The Mental Health of Children and Youth in Ontario

2017 Scorecard

TECHNICAL APPENDIX

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

Technical Appendix

MHASEF Research Team,

with a contribution by the Ministry of Children and Youth Services

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Data

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Contents

List of Abbreviations

CYMH	child and youth mental health
DA	dissemination area
DAD	Discharge Abstract Database
DATIS	Drug and Alcohol Treatment Information System
GP/FP	general practitioner/family physician
IRCC-PR	Immigration, Refugees and Citizenship Canada – Permanent Resident database
LHIN	Local Health Integration Network
MCYS	Ministry of Children and Youth Services
MHA	mental health and addictions
NACRS	National Ambulatory Care Reporting System
NAS	neonatal abstinence syndrome
NOS	not otherwise specified
OHIP	Ontario Health Insurance Plan
OMHRS	Ontario Mental Health Reporting System
ORG-D	Office of the Registrar General – Deaths (Vital Statistics database)

1.0 Indicators Appearing in the 2017 Scorecard

Type of Indicator				
Contextual Indicators		**System Performance Indicators**		
Domain				
System Use	**Outcomes**	**Access**	**Quality**	**Early Identification**
Indicators				
Rate at which children and youth were seen by a psychiatrist	Prevalence of neonatal abstinence syndrome in infants	**NEW:** Rate of outpatient visits within 7 days of leaving the hospital after treatment for mental health and addictions	Rate of 30-day repeat unscheduled emergency department (ED) visit after a mental health and addictions-related ED discharge for children and youth	Rate of emergency department visits as first point of contact for mental health and addictions care for children and youth
Rate of outpatient physician visits for mental health and addictions conditions among children and youth	Rate of deaths by suicide among children and youth		**NEW:** Proportion of mental health and addictions-related ED revisits that resulted in admission	**NEW:** Proportion of emergency department visits that were first point of contact for mental health and addictions care that resulted in admission
Rate at which children and youth were treated for alcohol and drug problems	Rate of emergency department visits for deliberate self-harm among children and youth		Rate of 30-day readmission after a mental health and addictions-related hospital discharge for children and youth	
Rate of hospitalizations for eating disorders among children and youth	Rate of emergency department visits related to mental health and addictions among children and youth		**NEW:** Proportion of hospital readmissions that were due to a non-mental health and addictions-related reason	
Length of stay for psychiatric hospitalizations among children and youth	Rate of hospitalizations related to mental health and addictions among children and youth			

2.0 Indicators Not Updated in the 2017 Scorecard

Type of Indicator					
Contextual Indicators			**System Performance Indicators**		
Domain					
Known Prevalence	**System Use**	**Outcomes**	**Access**	**Quality**	**Early Identification**
Indicators					
• Prevalence of self-reported mental illness and substance use for youth Rationale: Rates are not expected to change. • Treated prevalence of schizophrenia in children and youth Rationale: Rates are not expected to change. • Annualized prevalence of students identified with autism spectrum disorder Rationale: No new data. Rates are not expected to change. • Annualized prevalence of students identified with behavioural issues Rationale: No new data. Rates are not expected to change. • Annualized prevalence of students identified with a learning disability. Rationale: No new data. Rates are not expected to change.	• Physicians' full-time equivalent allocation to mental health care for children and youth Rationale: Rates are not expected to change. • Number of funded applications for out-of-country treatment of eating disorders for children and youth Rationale: No new data.	• Annualized prevalence of K–12 students suspended from school Rationale: No new data.	• Wait time to first use of mental health specialist service from last referring physician visit for children and youth Rationale: No new data.		• Rate of hospitalizations as first contact for mental health and addictions for children and youth Rationale: Overlaps with 'Rate of emergency department visit as first point of contact' indicator. • Proportion of youth in provincial correctional centres using mental health and addictions services Rationale: Existing data do not fully capture all mental health and addictions services provided in provincial correctional centres.

3.0 Indicator Methodology

3.1 General instructions for indicator creation

3.1.1 General exclusion criteria for indicators

Unless otherwise stated, the following numerator and denominator exclusion criteria were consistent across all indicators (for additional indicator-specific exclusions, please see **Section 3.2**):

- Age older than 24 years
- Non-residents of Ontario
- Individuals with an invalid health card number
- Missing sex information

For indicators that used a general Ontario population denominator, in addition to the exclusions above, exclude:

- Individuals born after the midpoint (July 1) of the calendar year
- Individuals not eligible for OHIP at the midpoint of the calendar year
- Individuals whose date of last contact with the health care system was more than 10 years from the midpoint of the calendar year

Note: Exclusion criteria were applied to the numerator independently, as the denominator is a population estimate at the midpoint of the year (i.e., the numerator is not a subset of the population denominator).

3.1.2 Indicator stratifications

These variables are used for stratification of the indicators. Please note that stratifications may vary across indicators. For indicator-specific calculations, please refer to Section 3.2.

Stratification	Definition	Categories
Age group	Age group cut-offs were defined in order to examine transitions between child, youth and adult services.	• 0–9 years • 10–13 • 14–17 • 18–21 • 22–24
Sex	Sex	• Male • Female
Diagnostic category	Some indicators were stratified by type of disorder. These diagnostic groups do not add up to the overall MHA category, as they are more specific. For more detail on diagnostic codes and definitions, see Section 3.3.	• Substance-related disorders • Schizophrenia • Mood disorders • Anxiety disorders • Neurodevelopmental and other selected disorders • Deliberate self-harm
Hospital type	To explore variation by hospital type and volume, some indicators were stratified according to the Ministry of Health and Long-Term Care hospital classification.[1]	• Paediatric teaching hospitals • Teaching hospitals • Small hospitals • Community hospitals
Neighbourhood income quintile	In the absence of individual-level socioeconomic data, area-based income was calculated according to methods developed by Statistics Canada. Individuals' postal codes were first matched to dissemination areas (DAs), the smallest available geographic census area, where the average income per single-person equivalent (weighing for household size) was obtained from the 2006 Canadian census. DAs within each metropolitan census area were ranked, and assigned to five groups, or quintiles, of approximately equal size. The corresponding neighbourhood income quintile of that DA was assigned to the individual.	• Quintile 1 (lowest) • Quintile 2 • Quintile 3 • Quintile 4 • Quintile 5 (highest)
Immigrant category	Information on immigrant category was taken from the Ontario portion of the Immigration, Refugees and Citizenship Canada Permanent Resident (IRCC-PR) Database, which contains records of individuals who landed in Ontario between 1985 and 2012. Individuals in the refugee category include government-assisted refugees, privately sponsored refugees, refugees landed in Canada and refugee dependents. Individuals in the immigrant category include economic immigrants identified as permanent residents selected for their skills and ability to contribute to Canada's economy, and family class immigrants who are permanent residents sponsored by a Canadian citizen or a permanent resident living in Canada who is 18 years of age or older. Non-immigrants were identified as all other persons not found in the IRCC-PR Database, including immigrants who landed in Ontario prior to 1985.	• Refugee • Immigrant • Non-immigrant

Stratification	Definition	Categories
Local Health Integration Network	Local Health Integration Networks (LHINs) are the regional health authorities responsible for administering public health care services funded by the Ontario Ministry of Health and Long-Term Care.[3] Individual postal codes were first mapped to census geography and then to a LHIN.	1. Erie St. Clair 2. South West 3. Waterloo Wellington 4. Hamilton Niagara Haldimand Brant 5. Central West 6. Mississauga Halton 7. Toronto Central 8. Central 9. Central East 10. South East 11. Champlain 12. North Simcoe Muskoka 13. North East 14. North West
Child and Youth Mental Health Service Area	Community-based child and youth mental health care, funded by the Ministry of Children and Youth Services , is localized across Child and Youth Mental Health Service Areas.[4] Individual postal codes were first mapped to census geography and then to a service area.	1. Stormont, Dundas and Glengarry 2. Prescott and Russell 3. Ottawa 4. Lanark/Leeds and Grenville 5. Frontenac/Lennox/Addington 6. Hastings/Prince Edward/Northumberland 7. Haliburton/Kawartha Lakes/Peterborough 8. Durham 9. York 10. Toronto 11. Peel 12. Dufferin/Wellington 13. Halton 14. Hamilton 15. Niagara 16. Haldimand-Norfolk 17. Brant 18. Waterloo 19. Elgin/Oxford 20. Chatham-Kent 21. Essex 22. Lambton 23. Middlesex 24. Huron/Perth 25. Grey/Bruce 26. Simcoe 27. Renfrew 28. Nipissing/Parry Sound/Muskoka 29. Greater Sudbury/Manitoulin/Sudbury 30. Algoma 31. Timiskaming/Cochrane (including James Bay Coast) 32. Thunder Bay 33. Kenora/Rainy River

3.1.3 Indicator rates that were calculated

Indicator Rate	Calculation	Categories
Rate calculation	Over time (calendar years 2006–2014)	• Ontario • Age • Sex • Diagnostic category
	Three-year average rate (calendar years 2012–2014)	• Age • Sex • Diagnostic category • Hospital type • Equity lens: – Neighbourhood income quintile – Immigrant category (calendar years 2010–2012) – Local Health Integration Network – Child and Youth Mental Health Service Area
Standardization	Method	• Direct[5]
	Standardized population	2006 Ontario population standardized by age and sex: • Males: 0–9, 10–13, 14–17, 18–21, 22–24 years • Females: 0–9, 10–13, 14–17, 18–21, 22–24 years
	Standardized rate by age and sex	• Ontario • Local Health Integration Networks • Child and Youth Mental Health Service Areas
Calculation of three-year averages	Crude rate	• (N1/D1+N2/D2+N3/D3)/3 where N1 = numerator for 2012 and D1 = denominator for 2012
	Standardized rate	• (N1/D1+N2/D2+N3/D3)/3 where N1 = standardized numerator for 2012 and D1 = reference population denominator
Maps	Heat maps were produced using ArcGIS software. Breaks were established using the natural breaks method, which partitions data into classes based on natural groups in the data distribution.[6]	• Local Health Integration Network strata • Child and Youth Mental Health Service Area strata

3.2 Indicator calculation

For a list of the diagnostic codes used to calculate indicators, please refer to **Section 3.3**.

