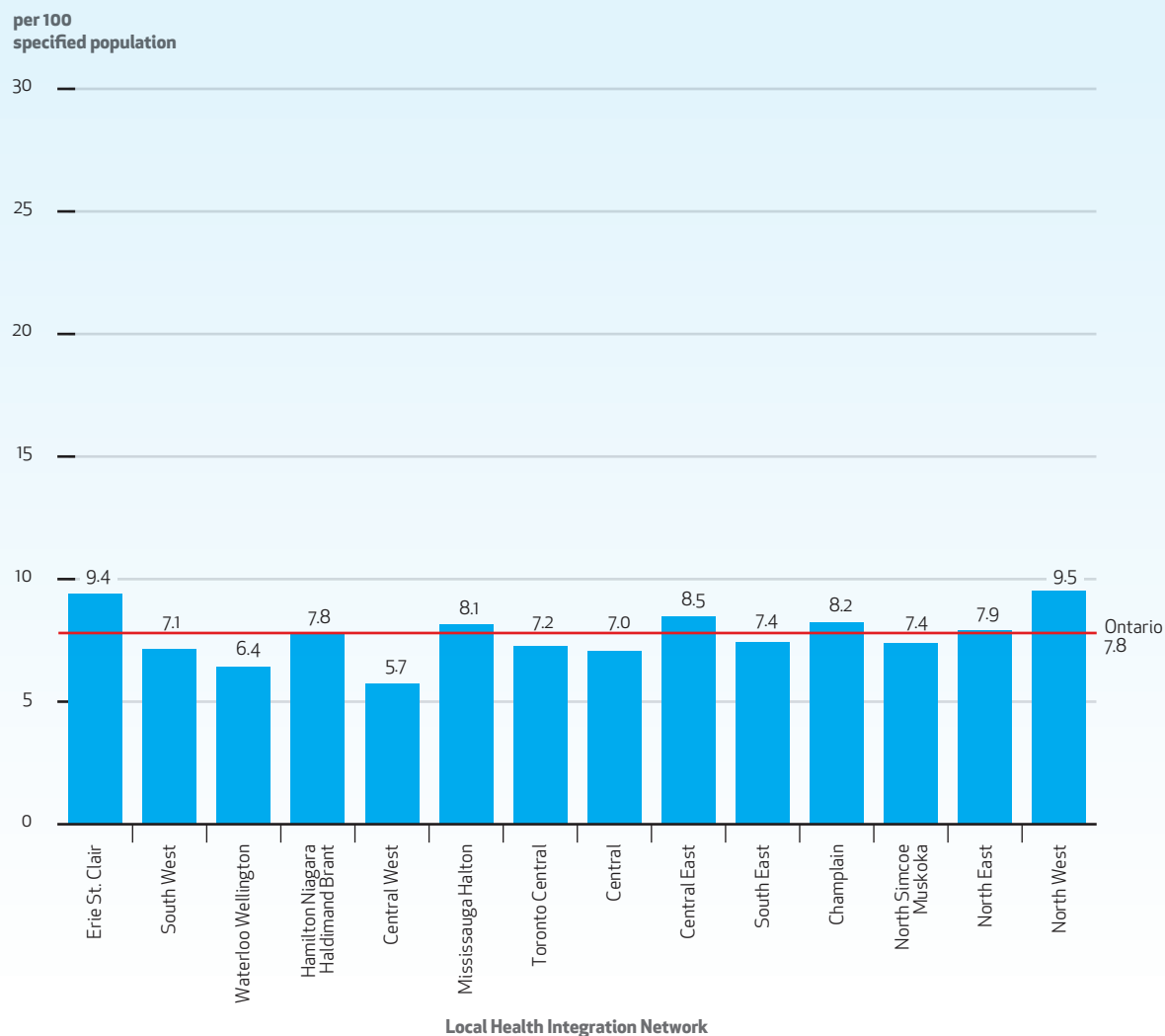


\* Age- and sex-adjusted.

**EXHIBIT 2.12.10** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of ED revisits within 30 days of an MHA-related ED visit was highest for children and youth in the Erie St Clair and North West LHINS and lowest for those in the Central West LHIN.

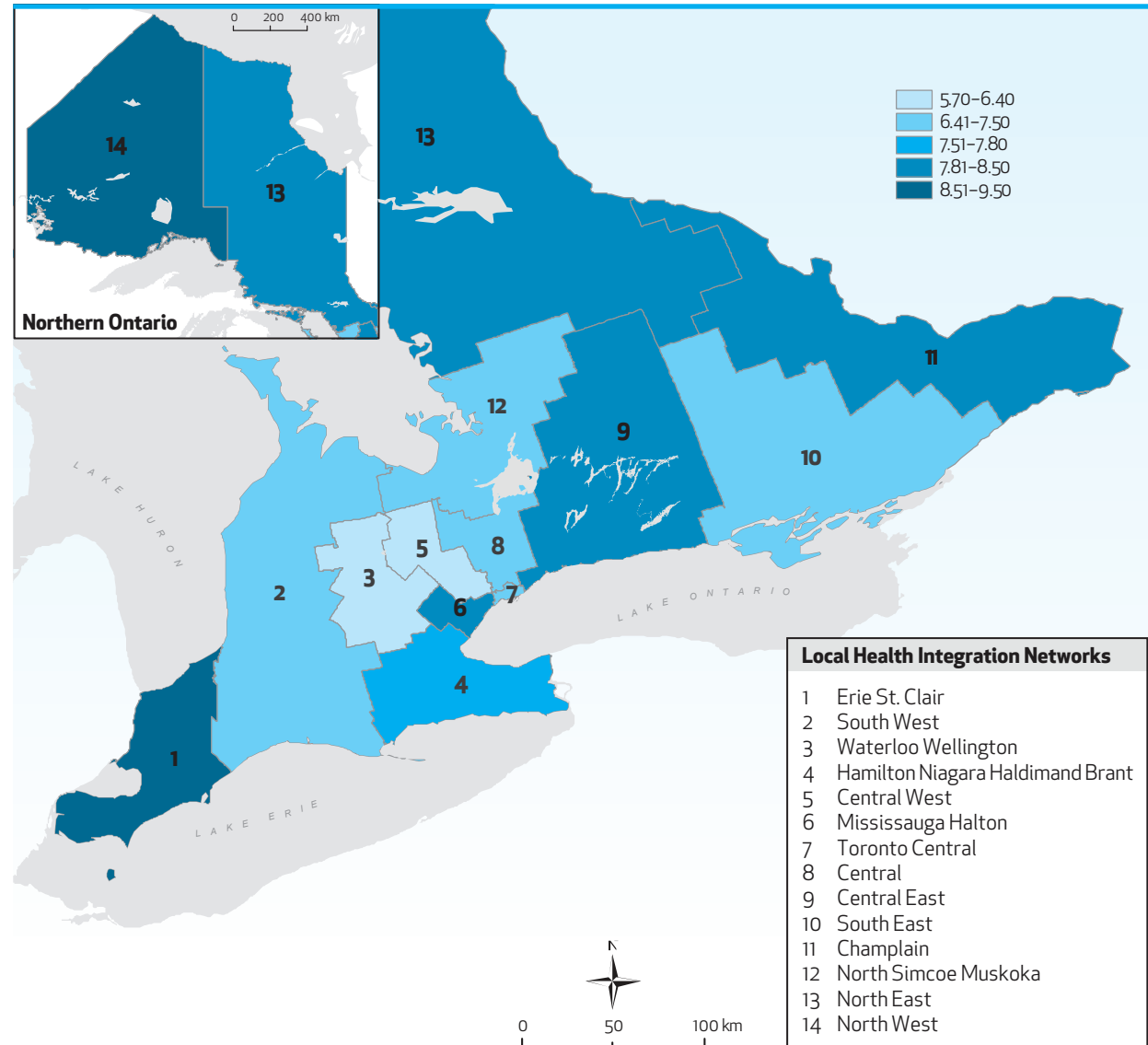




**EXHIBIT 2.12.11** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Findings

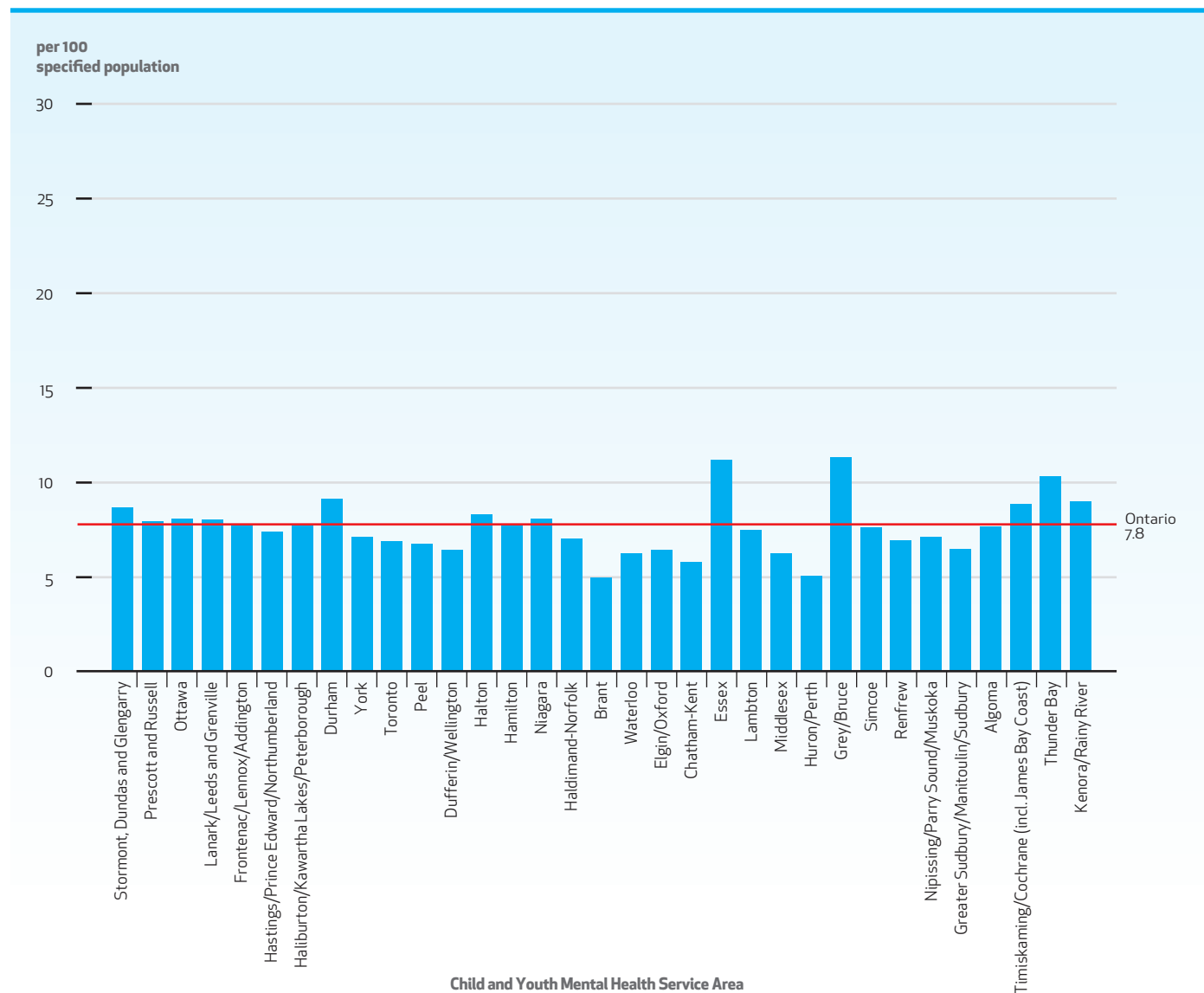
- Between 2012 and 2014, the average age- and sex-standardized rate of ED revisits within 30 days of an MHA-related ED visit was highest for children and youth in the Erie St Clair and North West LHINs.
- The rate of ED revisits was lowest for children and youth in the Waterloo Wellington and Central West LHINs.



**EXHIBIT 2.12.12** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

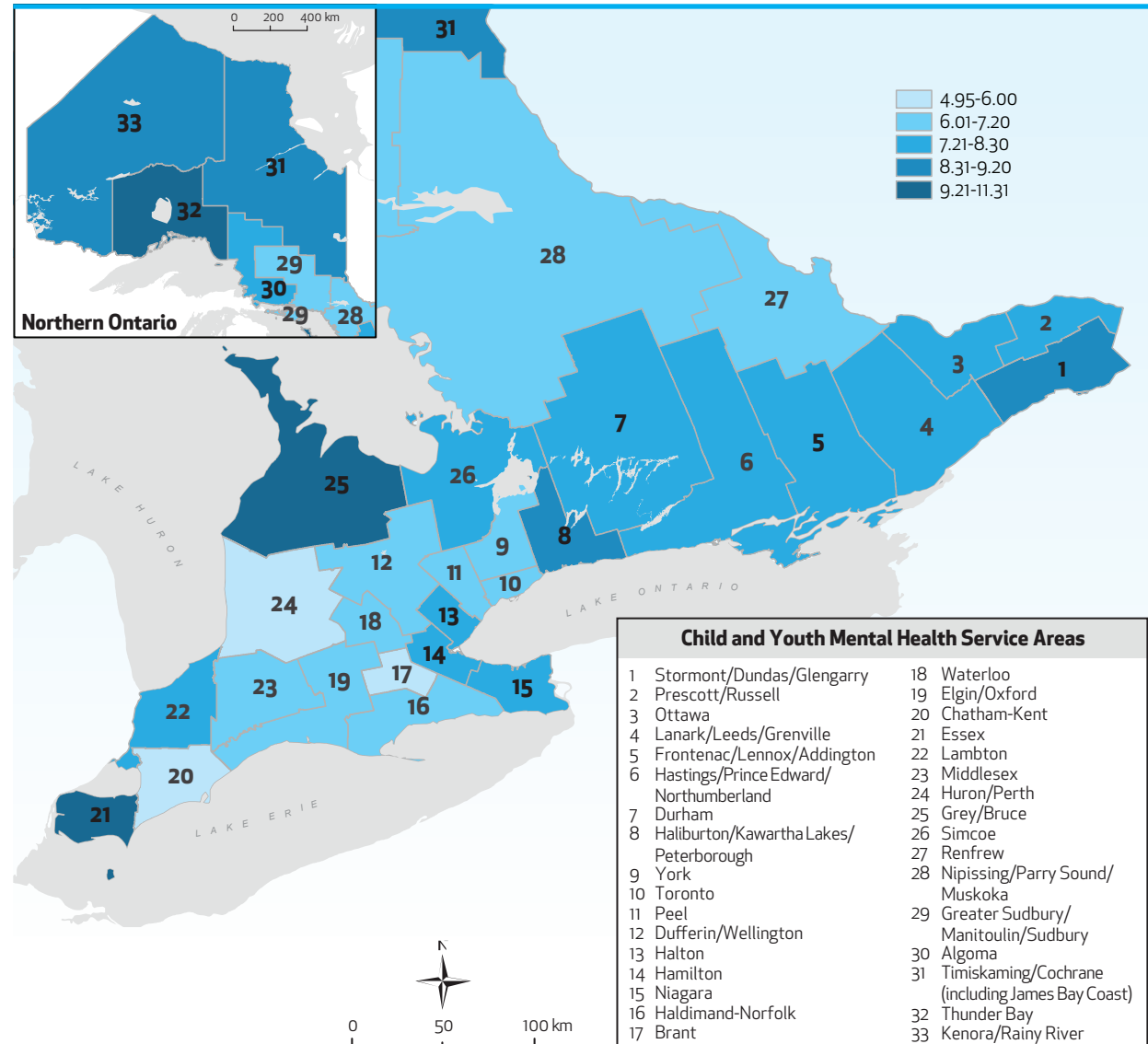
- Between 2012 and 2014, the average age- and sex-standardized rate of ED revisits within 30 days of an MHA-related ED visit was highest for children and youth living in the Essex and Grey/Bruce Child and Youth Mental Health Service Areas.



