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## Child and Youth Mental Health and Addictions in Ontario Briefing Note March 2, 2015

### What we know

Child and youth mental health and addictions service delivery in Ontario is complex and is offered through a number of different channels including the health care system, primary and post-secondary education, and community and social services. In July 2011, Ontario's Comprehensive Mental Health and Addictions Strategy, *Open Minds, Healthy Minds*, was released as an effort to examine and address how these services are delivered.

The presentation and effects of mental illness and addictions can span a lifetime; however, up to 70 percent of mental health problems begin in childhood or adolescence. As many as one in five people in Ontario between the ages of four and 16 experience some form of mental health problem at any given time, yet fewer than one in six children and youth receive the specialized treatment services they require.<sup>1,2</sup>

To address this issue, the first three years of *Open Minds, Healthy Minds* focused on children and youth. Four government ministries (Children and Youth Services; Education; Health and Long-Term Care; and Training, Colleges and Universities) collaborated to create a strategy aimed at: providing fast access to high-quality services, identifying and intervening in the mental health needs of children and youth early, and closing service gaps for children and youth with unique needs.

On March 2, 2015, ICES released [\*The Mental Health Of Children and Youth Ontario: A Baseline Scorecard\*](#).<sup>3</sup> This report is a snapshot of the characteristics of children and youth at risk, how mental health and addictions care is delivered to this population, outcomes related to their mental health and addictions, and a discussion about significant service and data gaps that exist. This report represents the first attempt in Canada to fill the gap in population-based mental health research on children and youth. Presented below are selected findings from this report.

### What the baseline scorecard tells us

#### The prevalence of mental health disorders varies by geography and income, for example:

- Compared to those in the highest-income neighbourhoods, children and youth living in the lowest-income neighbourhoods had the highest rates of:
  - suicide (6.8 vs. 5.4 deaths by suicides per 100,000 children and youth aged 10 to 24 in the lowest- and highest-income neighbourhoods, respectively);
  - emergency department visits for deliberate self-harm (24.0 vs. 15.1 visits per 10,000 children and youth aged 10 to 24);
  - acute care mental health service use (11.1 vs. 7.4 emergency department visits for mental health reasons per 1,000 children and youth aged 0 to 24 and 2.4 vs. 1.7 mental health-related hospitalizations per 1,000 children and youth);
  - treated prevalence of schizophrenia (17.1 vs. 8.5 individuals per 10,000 children and youth aged 0 to 24).

- 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 (NAS) — a withdrawal syndrome observed in the babies of mothers who are either using opioids or being treated for opioid dependence with methadone — than other babies. Rates of NAS were:
  - more than five times higher in babies born to mothers who had their first child prior to the age of 20 (9.2 vs. 1.6 babies per 1,000 hospital births);
  - 2.5 times higher in babies from the lowest income neighbourhoods compared to the highest-income neighbourhoods (7.2 vs. 2.7 babies per 1,000 hospital births);
  - 58 times higher in the North West LHIN compared to the Central LHIN, which had the lowest rate (52.8 vs 0.9 babies per 1,000 hospital births).
- Rates of suicide were six times higher in the North West LHIN (33.2 deaths by suicide per 100,000 children and youth aged 10 to 24) than in the other 13 LHINs.
- Children in LHINs in Northern Ontario had the highest rates of behavioural issues identified by the education system (the North East LHIN had behavioural issues identified 5 times more frequently than in the lowest LHINs, Central West and Mississauga-Halton; 18.8 vs. 3.4 per 1,000 K-12 students in schools where the primary language of instruction is English).

**Rates of service use and prevalence of mental health issues vary by immigration status, for example:**

- Emergency department visits for deliberate self-harm were higher for refugees than for non-refugee immigrants (12.6 vs. 9.7 per 10,000 children and youth aged 10 to 24), the reverse of the observed pattern in suicide rates (2.5 vs. 3.3 deaths by suicide per 100,000 children and youth aged 10 to 24).
- The treated prevalence of schizophrenia was 1.5 times higher in refugees than in non-refugee immigrants and more than two times higher than in non-immigrants (26.3 vs. 18.0 vs. 11.0 per 10,000 children and youth aged 0 to 24, respectively).
- 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 outcomes indicate that refugee children and youth are a vulnerable population. However, this group also had high rates for overall mental health-related physician visits (including psychiatrist visits).

