The Mental Health of Children and Youth in Ontario

A Baseline Scorecard Summary

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ICES

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SUMMARY

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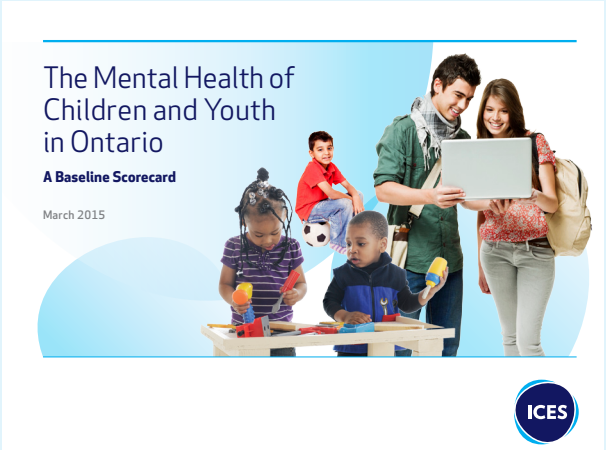

The full report and technical appendix are available at **www.ices.on.ca.**

About the Baseline Scorecard

The Government of Ontario's Comprehensive Mental Health and Addictions Strategy, Open Minds, Healthy Minds, was released in June 2011. In its first three years, the strategy has focused on children and youth. The Ministry of Health and Long-Term Care has tasked the Institute for Clinical Evaluative Sciences (ICES) with developing a baseline scorecard for child and youth mental health.

The baseline scorecard describes:

- the contexts of the populations at risk
- the existing processes of mental health and addictions care provided to children and youth in Ontario
- the state of relevant child and youth mental health and addictions outcomes

The baseline scorecard is made up of two types of indicators:

- contextual indicators, which describe the state of child and youth mental health and addictions service provision in Ontario
- performance indicators, which can be used to track mental health and addictions system performance and outcomes over time

The baseline scorecard used the most current data that were available for these indicators in 2013/14; this was restricted to ICES health administrative data, population-based survey data and school-level education data. Consequently, the ability of these indicators to comprehensively describe the potential impact of the Comprehensive Mental Health and Addictions Strategy is limited.

As the Comprehensive Mental Health and Addictions Strategy matures, more data may become available (e.g., from community-based children's mental health agencies, youth justice and post-secondary education) and linkable across sectors. This set of indicators will also be expanded, so as to tell a more complete story of child and youth mental health in Ontario.

Key Findings

Prevalence of mental health disorders varied by sociodemographic characteristics.

- Immigrants and non-immigrants reported similar rates of mood and anxiety disorders, but immigrants were less likely to have alcohol and drug problems.
- The treated prevalence of schizophrenia was higher in refugees than in non-refugee immigrants and non-immigrants. This disorder was also much more prevalent among those living in the lowest-income neighbourhoods.
- Babies of mothers who were young, who lived in the lowest-income neighbourhoods, or who lived in the North West Local Health Integration Network (LHIN) had much higher rates of neonatal abstinence syndrome than other babies.
- Children and youth living in the lowest-income neighbourhoods had the highest suicide rates. Rates of suicide were six times higher in the North West LHIN than in the other 13 LHINs.
- Rates of emergency department visits for self-harm were higher for children and youth living in the lowest-income neighbourhoods and in northern Ontario, a pattern similar to that found in suicide rates. However, emergency department visits for self-harm were higher for refugees than for non-refugee immigrants, the reverse of the observed pattern in suicide rates.
- Children and youth living in the lowest-income neighbourhoods had the highest rates of acute care mental health service use (emergency department visits and hospitalizations).
- Rates of behavioural issues identified by the education system were highest in the LHINs in northern Ontario.

Prevalence trends increased over time.

- There was a fourfold increase in the prevalence of neonatal abstinence syndrome over 10 years.
- There was an upward trend in emergency department visits and hospitalizations for anxiety disorders.

Rates of physician visits for mental health and addictions were linked to where children and youth lived.

- The number of children and youth seen by psychiatrists increased over time, but there were large regional differences in rates of visits to psychiatrists.
- Rates were highest among LHINs with academic health sciences centres where a larger supply of child psychiatrists per capita would be expected.
- Children and youth living in the highest-income neighbourhoods saw psychiatrists most often.
- Wait times to see mental health specialists were very long across the province but longest in rural areas.

Use of physician-based mental health and addictions services was not always aligned with need.

- Regions with higher need, as demonstrated by higher rates of substance use, neonatal abstinence syndrome, hospital admissions, emergency department visits, suicide and behavioural issues, are also areas where there are fewer outpatient services and resources, the longest wait times and the lowest rates of mental health visits by all physician types.
- Outpatient physician services were used the least in regions having the greatest social disadvantage and high rates of substance use, emergency department visits, hospital admissions, deaths by suicide and behavioural issues. This suggests a misalignment between need for and availability of services.
- Neighbourhood income levels were inversely related to rates of indicators that are linked to high service needs (e.g., emergency department visits and hospital admissions). Conversely, children and youth living in high income neighbourhoods had higher rates of outpatient physician visits. This suggests that socioeconomic status is associated with better access to physician mental health services.
- Although children and youth in northern Ontario had a high prevalence of mental health and addictions problems and school-related behavioural issues, they had the lowest rates of physician-based mental health care (with the exception of telepsychiatry).
- Refugee children and youth had a high treated prevalence of schizophrenia, the highest rates of emergency department visits (including visits for self-harm), high acute care revisit rates and, among the youth correctional centre population, the highest use of mental health and addictions services. These indicate that refugee children and youth are a high need population. However, this group also had high rates for overall mental health-related physician visits (including psychiatrist visits).