**EXHIBIT 2.12.13** Number of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

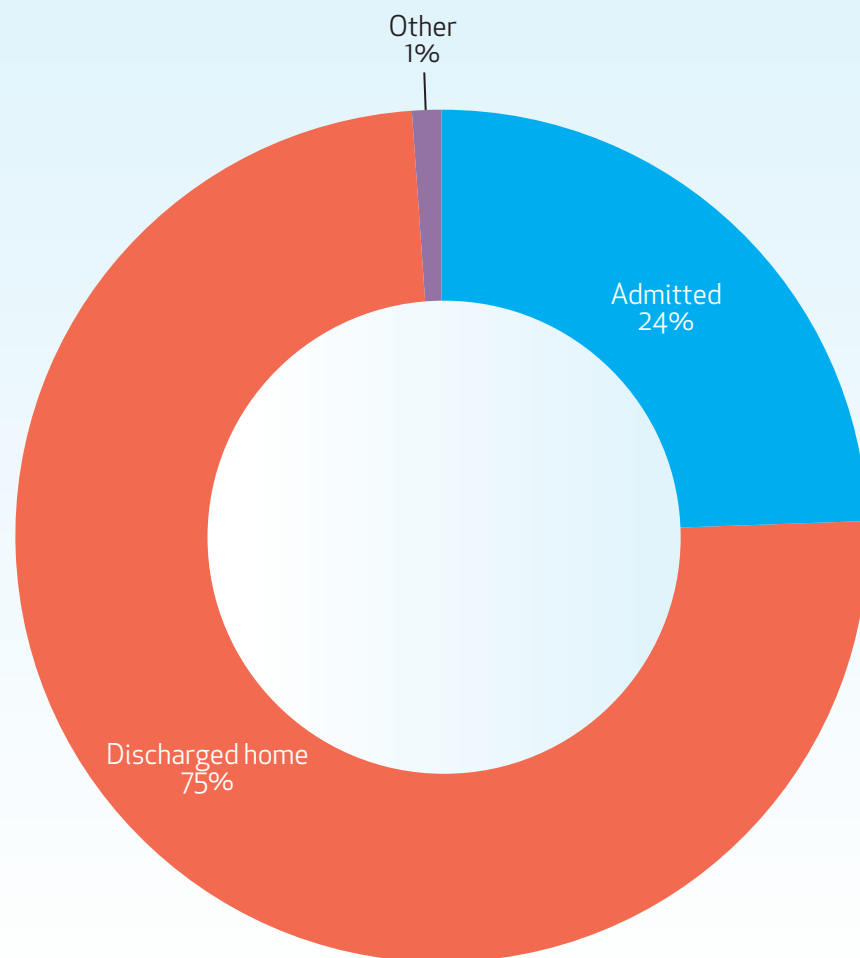
- Between 2012 and 2014, the average age- and sex-standardized rate of ED revisits within 30 days of an MHA-related ED visit was highest for children and youth living in the Essex, Grey/Bruce and Thunder Bay Child and Youth Mental Health Service Areas.



**EXHIBIT 2.12.14** Proportion of emergency department (ED) revisits within 30 days of an incident ED visit related to mental health and addictions that resulted in a hospital admission, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the majority of ED revisits within 30 days of an MHA-related ED visit resulted in a discharge home.



## 2.13 Rate of 30-day readmission after a mental health and addictions-related hospital discharge for children and youth

### Rationale

Mental health and addictions-related hospital readmissions following an inpatient discharge could signal inadequate discharge planning and support and poor integration and continuity with community-based mental health and addictions services.

### Results

Rates of hospital readmissions within 30 days of an incident mental health and addictions-related hospital discharge remained relatively stable over time. However, there was an increase between 2006 and 2014 among children aged 0 to 13 and among those discharged with a diagnosis of substance-related disorders; there was a decline for those discharged with a diagnosis of schizophrenia. Overall, rates of hospital readmissions were higher in males, in older age groups, and in those diagnosed with schizophrenia and mood disorders, and were lowest for those admitted to hospital with a diagnosis of deliberate self-harm. The Hamilton Niagara Haldimand Brant, Central West, and Waterloo Wellington LHINs and the Waterloo Child and Youth Mental Health Service Area had the highest age- and sex-standardized rates of hospital revisits within 30 days, while the lowest rates were observed in the North Simcoe Muskoka LHIN and the Stormont, Dundas and Glengarry Child and Youth Mental Health Service Area. Although there was minimal variation by hospital type and volume, some teaching hospitals had higher than average readmission rates given their volume. There were almost no admissions for non-mental health and addictions-related reasons that followed a mental health and addictions-related hospital discharge.

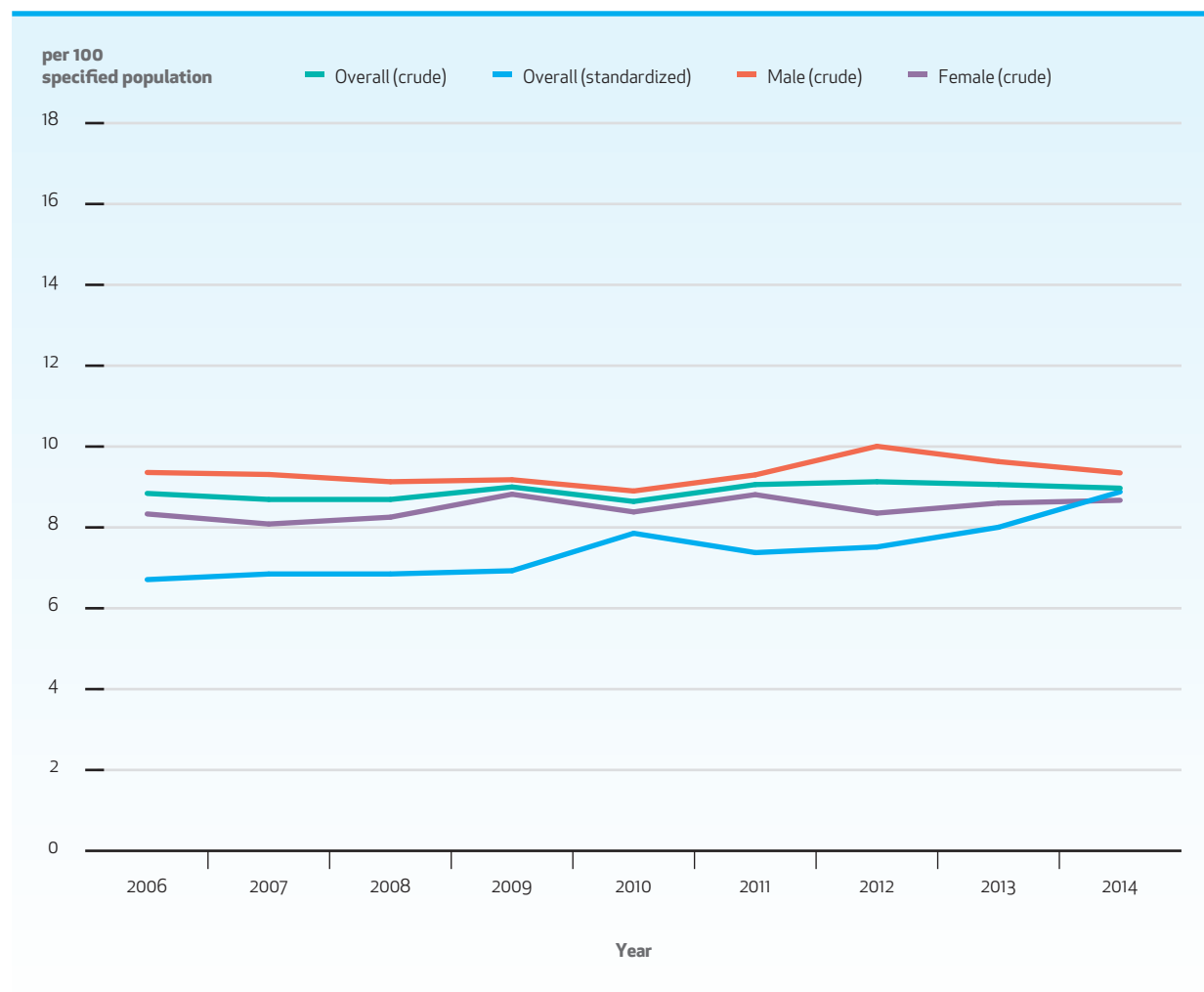
### Interpretation

Approximately 8% of children and youth were readmitted to the hospital for mental health and addictions-related reasons within 30 days following discharge. While overall rates have been stable over time, we observed an increase among younger children and those discharged with a diagnosis of substance-related disorders, who may require considerable community-based resources to avoid hospital readmissions.

**EXHIBIT 2.13.1** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital admission, overall and by sex, in Ontario, 2006 to 2014

## Key Finding

- Between 2006 and 2014, the rate of hospital readmissions within 30 days of an MHA-related hospital discharge was fairly stable. The rate was higher among males.



**EXHIBIT 2.13.2** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by age group, in Ontario, 2006 to 2014

## Key Findings

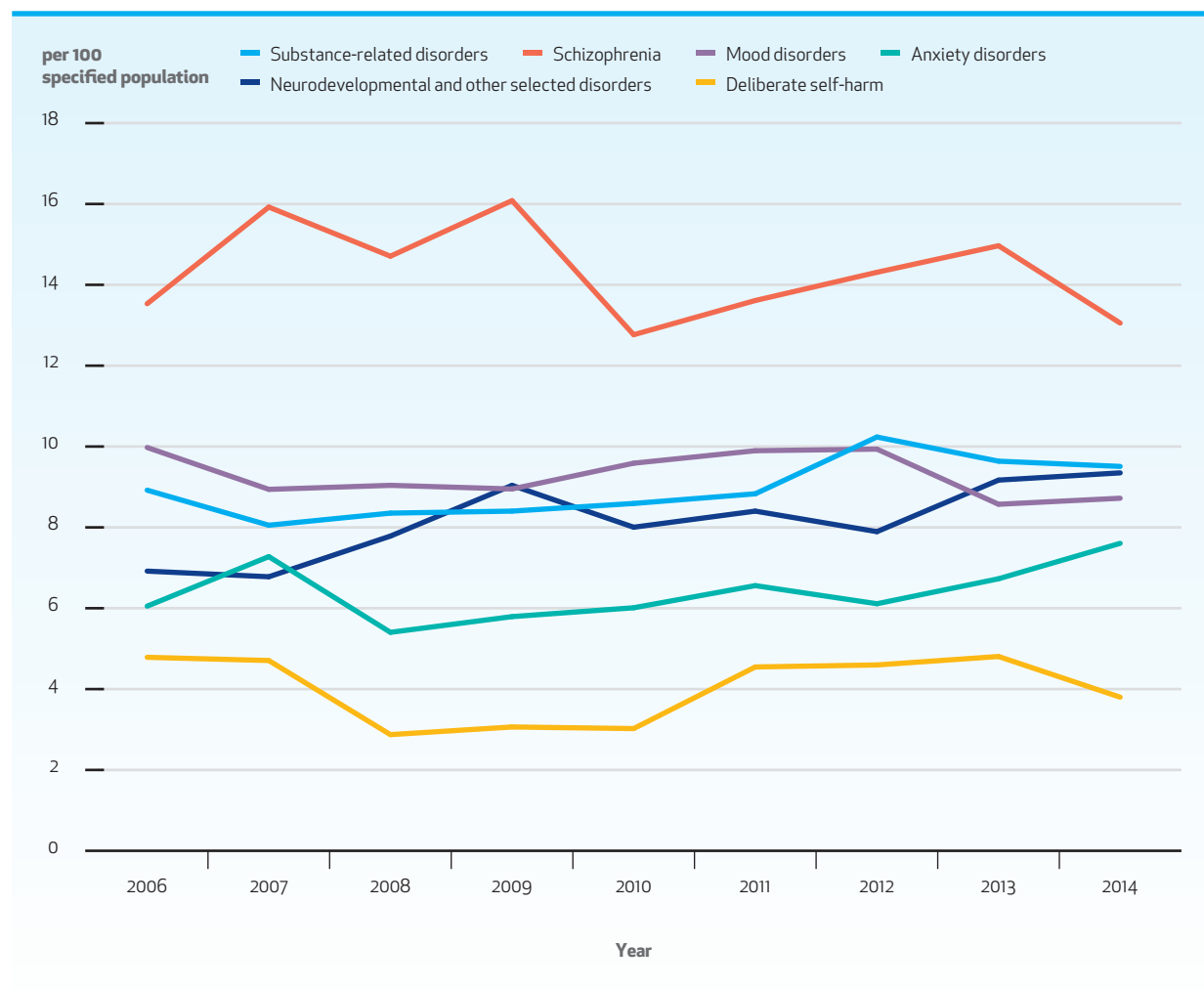
- Between 2006 and 2014, the rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest among older age groups.
- Over time, the rate increased in the youngest age groups, particularly those aged 0 to 9.



**EXHIBIT 2.13.3** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by type of disorder, in Ontario, 2006 to 2014

## Key Findings

- Between 2006 and 2014, the rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest among children and youth discharged with a diagnosis of schizophrenia, followed by mood disorders.
- The rate was lowest for those discharged with deliberate self-harm.

