TRACKING ADVERSITY, MEASURING RESILIENCE:

DEVELOPMENT OF EARLY ADVERSITY AND RESILIENCE POPULATION HEALTH INDICATORS FOR ONTARIO



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This document was produced by the APHEO Ontario Early Adversity and Resilience (OEAR) Indicator Subgroup

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LIST OF ABBREVIATIONS

Abbreviation	Description
ACER CoP	Ontario Adverse Childhood Experiences and Resilience Community of Practice
ACEs	Adverse Childhood Experiences
alPHa	Association of Local Public Health Agencies
APHEO	Association of Public Health Epidemiologists of Ontario
ASQ	Ages and Stages Questionnaire
BIS	BORN Information System
BORN	Better Outcomes Registry & Network
CanDDIS	The Canadian Database of Development, Infancy to Six
CCHS	Canadian Community Health Survey
CDAC	APHEO Core Data Advisory Collaborative
CHSCY	Canadian Health Survey on Children and Youth
CIWG	APHEO Core Indicator Working Group
DAD	Discharge Abstract Database
EDI	Early Development Instrument
HBHC	Healthy Babies Healthy Children
HGD	Healthy Growth and Development
IC/ES	Institute for Clinical Evaluative Sciences
MCCSS	Ministry of Children, Community and Social Services
NACRS	National Ambulatory Care Reporting System
OEAR	Ontario Early Adversity and Resilience
OMHRS	Ontario Mental Health Reporting System
OPHS	Ontario Public Health Standards
OSDUHS	Ontario Student Drug Use and Health Survey
PHAC	Public Health Agency of Canada
PHO	Public Health Ontario
PHUs	Public Health Units
PMK	Person Most Knowledgeable of the child and/or youth
RBA	Results-Based Accountability



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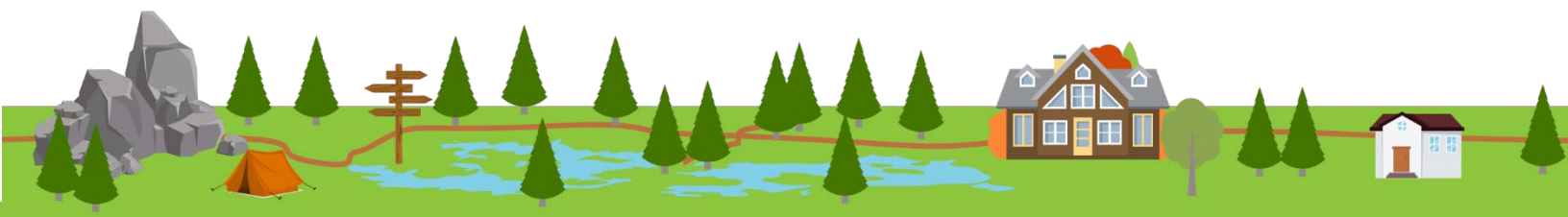
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EXECUTIVE SUMMARY

Early adversity and resilience are foundational determinants of population health, shaping physical, mental, and social outcomes across the life course and contributing to persistent health inequities. While public health has increasingly recognized the importance of addressing adverse childhood experiences (ACEs) and strengthening protective factors, measurement within Ontario's public health system has remained fragmented, with no standardized core set of population-level indicators to support consistent surveillance, comparison across regions, or monitoring of progress over time.

This report presents the results of a provincial, collaborative effort led by the Association of Public Health Epidemiologists of Ontario (APHEO) Ontario Early Adversity and Resilience (OEAR) Indicator Subgroup to identify, prioritize, and organize population-based indicators aligned with the Ontario Early Adversity and Resilience (OEAR) Framework. This work aims to support population health assessment, health equity-informed planning, cross-sector collaboration, and evaluation of OEAR Framework implementation across Ontario public health units (PHUs).

Using a multi-stage, iterative, consensus-based process, the subgroup reviewed existing population-level data sources available to Ontario PHUs. An initial list of 261 potential indicators was developed through an environmental scan of APHEO Core Indicators, PHU population health reporting practices, Public Health Ontario products, national surveillance frameworks, Government of Ontario reports, and expert consultation. Indicators were mapped to the OEAR Framework, screened using inclusion and exclusion criteria, and rated using adapted Results-Based Accountability criteria across three domains: communication power, importance/proxy power, and data power. Indicators were scored through facilitated group discussion and consensus.