Targeted investments in services were associated with improved access to mental health and addictions care.

- Out-of-country treatment for eating disorders decreased significantly after implementation of a systematic referral screening process in Ontario in 2008.
- Rates of telepsychiatry increased dramatically after 2009/10, particularly in remote regions with a low per capita supply of psychiatrists.

Limitations

The work outlined in the scorecard has several limitations.

- There were very few validated performance measures for child and youth mental health and addictions systems. For indicators without pre-existing validation, expert opinion was used as face validity of the measures and, in particular, their relevance to the strategy initiatives.

- Data-related limitations included different biases introduced by using different data sources; no data for certain populations (e.g., Aboriginal and other ethnocultural groups) and service delivery areas (e.g., community- and school-based mental health services); and an inability to link data across sectors. Since multiple sectors (e.g., health care, community-based care, youth justice, child welfare and education) are involved in identification and treatment of mental health issues, linkage of data across these settings would allow for a more robust understanding of the trajectories of care and outcomes.

The interpretation of the scorecard indicators, individually and as a whole, is complex and somewhat limited. Because the data were collected largely prior to implementation of the Comprehensive Mental Health and Addictions Strategy, the scorecard cannot be seen as a measure of the strategy's impact. As the strategy matures and data become more comprehensive, our ability to paint a richer and fuller picture of child and youth mental health in Ontario and to more directly measure the impact of the mental health and addictions strategy will be enhanced.

Future Directions

The baseline scorecard is a snapshot of the state of various context and system performance indicators from data available in 2013/14. These indicators are directly or indirectly relevant to the Government of Ontario's Comprehensive Mental Health and Addictions Strategy. As implementation of the strategy continues, the scorecard will be updated so that trends can be compared over time. The baseline scorecard outlines a number of actions.

Standardized performance measurement

A system can be responsive only when performance is measured systematically. There are currently no plans to mandate a single standardized outcome measurement tool to be used by child and youth mental health agencies funded by the Ministry of Children and Youth Services. Instead, they are required to report on a standardized set of data elements that will include some outcome measures. Future child and youth mental health performance measurement would be enhanced by widespread, cross-sectoral adoption of standardized assessment.

Ongoing scorecard development

Future evaluation of the Comprehensive Mental Health and Addictions Strategy (and any future intervention on child and youth mental health and addictions) depends on the capacity to measure individual-level outcomes longitudinally and the ability to link data from different sectors (e.g., education, community-based child and youth mental health, postsecondary education, youth justice). To generate a longitudinal perspective, the contextual and performance indicators in this baseline scorecard will be monitored by replicating the scorecard every two years. Additional surveillance surveys (e.g., the 2012 Canadian Community Healthy Survey; the 2014 Ontario Child Health Study) will be incorporated to update the contextual indicators (e.g., prevalence, social risk factors). More indicators will be included as further administrative and population health data become available, or as it becomes possible to link data across sectors.

Data linkage proof-of-principle project

Kinark Child and Family Services is a Ministry of Children and Youth Services–funded organization that provides mental health services to residents of Durham, Northumberland, Peterborough, Simcoe and York counties. In partnership with Kinark, ICES has created a linked dataset that combines administrative data from a large, community-based children's mental health organization with health administrative data from the province of Ontario. These data can provide a proof of principle by demonstrating how concurrent mental health service use and patterns may be explored. The utility and importance of data linkage for the baseline scorecard will be illustrated by measuring pathways of care (e.g., Kinark clients' presenting at emergency department), performance (e.g., Kinark clients presenting at emergency department or being admitted to hospital during or after community treatment) and system integration (e.g., Kinark clients co-managed by family practitioners or psychiatrists).

Child and Youth Linkable Data Repository

ICES has proposed the development of an integrated repository of record-level, linkable and encoded data on Ontario children and youth that will span multiple ministries and sectors. To mitigate risks to privacy, ICES is investigating methodologies to integrate encoded data in such a manner that they cannot be re-identified.

Mental health and addictions service delivery

In recognition of the challenges of the current community-based mental health system for children, youth and families, the Ministry of Children and Youth Services (MCYS) is leading the implementation of Moving on Mental Health, an action plan to transform the community-based mental health system. As part of the plan, 34 service areas have been identified, and lead agencies in each of them will be responsible for analyzing, planning, funding, monitoring and evaluating child and youth mental health services.

Telepsychiatry is enabling greater access to mental health care. The MCYS-funded Tele-Mental Health Service was enhanced in 2013/14 to provide more care to children and youth in rural, remote and underserved communities through the expansion of technology, linkages with telemedicine, establishment of coordination agencies and more service access sites.

In addition, Health Links is an emerging development from the Ministry of Health and Long-Term Care whereby interprofessional teams of primary care providers and specialists are organizing to provide more integrated care for individuals with complex needs, including children and youth with mental illnesses or addictions. Linkages between Health Links, the lead child and youth mental health agencies, and specialized mental health care providers could improve integration of mental health care and address the transitional needs of individuals moving from the child and youth mental health system to the adult system or between hospitals and community-based care. These changes in service delivery may also have implications for the availability of new data for future monitoring of child and youth mental health in Ontario. For example, in the future, the 34 MCYS child and youth mental health lead agencies will be required to report on a standardized set of data elements, including some measures of outcome.

About the Institute for Clinical Evaluative Sciences

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

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