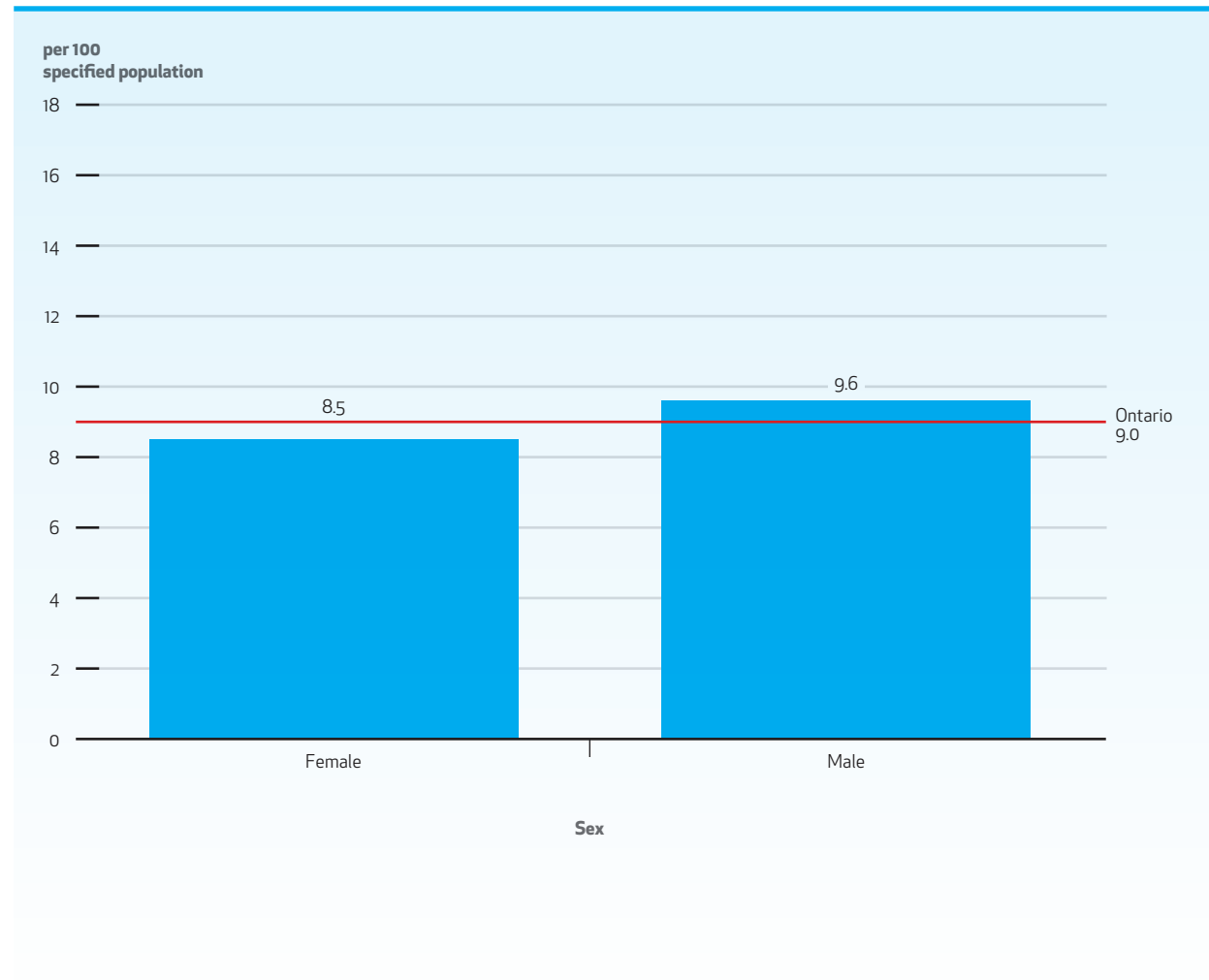




**EXHIBIT 2.13.4** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

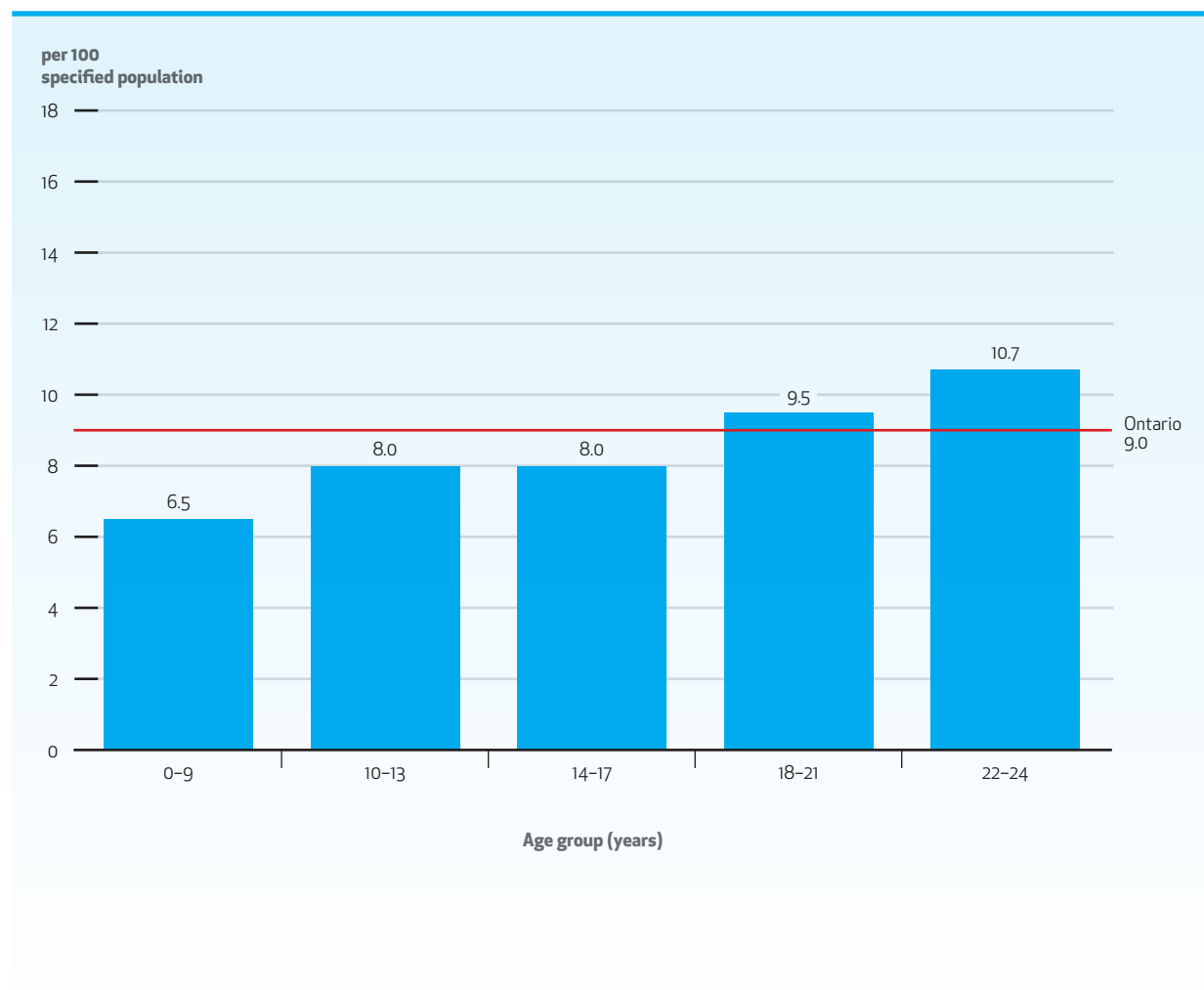
- Between 2012 and 2014, the average rate of hospital readmissions within 30 days of an MHA-related hospital discharge was higher among males.



**EXHIBIT 2.13.5** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

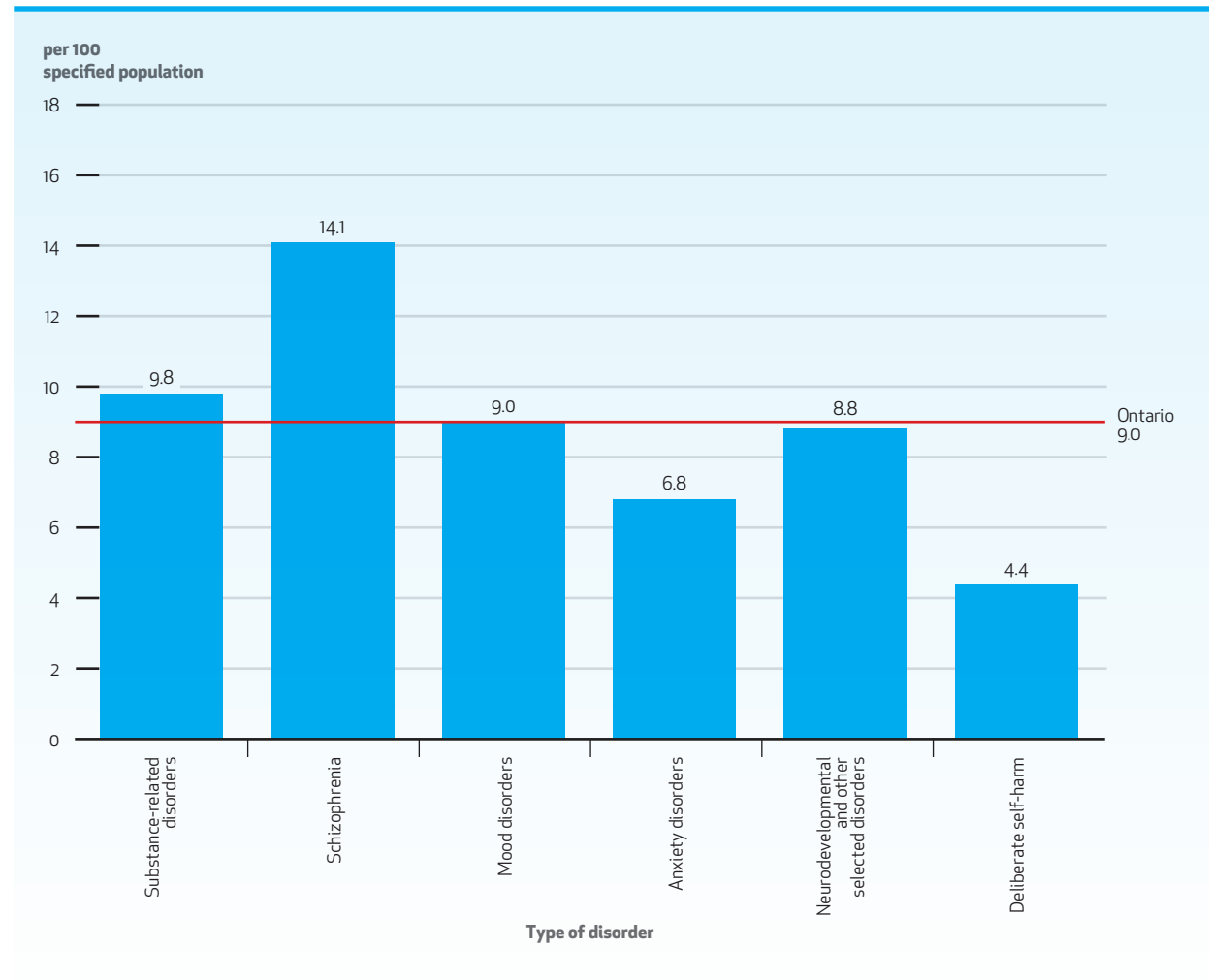
- Between 2012 and 2014, the average rate of hospital readmissions within 30 days of an MHA-related hospital discharge was higher among the older age groups and highest for those aged 22 to 24.



**EXHIBIT 2.13.6** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Finding

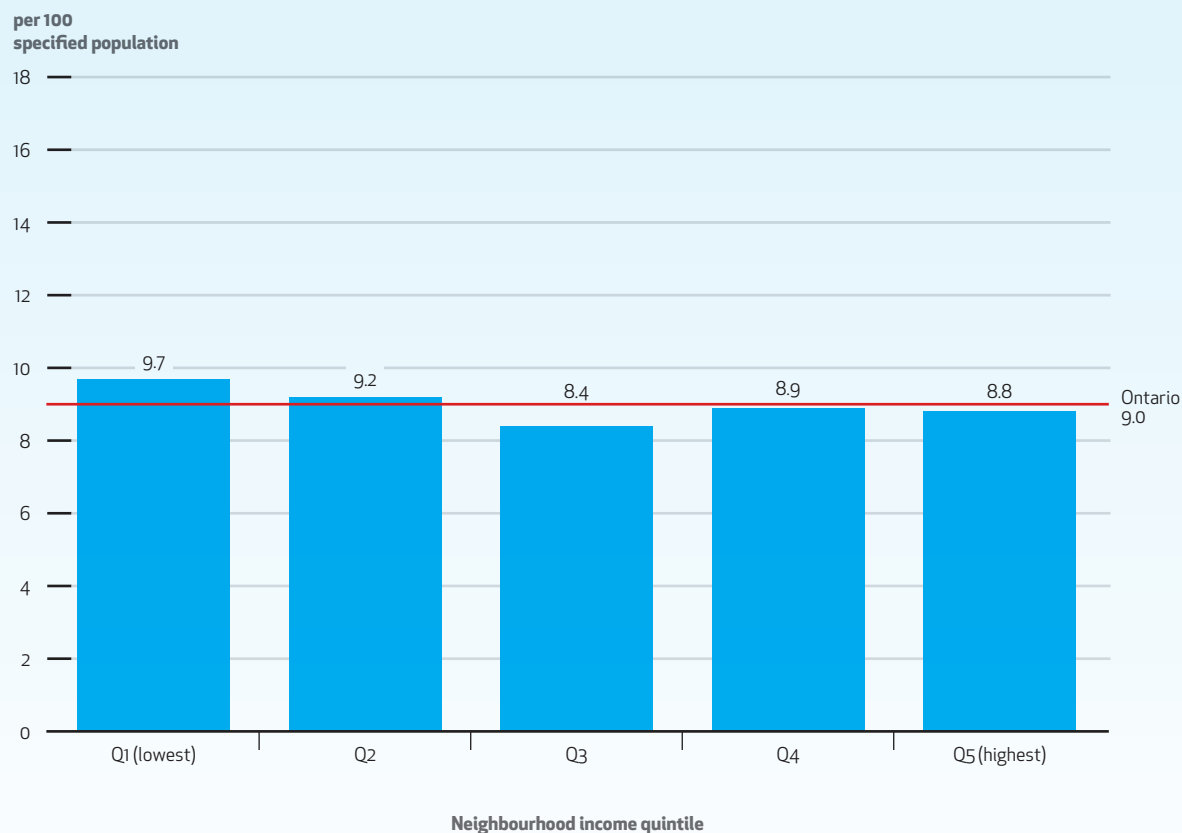
- Between 2012 and 2014, the average rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest in children and youth discharged with a diagnosis of schizophrenia and lowest in those discharged with deliberate self-harm.



**EXHIBIT 2.13.7** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

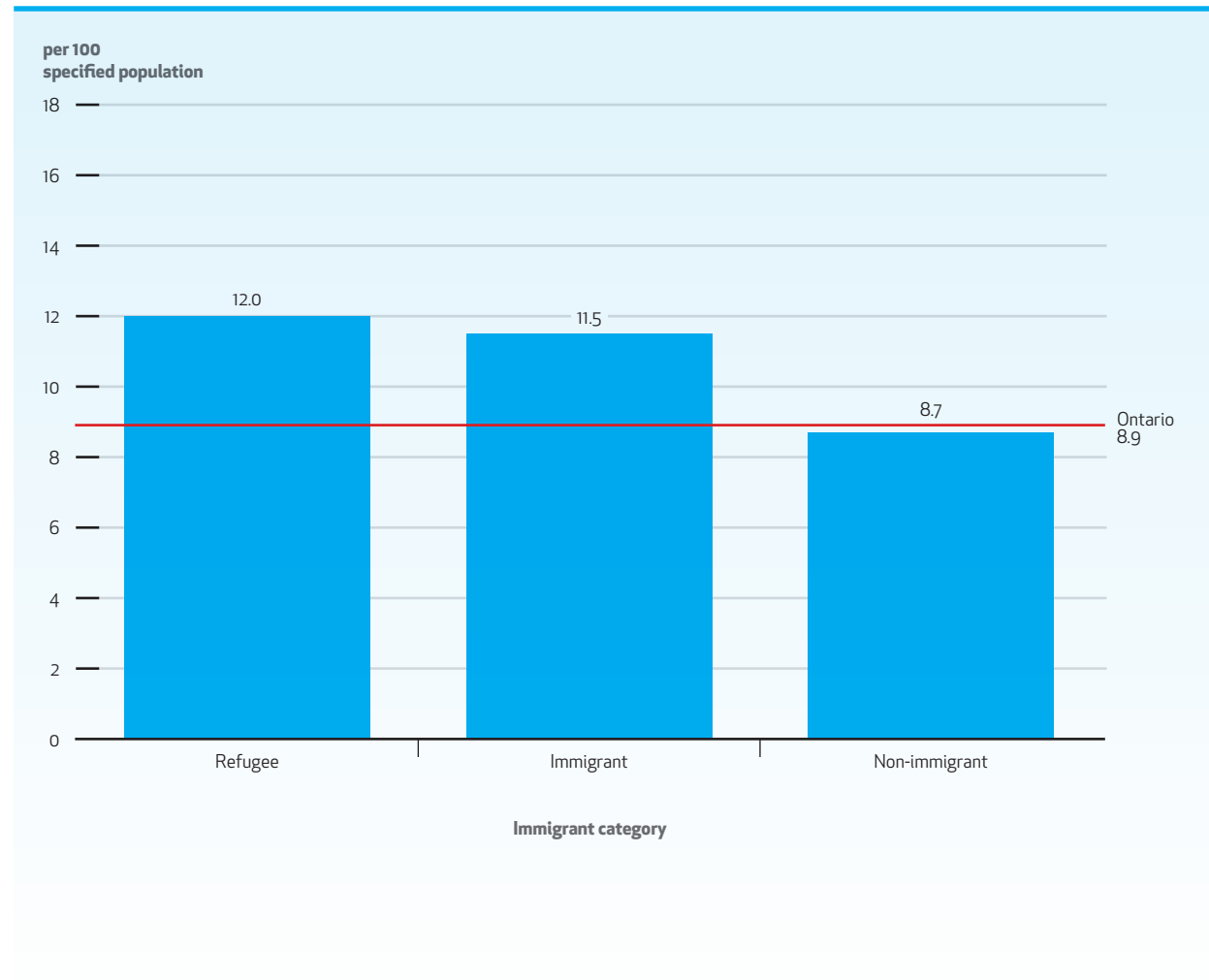
- Between 2012 and 2014, the average rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest for children and youth living in the poorest neighbourhoods.



