The Mental Health of Children and Youth in Ontario

2017 Scorecard

SUMMARY

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ICES

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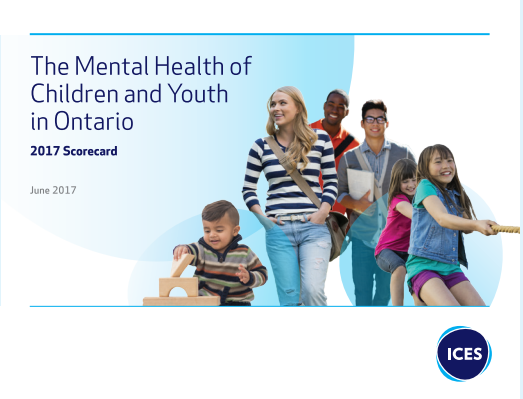

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About This Report

At any given time in Ontario, one in five children and youth has a mental illness.[1] About 70% of mental illnesses begin in childhood or adolescence.[2] *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* was released by the Government of Ontario in 2011. The first three years of the strategy focused on children and youth.[3] As a part of this strategy, ICES released *The Mental Health of Children and Youth in Ontario: A Baseline Scorecard* in 2015.[4]

This report is an update of the baseline scorecard. The purpose of this updated scorecard is to describe child and youth mental health care and related outcomes. The indicators it uses are focused predominantly on care provided in outpatient physician and acute care settings. We also report on a pilot project that integrated community-based child and youth mental health data from one agency with that of the health system. In addition, the Ministry of Children and Youth Services has contributed a section on the 13 performance indicators for community-based child and youth mental health. The reporting of these latter data is critical to our understanding of service needs, delivery and access; however, the lack of reporting on mental health and addictions care provided in schools, correctional centres and other community settings remains a limitation.

There are some notable differences between this report and the 2015 baseline scorecard. This report includes only those indicators that could be updated with new data since 2011/12; as well, it introduces four new indicators that improve our ability to measure the performance of child and youth mental health care. This report is a culmination of two years of work to refine our understanding of child and youth mental health and health system performance in Ontario and inform ongoing efforts to improve outcomes.

Key Findings

Children and youth are seeking more mental health and addictions–related care from physicians and in hospitals.

- Between 2006 and 2014, the rate of outpatient physician visits for mental health concerns grew by 25%, from 24.4 to 33.5 visits per 100 children and youth in Ontario. This amounted to 1.35 million physician visits in 2014. The increase was seen in visits to psychiatrists, family physicians and paediatricians.

- In the same period, the rate of emergency department (ED) visits for mental health and addictions care grew by 53%, from 11.6 to 17.7 visits per 1,000 children and youth. The rate of hospitalizations for mental health and addictions grew by 56%, from 3.2 to 5.0 hospitalizations per 1,000 children and youth.

- Anxiety disorders were the most common reason for ED visits among children and youth and the second most common reason for hospitalizations, behind mood disorders. Anxiety disorders accounted for the largest disease-specific increase in acute care service use.

- While some ED or hospital visits may be appropriate, increased rates may signal missed opportunities for prevention and early intervention. These increased rates suggest a need for enhanced interventions targeted at children and youth with mental health issues, including better discharge planning following care in hospital and improved coordination between primary care physicians and other providers.

Transitions between acute care and outpatient care are poor.

- In 2014, only 4 in 10 (38.3%) children and youth who were hospitalized for a mental health and addictions–related reason received follow-up care with a physician within 7 days of discharge from hospital. This has not significantly changed over time.

- In 2014, 8.1% of children and youth made an unscheduled return visit to the ED within 30 days of an initial visit for a mental health or addictions–related condition. Between 2006 and 2014, this measure increased by 18%. Individuals with schizophrenia had the highest rate of return visits to the ED.

- In 2014, 8.9% of children and youth admitted to hospital for a mental illness were readmitted within 30 days of discharge. This measure increased by 33% between 2006 and 2014.

- The rising trend in return visits and readmissions coupled with stagnant rates of follow-up care suggests opportunities for improvement in how hospitals link children and youth to appropriate outpatient mental health services before they are discharged home. Better care planning during the hospital stay and more timely and accessible outpatient services may improve the transition between acute care and outpatient care.

Access to care varies by sociodemographic characteristics.