Of the 261 potential indicators identified, 161 were retained for detailed review and rating. Through this process, 58 headliner indicators were prioritized for population-level surveillance in Ontario. These indicators align with the four focus areas of the OEAR Framework:

1. **Socially Connected, Equitable, and Inclusive Communities** (7 indicators)
2. **Social and Emotional Development and Resilience** (17 indicators)
3. **Reproductive Health and Parenting/Caregiver Readiness** (7 indicators)
4. **Responsive and Culturally Safe Parenting/Caregiving (**18 indicators)

In addition, the indicator set includes indicators measuring the prevalence of adverse childhood experiences (22 indicators), child and youth health and well-being outcomes related to early adversity and resilience (12 indicators), and key social determinants of health (5 indicators). The prioritized indicators provide balanced coverage across early years, middle years, and youth populations, with complementary indicators relevant to prenatal populations, parents, and households. Most indicators draw on existing, accessible data sources such as the Canadian Health Survey on Children and Youth (CHSCY), the Canadian Community Health Survey (CCHS), the Canadian Census, administrative health data available through IntelliHealth, the Early Development Instrument (EDI), and the Better Outcomes Registry & Network (BORN).

The review also identified emerging indicators, including measures available only to some PHUs, indicators in development by researchers, and indicators requiring further refinement. Importantly, several critical data gaps were identified, particularly in strengths-based measures of resilience, Indigenous-led and culturally grounded indicators, gender-based and intimate partner violence, parental substance use, and community-level social and built environment measures.



This report represents the first coordinated, province-wide effort to systematically identify and prioritize population-level indicators of early adversity and resilience aligned with a shared framework. The resulting indicator set supports the Ontario Public Health Standards by strengthening population health assessment, advancing health equity, and enabling more consistent monitoring of early adversity and resilience across PHUs. While many determinants reflected in the indicators extend beyond the direct control of public health, the data provides a critical foundation for upstream prevention, health promotion, and cross-sector collaboration.

As data availability and quality evolve, these indicators are expected to be refined over time through APHEO Core Indicator Working Groups and Core Data Advisory Collaboratives.

PHUs are encouraged to adopt the prioritized OEAR indicators as part of routine population health surveillance and to use them to inform local planning, prioritization, partnership development, and evaluation of efforts to prevent early adversity and build resilience among children, youth, and families across Ontario.

BACKGROUND

Early adversity and resilience are important determinants of population health, shaping outcomes across the life course and contributing to patterns of health and inequities at the population level. **Early adversity refers to stressful or potentially traumatic experiences in childhood that can trigger extreme or prolonged stress responses, particularly in the absence of supportive relationships**.[1] Adverse Childhood Experiences (ACEs) are a commonly used term that refers to a defined set of ten exposures identified in the original ACEs study, grouped into abuse, neglect, and household dysfunction.[2] While ACEs have been instrumental in advancing understanding of childhood trauma, the broader term early adversity is preferred because it captures a wider range of exposures such as poverty, housing instability, discrimination, and community violence that may also lead to a toxic stress response.[3] This broader framing avoids narrowing adversity to individual or family experiences alone and better reflects the role of social and structural determinants of health as drivers of early adversity while supporting more comprehensive, upstream prevention approaches. To advance population health action in this area, it is essential to measure early adversity and resilience using well-defined indicators that capture both risk and protective factors across populations, enabling the monitoring of trends, the identification of inequities, and more effective policy and program responses.



Despite growing recognition of the lifelong and intergenerational impacts of early adversity, measurement within public health systems remains fragmented due to the complex intersectoral nature of these issues. Currently, there is no established set of standardized, core indicators in public health to measure early adversity and resilience, limiting comparability across regions and the ability to assess progress over time. Early Adversity and resilience are identified topic areas in *Table 1: Population Health Assessment and Surveillance Categories and Topics* of Population Health Assessment and Surveillance Protocol of the Ontario Public Health Standards,[4] including:

- **Health and Wellness:** Adverse childhood experiences and the achievement of developmental milestones (Early Childhood)
- **Demographics:** Family
- **Natural & Built Environment**: Natural Assets (including parks and green spaces) and Physical Activity and Recreation Environments
- **Social Environment:** Social Cohesion/Support/Isolation, Healthy Family Dynamics, Violence (including intimate partner violence, family violence, gender-based violence, bullying/trauma), Community Connectedness and Barriers to Accessing Supports and Services (including client/community experiences, Stigma and Discrimination)

Early adversity and resilience indicators span multiple cross-cutting public health areas, such as mental health, social health, and health equity. They can also apply to a variety of topic areas and programs in public health including Healthy Growth and Development; Healthy Babies, Healthy Children; School Health; Substance Use Prevention and Harm Reduction; Chronic Disease Prevention; Healthy Environments and Climate Change; Mental Health Promotion; and Health Equity.

The **Ontario Early Adversity and Resilience (OEAR) Framework** provides a foundation for coordinated, collective action across sectors to address early adversity and build resilience for children, youth and families across Ontario. The framework aims to inspire and mobilize communities to work together to develop innovative and meaningful solutions that prevent adversity, strengthen protective factors, build resilience and support healing in families and communities.