**EXHIBIT 2.13.8** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 crude population aged 0 to 24 years with an incident MHA-related hospital admission, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

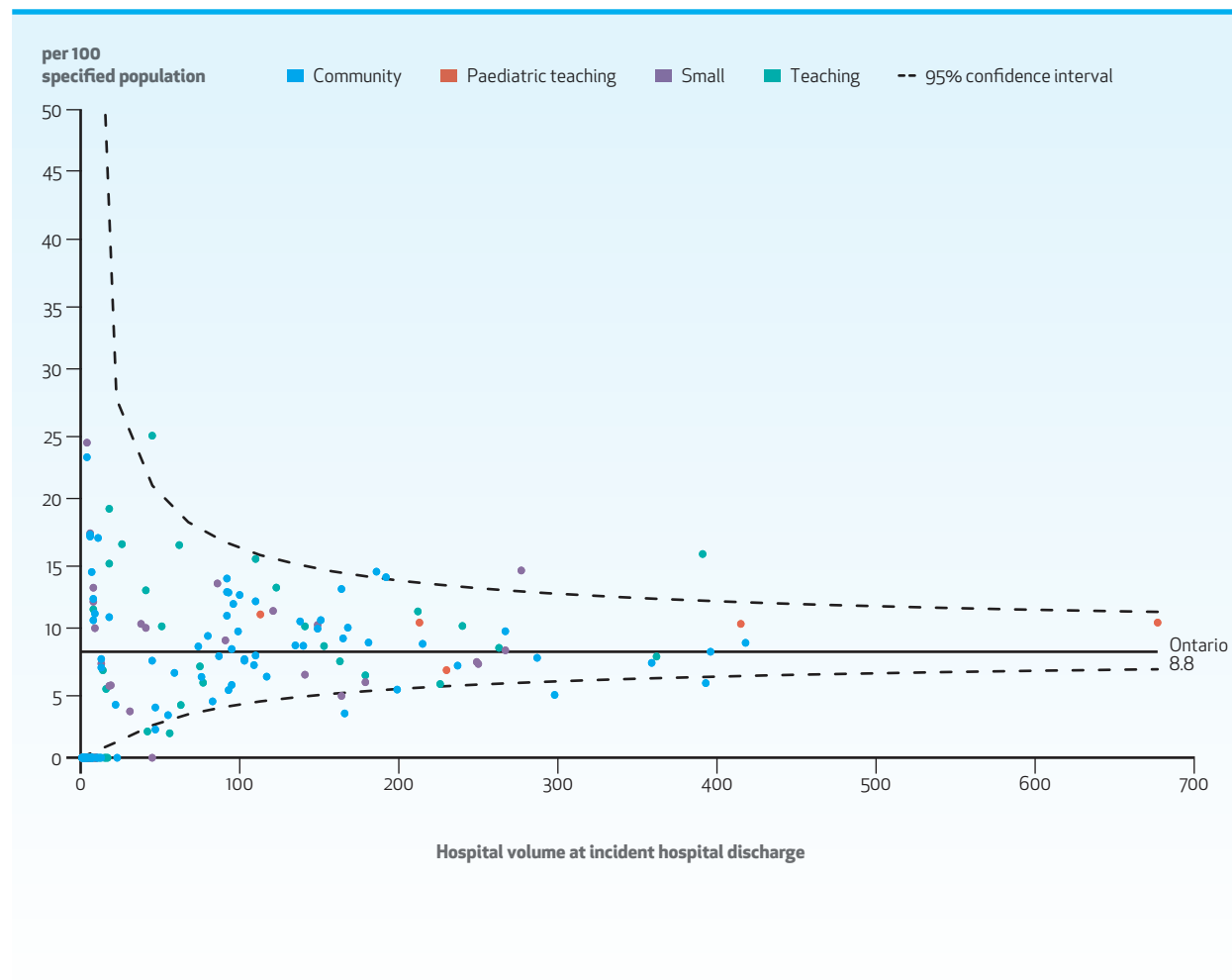
- Between 2010 and 2012, the average rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest for refugees, followed by immigrants.



**EXHIBIT 2.13.9** Number\* of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 population aged 0 to 24 years with an incident MHA-related hospital admission, by hospital type, weighted by hospital discharge volume, in Ontario, 2014

## Key Findings

- In 2014, the age- and sex-adjusted rate of hospital readmissions within 30 days of an MHA-related hospital discharge had minimal variation by hospital type and volume.
- Two teaching hospitals had higher than average readmission rates given their volume.
- These rates do not account for potential differences in patient severity.

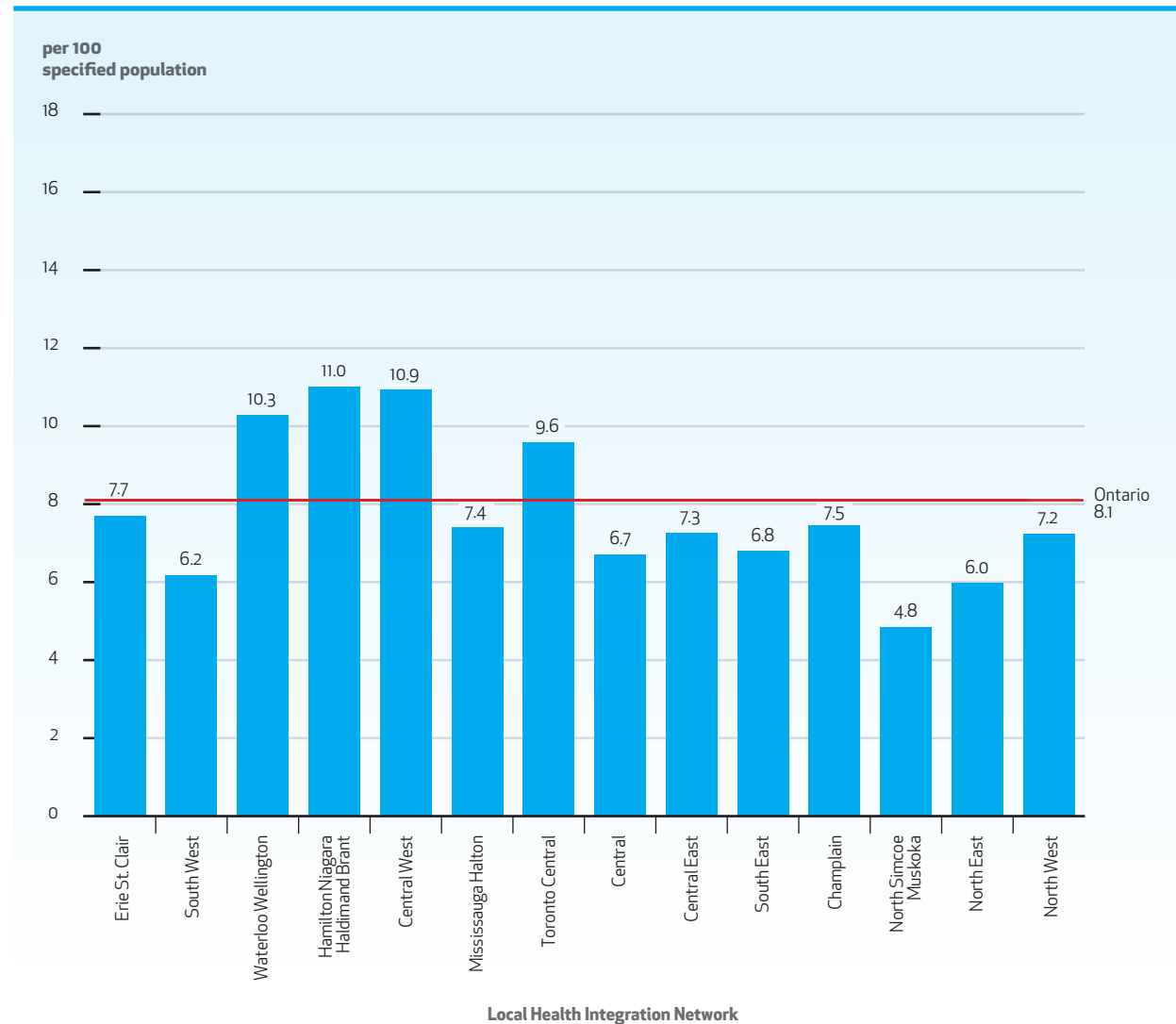


\* Age- and sex-adjusted.

**EXHIBIT 2.13.10** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

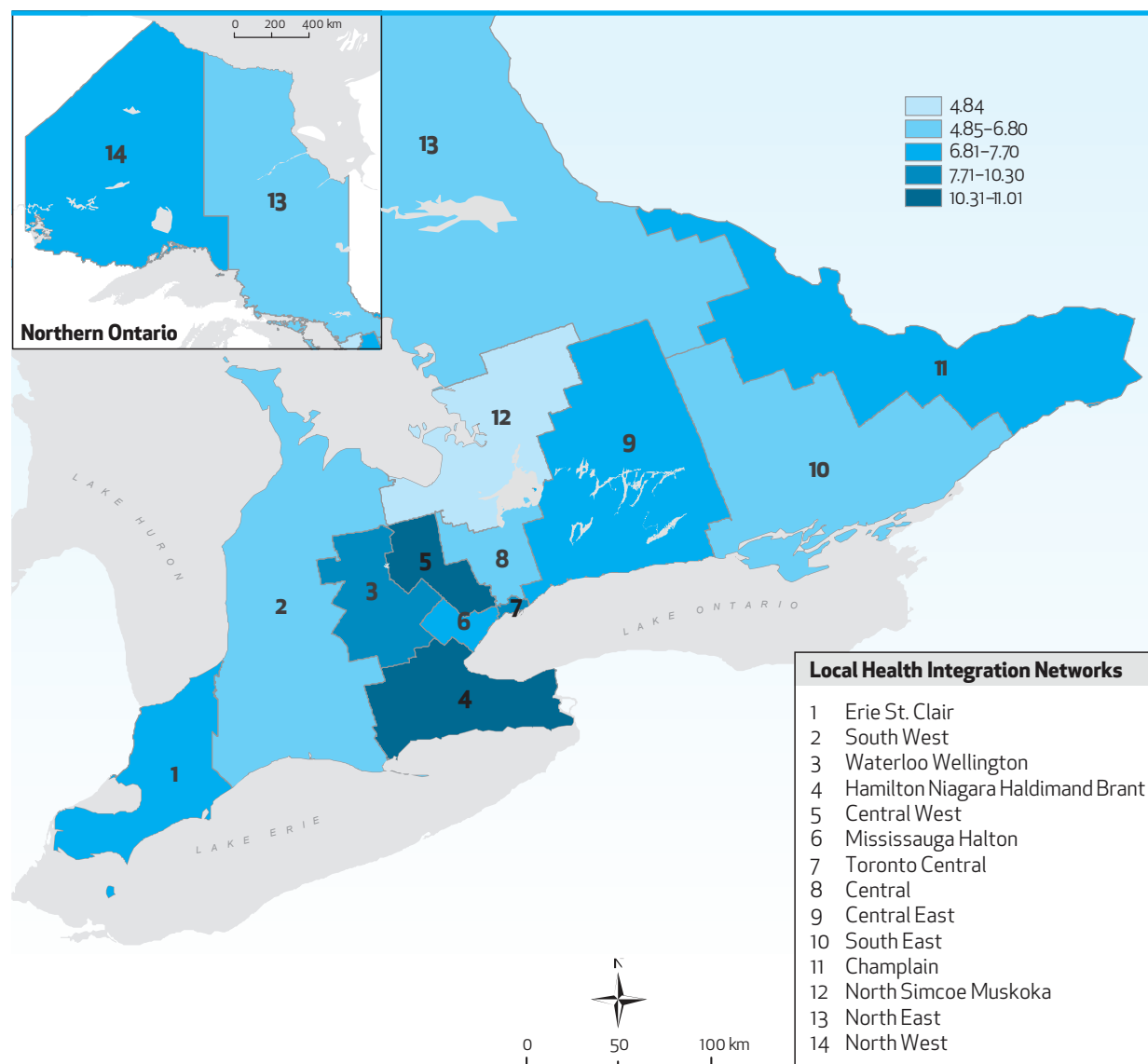
- Between 2012 and 2014, the average age- and sex-standardized rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest for children and youth living in the Hamilton Niagara, Haldimand Brant, Central West, and Waterloo Wellington LHINs and lowest for those in the North Simcoe Muskoka LHIN.



**EXHIBIT 2.13.11** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest for children and youth living in the Hamilton Niagara Haldimand Brant, Central West, and Waterloo Wellington LHINs and lowest for those in the North Simcoe Muskoka LHIN.