- Compared to children and youth in the wealthiest neighbourhoods, those in the poorest ones had higher rates of unscheduled return visits to the ED within 30 days of an initial visit for a mental health or addictions–related condition (respectively, 9.0 and 10.0 revisits per 100 children and youth with an incident ED visit), and they had higher rates of readmission within 30 days of discharge from hospital (8.8 and 9.7 readmissions per 100 children and youth with an incident hospitalization).

- There was no difference by income among those using the ED as the first point of contact with the health system for mental health and addictions care: 39.6% of children and youth from the wealthiest neighbourhoods and 39.7% from the poorest used the ED as the first point of contact. This may be related to a generally good level of access to primary care in the province.

- Among children and youth who presented to the ED for a mental health and addictions-related condition, 51.7% of refugees, 48.9% of immigrants and 42.1% of non-immigrants had never received physician care for their illness. However, follow-up with a physician within 7 days of discharge for a mental health and addictions-related hospitalization was marginally higher among refugees (35.2 %) and immigrants (36.8%) compared with non-immigrants (32.4 %). These findings suggest that immigrants and refugees may be more likely than non-immigrants to face barriers in accessing outpatient care, but once connected to care, they have better outcome measures of accessibility and quality of care.

Mental health needs and access to care vary by geography.

- There is wide geographic variation in mental health needs, as well as in how children and youth access physician- and hospital-based mental health care and the quality of care they receive.

    - Among Local Health Integration Networks, the North West LHIN had the highest rates of neonatal abstinence syndrome (48.1 per 1,000 live births compared to the provincial rate of 5.5), ED visits for deliberate self-harm (92.8 per 10,000 population compared to 30.0 provincially) and deaths by suicide (33.0 per 100,000 population compared to 5.9 for Ontario).

    - Children and youth in the Central West LHIN were the most likely to have had no prior contact with physician- or hospital-based mental health and addictions services when they presented to the ED (53.9%), and those in the Hamilton Niagara Haldimand Brant LHIN were the least likely (40.7%).

    - Children and youth in the Toronto Central LHIN were the most likely to have follow-up with a physician within 7 days of discharge from hospital (48.9%), and those in the North West LHIN were the least likely (19.6%). By Child and Youth Mental Health Service Area, the highest rate of physician follow-up was in Toronto and Halton (49.5% each) and the lowest rate was in Chatham-Kent (14.0%).

- Coupled with findings of greater mental health needs in Northern Ontario (as evidenced by higher rates of neonatal abstinence syndrome, self-harm and suicide), these geographic inequities suggest a mismatch between

need and access to physician services. The expansion of telepsychiatry and other innovative models into more rural and remote communities will be an important step in improving access to care.

- While we report some progress in lower suicide rates in some urban settings, this remains a persistent and troubling phenomenon in Northern Ontario reflecting, in part, specific mental health needs within First Nations communities. Continued attention to these important inequities and outcomes is critical, and progress will require partnership of the federal and provincial governments with local communities.

MCYS performance indicators provide a better picture of community-based mental health care.

- As part of its *Moving on Mental Health* action plan,[5] the Ministry of Children and Youth Services developed 13 performance indicators for community-based child and youth mental health services. These indicators, which are being publicly reported for the first time, provide information about who is being served, what is being provided, how well children and youth are being served, and how well the service system is performing.

- In 2015/16, more than 121,000 children and youth accessed community-based mental health services. On average, those needing a crisis program received services within 2 days; less critical services were available within 4 months.

- The Ministry of Children and Youth Services is working with the community-based child and youth mental health sector to develop and implement a business intelligence solution that will received linked and anonymized data. These data will inform service delivery, service system planning, performance measurement and monitoring, and continuous improvement of the community-based child and youth mental health service system.

Where Do We Go From Here?

Monitoring Ontario's child and youth mental health system is an ongoing process. This scorecard will be updated in two years to generate a longitudinal perspective. As new data sources are identified and integrated with existing data, the ability to track care trajectories will be enhanced. Because indicators are descriptive by nature, further targeted investigations into issues brought to light by the scorecard will be conducted.

As the province's mental health and addictions strategy has expanded its focus from children and youth to adults, we will develop an additional scorecard focused on the older population. We have aligned the measurement framework for both scorecards where possible and will capture the important period of transition from youth to adult services.

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About the Institute for Clinical Evaluative Sciences

The Institute for Clinical Evaluative Sciences is a not-for-profit research institute encompassing a community of research, data and clinical experts, and a secure and accessible array of Ontario's health-related data.

ICES research provides measures of health system performance, a clearer understanding of the shifting health care needs of Ontarians, and a stimulus for discussion of practical solutions to optimize scarce resources.