3.2.1 Contextual indicators

SYSTEM USE

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, a referral from another physician is required. Psychiatric services differ from 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.
Data sources	OHIP, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Ontario population aged 0 to 24 years (see Section 3.1)
Numerator	Number of unique individuals who received service from a psychiatrist
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Date of OHIP service claim
Notes	If a patient has multiple OHIP claims, keep only first OHIP claim (i.e., count each person once).
Limitations	Rates may be undercounted because some psychiatrists only shadow bill (submit claims for services provided to patients that are funded through sources other than fee for service).

Rate of outpatient physician visits for mental health and addictions 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.
Data sources	OHIP, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Ontario population aged 0 to 24 years (see Section 3.1)
Numerator	Number of MHA-related outpatient (office, home, long-term care) visits to: • Any physician specialty: psychiatrist or general practitioner/family physician (GP/FP) or paediatrician • Psychiatrist only • GP/FP only • Paediatrician only For a definition of MHA-related outpatient visits based on physician specialties, diagnostic codes and fee codes, see Section 3.3.
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Date of OHIP service claim
Notes	• When reporting visits, rather than unique individuals, the numerators for different physician specialties are mutually exclusive and should add up to 'any specialty.' • Visit = at most one claim per patient per physician per service date (individuals may contribute more than one visit to various physician specialties within a single calendar year).
Limitations	• Data did not include individuals with mental health and addictions problems who did not visit a physician. • General limitations of health administrative data include potential coding errors and lack of clinical data.

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.
Data sources	DATIS, RPDB
Years	2006 to 2014
Denominator	Ontario population aged 0 to 24 years (see Section 3.1)
Numerator	Number of children and youth seeking treatment for the following problem substances: alcohol, cannabis, tobacco, stimulants (cocaine, amphetamines, crack, crystal methamphetamine), opioids (heroin, opium, prescription opioids, over-the-counter codeine preparations) and other substances (benzodiazepines, barbiturates, hallucinogens, glue and other inhalants, other psychoactive drugs, steroids, ecstasy).
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Date of treatment
Notes	This indicator was calculated externally using Drug and Alcohol Treatment Information System (DATIS) data.
Limitations	Individuals may list up to five problem substances during intake for treatment, so rates for different substances are not mutually exclusive.

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 use 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.
Data sources	DAD, OMHRS, RPDB, IRCC-PR
Years	2003 to 2014
Denominator	Ontario population aged 7 to 24 years
Numerator	Number of hospitalizations for an eating disorder among children and youth
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Hospital discharge date
Notes	In addition to rate of hospitalizations, the median length of stay for eating disorders hospitalizations were also calculated.
Limitations	Only children and youth receiving inpatient treatment are included. Since untreated youth will not be accounted for, the burden of the problem in the population will be underestimated.

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. Along with analyses of rates of hospitalizations, trends in lengths of stay could reflect the efficiency of the mental health and addictions care system.
Data sources	DAD, OMHRS, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	N/A
Numerator	Median length of stay (in days) for hospitalizations related to mental health and addictions
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Hospital discharge date
Notes	• Diagnoses-specific lengths of stay do not add up to the overall length of stay for all psychiatric hospitalizations (see Section 3.3). • In addition to median length of stay for psychiatric hospitalizations, interquartile ranges (25th and 75th percentile) were also calculated.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

OUTCOMES

Prevalence of neonatal abstinence syndrome in infants	
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.
Data sources	DAD, MOMBABY (ICES-derived data set linking the admission records of delivering mothers and their newborn), IRCC-PR
Years	2002 to 2014
Denominator	Total number of hospital live births in Ontario
Numerator	Number of newborns diagnosed with NAS within the first 15 days of life • ICD-9: 779.5 • ICD-10-CA: P96.1
Exclusions	Non-residents of Ontario; infants with an invalid health card number; missing sex; still births
Date used to pull patient characteristics and group individuals into calendar years	Hospital discharge date
Notes	In addition to the indicator stratifications listed in Section 3.1 (excluding diagnostic categories, Child and Youth Mental Health Service Areas and hospital types), prevalence of NAS was also stratified by the mother's age at first delivery.
Limitations	• Diagnoses made more than 15 days after birth will not be captured. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

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.
Data sources	ORG-D, RPDB, IRCC-PR
Years	2003 to 2012
Denominator	Ontario general population aged 10 to 24 years
Numerator	Number of deaths caused by suicide
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Date of death
Notes	• Age groups for this indicator: 10–14, 15–19, 20–24. • In addition to the indicator stratifications listed in Section 3.1 (excluding diagnostic categories and hospital types), rates of death by suicide were also stratified by type of suicide method: poisoning, hanging, drowning, firearms, cutting, jumping and other.
Limitations	Suicide rates may be underreported due to misclassification. The number of deaths among youth aged 10 to 14 years is low and may not reflect actual rates.

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.
Data sources	NACRS, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Ontario general population aged 10 to 24 years
Numerator	Number of emergency department visits for deliberate self-harm
Exclusions	In addition to the exclusions listed in Section 3.1, also excluded were deaths on arrival or in the emergency department, scheduled emergency department visits, individuals who left the emergency department without being seen, and transfers from another emergency department.
Date used to pull patient characteristics and group individuals into calendar years	Date of the emergency department visit
Notes	In addition to the indicator stratifications listed in Section 3.1 (excluding diagnostic categories and hospital types), rates of emergency department visits for deliberate self-harm were also stratified by self-harm method: self-poisoning, self-cutting, other injuries and multiple methods.
Limitations	• Individuals who self-harm but do not present to the emergency department are not included. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

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.
Data sources	NACRS, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Ontario population aged 0 to 24 years (see Section 3.1)
Numerator	Number of emergency department visits related to mental health and addictions
Exclusions	In addition to exclusions listed in Section 3.1, also excluded were: • Scheduled emergency department visits • Transfers from another emergency department
Date used to pull patient characteristics and group individuals into calendar years	Date of the emergency department visit
Notes	• Diagnoses-specific rates do not add up to the overall rate (see Section 3.3). • For deliberate self-harm emergency department visits, there must not be a mental illness (i.e., ICD-10-CA codes F04–F99) listed as a most responsible diagnosis.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

Rate of hospitalizations related to mental health and addictions among children and youth	
Rationale	Hospitalizations for mental health and addictions may reflect the burden of severe disease or may be the result of inadequate early identification and treatment of mental health and addictions problems. 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.
Data sources	DAD, OMHRS, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Ontario population aged 0 to 24 years (see Section 3.1)
Numerator	Number of hospitalizations related to mental health and addictions
Exclusions	General exclusions (see Section 3.1)
Date used to pull patient characteristics and group individuals into calendar years	Hospital discharge date
Notes	• Diagnoses-specific rates do not add up to the overall rate (see Section 3.3). • Hospitalizations were constructed as episodes whereby admission and discharge dates that overlapped by ± 1 day were considered part of the same hospitalization stay. • For deliberate self-harm hospitalizations, there must not be a mental illness (i.e., ICD-10-CA codes F04-F99) listed as a most responsible diagnosis.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

3.2.2 System performance indicators

ACCESS

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 prevent hospital readmissions.
Data sources	OMHRS, DAD, OHIP, RPDB, IRCC-PR
Years	2006 to 2014
Denominator	Incident (first in a calendar year) hospital discharge for MHA (overall, and by diagnostic group: see Section 3.3) in children and youth. • Hospitalizations were constructed as episodes whereby admission and discharge dates that overlapped by ± 1 day were considered part of the same hospitalization. • The final discharge of the hospital episode must result in a discharge home (with or without supportive services); a transfer to a long-term or continuing care facility or to other ambulatory care; palliative care/hospice; addiction treatment centre; jail or social services; or a sign out against medical advice/AWOL.
Numerator (subset of denominator)	Within 7 days following hospital discharge, the number of children and youth with: • Any outpatient (office, home, long-term care) visit to a psychiatrist or general practitioner/family physician (GP/FP) or paediatrician • Only an outpatient GP/FP visit • Only an outpatient psychiatrist visit • Only an outpatient paediatrician visit* • Combined care: visits to a psychiatrist and either a GP/FP or a paediatrician
Exclusions	In addition to the exclusions listed in Section 3.1, also excluded were individuals who died or were admitted to hospital within 7 days of discharge without outpatient follow-up.
Date used to pull patient characteristics and group individuals into calendar years	• Date used to identify the denominator: Hospital discharge date (follow-up starts after discharge date). • Date used to identify the numerator: OHIP claim service date.
Notes	• Index hospital discharges were restricted to calendar years but 7-day follow-up can cross over into the next calendar year. • Diagnostic categories represent the reason for the incident hospital discharge (i.e., denominator). • Diagnoses-specific denominators do not add up to the overall denominator (see Section 3.3). • This indicator was additionally stratified by hospital type (see Section 3.1: Indicator stratifications) based on the institution of the index hospital discharge. A funnel plot was produced with rates weighted by hospital volume (i.e., denominator size).
Limitations	• Data did not capture non-physician follow-up care provided in the community. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

*Paediatrician visits may also occur in Location=Unknown, which may be in a non-outpatient setting (for more detail, see **Section 3.3**).