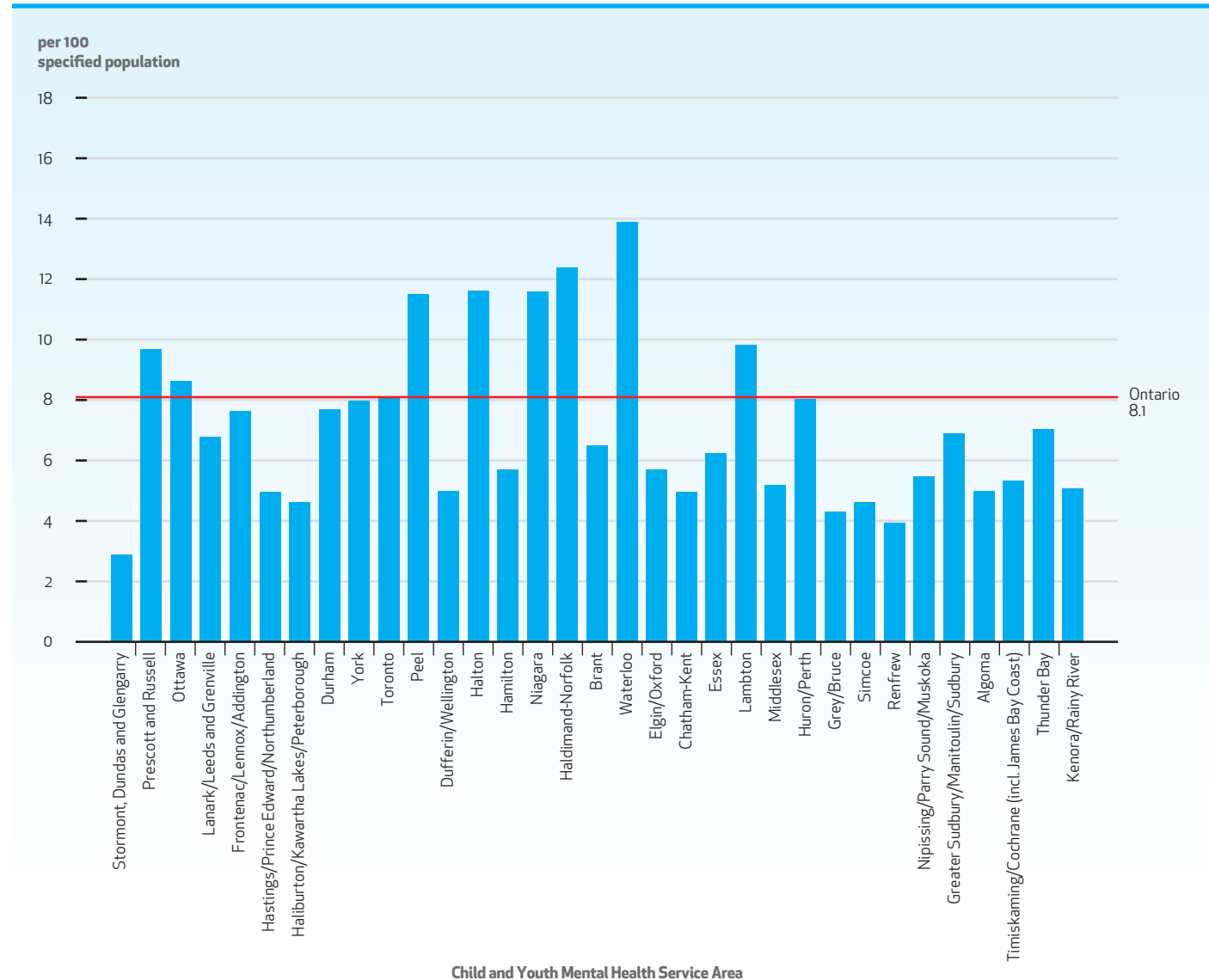




**EXHIBIT 2.13.12** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

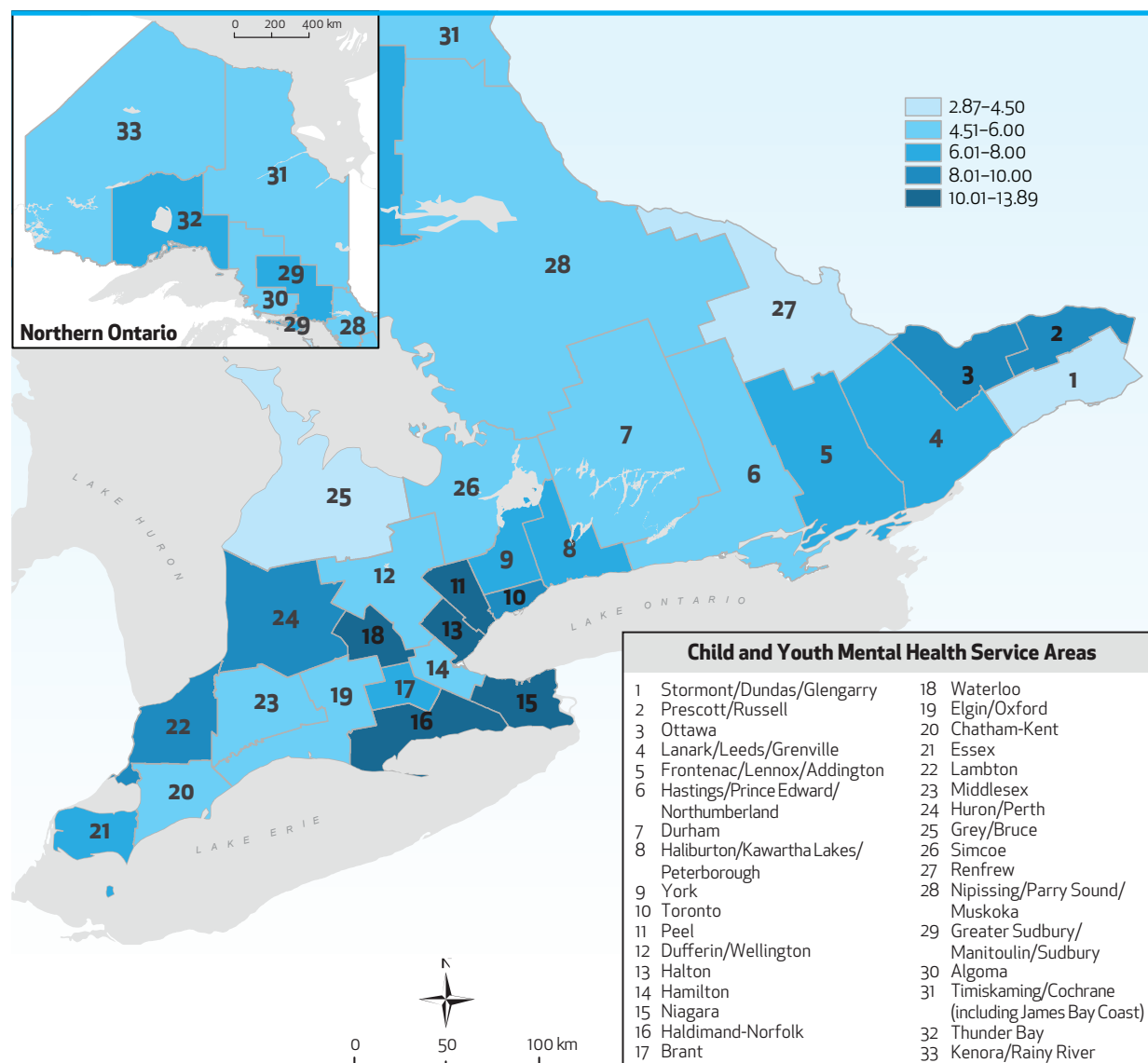
- Between 2012 and 2014, the average age- and sex-standardized rate of hospital readmissions within 30 days of a mental health and addictions-related hospital discharge was highest for individuals in the Waterloo Child and Youth Mental Health Service Area.



**EXHIBIT 2.13.13** Number of readmissions within 30 days of an incident hospital admission related to mental health and addictions (MHA) per 100 standard population aged 0 to 24 years with an incident MHA-related hospital admission, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of hospital readmissions within 30 days of an MHA-related hospital discharge was highest for individuals living in the Waterloo Child and Youth Mental Health Service Area.



**EXHIBIT 2.13.14** Number and proportion of incident hospital admissions related to mental health and addictions that resulted in readmission within 30 days of discharge, in Ontario, from 2006 to 2014

## Key Finding

- Between 2006 and 2014, less than 1% of hospital readmissions within 30 days of an MHA-related hospital discharge were for non-MHA-related reasons.

Readmissions	Incident hospital admissions, n (%)									
	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total
<b>None</b>	8,535 (90.4)	8,713 (90.6)	8,881 (90.7)	8,884 (90.3)	9,701 (90.6)	10,569 (90.4)	12,321 (90.3)	13,076 (90.4)	13,358 (90.4)	94,038 (90.4)
<b>MHA-related</b>	832 (8.8)	833 (8.7)	848 (8.7)	883 (9.0)	922 (8.6)	1,056 (9.0)	1,241 (9.1)	1,305 (9.0)	1,322 (8.9)	9,242 (8.9)
<b>Non-MHA-related</b>	76 (0.8)	70 (0.7)	63 (0.6)	73 (0.7)	82 (0.8)	73 (0.6)	80 (0.6)	79 (0.6)	102 (0.7)	698 (0.7)
<b>Total</b>	9,443 (100.0)	9,616 (100.0)	9,792 (100.0)	9,840 (100.0)	10,705 (100.0)	11,698 (100.0)	13,642 (100.0)	14,460 (100.0)	14,782 (100.0)	103,978 (100.0)

---

# System Performance Indicators: Early Identification

---

**2.14** Rate of emergency department visits as first point of contact for mental health and addictions care for children and youth

## 2.14 Rate of emergency department visits as first point of contact for mental health and addictions care for children and youth

### Rationale

When the emergency department (ED) is the first point of contact for mental health and addictions care, it could be a signal that access to timely community-based physician mental health assessment and treatment is insufficient.

### Results

Visits to the ED that were the first point of contact with the health system for mental health and addictions decreased over time. These visits were more common in males, among the younger age groups, and in refugees. First contact for MHA care occurred most often in the ED for those diagnosed with substance-related disorders, anxiety disorders, and deliberate self-harm, and least often for those diagnosed with schizophrenia. Age- and sex-standardized rates of first MHA-related contact in the ED were also higher for individuals living in the Central West, North West, and North East LHINs and in the Kenora/Rainy River and Timiskaming/Cochrane Child and Youth Mental Health Service Areas. Most children and youth with a first MHA contact in the ED were not hospitalized during their visit.

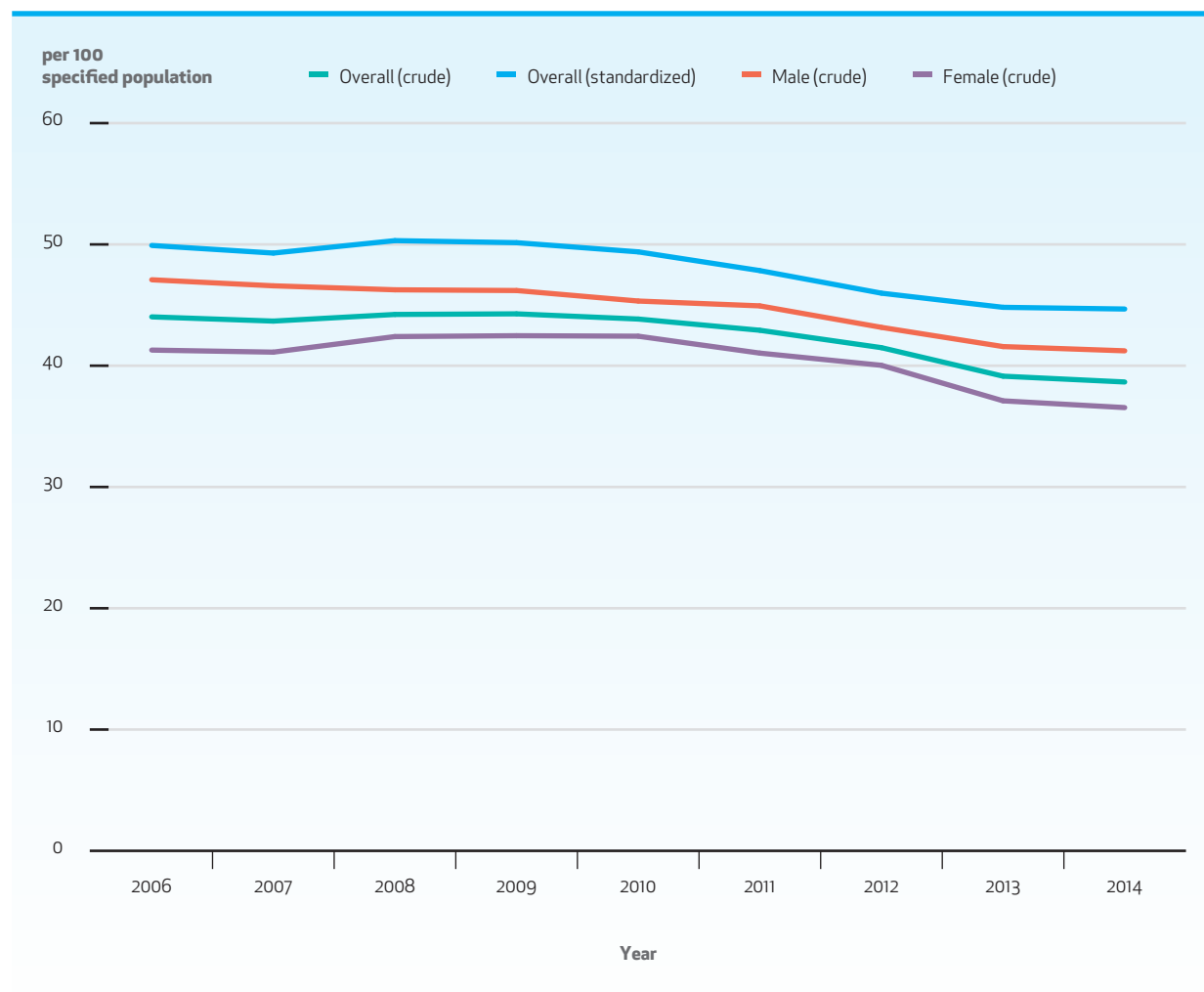
### Interpretation

Approximately half of the children and youth presenting in the ED for mental health and addictions-related reasons did not have prior contact with the health system in acute, ambulatory or outpatient settings. Although these rates have declined over time, this finding may signal inadequate access to physician- and community-based services.

**EXHIBIT 2.14.1** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 population aged 0 to 24 years with an MHA-related ED visit, overall and by sex, in Ontario, 2006 to 2014

## Key Finding

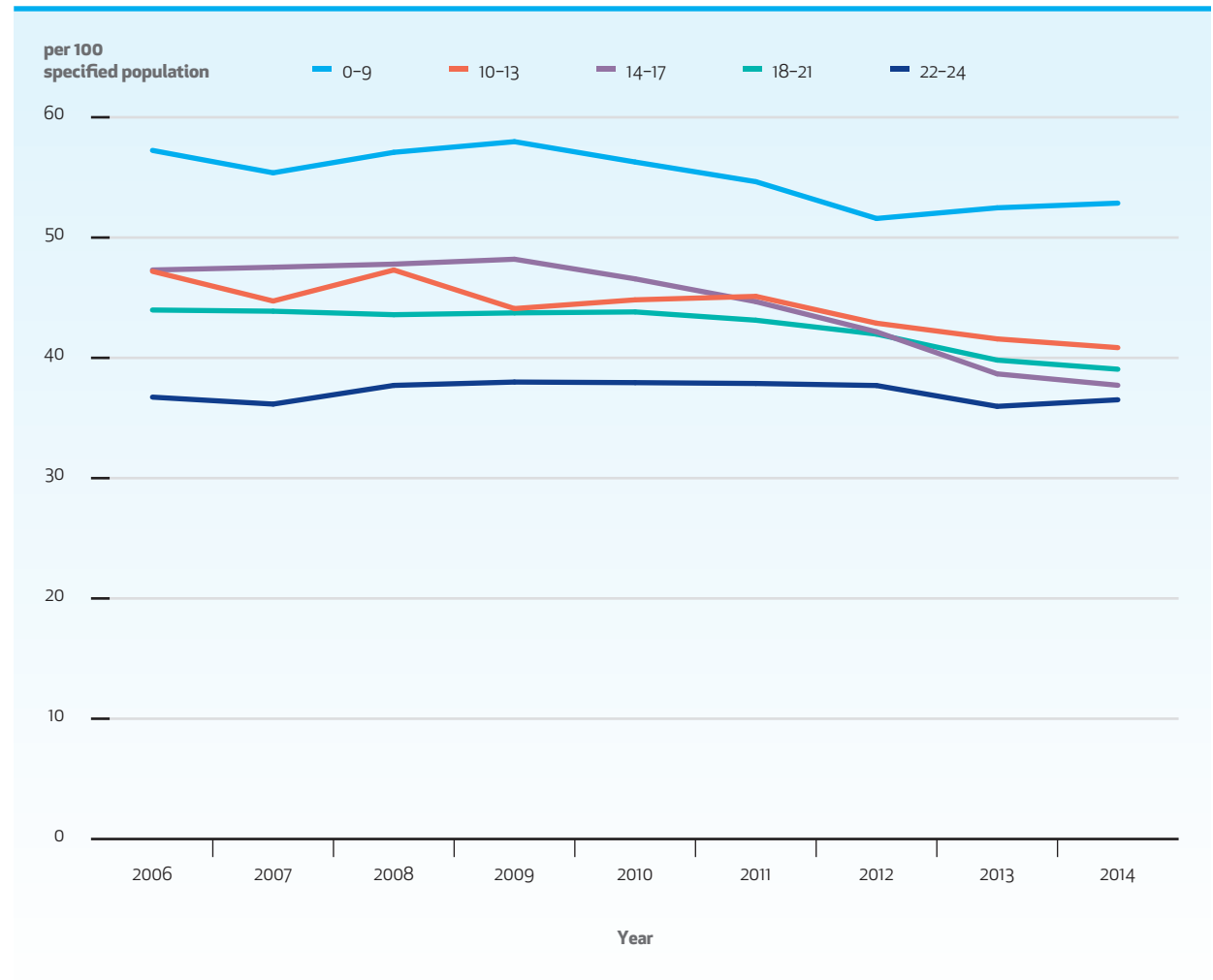
- Between 2006 and 2014, the rate of ED visits that were the first point of contact for mental health and addictions care decreased over time. The rate was higher among males.