The OEAR Framework was developed by members of the Ontario Adverse Childhood Experiences and Resilience Community of Practice (ACER CoP) and endorsed by the Association of Local Public Health Agencies (alPHa) in 2025. Building on this work, a subgroup was struck in fall 2025 to provide support for population health assessment by assisting in the selection, prioritization and organization of health indicators related to early adversity and resilience. Mapping indicators to the OEAR Framework helps address current gaps in measurement by supporting a consistent and meaningful approach to population health assessment, improving the usability of data for evidence-informed decision making and maximizing public health impact.

Early adversity and resilience indicators can be used by Public Health Units (PHUs) and community/cross-sectoral partners to:

- **understand** the burden of early adversity and beneficial resilience factors within the population and potential outcomes related to early adversity and resilience;
- **strengthen** cross-sectoral collaborations and advocacy by providing a shared evidence base;
- **inform** local program planning through identification of priority areas and priority populations (health equity lens); and
- **monitor and evaluate** progress in the implementation of the OEAR Framework (population-level outcomes).



METHODS

A multi-staged, iterative, consensus process was used to identify and prioritize indicators related to early adversity and resilience.

Subgroup Formation

A multidisciplinary *APHEO Ontario Early Adversity and Resilience Indicator Subgroup* was formed to support this work. The subgroup consisted of six Epidemiologists from Ontario PHUs, and the lead for Healthy Growth and Development at Public Health Ontario, all of whom were members of the *APHEO Healthy Growth and Development Core Indicator Working Group*. The subgroup also included four program content experts and advisors from the ACER CoP. Three of the members additionally participated in the ACER CoP Framework Subcommittee and authored or contributed to the development of the OEAR framework.

Indicator Identification

A list of potential population health indicators was established with existing data sources available to PHUs in Ontario. This list was established based on a review of:

- existing APHEO Core Indicators;
- population health assessment indicators reported by PHUs, as summarized by epidemiologists in the APHEO Healthy Growth and Development Core Indicator Working Group;
- population health assessment indicators reported by Public Health Ontario, including CHSCY Epidemiological Summary reports;
- indicators identified by program content experts and advisors from the ACER CoP;
- Public Health Agency of Canada (PHAC) Childhood Maltreatment Surveillance Indicator Framework;[5]
- a Ministry of Children and Youth Services (MCCSS) report with middle years indicators from 2017, entitled Gearing Up: A Strategic Framework to Help Ontario Middle Years Children Thrive;[6] and
- new indicators in data sources available to PHUs in Ontario. Data sources reviewed included:
    - population health surveys related to parent or child and youth behaviours and perceptions (CHSCY,[7] OSDUHS,[8] CCHS[9])
    - Vital Statistics (Births, Stillbirths, Deaths)
    - Inpatient Discharges (DAD)[10] and Emergency Department Visits (NACRS)[11]
    - Ontario Mental Health Reporting System (OMHRS)[12]
    - demographic information (Canadian Census)[13]
    - Early Development Instrument (EDI)[14]
    - Data related to every pregnancy, birth, and child in Ontario in the Better Outcomes Registry & Network (BORN)[15]
    - data from the Healthy Babies Healthy Children (HBHC) postpartum screening tool,[16] housed by the MCCSS Child Development Information System (CDIS) (formerly the Healthy Child Development - Integrated Services for Children Information System, HCD-ISCIS)[17] which is used to identify families with potential risk of negative development outcomes for children through the HBHC program in Ontario, designed to support families from pregnancy until a child starts school by helping to ensure every child has a healthy start in life.[18]

Additional potential indicators were identified (or refined) through consultations with additional content expertise related to built environment indicators, substance use indicators, and ACEs prevalence indicators to align with ongoing work in Ontario and Canada, such as PHAC indicators, other APHEO Core Indicators, and subject expertise through researchers. Furthermore, additional public health colleagues with expertise in school health, environmental health (built environment and climate change), chronic disease prevention, substance use, nutrition, and household food insecurity were also consulted.



Indicator Mapping to OEAR Framework

Potential indicators were organized and mapped onto the following topic areas to support indicator review, refinement, prioritization, selection and organization:

- 4 focus areas of the Ontario Early Adversity and Resilience (OEAR) Framework:
    1. Socially Connected, Equitable, and Inclusive Communities
    2. Social and Emotional Development and Resilience
    3. Reproductive Health and Parenting/Caregiving Readiness
    4. Responsive and Culturally Safe Parenting/Caregiving
- Adverse Childhood Experience Prevalence indicators
- Outcomes related to early adversity and resilience among children and youth
- Social determinants of health indicators that may influence all four focus areas of the OEAR Framework

Indicator Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were used to guide the selection of indicators that were relevant, feasible, and aligned with the purpose of the OEAR Framework.

Inclusion Criteria:

- Mapped onto the OEAR Framework
- Could be measured using existing population-level data sources accessible to all Ontario PHUs
- Relevant outcomes for early childhood, middle years and youth populations.