QUALITY

Rate of 30-day repeat unscheduled emergency department (ED) visit after a mental health and addictions-related ED discharge for children and youth	
Rationale	Acute care emergency department revisits following an incident emergency department discharge could signal inadequate support from community-based and outpatient mental health services.
Data sources	NACRS, DAD, OMHRS, RPDB, IRCC-PR
Denominator	Incident (first in a calendar year) unscheduled ED visit for MHA (overall and by diagnostic group: see Section 3.3) with a disposition of discharge home in children and youth
Numerator (subset of denominator)	Number of children and youth with an unscheduled ED visit for any MHA reason within 30 days following the index ED visit
Exclusions	In addition to exclusions listed in Section 3.1, also excluded were: • Scheduled emergency department visits from both numerator and denominator. • Individuals who died within 30 days of the index ED visit without revisiting the ED. • For the index visit (i.e., denominator), individuals that were transferred to a different ED or to inpatient care, or those who died before leaving the ED.
Date used to pull patient characteristics and group individuals into calendar years	Date of emergency department visit
Notes	• Index ED visits were restricted to calendar years but 30-day follow-up can cross over into the next calendar year. • Diagnostic categories represent the reason for the incident index ED visit (i.e., denominator); repeat ED visit may be for any MHA reason (i.e., does not have to be the same diagnosis as the initial visit). • Diagnoses-specific denominators do not add up to the overall denominator (see Section 3.3). • This indicator was additionally stratified by hospital type (see Section 3.1: Indicator stratifications) based on the institution of the index ED visit. A funnel plot whereby rates were weighted by hospital volume (i.e., denominator size) was produced.
Limitations	• Data did not capture non-physician mental health care that may have been provided in the period between emergency department discharge and revisit. • General limitations of health administrative data include potential coding errors and lack of clinical detail.
Proportion of MHA-related ED revisits that resulted in a hospital admission	
Additional analyses	From the numerator above, the proportion of ED visits that resulted in an inpatient admission and the proportion discharged home were calculated.

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 or support and poor integration and continuity with community-based mental health services.
Data sources	DAD, OMHRS, RPDB, IRCC-PR
Denominator	Incident (first in a calendar year) hospital discharge for MHA (overall, and by diagnostic group: see Section 3.3) in children and youth. • Hospitalizations were constructed as episodes whereby adjoining admission and discharge dates that overlapped by ± 1 day were considered part of the same hospitalization stay. • The final discharge of the hospital episode must result in a discharge home (with/without supportive services); a transfer to a long-term or continuing care facility or to other ambulatory care; palliative care/hospice; addiction treatment centre; jail or social services; or a sign out against medical advice/AWOL.
Numerator (subset of denominator)	Number of children and youth with a hospital admission for any MHA reason within 30 days following the index hospital discharge visit.
Exclusions	In addition to exclusions listed in Section 3.1, also excluded were Individuals who died without a readmission within 30 days of the index hospital discharge.
Date used to pull patient characteristics and group individuals into calendar years	• Date used to identify the denominator: Hospital discharge date (follow-up starts after discharge date). • Date used to identify the numerator: Hospital admission date.
Notes	• Index discharges (i.e., denominator) were restricted to calendar years but 30-day follow-up can cross over into the next calendar year. • Diagnostic categories represent reason for the incident hospital discharge (i.e., denominator); readmission is for any MHA reason (i.e., does not have to be the same diagnosis as initial visit). • Diagnoses-specific denominators do not add up to the overall denominator (see Section 3.3). • This indicator was additionally stratified by hospital type (see Section 3.1: Indicator stratifications) based on the institution of the index hospital discharge. A funnel plot whereby rates were weighted by hospital volume (i.e., denominator size) was produced.
Limitations	• Data did not capture non-physician mental health services that may have been provided in the period between hospital discharge and readmission. • General limitations of health administrative data include potential coding errors and lack of clinical detail.
Proportion of hospital readmissions that were due to a non-mental health and addictions-related reason	
Additional analyses	The proportion of readmissions that were due to non-MHA-related reasons was reported.

EARLY IDENTIFICATION

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 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.
Data sources	NACRS, DAD, OHMRS, OHIP, RPDB, IRCC-PR
Denominator	Incident (first in a calendar year) unscheduled ED visit for MHA (overall and by diagnostic group: see Section 3.3) with a disposition of discharge home in children and youth
Numerator (subset of denominator)	Number of children and youth without any MHA-related service contact in a 2-year lookback period: • Only included those who did not have an MHA-related outpatient visit to a psychiatrist or a general practitioner/family physician or a paediatrician or an MHA-related ED visit (scheduled or unscheduled) or an MHA-related hospitalization in the 2 years preceding the index ED visit (see Section 3.3).
Exclusions	In addition to the exclusions listed in Section 3.1, also excluded were scheduled ED visits (from the denominator only).
Date used to pull patient characteristics and group individuals into calendar years	• Date used to identify the denominator: Date of emergency department visit. • Date used to identify the numerator: OHIP service date, date of ED visit, date of hospital admission.
Notes	• Diagnostic categories represent the reason for the incident ED visit (i.e., the denominator). • Diagnoses-specific denominators do not add up to the overall denominator (see Section 3.3). • ED visits in the 2-year lookback period can include scheduled and unscheduled visits. • The numerator only included individuals who did not have any MHA-related visits in any setting as captured by available data.
Limitations	• The data do not capture non-physician mental health and addictions-related care provided in the community. • General limitations of health administrative data include potential coding errors and lack of clinical detail.
Proportion of emergency department visits as first point of contact for mental health and addictions care that resulted in admission	
Additional analyses	From the numerator above, the proportion of ED first-contact visits that resulted in an inpatient admission and the proportion discharged home were calculated.

3.3 Diagnostic groupings used in indicator calculation

3.3.1 Hospitalizations

Disorder	ICD-10-CA (DAD)	DSM-IV or Provisional Diagnosis* (OMHRS)
Overall, any mental health and addictions condition	Primary diagnosis at discharge equals F04–F99 (which excludes dementia), or secondary diagnoses fields equal X60–X84, Y10–Y19, Y28 when primary diagnosis is not F04–F99	Any diagnoses (including missing diagnoses; excluding 290.x or 294.x, which are dementia codes)
Substance-related disorders	F10–F19, F55	291.x (all 291 codes, excluding 291.82), 292.x (all 292 codes, excluding 292.85), 303.x (all 303 codes), 304.x (all 304 codes), 305.x (all 305 codes) or provisional diagnosis 4
Schizophrenia	F20 (excluding F20.4), F22–F25, F28, F29, F53.1	295.x (all 295 codes), 297.x (all 297 codes), 298.x (all 298 codes) or provisional diagnosis 5
Mood disorders	F30–F34, F38, F39, F53.0	296.x (all 296 codes), 300.4x, 301.13 or provisional diagnosis 6
Anxiety disorders	F40–F43, F48.8, F48.9 F93.1, F93.2	300, 300.0x, 300.2x, 300.3x, 308.3x, 309.0x, 309.24, 309.28, 309.3x, 309.4x, 309.8x, 309.9x or provisional diagnosis 7, 15
Neurodevelopmental and personality disorders	F21, F60–F62, F68, F69, F80–F84, F88–F92, F93 (excluding F93.1, F93.2), F94, F95, F98	299.x (all 299 codes), 300.16, 300.19, 301.x (all 301 codes excluding 301.13), 302.6, 307.1x, 307.2x, 307.3x, 307.5x, 307.6x, 307.7x, 309.21, 312.x, 313.23, 313.81, 313.89, 313.9x, 314.x, 315.x, 787.6x or provisional diagnosis 1, 16
Deliberate self-harm	Secondary diagnoses fields X60–X84, Y10–Y19, Y28 when primary diagnosis is not F04–F99	Not applicable

*Provisional diagnoses were used when the primary diagnosis at discharge field was not complete.
Note: Diagnostic groupings included suspect diagnoses; for more details on diagnostic codes, see **Mental health and addictions-related diagnostic codes.**

3.3.2 Emergency department visits

Disorder	ICD-10-CA (NACRS)*
Overall, any mental health and addictions condition	Primary diagnosis field equals F04–F99 (which excludes dementia), or secondary diagnoses fields equal X60–X84, Y10–Y19, Y28 when primary diagnosis is not F04–F99
Substance-related disorders	F10–F19, F55
Schizophrenia	F20 (excluding F20.4), F22–F25, F28, F29, F53.1
Mood disorders	F30–F34, F38, F39, F53.0
Anxiety disorders	F40–F43, F48.8, F48.9, F93.1, F93.2
Neurodevelopmental and personality disorders	F21, F60–F62, F68, F69, F80–F84, F88–F92, F93 (excluding F93.1, F93.2), F94, F95, F98
Deliberate self-harm	Secondary diagnoses fields X60–X84, Y10–Y19, Y28 when primary diagnosis is not F04–F99

*Includes suspect diagnoses.
Note: For more details on diagnostic codes, see **Mental health and addictions-related diagnostic codes.**

3.3.3 Outpatient physician visits

Physician specialty	OHIP algorithm
Any specialty	Psychiatrist or general practitioner/family physician (GP/FP) or paediatrician (as defined below)
Psychiatrist	Any outpatient (office, home, long-term care) OHIP visit/consult to a psychiatrist (exclude all laboratory fee codes G.x)
General practitioner or family physician	Any outpatient (office, home, long-term care) OHIP visit/consult to a GP/FP and a mental health and addictions diagnostic code listed below (exclude all laboratory fee codes G.x)
Paediatrician	Any outpatient (office, home, long-term care) OHIP visit/consult to a paediatrician and a mental health and addictions diagnostic code listed below (exclude all laboratory fee codes G.x) or any OHIP visit/consult in an undefined location to a paediatrician with service codes K122, K123 and K704* and a mental health and addictions diagnostic code listed below
Mental health diagnostic codes for children and youth	OHIP diagnostic codes: 291, 292, 295–304, 306, 307, 309, 311, 313–315, 897–902, 904–906, 909

*K122: Individual developmental and/or behavioural care; K123: Family developmental and/or behavioural care; K704: Paediatric outpatient case conference.
Note: For more details on diagnostic codes, see **Mental health and addictions-related diagnostic codes**.