**EXHIBIT 2.14.2** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by age group, in Ontario, 2006 to 2014

## Key Findings

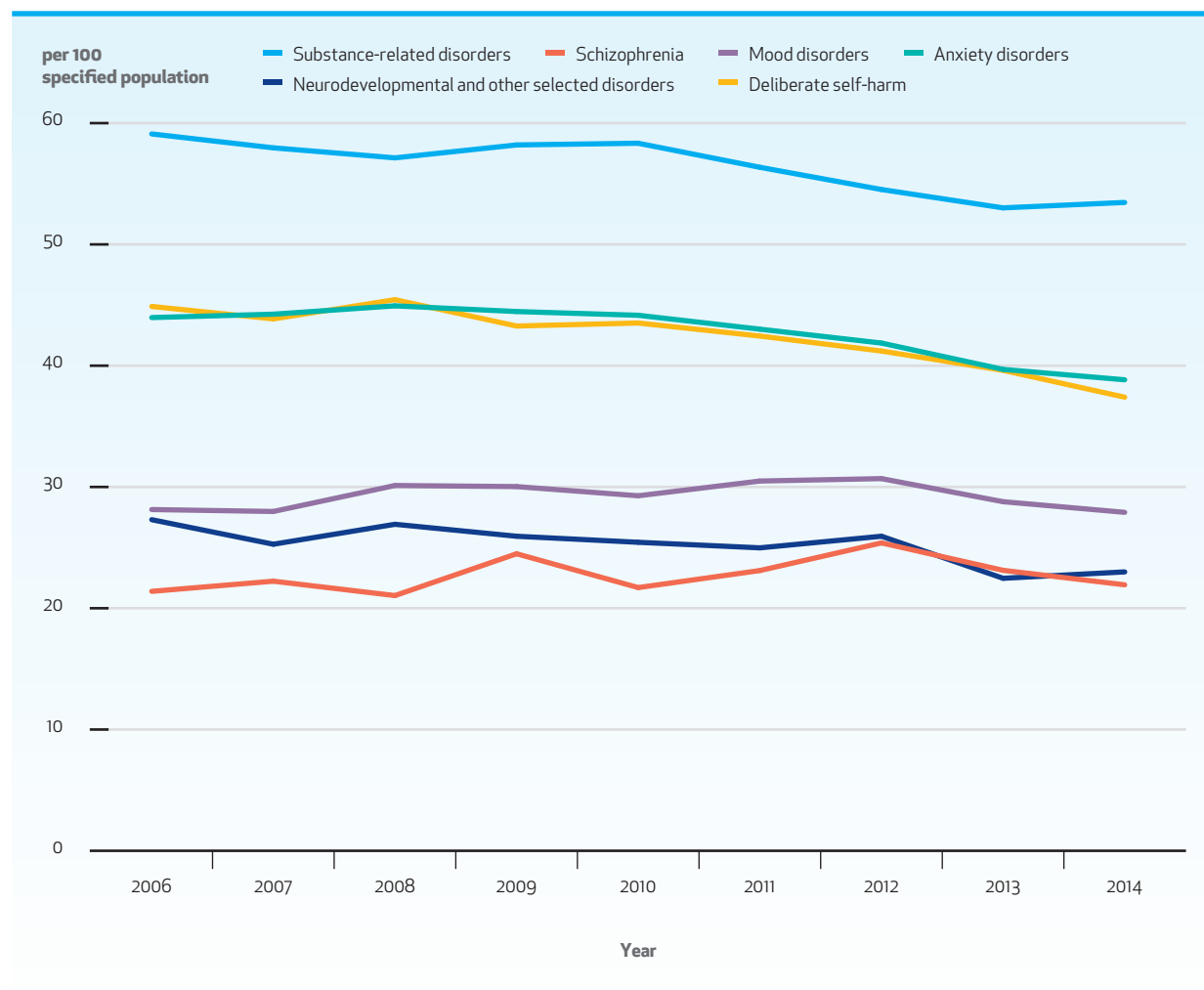
- Between 2006 and 2014, the rate of ED visits that were the first point of contact for mental health and addictions care was higher among the younger age groups.
- Over time, the rate decreased for those aged 21 and younger and was stable for those aged 22 to 24.



**EXHIBIT 2.14.3** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

## Key Findings

- Between 2006 and 2014, the rate of ED visits that were the first point of contact for mental health and addictions care was highest among individuals diagnosed with substance-related disorders, followed by individuals with anxiety disorders and those with deliberate self-harm.
- The rates for these types of disorders declined over time.

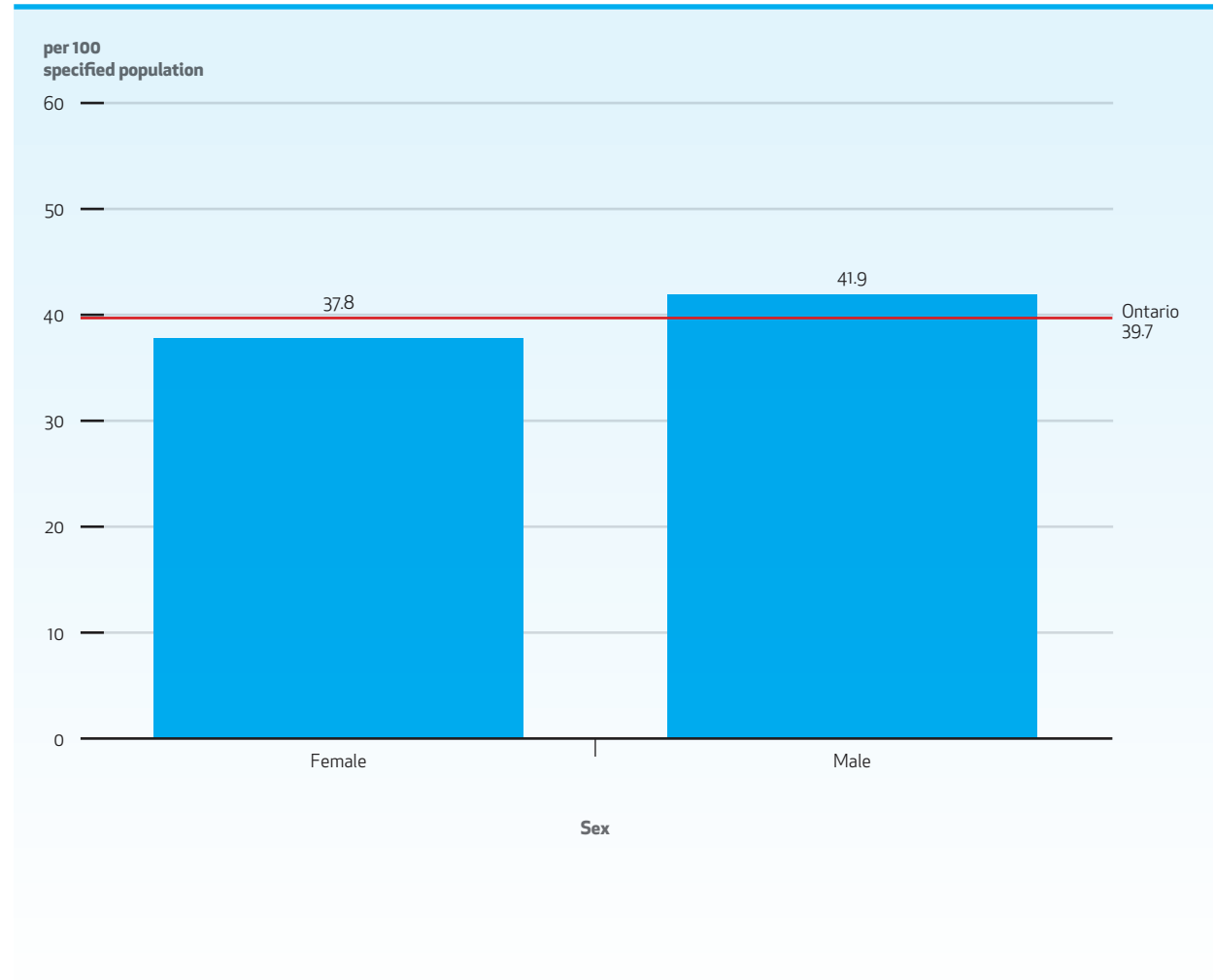




**EXHIBIT 2.14.4** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by sex, in Ontario, three-year average for 2012 to 2014

## Key Finding

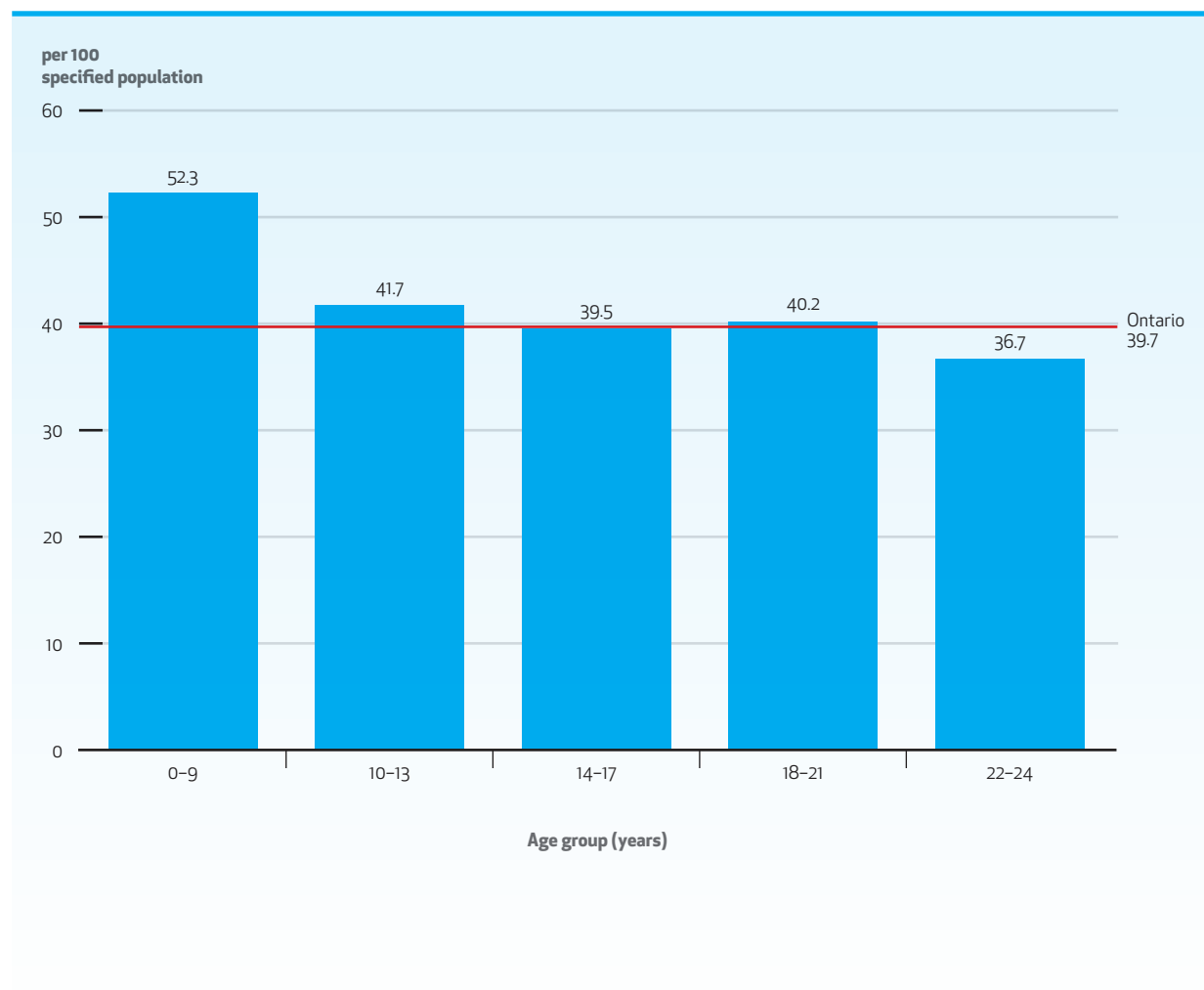
- Between 2012 and 2014, the average rate of ED visits that were the first point of contact for mental health and addictions care was higher among males.



**EXHIBIT 2.14.5** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by age group, in Ontario, three-year average for 2012 to 2014

## Key Finding

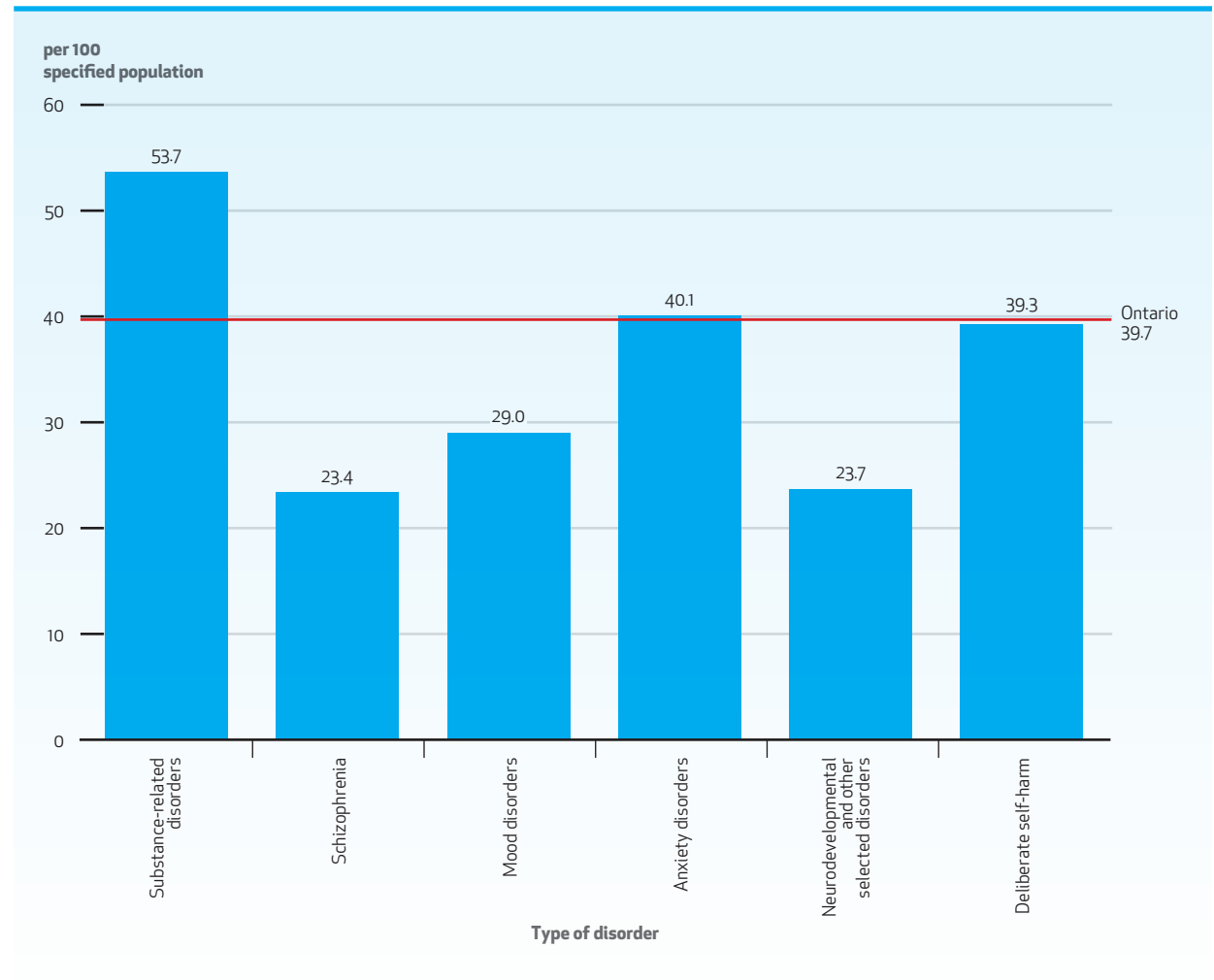
- Between 2012 and 2014, the average rate of ED visits that were the first point of contact for mental health and addictions care was higher among the younger age groups and highest in those aged 0 to 9 years.



**EXHIBIT 2.14.6** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, three-year average for 2012 to 2014

## Key Finding

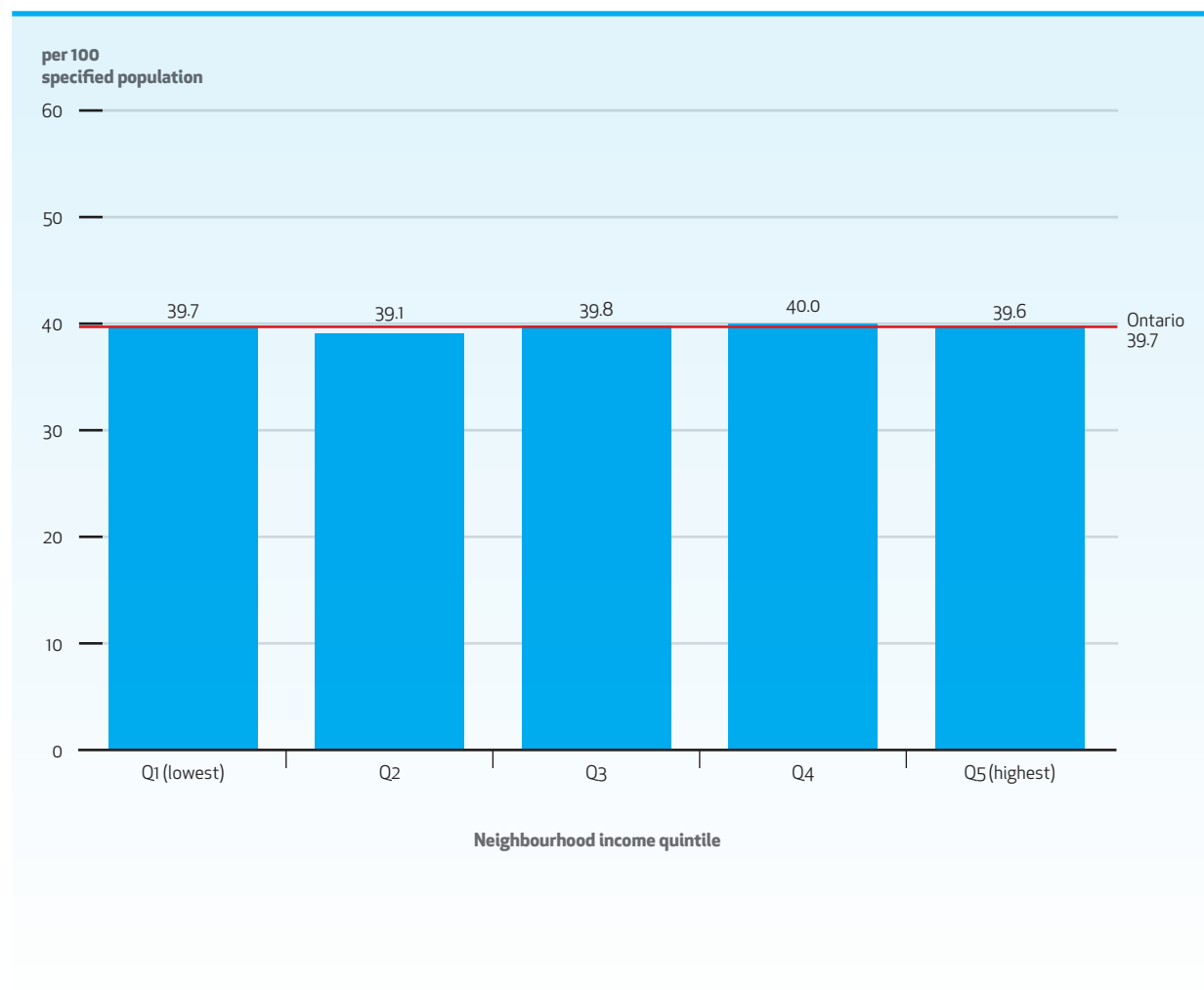
- Between 2012 and 2014, the average rate of ED visits that were the first point of contact for mental health and addictions care was highest for children and youth with a diagnosis of substance-related disorders, followed by those with anxiety disorders and deliberate self-harm.