Exclusion Criteria:

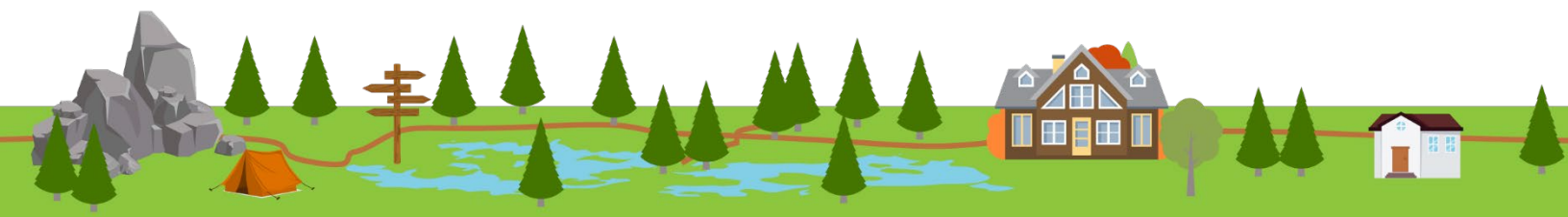
- No Ontario data source existed
- Further data development or standardization was required
- Did not align with the OEAR Framework Focus Areas, ACE prevalence, or outcome indicators
- Indicators that were considered “out of scope” such as long-term outcomes in adults associated with early adversity and resilience (e.g., chronic conditions, mental health, mental illness, and substance use).

Indicator Rating

Three criteria were used to rate indicators based on adapted Results-Based Accountability (RBA)[19] population indicator selection criteria (Table 1).

TABLE 1: Indicator rating criteria used in OEAR indicator selection process

Criteria	Definition
Communication Power	Does the indicator communicate to a broad range of audiences?
Importance/ Proxy Power	Does the indicator say something of central importance about the result*? **Condition of well-being or outcome (early adversity and resilience)*
Data Power	Is quality data available on a timely basis? Is it reliable and valid? Is it cost effective to produce? Is it available for all public health units in Ontario?



Indicators were scored on each criterion using a 1 to 5 Likert scale, with 1 being the lowest score and 5 being the highest score. A total score (ranging from 3-15) was calculated as the sum of the three criteria scores. Indicators were scored in a group setting based on group discussion and consensus. Where consensus was not reached through group voting, the following logic was used for rating:

- **Program content expertise** was prioritized for ratings on Communication and Importance/Proxy power, given program representatives have direct knowledge of, and work closely with community partners and program staff.
- **Epidemiologist expertise** was prioritized for Data Power ratings, given their knowledge of data sources and analytics.

Data sources generally received consistent scores on Data Power (Table 2), with some nuances identified across population groups or topic areas.

Secondary, "non-core" indicators were also identified, reflecting other high-quality indicators that can be used based on local importance and programming needs. These included indicators in priority areas that:

- are not available to all PHUs;
- are currently in development by researchers; and
- could be used at the discretion of local PHUs, based on varying data quality/availability.

For survey data with multiple questions and a derived or composite indicator (as derived by Statistics Canada), a general approach was taken in which these variables were rated highest for importance/Proxy Power (5) but lower for Communication Power (4). In contrast, the specific indicators were rated higher for Communication Power (5) but lower for Importance/Proxy Power (4). In these cases, it is recommended for PHUs to report derived variables as headliner indicators, with selected specific indicators for additional context or explanation.

Lastly, some indicators were flagged that would require:

- **future data development:** For some indicators, there is no recent, usable data source available (e.g., data do not exist, are outdated or are not available at the PHU level). In these cases, PHUs would need to collect their own data.
- **further indicator development:** For some indicators, potential data sources were identified, but there is uncertainty about how the indicator should be defined and calculated (e.g., determining appropriate cut-offs/thresholds, calculation methods, or combining variables to create a composite score).

During the rating process, indicators were also categorized according to their alignment with APHEO Core Indicator Working Groups (e.g. Healthy Growth and Development, Reproductive Health, Mental Health and Substance Use), alignment with more than one topic area (e.g., focus areas of the OEAR framework, ACE prevalence indicators or outcome indicators), population of focus (e.g., prenatal, early years, middle years, youth, parents, adults or household/community level) and whether they were classified as strengths-based or deficit-based.