3.3.4 Indicator-specific diagnostic codes

Disorder	Diagnostic codes
Eating disorders	ICD-10-CA: F50.0, F50.1, F50.2, F50.3, F50.8, F50.9 DSM-IV: 307.1, 307.10, 307.50, 307.51
Death by suicide	ICD-9: • E950–E952: Poisoning • E953: Hanging • E954: Drowning • E955: Firearm • E956: Cutting • E957: Jumping • E958, E959: Other

Note: For more details on diagnostic codes, see **Mental health and addictions-related diagnostic codes**.

3.3.5 Mental health and addictions-related diagnostic codes

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) codes	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) codes
Substance-related disorders	F10: Mental and behavioural disorders due to use of alcohol F11: Mental and behavioural disorders due to use of opioids F12: Mental and behavioural disorders due to use of cannabinoids F13: Mental and behavioural disorders due to use of sedatives or hypnotics F14: Mental and behavioural disorders due to use of cocaine F15: Mental and behavioural disorders due to use of other stimulants, including caffeine F16: Mental and behavioural disorders due to use of hallucinogens F17: Mental and behavioural disorders due to use of tobacco F18: Mental and behavioural disorders due to use of volatile solvents F19: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances F55: Abuse of non-dependence-producing substances	291.00: Alcohol – Intoxication or withdrawal delirium 291.10: Alcohol – Induced persisting amnestic disorder 292.20: Alcohol – Induced persisting dementia 291.30: Alcohol – Induced psychotic disorder, with hallucinations 291.50: Alcohol – Induced psychotic disorder, with delusions 291.81: Alcohol – Withdrawal 291.89: Alcohol – Induced anxiety/mood disorder or sexual dysfunction 291.90: Alcohol – Related disorder not otherwise specified (NOS) 292.00: Substance – Withdrawal 292.11: Substance – Induced psychotic disorder, with delusions 292.12: Substance – Induced psychotic disorder, with hallucinations 292.81: Substance – Intoxication or withdrawal delirium 292.82: Substance – Induced persisting dementia 292.83: Substance – Induced persisting amnestic disorder 292.84: Substance – Induced mood disorder 292.89: Substance – Intoxication or induced anxiety disorder/sexual dysfunction 292.90: Substance – Related NOS 303.00: Alcohol intoxication 303.90: Alcohol dependence 304.00: Opioid dependence 304.10: Sedative, hypnotic or anxiolytic dependence 304.20: Cocaine dependence 304.30: Cannabis dependence 304.40: Amphetamine dependence 304.50: Hallucinogen dependence 304.60: Inhalant or phencyclidine dependence 304.80: Polysubstance dependence 304.90: Other (or unknown) substance dependence 305.00: Alcohol abuse 305.10: Nicotine dependence 305.20: Cannabis abuse 305.30: Hallucinogen abuse 305.40: Sedative, hypnotic or anxiolytic abuse 305.50: Opioid abuse 305.60: Cocaine abuse 305.70: Amphetamine abuse 305.90: Other (or unknown) substance abuse

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) codes	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) codes
Schizophrenia	F20: Schizophrenia (excluding F20.4: Post-schizophrenic depression) F22: Persistent delusional disorders F23: Acute and transient psychotic disorders F24: Induced delusional disorder F25: Schizoaffective disorders F28: Other nonorganic psychotic disorders F29: Unspecified nonorganic psychosis F53.1: Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified	295.10: Schizophrenia, disorganized type 295.20: Schizophrenia, catatonic type 295.30: Schizophrenia, paranoid type 295.40: Schizophreniform disorder 295.60: Schizophrenia, residual type 295.70: Schizoaffective disorder 295.90: Schizophrenia, undifferentiated type 297.10: Delusional disorder 297.30: Shared psychotic disorder 298.80: Brief psychotic disorder 298.90: Psychotic disorder NOS
Mood disorders	F30: Manic episode F31: Bipolar affective disorder F32: Depressive episode F33: Recurrent depressive disorder F34: Persistent mood [affective] disorders F38: Other mood [affective] disorders F39: Unspecified mood [affective] disorder F53.0: Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified	296.0x: Bipolar I disorder, single manic episode 296.2x: Major depressive disorder, single episode 296.3x: Major depressive disorder, recurrent 296.4x: Bipolar I disorder, most recent episode manic 296.5x: Bipolar I disorder, most recent episode depressed 296.6x: Bipolar I disorder, most recent episode mixed 296.7: Bipolar I disorder, most recent episode unspecified 296.80: Bipolar disorder NOS 296.89: Bipolar II disorder 296.90: Mood disorder NOS 300.4: Dysthymic disorder 301.13: Cyclothymic disorder
Anxiety disorders	F40: Phobic anxiety disorders F41: Other anxiety disorders F42: Obsessive-compulsive disorder F43: Reaction to severe stress and adjustment disorders F48.8: Other specified neurotic disorders F48.9: Neurotic disorder, unspecified F93.1: Phobic anxiety disorder of childhood F93.2: Social anxiety disorder of childhood	300.00: Anxiety disorder NOS 300.01: Panic disorder without agoraphobia 300.02: Generalized anxiety disorder 300.21: Panic disorder with agoraphobia 300.22: Agoraphobia without history of panic disorder 300.23: Social phobia 300.29: Specific phobia 300.3: Obsessive-compulsive disorder 308.3: Acute stress disorder 309.0: Adjustment disorder with depressed mood 309.24: Adjustment disorder with anxiety 309.28: Adjustment disorder with mixed anxiety and depressed mood 309.3: Adjustment disorder with disturbance of conduct 309.4: Adjustment disorder with mixed disturbance of emotions and conduct 309.81: Posttraumatic stress disorder 309.9: Adjustment disorder unspecified

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) codes	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) codes
Neurodevelopmental and other selected disorders	F21: Schizotypal disorder F60: Specific personality disorders F61: Mixed and other personality disorders F62: Enduring personality changes, not attributable to brain damage and disease F68: Other disorders of adult personality and behaviour F69: Unspecified disorder of adult personality and behaviour F80: Specific developmental disorders of speech and language F81: Specific developmental disorders of scholastic skills F82: Specific developmental disorder of motor function F83: Mixed specific developmental disorders F84: Pervasive development disorders F88: Other disorders of psychological development F89: Unspecified disorder of psychological developmental F90: Hyperkinetic disorders F91: Conduct disorders F92: Mixed disorders of conduct and emotions F93: Separation anxiety disorder of childhood (excluding F93.1 and F93.2)	299.00: Autistic disorder 299.10: Childhood disintegrative disorder 299.80: Asperger's disorder/Pervasive developmental disorder NOS/Rett's disorder 300.16: Factitious disorder with predominantly psychological signs and symptoms 300.19: Factitious disorder NOS or with combined psychological and physical signs and symptoms 301.0: Paranoid personality disorder 301.20: Schizoid personality disorder 301.22: Schizotypal personality disorder 301.4: Obsessive-compulsive personality disorder 301.50: Histrionic personality disorder 301.6: Dependent personality disorder 301.7: Antisocial personality disorder 301.81: Narcissistic personality disorder 301.82: Avoidant personality disorder 301.83: Borderline personality disorder 301.9: Personality disorder NOS 302.6: Gender identity disorder 307.1x: Anorexia nervosa 307.20: Tic disorder NOS 307.21: Transient tic disorder 307.22: Chronic motor or vocal tic disorder 307.23: Tourette's disorder 307.3: Stereotypic movement disorder 307.50: Eating disorder NOS 307.51: Bulimia nervosa 307.52: Pica 307.53: Rumination disorder 307.59: Feeding disorder of infancy or early childhood 307.6: Enuresis 307.7: Encopresis, without constipation and overflow incontinence 309.21: Separation anxiety disorder 312.30: Impulse-control disorder NOS 312.31: Pathological gambling 312.32: Kleptomania 312.33: Pyromania 312.34: Intermittent explosive disorder 312.39: Trichotillomania 312.81: Conduct disorder childhood-onset type 312.82: Conduct disorder adolescent-onset type 312.89: Conduct disorder unspecified onset 312.9: Disruptive behavior disorder NOS 313.23: Selective mutism 313.81: Oppositional defiant 313.89: Reactive attachment disorder of infancy or early childhood 313.9: Disorder of infancy, childhood, or adolescence NOS