**EXHIBIT 2.14.7** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by neighbourhood income quintile, in Ontario, three-year average for 2012 to 2014

## Key Finding

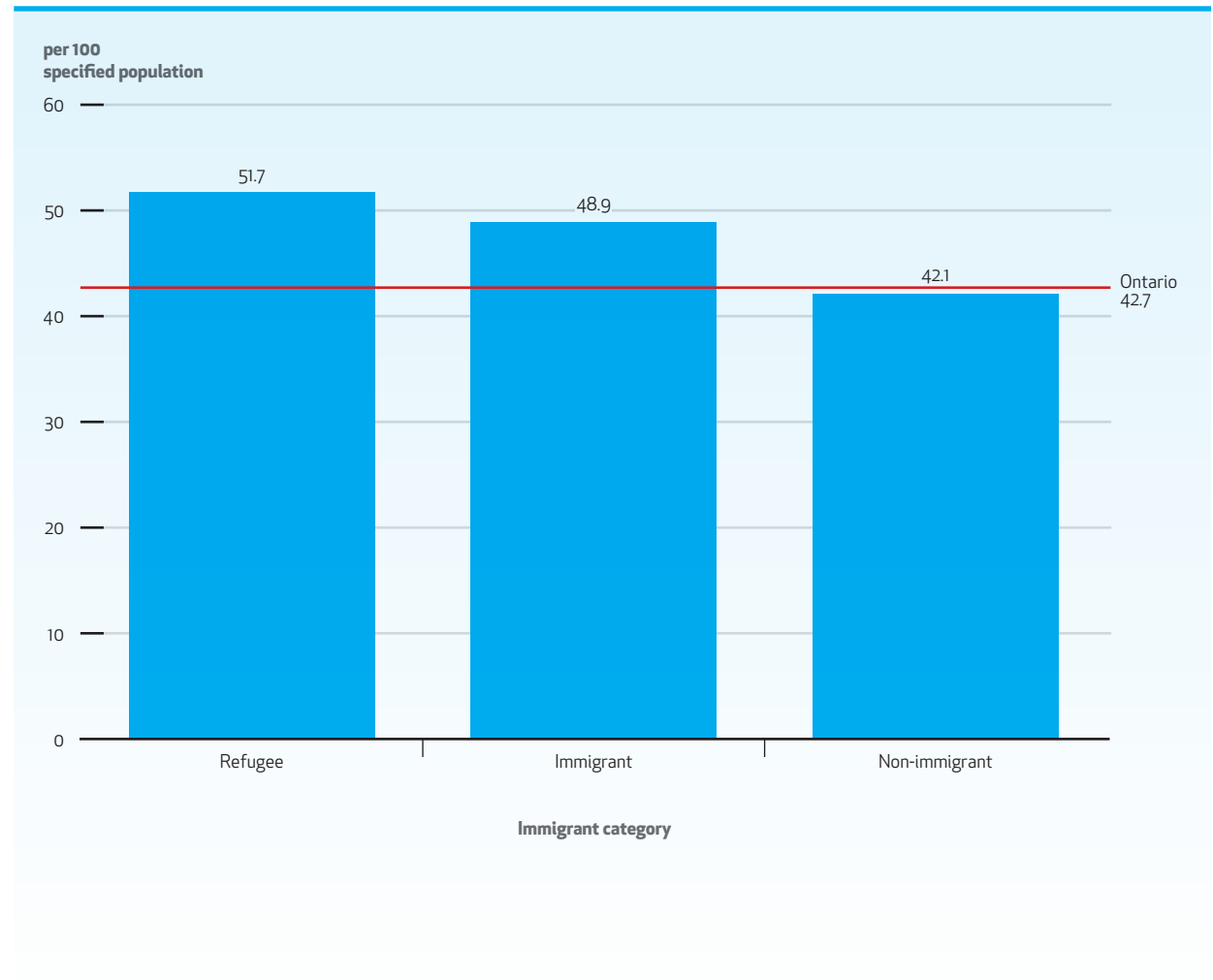
- Between 2012 and 2014, the average rate of ED visits that were the first point of contact for mental health and addictions was similar for all neighbourhood income levels.



**EXHIBIT 2.14.8** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by immigrant category, in Ontario, three-year average for 2010 to 2012

## Key Finding

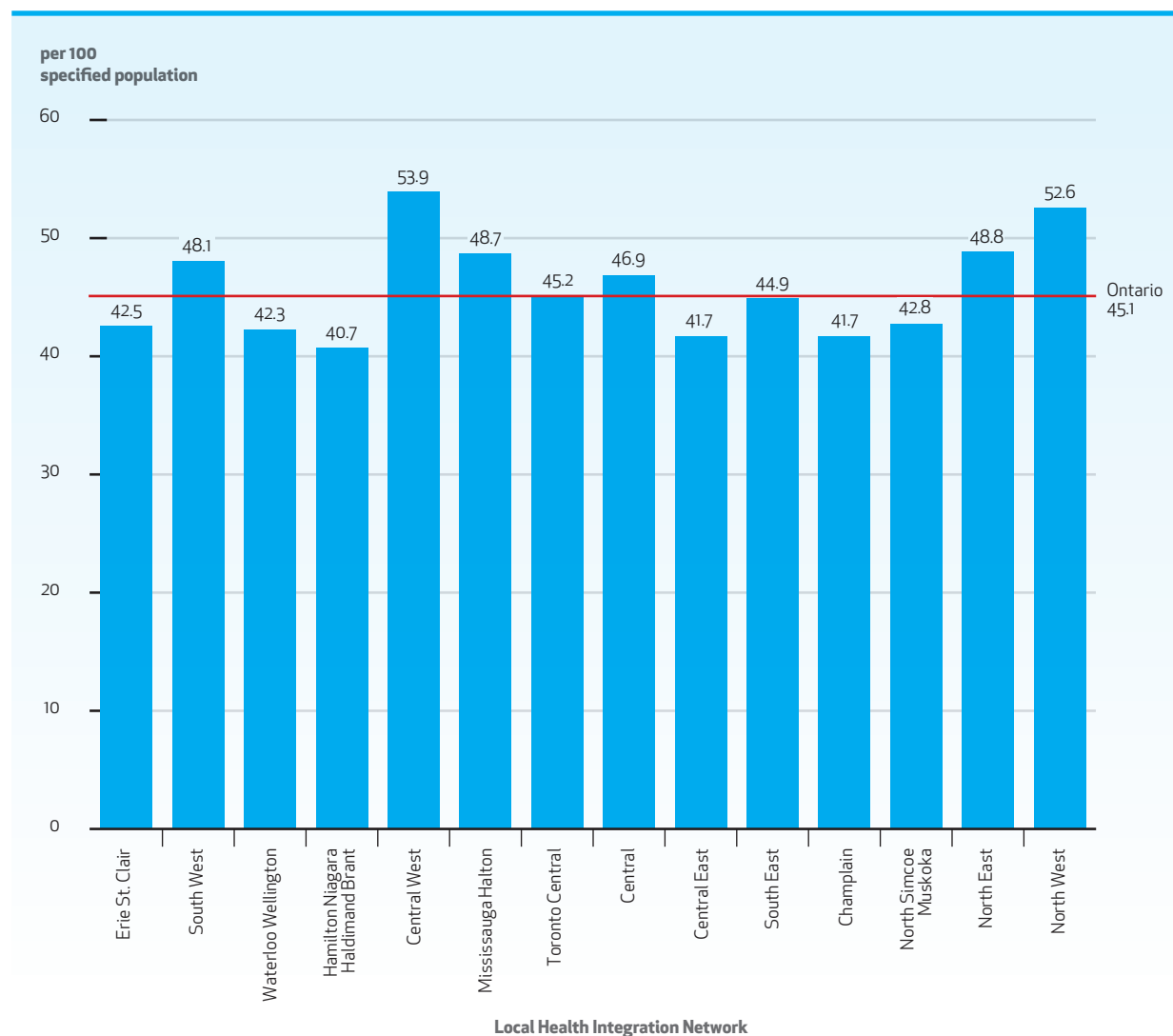
- Between 2010 and 2012, the average rate of ED visits that were the first point of contact for mental health and addictions care was highest among refugees, followed by immigrants.



**EXHIBIT 2.14.9** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

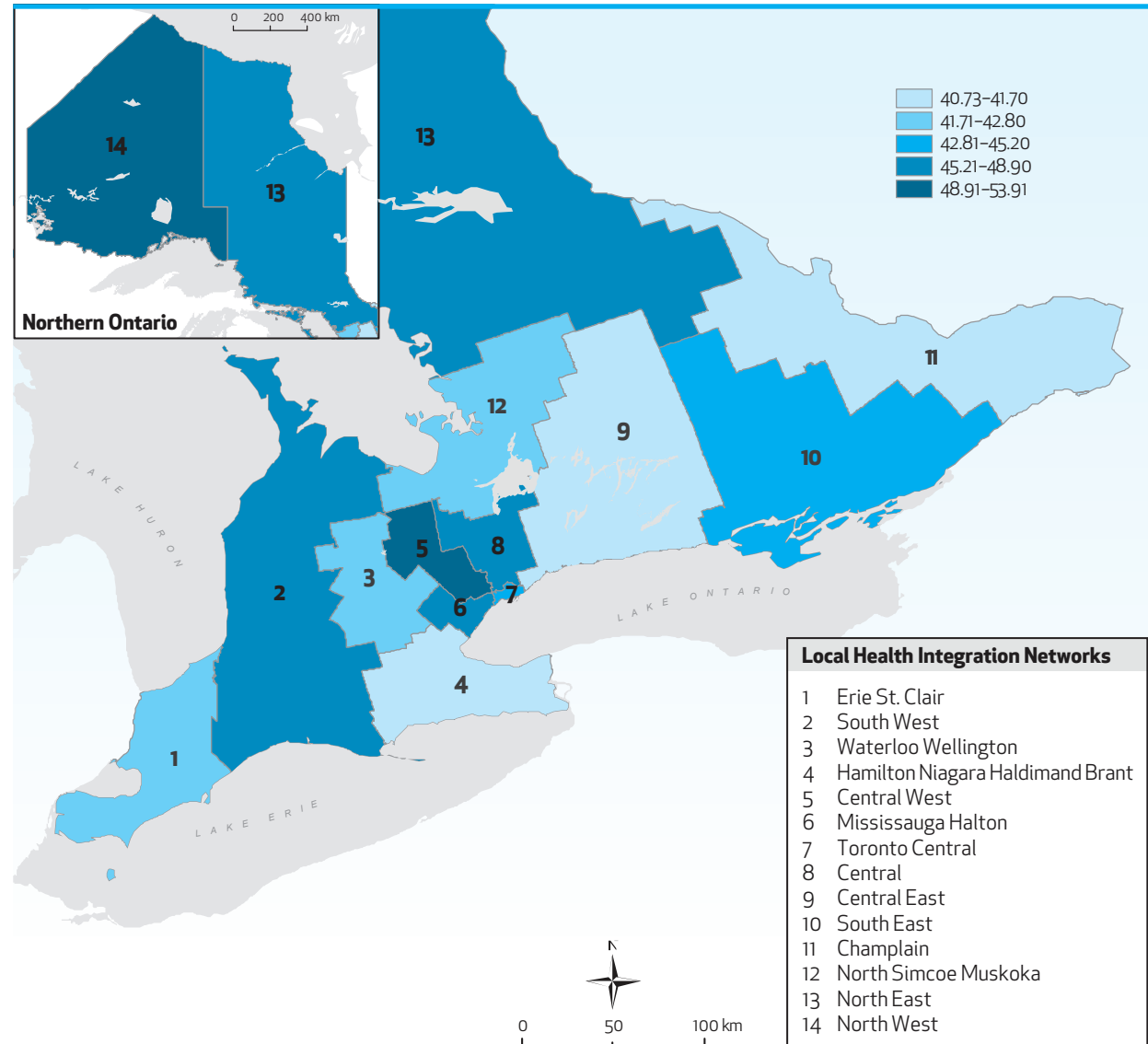
- Between 2012 and 2014, the average age- and sex-standardized rate of ED visits that were the first point of contact for mental health and addictions care was highest for children and youth living in the Central West, North West and North East LHINs and lowest for those in the Hamilton Niagara Haldimand Brant LHIN.