TABLE 2: Indicator rating criteria scores used in OEAR indicator selection process, by data source

Data Power Score	Data Source	Comment (if applicable)
5 - Highest	**Administrative Data** from IntelliHealth	Includes: ● hospitalization data from Discharge Abstract Database (DAD) ● Emergency Department Visits from National Ambulatory Care Reporting System (NACRS) ● Ontario Mental Health Reporting Health System (OMRHS) ● Live Births, Still Births and Deaths from Vital Statistics
	Census	Despite limitations in timeliness of data, data is reliable, high quality and widely available to all PHUs
	Better Outcomes Registry Data (BORN) Information System (BIS)	Registry and administrative data, unless known data quality issues (such as under-reporting for intimate partner violence)
	Early Development Instrument (EDI)	For 7 core indicators, all PHUs can access at minimum via PHO Snapshots; The EDI is a well-validated, well-established tool for public health.
4	**Canadian Health Survey on Children and Youth (CHSCY)**	Where indicator focuses on children, youth and person most knowledgeable (PMK) of child/youth; may be lower data power score in instances where reporting may be biased due to data collection in home setting (such as youth substance use, youth mental health indicators)[1]
	Canadian Community Health Survey (CCHS)	Where indicator focused on adults (18+ years) or household/community level
3	**Canadian Community Health Survey (CCHS)**	For indicators focused on parents with children under 18 years in their household, CCHS was rated as 3 for data power due to sample size limitations. CCHS samples the general population (aged 18+ in recent cycles) rather than specifically targeting parents of children under 18. As a result, the number of parents captured within each health unit may be smaller compared to CHSCY, which is specifically sampled based on children aged 1 to 17 years.
	Canadian Health Survey on Children and Youth (CHSCY)	As noted above, for youth-reported substance use and mental health[1]
	Ontario Student Drug Use and Health Survey (OSDHUS)	Due to limitations in representativeness of provincial data by PHU region, not all PHUs are able to report (due to inability to oversample based on school board participation or funding for oversampling)

[1] Youth substance use and youth mental health reports as “fair/poor” may be underreported in CHSCY when compared with OSDUHS estimates from similar years. This is anticipated to be due to increased social desirability bias of youth self-reports in the home setting for CHSCY compared with school setting in OSDUHS.

Data Power Score	Data Source	Comment (if applicable)
2	**Healthy Babies, Healthy Children Screen** Data via: • Better Outcomes Registry Network (BORN) Information System (BIS); or • Healthy Child Development - Integrated Services for Children Information System (HCD-ISCIS)	Most PHUs in Ontario do not meet the ≥80% universal screening threshold that would support population-level use. Because of this low and variable completion rate, HBHC Screen data are generally not representative of the broader population, but rather of those who complete the screen. Furthermore, some HBHC screen questions were identified as having inconsistent data entry or interpretation across PHUs, further limiting suitability for population-level indicators.
1 - Lowest	No data sources identified	N/A

Consensus on Core Indicators and Priority Gaps

After all indicators were reviewed and scored, the group reviewed the final, rank ordered list by topic area – excluding indicators identified for further data development.

"Headliner" indicators were selected, with a target of three to five indicators per Focus Area of the OEAR Framework, based on the prioritized ranking of indicator rating scores, with attention to balance and cross-representation across population groups (e.g., early years, middle years, youth), as well as across strength and deficit-based indicators. In addition, the group considered the following questions when selecting core "headliner indicators":

- What does success mean at a population level?
- Do the prioritized indicators meet the "public square test," meaning the small set of measures that could be confidently presented to community members, leaders or policy makers? According to RBA methods, headliner indicators should be those that you would be comfortable defending in public, due to their communication power, importance/proxy power and data power.
- Would people understand the indicators, trust them and agree that they reflect what we are trying to measure?