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) codes	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) codes
		314.00: Attention-deficit/hyperactivity disorder, predominantly inattentive type 314.01: Attention-deficit/hyperactivity disorder, combined type or predominantly hyperactive-impulsive type 314.9: Attention-deficit/hyperactivity disorder NOS 315.00: Reading disorder 315.1: Mathematics disorder 315.2: Disorder of written expression 315.31: Expressive language disorder 315:32: Mixed receptive-expressive language disorder 315.39: Phonological disorder 315.4: Developmental coordination disorder 315.9: Learning disorder NOS 787.6: Encopresis, with constipation and overflow incontinence
Deliberate self-harm	X60: Intentional self-poisoning by and exposure to non-opioid analgesics, antipyretics and antirheumatics X61: Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, NOS X62: Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], NOS X63: Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system X64: Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances X65: Intentional self-poisoning by and exposure to alcohol X66: Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours X67: Intentional self-poisoning by and exposure to other gases and vapours X68: Intentional self-poisoning by and exposure to pesticides X69: Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances X70: Intentional self-harm by hanging, strangulation and suffocation X71: Intentional self-harm by drowning and submersion X72: Intentional self-harm by handgun discharge X73: Intentional self-harm by rifle, shotgun and larger firearm discharge X74: Intentional self-harm by other and unspecified firearm discharge X75: Intentional self-harm by explosive material X76: Intentional self-harm by smoke, fire and flames X77: Intentional self-harm by steam, hot vapours and hot objects X78: Intentional self-harm by sharp object X79: Intentional self-harm by blunt object X80: Intentional self-harm by jumping from a high place X81: Intentional self-harm by jumping or lying before a moving object X82: Intentional self-harm by crashing of motor vehicle X83: Intentional self-harm by other specified means X84: Intentional self-harm by unspecified means Y10: Poisoning by and exposure to non-opioid analgesics, antipyretics and antirheumatics, undetermined intent	Not applicable

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canadian Enhancement (ICD-10-CA) codes	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) codes
	Y11: Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent Y12: Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent Y13: Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent Y14: Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent Y15: Poisoning by and exposure to alcohol, undetermined intent Y16: Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent Y17: Poisoning by and exposure to other gases and vapours, undetermined intent Y18: Poisoning by and exposure to pesticides, undetermined intent Y19: Poisoning by and exposure to other and unspecified chemicals and noxious substances, undetermined intent Y28: Contact with sharp object, undetermined intent	
Eating disorders	F50.0: Anorexia nervosa F50.1: Atypical anorexia nervosa F50.2: Bulimia nervosa F50.3: Atypical bulimia nervosa F50.8: Other eating disorders F50.9: Eating disorder, unspecified	307.1x: Anorexia nervosa 307.50: Eating disorder NOS 307.51: Bulimia nervosa
Death caused by suicide (ICD-9)	E950: Suicide and self-inflicted poisoning by solid/liquid substances E951: Suicide and self-inflicted poisoning by gases in domestic use E952: Suicide and self-inflicted poisoning by other gases and vapours E953: Suicide and self-inflicted injury by hanging, strangulation and suffocation E954: Suicide and self-inflicted injury by submersion (drowning) E955: Suicide and self-inflicted injury firearms and explosives E956: Suicide and self-inflicted injury by cutting and piercing instruments E957: Suicide and self-inflicted injury jumping from a high place E958: Suicide and self-inflicted injury by other and unspecified means E959: Late effects of self-inflicted injury	Not applicable

3.3.6 Ontario Health Insurance Program diagnostic codes

Diagnostic category	Diagnostic code (3-digit codes based on DSM-IV)
Any mental health and addictions condition	Psychotic disorders • 295 Schizophrenia • 296 Manic-depressive psychoses, involutional melancholia • 297 Other paranoid states • 298 Other psychoses Non-psychotic disorders • 300 Anxiety neurosis, hysteria, neurasthenia, obsessive-compulsive neurosis, reactive depression • 301 Personality disorders • 302 Sexual deviations • 306 Psychosomatic illness • 309 Adjustment reaction • 311 Depressive disorder Substance use disorders • 303 Alcoholism • 304 Drug dependence Social problems • 897 Economic problems • 898 Marital difficulties • 899 Parent-child problems • 900 Problems with aged parents or in-laws • 901 Family disruption/divorce • 902 Education problems • 904 Social maladjustment • 905 Occupational problems • 906 Legal problems • 909 Other problems of social adjustment Other • 291 Alcoholic psychosis, delirium tremens, Korsakov's psychosis • 292 Drug psychosis • 299 Childhood psychoses (e.g., autism) • 307 Habit spasms, tics, stuttering, tension headaches, anorexia nervosa, sleep disorders, enuresis • 313 Behaviour disorders of childhood and adolescence • 314 Hyperkinetic syndrome of childhood • 315 Specified delays in development (e.g., dyslexia, dyslalia, motor retardation)

4.0 MCYS Child and Youth Mental Health Indicators

Contributed by the Ministry of Children and Youth Services

4.1 Background

The Ministry of Children and Youth Services (MCYS) relies on data provided by children and youth mental health (CYMH) services to capture an accurate picture of how children, youth and families are being served.

As part of Ontario's Mental Health and Addictions Strategy, in 2012 MCYS released *Moving on Mental Health*, an action plan that defined the new core services to be made available in every service area in the province.[7] Specifically, MCYS defined seven core services and two key processes that will be measured through the CYMH transfer payment budget package.

Core services

- A348 Brief Services
- A349 Counselling/Therapy Services
- A350 Crisis Services
- A351 Family/Caregiver Skills Building and Support
- A353 Intensive Treatment Services
- A355 Specialized Consultation/ Assessment Services
- A356 Targeted Prevention

Key processes

- A352 Access Intake Service Planning
- A354 Service Coordination

In alignment with the vision and goals outlined in *Moving on Mental Health*, in 2013, MCYS introduced 13 performance indicators. These indicators address four key questions and will support provincial monitoring of the service system over time.

Children and Youth Mental Health Performance Indicators

Question	Indicator
Who are we serving?	Proportion of children and youth population served Profile of children and youth served Age of children and youth served Profile of clients with complete mental health needs
What are we providing?	Service utilization Service duration Clients receiving brief treatment requiring no other services
How well are we serving children, youth and families?	Client with positive outcomes Client and/or parent/caregiver perception of positive outcome Number of incidents (including serious occurrence and client complaints*)
How well is the system performing?	Wait times for clients receiving services Client perception of the service system* Value for investment*

*Performance indicators and data collection mechanisms have not yet been defined for CYMH agency serious occurrence reporting, client experience and value for investments. Their definitions and associated data attributes are being considered as part of the development of the CYMH Business Intelligence Solution and through ongoing consultations.

In 2014/15, MCYS began capturing data consistently across Ontario for many of the performance indicators developed. Associated data measures for 10 of the 13 indicators were introduced into the ministry's transfer payment business process, which captures service and financial data through contracts with service providers.

As part of the transfer payment business cycle, service providers are required to report service activity data to the ministry on a quarterly basis. If a CYMH core service agency provides one of the services listed above, it must report service activity data to the ministry. These data are used to calculate the performance indicators.

4.2 Performance indicator data elements and calculations

Performance Indicator	Description	Calculation*
Proportion of child and youth population served	Proportion of total child and youth population that were registered as clients in a fiscal year.	MHUCYS# ÷ pop_0_18 (population data at the Census Division level, from the Ontario Ministry of Finance)
Profile of children and youth served	Proportion of clients receiving Counselling/Therapy Services who present with Behavioural Assessed Needs	MHBNA# ÷ INDSER# for A349
	Proportion of clients receiving Counselling/Therapy Services who present with Complex Needs	MHCNA# ÷ INDSER# for A349
	Proportion of clients receiving Counselling/Therapy Services who present with Emotional Assessed Needs	MHENA# ÷ INDSER# for A349
	Proportion of clients receiving Counselling/Therapy Services who present with Social Assessed Needs	MHSNA# ÷ INDSER# for A349
	Proportion of clients receiving Counselling/Therapy Services who present with Substance Use Assessed Needs	MHSUNA# ÷ INDSER# for A349
	Proportion of clients receiving Counselling/Therapy Services who present with Trauma Assessed Needs	MHTNA# ÷ INDSER# for A349
	Proportion of registered clients who are Gender – Female	MHGF# ÷ MHUCYS# for A352
	Proportion of registered clients who are Gender – Male	MHGM# ÷ MHUCYS# for A352
	Proportion of registered clients who are Gender – Other	MHOG# ÷ MHUCYS# for A352
	Proportion of clients receiving Specialized Consultation/Assessment Services who present with Psychiatric Assessed Needs	INTPNA# for A355 ÷ INDSER# for A355
Ages of children and youth served	Ages of children and youth served	MH0-5# ÷ MHUCYS# for A352
	Proportion of registered clients aged 6–10 years	MH6-10# ÷ MHUCYS# for A352
	Proportion of registered clients aged 11–14 years	MH11-14# ÷ MHUCYS# for A352
	Proportion of registered clients aged 15–18 years	MH15-18# ÷ MHUCYS# for A352
Profile of clients with complex mental health needs	Proportion of clients receiving Intensive Services who present with Complex Assessed Needs	MHCNA# for A353 ÷ INDSER# for A353
	Proportion of clients receiving Specialized Consultation/Assessment Services who present with Complex Needs	MHCNA# for A355 ÷ INDSER# for A355
Service utilization	Proportion of the total child and youth population who were clients that received Brief Services	INDSER# for A348 ÷ MHUCYS# for A352
	Proportion of the total child and youth population who were clients that received Counselling/Therapy Services	INDSER# for A349 ÷ MHUCYS# for A352
	Proportion of the total child and youth population who were clients that received Crisis Services	INDSER# for A350 ÷ MHUCYS# for A352
	Proportion of the total child and youth population who were clients that received Intensive Treatment Services	INDSER# for A353 ÷ MHUCYS# for A352