**EXHIBIT 2.14.10** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Local Health Integration Network, in Ontario, three-year average for 2012 to 2014

## Key Finding

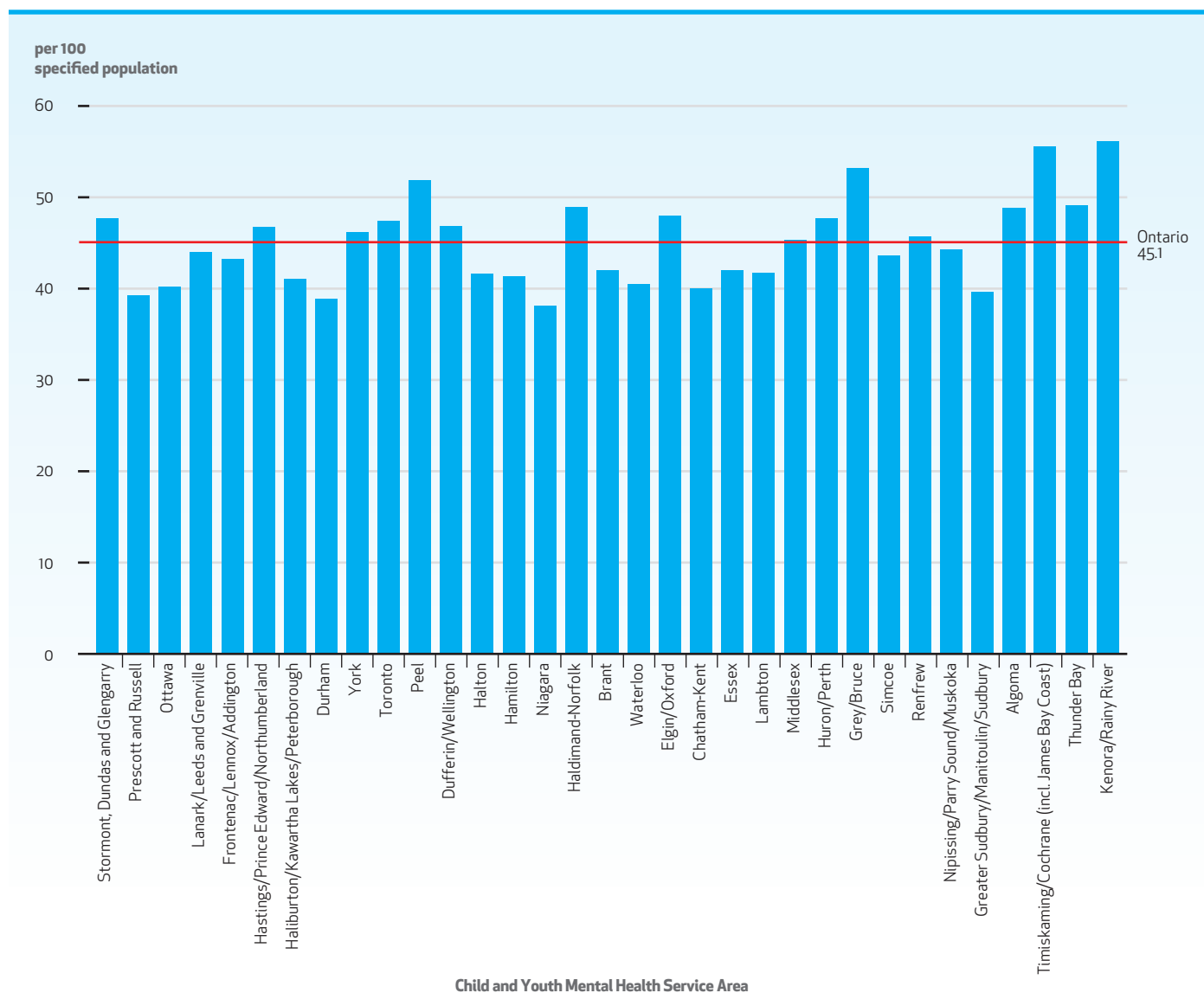
- Between 2012 and 2014, the average age- and sex-standardized rate of ED visits that were the first point of contact for mental health and addictions care was highest for children and youth in the Central West, North West and North East LHINs and lowest for those in the Hamilton Niagara Haldimand Brant LHIN.



**EXHIBIT 2.14.11** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

- Between 2012 and 2014, the average age- and sex-standardized rate of ED visits that were the first point of contact for mental health and addictions care was highest for children and youth in the Kenora/Rainy River and Timiskaming/Cochrane Child and Youth Mental Health Service Areas.

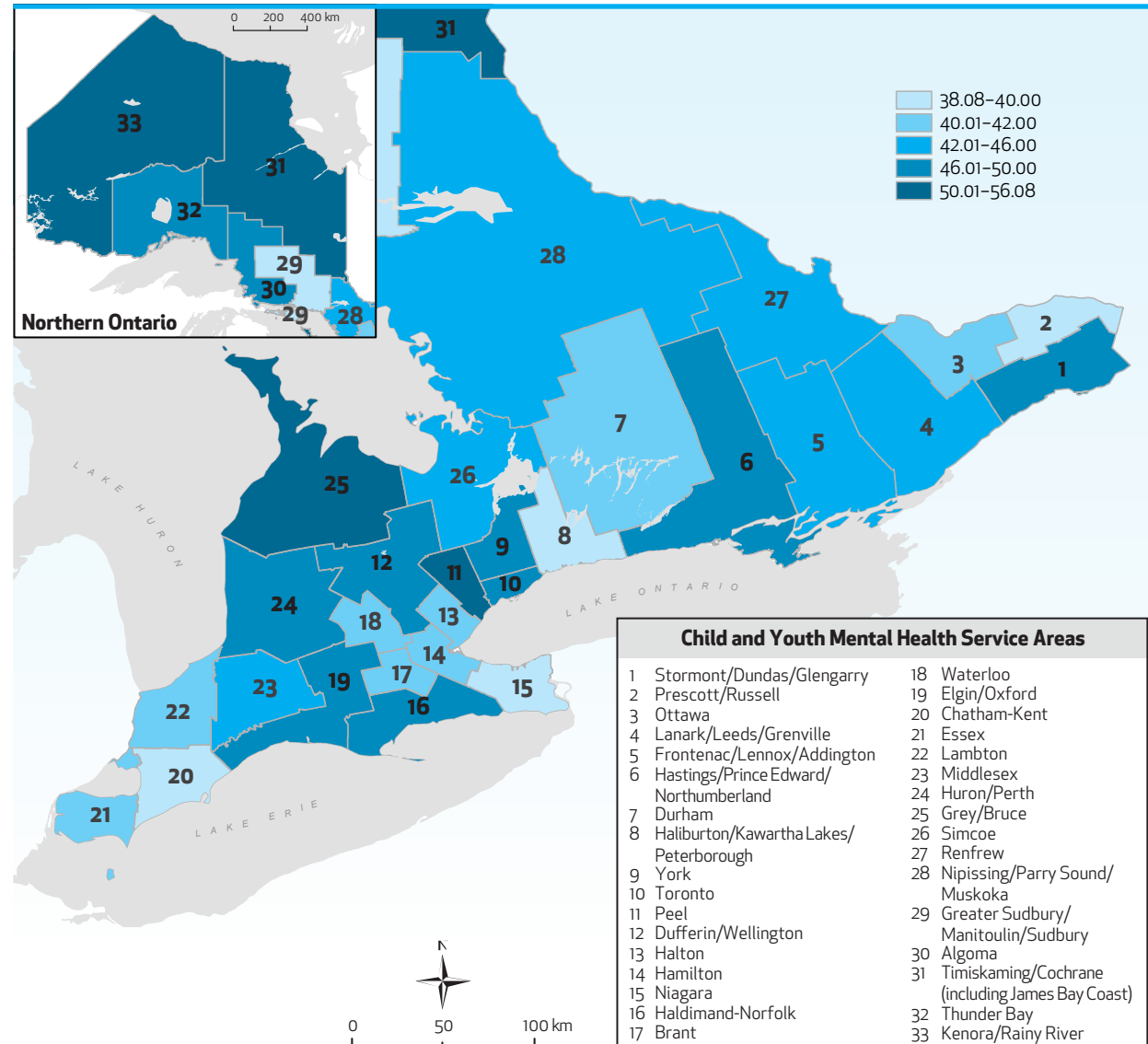




**EXHIBIT 2.14.12** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care per 100 standard population aged 0 to 24 years with an MHA-related ED visit, by Child and Youth Mental Health Service Area, in Ontario, three-year average for 2012 to 2014

## Key Finding

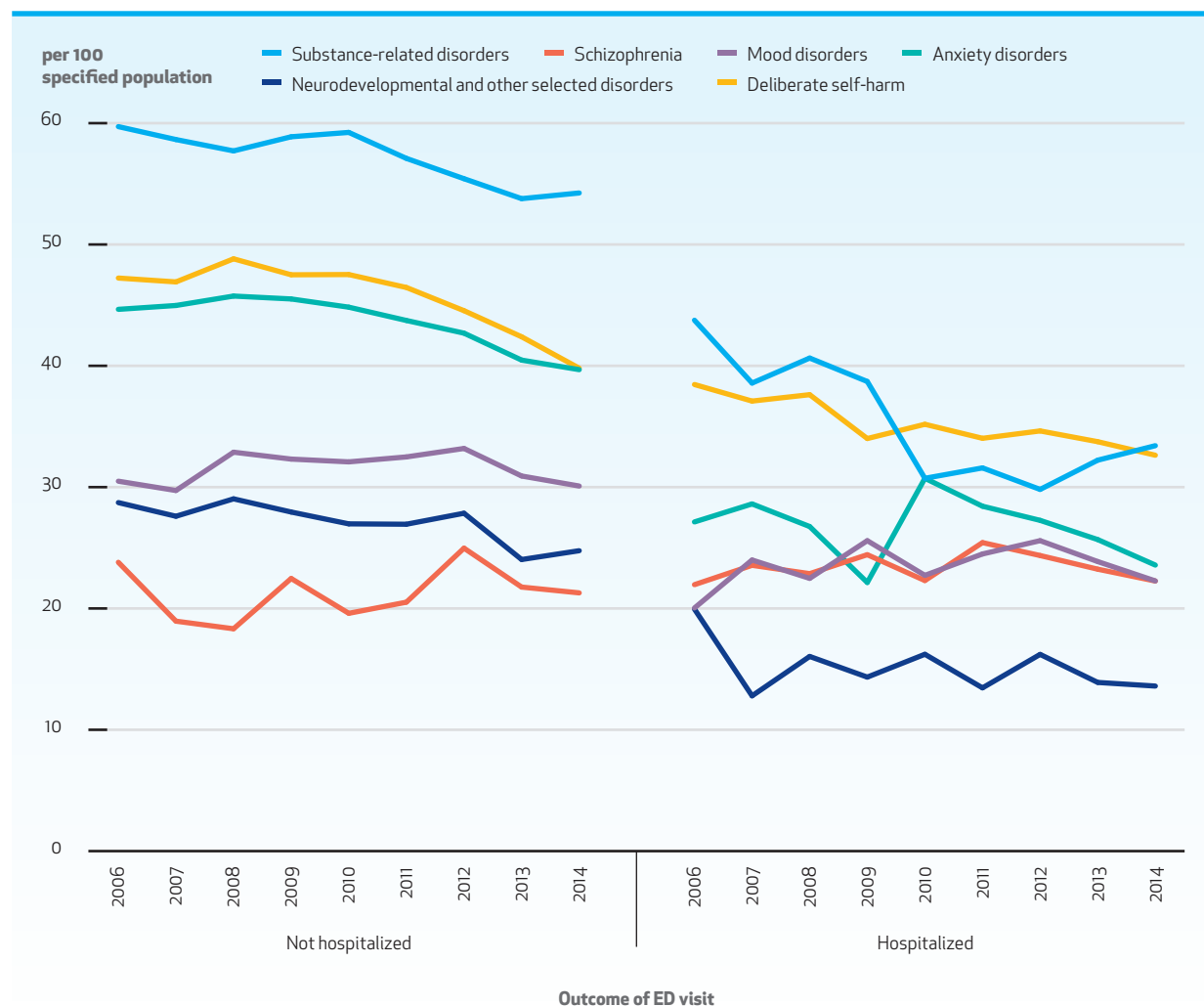
- Between 2012 and 2014, the average age- and sex-standardized rate of ED visits that were the first point of contact for mental health and addictions care was highest for individuals living in the Kenora/Rainy River and Timiskaming/Cochrane Child and Youth Mental Health Service Areas.



**EXHIBIT 2.14.13** Number of children and youth for whom the emergency department (ED) was the first point of contact for mental health and addictions (MHA) care who were or were not hospitalized during their ED visit per 100 crude population aged 0 to 24 years with an MHA-related ED visit, by type of disorder, in Ontario, 2006 to 2014

## Key Findings

- Between 2006 and 2014, the rate of ED visits that were the first point of contact for mental health and addictions care was highest among those who were not hospitalized during their visit.
- The rate of ED visits was highest for individuals with substance-related disorders; this rate decreased over time, particularly for those whose visit resulted in a hospitalization.



## 3.0

# Summary of MCYS Child and Youth Mental Health Performance Indicators, 2015/16

*Data contributed and analyzed by the Ministry of Children and Youth Services*

**EXHIBIT 3.1** Ministry of Children and Youth Services child and youth mental health performance indicators, Ontario, 2015/16

This exhibit summarizes the 2015/16 performance indicators as organized according to these questions:

<b>Children and Youth Mental Health Performance Indicators</b>	
<b>Question</b>	<b>Indicator</b>
Who are we serving?	Proportion of children and youth population served Profile of children and youth served Ages of children and youth served Profile of clients with complete mental health needs
What are we providing?	Service utilization Service duration Clients receiving brief service requiring no other services
How well are we serving children, youth and families?	Clients with positive outcomes Client or parent/caregiver perception of positive outcome
How well is the system performing?	Wait times for clients receiving services Client perceptions of the service system

The database from which the data are pulled can be used to review the source reporting information and identify data that were reported incorrectly, based on prescribed business rules. For each indicator or metric, a count is provided. The count indicates how the number of Transfer Payment Agencies (TPAs) that correctly met the prescribed business rules for the reported data element (see numerator) out of the number of TPAs reporting the data element (see the denominator for the number of reporting agencies). These performance indicator metrics include only information from those TPAs that met the prescribed business rule. An outlier detection analysis (using the interquartile range rule) was also applied to the wait-time data.

Performance Indicator	Description	Ontario Value	Agency Count
Proportion of children and youth population served	Number of unique children and youth who were registered as clients (at an agency level)	121,652	158/158
	Number of children and youth in Ontario	2,858,843	n/a
	Proportion of total children and youth population who were registered as clients in that fiscal year	4%	158/158
Profile of children and youth served	Proportion of registered clients who were Gender – Female	47%	139/158
	Proportion of registered clients who were Gender – Male	52%	139/158
	Proportion of registered clients who were Gender – Other	1%	139/158
	Proportion of clients receiving Counselling/Therapy Services who presented with Behavioural Assessed Needs	42%	115/128
	Proportion of clients receiving Counselling/Therapy Services who presented with Emotional Assessed Needs	52%	118/128
	Proportion of clients receiving Counselling/Therapy Services who presented with Social Assessed Needs	36%	117/128
	Proportion of clients receiving Counselling/Therapy Services who presented with Substance Use Assessed Needs	7%	120/128
	Proportion of clients receiving Counselling/Therapy Services who presented with Trauma Assessed Needs	19%	119/128
	Proportion of clients receiving Counselling/Therapy Services who presented with Complex Needs	43%	120/128
	Proportion of clients receiving Specialized Consultation/Assessment Services who presented with Psychiatric Assessed Needs	69%	90/90
Ages of children and youth served	Proportion of registered clients aged 0–5 years	11%	135/158
	Proportion of registered clients aged 6–10 years	28%	135/158
	Proportion of registered clients aged 11–14 years	30%	135/158
	Proportion of registered clients aged 15–18 years	31%	135/158

Performance Indicator	Description	Ontario Value	Agency Count
Profile of clients with complex mental health needs	Proportion of clients receiving Intensive Services who presented with Complex Assessed Needs	67%	97/111
	Proportion of clients receiving Specialized Consultation/Assessment Services who presented with Complex Needs	81%	90/90
Service utilization	Proportion of the total children and youth who were clients that received Brief Services	31%	77/79
	Proportion of the total children and youth who were clients that received Counselling/Therapy Services	44%	120/128
	Proportion of the total children and youth who were clients that received Crisis Services	22%	58/60
	Proportion of the total children and youth who were clients that received Intensive Treatment Services	12%	100/111
Service duration	Average number of days children and youth were enrolled in Brief Services	31	74/79
	Average number of direct service hours delivered for Brief Services	3	75/79
	Average number of days children and youth were enrolled in Counselling/Therapy Services	146	117/128
	Average number of direct service hours delivered for Counselling/Therapy Services	12	119/128
	Average number of days children and youth were enrolled in Crisis Services	28	58/60
	Average number of direct service hours delivered for Crisis Services	9	56/60
	Average number of days children and youth were enrolled in Intensive Treatment Services	159	98/111
	Average number of direct service hours delivered for Intensive Treatment Services	246	100/111
Clients receiving Brief Service requiring no other services	Proportion of children and youth requiring no further service following Brief Service	50%	77/79
Clients with positive outcomes	Proportion of clients who ended their CYMH service with an agency and had a positive outcome	62%	142/149
Client or parent/caregiver perception of positive outcome	Proportion of clients who ended their CYMH service with an agency and reported having a positive outcome	60%	142/149
Wait times for clients receiving services	Average number of days children and youth waited for Brief Services from initial contact date	35	73/79
	Average number of days children and youth waited for Counselling/Therapy Services from initial contact date	78	117/128
	Average number of days children and youth waited for Crisis Services from initial contact date	2	43/60
	Average number of days children and youth waited for Intensive Treatment Services from initial contact date	98	95/111
Client perceptions of the service system	Proportion of clients who ended their CYMH service with an agency and reported having a positive experience	59%	142/149



Data  
Discovery  
Better Health

---

Institute for Clinical Evaluative Sciences  
G1 06, 2075 Bayview Avenue  
Toronto, Ontario M4N 3M5  
[www.ices.on.ca](http://www.ices.on.ca)

---