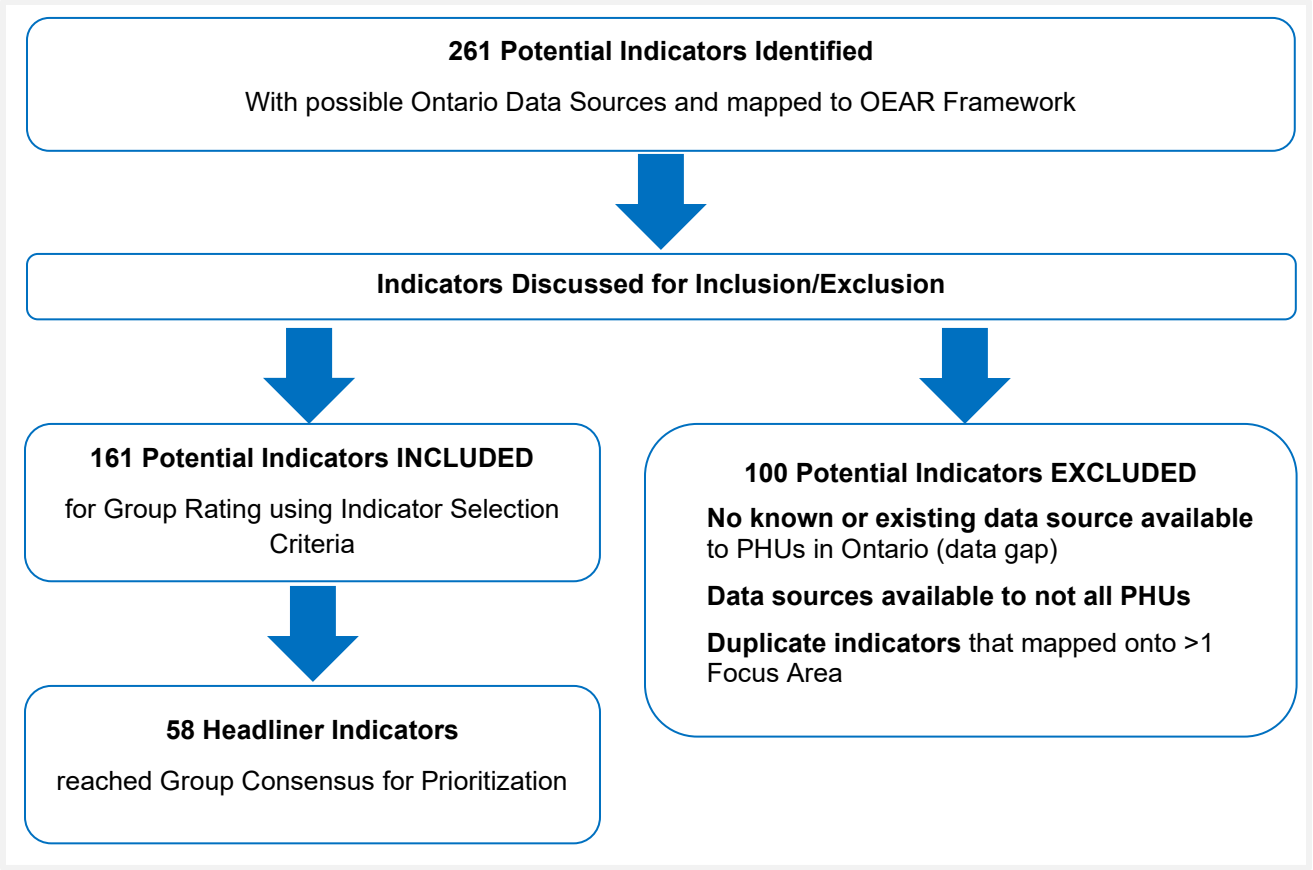
The indicators identified in this document will likely evolve over time. As new and improved data sources become available, indicators may be promoted to headline status, reclassified as secondary indicators or retired as part of the indicator life cycle. The indicator set will be periodically reviewed and updated through the APHEO Healthy Growth and Development Core Indicator Working Group/Core Data Advisory Collaborative through a subgroup that would include ACER CoP members.

RESULTS

Prioritized Indicators

A total of 261 potential indicators were identified and mapped onto the OEAR Framework. After group discussion, 161 indicators were included for group rating using the selection criteria and 100 indicators were excluded (Figure 1).

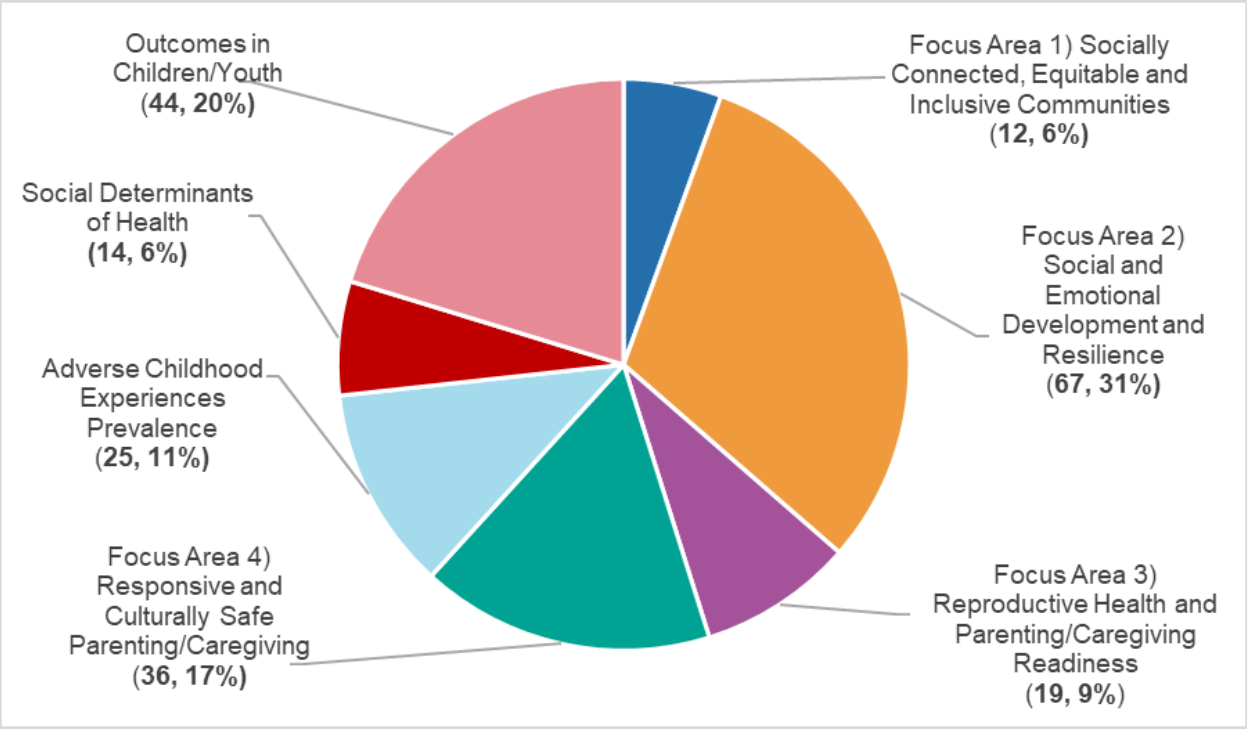
FIGURE 1: Overall process for prioritization of APHEO Ontario Early Adversity and Resilience (OEAR) indicators