Performance Indicator	Description	Calculation*
Service duration	Average number of direct service hours delivered for Brief Services	HOUDIRS# for A348 ÷ INDSER# for A348
	Average number of days children and youth were enrolled in Brief Services	MHSD# for A348 ÷ INDSER# for A348
	Average number of direct service hours delivered for Counselling/Therapy Services	HOUDIRS# for A349 ÷ INDSER# for A349
	Average number of days children and youth were enrolled in Counselling/Therapy Services	MHSD# for A349 ÷ INDSER# for A349
Service duration	Average number of direct service hours delivered for Crisis Services	HOUDIRS# for A350 ÷ INDSER# for A350
	Average number of days children and youth were enrolled in Crisis Services	MHSD# for A350 ÷ INDSER# for A350
	Average number of direct service hours delivered for Intensive Treatment Services	HOUDIRS# for A353 ÷ INDSER# for A353
	Average number of days children and youth were enrolled in Intensive Treatment Services	MHSD# for A353 ÷ INDSER# for A353
Clients receiving brief service requiring no other services	Proportion of children and youth requiring no further service following Brief Service	BSNOS# ÷ INDSER# for A348
Clients with positive outcomes	Proportion of clients who ended their CYMH service with an agency and who had a positive outcome	POSOC# for A354 ÷ MHENDCY# for A354
Client and/or parent/caregiver perception of positive outcome	Proportion of clients who ended their CYMH service with an agency and who reported having a positive outcome	CPOSOC# for A354 ÷ MHENDCY# for A354
Average wait times	Average number of days children and youth waited for Brief Services from the initial contact date	MHWT# for A348 ÷ INDSER# for A348
	Average number of days children and youth waited for Counselling/Therapy Services from the initial contact date	MHWT# for A349 ÷ INDSER# for A349
	Average number of days children and youth waited for Crisis Services from the initial contact date	MHWT# for A350 ÷ INDSER# for A350
	Average number of days children and youth waited for Intensive Treatment Services from the initial contact date	MHWT# for A353 ÷ INDSER# for A353
Client perception of the system	Proportion of clients who ended their CYMH service with an agency and reported a positive experience	CPOSEX# for A354 ÷ MHENDCY# for A354

*See **Section 4.4** for definitions of data elements.

4.3 Core service detail codes

Core Service	Detail Code
A348 Brief Services	• Brief services provide "quick access" therapeutic encounters to address the immediate or presenting needs of a child or youth. They provide a timely response to requests for service, maximizing the child or youth and family's readiness for change and diverting children, youth and families from waitlists whenever possible. • Brief services are provided through a service delivery mechanism that allows most effective service (e.g., walk-in clinic, single-session model, brief consultation). • Brief Services are distinguished from Counselling/Therapy Services in that they are episodic and time-limited (e.g., a single therapeutic session, or 3 sessions of therapy or consultation sessions within a six-week time frame).
A349 Counselling/ Therapy Services	• Counselling and therapy treatment services focus on reducing the severity of, and/or remedying, the emotional, social and behavioural problems of children and youth. • Services include a series of planned, interrelated interventions based on an assessment of the child, youth and family's multiple risks, needs and strengths. • Counselling and therapy services can include a range of modalities (e.g., individual, group, family, play-based) as well as clinical practices (e.g., cognitive behaviour therapy). Services are provided within the context of the family, culture and community, and can be provided in a range of settings and frequencies.
A350 Crisis Services	• Crisis support services are immediate, time-limited services, delivered in response to an identified child or youth who is experiencing an imminent mental health crisis, or an urgent or crisis situation that places the child/youth or others at serious risk. • Crisis services work actively to stabilize situations, ensure urgent access to services, and may facilitate as required access to a range of longer-term resources and supports.
A351 Family/Caregiver Skills Building and Support	• Family/caregiver skills building and support services enhance parent, caregiver or guardian capacity to understand, support and adaptively respond to the mental health needs of their children and youth. • Skills building and support services enable the family, including siblings, parents, and/or guardians to better address a child or youth's mental health issues by changing attitudes and behaviours, providing support as they adjust to new diagnoses, building skills and competencies, and/or creating awareness and resiliency. • Family/caregiver skills building and support services may include the provision of effective parenting strategies as well as access to peer supports to promote resilience and positive child/youth/family functioning. • Support services may be offered in a variety of settings, including agency settings, community settings and/or the family home. Examples include, but are not limited to, parenting programs and peer-to-peer support groups. Support services also include family/caregiver respite—time-limited relief for families by providing temporary care for identified children or youth who display significant mental health problems or disorders.
A352 Access Intake Service Planning	• The intake process is often the first point of contact for the child, youth or family with the CYMH service system and involves the collection of basic information about the child or youth requiring service. • Eligibility is determined based on the client's age (0 to 18 years), his or her presenting issues (mental health and other problems) and the core services available. • The intake process also includes obtaining informed consent from the youth and/or a parent or guardian on behalf of a child or youth who lacks the capacity to provide consent to receive a particular service or treatment. • The identification of strengths, needs and risks begins at intake (which includes basic information gathered through intake or brief services). For clients requiring more than brief services a more thorough process is engaged to specify strengths and needs. • This information is used to identify service and treatment needs, triage and prioritize children and youth for service when the level of risk is high, inform the development of a service/ treatment plan, identify areas of strength to build upon and to establish a baseline for outcome monitoring and measurement.

Core Service	Detail Code
A353 Intensive Treatment Services	• Intensive treatment services include: intensive in-home services, out-of-home services and day treatment, and may be supported by respite services where the respite is part of an integrated, customized service plan. • Intensive treatment services are provided in the least restrictive settings in local communities as close to home as possible, and are targeted to children and youth with significant mental health disorders, who require intensive intervention for a defined period of time, or who require intensive intervention periodically throughout their life span, to maintain functioning in their home, school or community. • Intensive treatment services should be customized to meet the individualized needs of each child or youth, and family, and can be provided in variety of settings, including in the home or out-of-home (e.g., a community, school or residential facility or a licensed residential setting such as a group home or foster home), matching the child, youth or family's level of need with the appropriate level of service (e.g., only those most in need will receive intensive services). • Flexibility in the provision of intensive treatment services will assist with smooth and timely transitions for children and youth to less intensive and disruptive forms of treatment and support as their needs fluctuate.
A354 Service Coordination Process	• Coordination of services begins with the development of an individualized plan for service delivery. The plan is reviewed throughout treatment to monitor the client's progress. • The service plan identifies the needs to be addressed, the services to be provided, who has responsibility for provision, and the goals to be achieved. • Service plans are to be reviewed on a regular basis and updated when needs change or when services are added, changed or completed. • Ongoing monitoring provides evidence as to whether treatment is having the intended impact and, if it is not, drives necessary changes in treatment to be reflected in the service plan. The process may identify the potential need to increase or decrease the intensity of services (step-up or step-down) and can be used to inform transitions to more or less intensive services or treatments and for discharge planning. Ongoing monitoring also provides a basis for outcome measurement and reporting. • Post-intervention transition planning and preparation represents a planned process for preparing children, youth and families for transitioning between services, or ending services when a transition from treatment has been negotiated. This is accomplished through the establishment of clear goals for treatment, as well as ongoing analysis and use of information to track progress and determine timing for transitioning to a new service or for discharge. • Transition supports are provided as required to facilitate the successful movement of a child or youth with chronic, complex mental health needs to services in another setting, community or sector, such as the adult mental health sector. Transition supports facilitate continuity of care and result in minimal disruption to treatment gains.
A355 Specialized Consultation/ Assessment Services	• Specialized consultation and assessments are clinical consultations and diagnostic assessment services designed to provide advice or direction in the diagnosis, prognosis or treatment of a child or youth with identified mental health needs. • Specialized consultation and assessments are not stand alone or "front-door" services. Children and youth may only receive a specialized consultation or assessment if it is deemed a necessary component of the individual's mental health treatment by the service provider. • Examples of specialized consultations and assessments include, but are not limited to, psychological consultation and assessments, and psychiatric consultation and assessments, which for remote, rural and underserved communities may be accessed through videoconferencing technology, such as Tele-Mental Health. • Specialized consultation and assessments are intended to address the mental health needs of the child or youth and are not intended to solely address or identify the need or eligibility for services funded by programs other than mental health (e.g., educational placement purposes, eligibility for autism behavioural intervention services).
A356 Targeted Prevention Services	• Targeted prevention services focus on changing views and behaviours, building skills and competencies, and creating awareness and resiliency through the provision of information, education and programming to specific at-risk population. • Targeted prevention services reduce the risk of child and youth mental health problems through specific therapeutic activities that either intervene in or avert the development or occurrence of a mental health problem. • Targeted prevention programs may occur in a variety of settings, including education, health and the community, and may involve health practitioners and educators as partners.