**Prevalence trends for some disorders increased over time, for example:**

- Over the 10-year period from 2002/03 to 2011/12, there was a fourfold increase in the prevalence of neonatal abstinence syndrome (from 0.9 to 5.1 babies per 1,000 hospital births).
- From 2006/07 to 2011/12, there was an upward trend in emergency department visits (from 3.2 to 4.5 visits per 1,000 children and youth aged 0 to 24) and hospitalizations for anxiety disorders (from 0.23 to 0.50 hospitalizations per 1,000 children and youth aged 0 to 24).

**Psychiatrist visits for mental health and addictions varied by geographic region, for example:**

- The number of children and youth seen by psychiatrists increased over time (from 15.7 per 1,000 children and youth aged 0 to 24 in 2002/03 to 20.3 per 1,000 in 2011/12), but there were large regional differences in rates of psychiatrist visits (e.g., there was a threefold difference between the Toronto Central LHIN and the North West LHIN, which had the highest and lowest rates respectively at 28.1 vs. 9.1 per 1,000 children and youth).
- Rates of psychiatrist visits were highest in LHINs with academic health sciences centres where a larger supply of child psychiatrists per capita would be expected (e.g., South West, Hamilton Niagara Haldimand Brant, Toronto Central, South East, Champlain).

- Children and youth living in the highest-income neighbourhoods saw psychiatrists most often (93.9 vs. 75.0 psychiatrist visits per 1,000 children and youth aged 0 to 24 living in the highest- vs. lowest-income neighbourhoods).
- Wait times to see a psychiatrist were very long (median of 45 days in 2011/12) across the province but were longest in rural areas.

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

- Regions such as the northern LHINs with higher needs as demonstrated by higher rates of substance use, neonatal abstinence syndrome, hospital admissions, emergency department visits, suicide and behavioural issues, are also areas with the longest wait times and the lowest rates of mental health visits by all physician types.
- Outpatient physician services were used the least in the northern regions (43.8 visits per 1,000 children and youth in the North West LHIN compared to 203.5 visits per 1,000 children and youth in the Toronto Central LHIN, the lowest and highest rates in Ontario) where there are high rates of substance use, emergency department visits, hospital admissions, and suicide and behavioural issues, suggesting a misalignment between need for and availability of services.
- Neighbourhood income levels were inversely related to indicators of high service needs:
  - Children and youth aged 0 to 24 from low-income neighbourhoods visited emergency departments for mental health and addictions reasons at a rate of 11.1 per 1,000 population, whereas children and youth from the highest-income neighbourhoods visited emergency departments at a rate of 7.4 per 1,000 population;
  - Children and youth aged 0 to 24 from low-income neighbourhoods were hospitalized at a rate of 2.4 per 1,000 population for mental health and addictions reasons, whereas children and youth from high income neighbourhoods were hospitalized at a rate of 1.7 per 1,000 population;
  - Conversely, children and youth living in high-income neighbourhoods had higher rates of outpatient physician visits (111.8 vs. 139.5 visits per 1,000 children and youth aged 0 to 24 from the lowest- and highest-income neighbourhoods, respectively). 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 [rates for addiction treatment were 25 times higher in the North West LHIN (highest rate) compared to the Central West LHIN (lowest rate) (55.9 vs. 2.2 per 10,000 children and youth aged 0 to 24)] and school-related behavioural issues, they had the lowest rates of physician-based mental health care (with the exception of telepsychiatry).

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

- Out-of-country treatments for eating disorders were reduced by 50 percent after implementation of a systematic referral screening process in Ontario in 2008.
- Rates of telepsychiatry quadrupled from 0.5 consultations per 10,000 children and youth in 2009/10 to 2.1 consultations per 10,000 children and youth in 2011/12, particularly in remote regions with a low per capita supply of psychiatrists.

## **Where do we go from here?**

Much of the scorecard data were collected prior to implementation of the Comprehensive Mental Health and Addictions Strategy and therefore its contents cannot be seen as a measure of the Strategy's impact. However, the scorecard indicators are considered a baseline that will be updated every two years to follow the progress of

the Strategy. These updates will provide a longitudinal assessment of changes in service delivery and population outcomes over time.

As the Comprehensive Mental Health and Addictions Strategy progresses, 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. ICES has proposed the development of an integrated repository of record-level, linkable and encoded data representing Ontario children and youth that will span multiple ministries and sectors. Linkable data will provide a more complete story of how children and youth are treated for mental health conditions and addictions and their outcomes.

## References

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