As shown in Figure 2, 31% of the 161 included indicators mapped onto the *Social and Emotional Development and Resilience* Focus Area of the OEAR Framework, followed by *Child and Youth Outcomes* (20%) and *Responsive and Culturally Safe Parenting/Caregiving* (17%). The *Socially Connected, Equitable and Inclusive Communities* Focus Area had the fewest indicators (6%).



FIGURE 2: Mapping potential indicators onto the OEAR framework (n=161 indicators*)

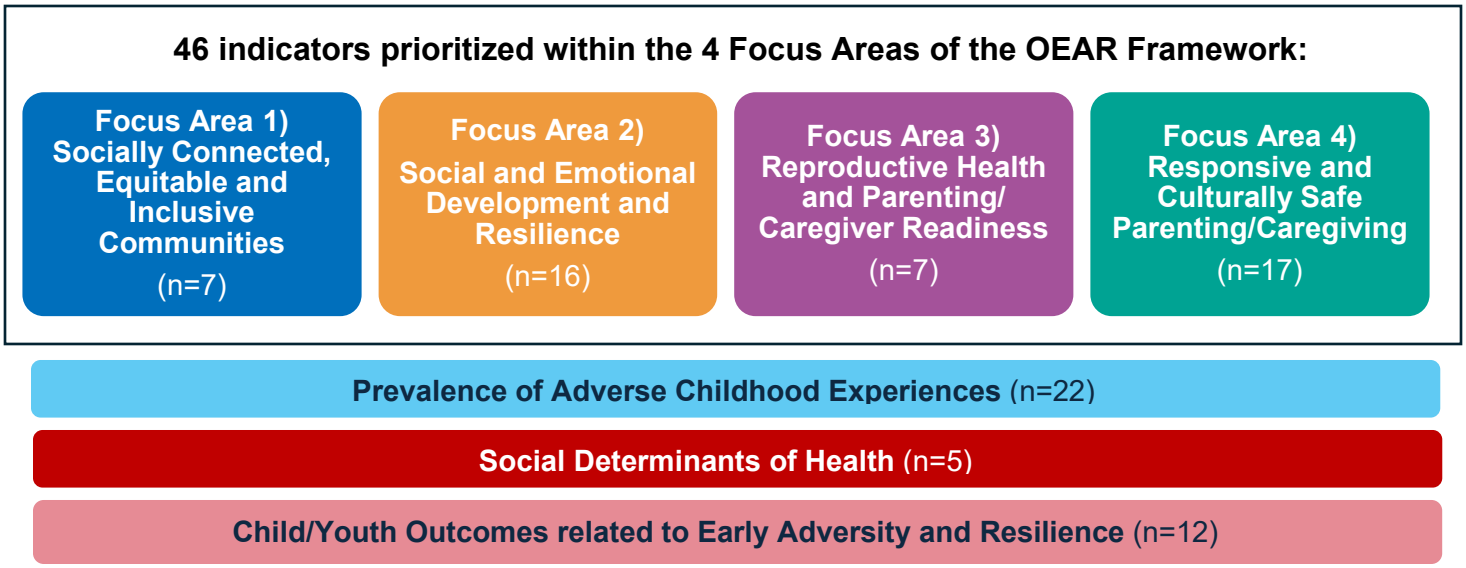


** Some indicators mapped onto >1 topic area*

A total of 58 indicators were prioritized as Headliner Indicators. As shown in Figure 3, of the 58 indicators, some mapped onto more than one Focus Area of the OEAR Framework:

- **46** indicators were prioritized within the 4 Focus Areas of the OEAR Framework:
    1) Socially Connected, Equitable and Inclusive Communities (n=7)
    2) Social and Emotional Development and Resilience (n=16)
    3) Reproductive Health and Parenting/Caregiver Readiness (n=7)
    4) Responsive and Culturally Safe Parenting/Caregiving (n=17)
- **22** measured the prevalence of Adverse Childhood Experiences
- **12** were health and well-being outcomes related to early adversity and resilience in children and youth
- **5** indicators were identified as social determinants of health.