4.4 Data element definitions

Short Name	Name	Definition
INDSER#	**Number of Individuals Served**	The number of individuals for whom a record has been created and who were recipients of the approved service(s) at some point during the fiscal year.
MHWT#	**Number of Days Children/ Youth Waited for Service**	The number of days between the initial contact date and the start date for service provided to a child or youth in the reporting period. The initial contact date is the date the child or youth or family member contacted the agency for service or treatment. The start date is defined as the date the worker or therapist delivering the service has first contact with the child or youth or family member to focus on the goals identified for treatment.
MHSD#	**Number of Elapsed Days (Service Duration) of Service Received by Children/Youth**	The number of days elapsed between the start and end dates for a particular core service provided to a child or youth in the reporting period. The start date is defined as the date the worker or therapist delivering a particular service has first contact with the child or youth to focus on the goals identified for treatment. The end date is defined as either the date of last contact between the worker or therapist and the child or youth or the date when the particular service is determined to have ended based on client preference (i.e., opting out), goal attainment or change in eligibility.
HOUDIRS#	**Number of Hours of Direct Service**	The total number of hours of "direct" service provided by staff to individuals during the fiscal year for a particular service. Direct hours: The hours spent interacting, whether in a group or individually, either face to face or on the phone. It does not include work done "on behalf of" clients, such as telephone calls, advocacy, etc. Administrative support to the service is not to be included. For group service, one hour of service equals one hour of service for the entire group. For example: one hour of group service with five participants equals one Hour of Direct Service. (Note: each individual in the group is recorded under "no. of individuals served" where there is a record.)
BSNOS#	**Number of Children/Youth Requiring No Further Services Following Brief Service**	The number of children/youth receiving brief service who require no additional or further service from the service provider as determined by/with the client at the end of, or within one month of, receiving the brief service. Children/youth are counted only once in a fiscal year in this data element. Children/youth deemed to require additional service following brief service are not included in this count. Children/youth initially deemed as not requiring additional service, but after one month or more are identified as requiring additional service, are included in this count for the first instance.
MHBNA#	**Number of Children/Youth with Behavioural Assessed Needs**	The number of children/youth receiving service and having Behaviour as a priority need for service/treatment based on an initial needs assessment using a standardized tool. If a child/youth has two or more priority needs identified through assessments these will be captured separately.
MHENA#	**Number of Children/Youth with Emotional Assessed Needs**	The number of children/youth receiving service and having Emotion as a priority need for service/treatment based on an initial needs assessment using a standardized tool. If a child/youth has two or more priority needs identified through assessments these will be captured separately.
MHSNA#	**Number of Children/Youth with Social Assessed Needs**	The number of children/youth receiving service having Social as a priority need for service/treatment based on an initial needs assessment using a standardized tool. If a child/youth has two or more priority needs identified through assessments these will be captured separately.
MHSUNA#	**Number of Children/Youth with Substance Use Assessed Needs**	The number of children/youth receiving service having Substance Use as a priority need for service/treatment based on an initial needs assessment using a standardized tool. If a child/youth has two or more priority needs identified through assessments these will be captured separately.

Short Name	Name	Definition
MHTNA#	**Number of Children/Youth with Trauma Assessed Needs**	The number of children/youth receiving service having Trauma as a priority need for service/treatment based on an initial needs assessment using a standardized tool. If a child/youth has two or more priority needs identified through assessments these will be captured separately.
MHCNA#	**Number of Children/Youth with Complex Assessed Needs**	The number of children/youth receiving service having more than one priority need requiring multiple services/treatments and/or multiple service providers based on assessed needs using a standardized tool. Children/youth will be counted only once per fiscal year in this data element.
FSFAMSER#	**Number of Families Served**	The number of families that received support services at some point during the fiscal year. This is a cumulative number and a family is reported in the initial quarter in which they received services and counted only once during the fiscal year.
TPPART#	**Number of Participants in Sessions/Workshops/ Training**	The total number of individuals participating in skill building or educational sessions/workshops/training to assist with building parenting skills, child/youth management skills, self-management, anger management, risk reduction, resiliency building, etc. Participants are counted each time they attend a program within the fiscal year. If a program (a workshop or seminar) lasts more than one day, a person is counted once, whether or not the person attended more than one day or whether they attended only part of the workshop or seminar.
MHUCYS#	**Number of Unique Children/ Youth Eligible for Service**	The total number of unique children/youth who were eligible for and consented to receive CYMH services from the service provider or its partners/sub-contractors, and for whom a record has been created, within one fiscal year. A child/youth cannot be counted more than once in a fiscal year in this data element. A child/youth is to be reported once in the initial quarter in which he/she was first deemed eligible and consent was provided to receive CYMH supports and services. If active service occurs across more than one fiscal year, the child/youth is to be counted once in each fiscal year. For example, a child/youth began receiving service on March 15 and ended this instance of service on July 15. On July 15, the individual is placed on a waitlist to receive another service and begins a second service on September 12 that ends on January 20. This individual would be counted as a unique client once in the fourth quarter of the first fiscal year and once again in the first quarter of the second fiscal year.
MHGM#	**Number of Children/Youth by Gender – Male**	The number of children/youth eligible for mental health services having male gender. Children/youth would be counted only once in this data element.
MHGF#	**Number of Children/Youth by Gender – Female**	The number of children/youth eligible for mental health services having female gender. Children/youth would be counted only once in this data element.
MHGO#	**Number of Children/Youth by Gender – Other**	The number of children/youth eligible for mental health services having gender of other (i.e., other than male or female). Children/ youth would be counted only once in this data element.
MHINA#	**Number of Initial Needs Assessments**	The number of children/youth with an initial needs assessment performed at or following intake, using a standardized tool to identify strengths and needs to inform service/treatment planning. If a child/youth has two or more needs assessments completed during service, only the initial needs assessment would be counted in this data element.
MH0-5#	**Number of Children and Youth Ages 0–5**	The number of children and youth who are deemed eligible for and have consented to service and who are between the ages of 0 and 5 (inclusive) at the date of intake or at the start of the fiscal year if service carries over.
MH6-10#	**Number of Children and Youth Ages 6–10**	The number of children and youth who are deemed eligible for and have consented to service and who are between the ages of 6 and 10 (inclusive) at the date of intake or at the start of the fiscal year if service carries over.
MH11-14#	**Number of Children and Youth Ages 11–14**	The number of children and youth who are deemed eligible for and have consented to service and who are between the ages of 11 and 14 (inclusive) at the date of intake or at the start of the fiscal year if service carries over.
MH15-18#	**Number of Children and Youth Ages 15–18**	The number of children and youth who are deemed eligible for and have consented to service and who are between the ages of 15 and 18 (inclusive) at the date of intake or at the start of the fiscal year if service carries over.

Short Name	Name	Definition
MHCNA#	**Number of Children/Youth with Complex Assessed Needs**	The number of children/youth receiving service with more than one priority need requiring multiple services/treatments and/or multiple service providers based on assessed needs using a standardized tool. Children/youth will be counted only once per fiscal year in this data element.
MHENDCY#	**Number of Children/Youth Who Ended Service**	The number of children/youth who ended their CYMH services in a quarter. A child/youth is to be reported in the initial quarter in which he/she stops receiving CYMH supports and services and is discharged from the agency/ service provider. Reasons for ending can include: service/treatment plan is complete and goals have been achieved, client has opted out of treatment/service, client is no longer eligible to receive service. A child/youth may be counted multiple times during the fiscal year if he/she returns for additional service and is re-opened as a client to the agency.
POSOC#	**Number of Children/Youth with Positive Outcomes**	The number of children/youth who have ended service and who display positive outcomes at end of service (once service plan is complete and/or discharge is planned). Positive outcome is determined based on the following: 1. Reduction in severity of needs or symptoms, and/or 2. Improvement in functioning/enhanced strengths, and/or 3. Successful attainment of majority (more than 50%) of treatment goals, and 4. Concurrence of child/youth or caregiver that outcome was positive.
CPOSOC#	**Number of Caregivers/Youth Reporting Positive Outcomes**	The number of caregivers and/or youth who have ended service and who report that positive outcomes have been achieved at end of service (once service plan is complete and/or discharge is planned). Positive outcome is subjective and based on caregiver/youth perception of the following: 1. Reduction in severity of needs or symptoms, and/or 2. Improvement in functioning/enhanced strengths, and/or 3. Successful attainment of majority of treatment goals, and 4. Other considerations.
CPOSEX#	**Number of Caregivers/Youth Reporting Positive Experience with the Service System**	The number of caregivers and/or youth who have ended service and who report a positive experience with the service system at end of service (once service plan is complete and/or discharge is planned). Positive experience of the service system is subjective and based on caregiver/youth perception of the following: 1. Reasonable length of time waiting for service, and/or 2. Extent to which service plan was integrated and coordinated, and/or 3. Involvement of client/caregiver in key service-related decisions, and/or 4. Transitions/referrals were supported and timely.
TPPART#	**Number of Participants in Sessions/Workshops/ Training**	The total number of individuals participating in educational sessions/workshops/training to assist with building parenting skills, child/youth management skills, self-management, anger management, risk reduction, resiliency building, etc. Participants are counted each time they attend a program in a fiscal year. If a program (a workshop or seminar) lasts more than one day, a person is counted once, whether or not the person attended more than one day or whether they attended only part of the workshop or seminar.

4.5 Child and youth mental health transfer payment budget package: rules for data element reporting in 2016/17

Rule	Explanation
1. Data should only be reported through the transfer payment budget package for funding provided by the Ministry of Children and Youth Services (MCYS) for Child and Youth Mental Health (CYMH) services.	
2. Clients are counted only once in the INDSER# data element per detail code per fiscal year.	• Example: If a client received individual, group and family therapy (A349) within a fiscal year he or she is counted only once in that fiscal year. If the same client received brief service (A348) and individual therapy (A349) within the fiscal year, he or she is counted once for each detail code (i.e., twice). If the same client received brief service in March and again in April (a new fiscal year), he or she is counted once in each fiscal year (i.e., twice).
3. Wait times (MHWT#) in days are reported separately for Brief, Crisis, Counselling/Therapy and Intensive services.	• Wait time (MHWT#) is the total number of days waited for Brief, Crisis, Counselling/Therapy and Intensive core service for individuals served by these services (e.g., the total number of days waited by all individuals receiving Brief Services). Wait time is based on the difference in days between the initial contact date and the service start date. Both dates are required. This is not an average; it is the total number of days. Services that are provided on the same day (e.g., Crisis Services) would register as a wait time of one day. • Note: As individuals are only counted once per fiscal year per core service (Rule 1), they will only have one wait time per core service per fiscal year. For example, if a child returns for crisis service multiple times in a fiscal year, the wait time for crisis for that child would be calculated and reported once.
4. Wait time begins at the initial contact date for Brief, Crisis, Counselling/Therapy and Intensive services, regardless of when the service need was identified.	• Wait time begins on the date the client or parent first contacts a CYMH agency for service, regardless of which CYMH agency is contacted (e.g., centralized access where the CYMH service is provided by another CYMH agency in the service system). • Note: If a client is discharged and returns for service more than 12 months later, a new initial contact date is established. It is assumed the client will require a new needs assessment and service plan. • If a client is discharged and returns within 12 months, it is assumed that the client's needs have not changed, and additional services are required to address the original identified needs; therefore, the original initial contact date is to be used (see Rule 11 below for more detail).
5. Wait time days are counted over quarters and the fiscal year end.	• Example: If the initial contact date was in Q4 of one year and service started in Q2 of the following year, the number of wait time days would be the difference between the two dates.
6. Elapsed days of service (i.e., service duration – MHSD#) are reported separately for Brief, Crisis, Counselling/ Therapy and Intensive services.	• Service duration is the total number of days between the start date and end date of a particular service for the total number of children receiving that service. Both dates are required. This is not an average; it is the total number of days. • Service duration is calculated at a detail code level.

Rule	Explanation
7. For service subtypes funded by the same detail code, the start date is the date the first service subtype started; the end date is the date the last service subtype ended.	• Example: Individual therapy, group therapy and family therapy are subtypes of Counselling/Therapy (A349). If a child or youth received service from more than one of these subtypes, service duration would be inclusive of all of them and would include waiting periods in between. • Intensive in-home, day treatment and residential are subtypes of Intensive Services (A353); if a child or youth received more than one of these subtypes, service duration would be inclusive of all three and would include waiting periods in between.
8. Direct service hours (HOUDIRS#) are from a staff-provided perspective and are reported separately for Brief, Crisis, Counselling/Therapy and Intensive services.	• Direct service can include telephone or technology interactions and can be with parents, caregivers or clients. • Residential direct service hours = hours/day x days/year x full-time equivalent (FTE) minus percentage spent on administration (record keeping); for example, (24 x 365 x 5) – 10% = 39,420 hours). • Group treatment service hours = # FTE providing group treatment x #hours x #clients x #days of treatment.
9. For A352 intake/access, the "number of unique children/youth eligible/consenting to service" (MHUCYS#) is the total count of unique CYMH "clients" open to an agency in a fiscal year.	• The count includes those waiting for, receiving or between services. • The count is irrespective of which CYMH service door the clients came through (e.g., agency intake, centralized intake, brief, crisis or school). • Clients are first counted in the quarter in which they become "clients" (i.e., had a client record created by the agency). It is a cumulative count. • Clients are counted in each fiscal year they are 'open' to the agency (waiting for, receiving and/or between services) even if they never receive service (i.e., drop out). • The primary client to be counted is the child or youth aged 0 to 18 years. • If a young parent is also receiving CYMH services, both the parent and child may be considered clients of the CYMH agency if each meets the service eligibility criteria (i.e., are aged 0 to 18 years, have a mental health risk or need).
10. The counts by gender (MHGF#, MHGM#, MHGO#) and age (MH0-5#, MH6-10#, MH11-14#, MH15-18#) category sum to the total count of unique CYMH clients (MHUCYS#).	• For MH15-18#, CYMH agencies are to count individuals older than 18 years.
11. The number of initial needs assessments (MHINA#) represents the number of unique clients (MHUCYS#) open to the agency that have had their needs assessed or identified using a standardized tool.	• A standardized tool is one that has been tested for validity and reliability. It is not a tool that an agency has developed and implemented without ensuring the tool has been tested and is valid and reliable. (Note: This is not the same as a specialized assessment or consultation provided by a specialist, such as a psychiatrist.) • The count for MHINA# can include initial needs assessments performed by another agency or by centralized intake using a standardized tool and referred for CYMH service. • Initial refers to the first needs assessment; subsequent needs assessments are not being counted at this time. The count for MHINA# should not exceed the total number of unique CYMH clients (MHUCYS#). • If a client had needs assessed using a standardized tool and remains an open case for the agency over the fiscal year end, the client is counted in each fiscal year, and would continue to be reported as having initial needs assessed using a standardized tool. • If a client had needs assessed using a standardized tool, received service, was discharged and returned more than 12 months later for service, it would be expected that a new initial needs assessment would be completed before counting the client in MHINA#. • It is expected that a proportion of clients will not have needs assessed using a standardized tool (e.g., those accessing Crisis or Brief services).
12. For Family/Caregiver Support, one family per client is counted in the number of families data element (FSFAMSER#) even if the family is comprised of multiple units (e.g., separated, divorced, extended).	• If a client has siblings who are also clients (i.e., each has a client record), the family can be counted for each sibling (i.e., one family per client). • Therapeutic services for family members that include treatment goals and outcomes (i.e., family therapy) are more appropriately aligned with Counselling/Therapy Services detail code A349.

Rule	Explanation
13. Clients receiving Counselling/Therapy Services are categorized based on identified needs (e.g., behavioural, emotional, social, substance use, trauma, complex).	• Needs can be identified based on clinical formulation, including multiple methods, presenting issues, standardized tools, etc. • To balance the burden on agencies, not all need categories are represented. • Standard descriptions of need categories are provided in Service Planning and Outcome. • A monitoring form is provided in the toolkit.
14. For the Intensive Service detail code, the number of individuals served (INDSER#) is reported both overall and for four subservices.	• The following are subsets of INDSER# for Intensive Service: – The number of individuals receiving residential service (RESSER#) – The number of individuals receiving day treatment service (DTSER#) – The number of families served in-home (INFAMSERV#) – The number of children and youth receiving intensive out-of-home respite (OUTCHILD#).
15. For Specialized Consultation/Assessment, one client may have multiple consultations or assessments.	• The number of client consultations (CLIENTCON#) represents the total number of consultations and assessments provided by a specialist about a client (the client may or may not be present). If there are multiple consultations and assessments about one client, all are counted. • The number of program consultations (PROGCONAS#) represents the total number of consultations provided by a specialist about a particular program (e.g., day treatment). • The number of education sessions (EDSESSAS#) represents the total number of education sessions provided by a specialist to staff or professionals (e.g., on symptoms of early psychosis).
16. For Targeted Prevention, the number of participants (TPPART#) represents the total number of individuals participating in a training, in a session or a workshop.	• This can include clients but can also represent non-registered individuals (e.g., a classroom of students known only by their first names). • If the same individual participates in more than one workshop, he or she is counted each time they attend. If a workshop is two days in length and the same individual participates on both days, he or she is counted once for the two-day session.
17. For the Service Coordination detail code, the number of children/youth who ended service (MHENDCY#) is the total count of unique CYMH clients (MHUCYS#) who are discharged from an agency (or from an agency's CYMH services) by fiscal year end.	• This includes those who received services and whose CYMH service plans were completed and those who dropped out or did not receive any CYMH service. • This number (MHENDCY#) should not exceed the total number of unique children and youth served by the agency in a fiscal year (MHUCYS#).
18. The number of children/youth with positive outcomes (POSOC#) is a subset of the discharged CYMH clients (MHENDCY#) and represents the number having positive outcomes based on the definition provided.	• Definition of positive outcome: symptoms decreased or improved and/or functioning improved and most treatment goals were attained and the client would agree the outcome was positive. • To inform this data element, clinicians are expected to monitor client feedback on progress over time, including that of clients who drop out before treatment is complete. • Children and youth receiving any CYMH treatment services (including Brief Services) are to be considered for this data element.
19. The number of caregivers/youth reporting a positive outcome (CPOSOC#) is based on survey or verbal responses by parents, caregivers or youth and is reported to represent their voice.	• Sample survey questions to elicit this data are contained in the toolkit provided to agencies.
20. The number of caregivers/youth reporting a positive experience (CPOSEX#) is based on survey or verbal responses by parents, caregivers or youth, and is reported to represent their voice.	• Sample survey questions to elicit this data are contained in the toolkit provided to agencies.
21. The number of children and youth requiring transitions at the end of CYMH service (SCTCY#) represents those clients who require other types of supports or services following discharge from an agency or an agency's CYMH services.	• The transition can include supports for children and youth transitioning out of CYMH services to other types of services, including adult mental health and addiction services, developmental services, etc. • For multiservice agencies, the transition may represent an internal transfer or referral. This number (SCTCY#) should not exceed the number of children who ended service (MHENDCY#).

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