FIGURE 3: 58 prioritized indicators and distribution across OEAR Framework focus areas and related domains*



** Indicators could be mapped to more than one OEAR Framework Focus Area and related domains. See Table 3 to see specific indicators and where they mapped to.*

The 58 prioritized indicators were balanced across early years (n=32), middle years (n=30), and youth populations (n=30) and some indicators mapped onto more than one population group. An additional 7 indicators related to the prenatal population, 18 to parents, and 9 to adults or households. The majority of the 58 prioritized indicators were deficit-framed (70%), with the remainder strengths-based. This is reflective of availability of data sources and number of ACE prevalence indicators and deficit-based outcomes, highlighting another data gap in strengths-based indicators.

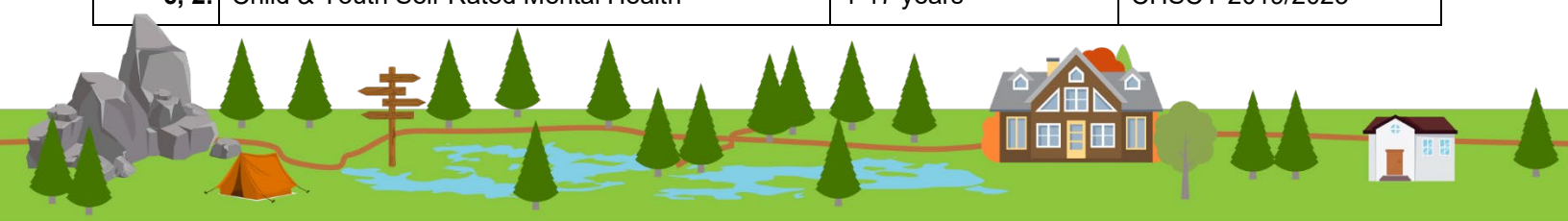
Table 3 presents the prioritized core OEAR indicators by focus area. Some indicators mapped onto more than one focus area. Appendix A presents the prioritized OEAR indicators and definitions by area of the OEAR Framework that is best met by the indicator to support review and uptake by APHEO and PHUs.

TABLE 3: Prioritized APHEO OEAR indicators, by population, data source and OEAR focus area(s)

LEGEND:

1. Focus Area 1) Socially Connected, Equitable & Inclusive Communities
2. Focus Area 2) Social & Emotional Development & Resilience
3. Focus Area 3) Reproductive Health & Parenting/Caregiving Readiness
4. Focus Area 4) Responsive & Culturally Safe Parenting/Caregiving
5. Prevalence of Adverse Childhood Experiences (ACEs)
6. Child/Youth Outcomes related to Early Adversity & Resilience
7. Social Determinants of Health

Focus Area(s)	Indicator	Population	Data Source(s)
1.	Neighborhood Safe for Outdoor Play	1-17 years	CHSCY 2019/2023
1.	Outdoor Play	3-17 years	CHSCY 2019/2023
1.	Youth Experienced Any Discrimination	12-17 years	CHSCY 2023
1.	Community Belonging	18+ years	CCHS 2015-2018, 2019-2021, 2022-2024
1.	Has Regular Primary Care Provider	1-17 years	CHSCY 2023
1, 7.	Core Housing Need	Household	Census
1, 7.	Housing Affordability	Household	Census
6, 2.	Child & Youth Self-Rated Health	1-17 years	CHSCY 2019/2023
2.	Child Functioning and Disability	1-17 years	CHSCY 2019/2023
2.	Youth Social Connections	12-17 years	CHSCY 2023
2.	Attend Licensed Child Care	1-3 years	CHSCY 2019/2023
2.	Attend Before or After School Care	4-11 years	CHSCY 2019/2023
2.	Participated in Sports/Clubs/Groups	3-17 years	CHSCY 2019/2023
2.	Connectedness at School	Grades 7-12	OSDUHS
2.	Youth Experienced Any Bullying	12-17 years	CHSCY 2019/2023
6, 2.	Child & Youth Self-Rated Mental Health	1-17 years	CHSCY 2019/2023



Focus Area(s)	Indicator	Population	Data Source(s)
2, 6.	Youth Self-Rated Life Stress	12-17 years	CHSCY 2019/2023
6, 2.	Youth Loneliness	12-17 years	CHSCY 2023
6, 7.	Vulnerable on Two or More Domains	SK Students	EDI
2, 6.	Vulnerable on Social Competence	SK Students	EDI
2, 6.	Vulnerable on Emotional Maturity	SK Students	EDI
6, 2.	Child & Youth Mental Illness Hospitalization Rate	<18 years	DAD, OMHRS
6, 2.	Child & Youth Mental Illness ED Visit Rate	<18 years	NACRS
6, 2.	Youth Substance Use (Intensity/Hazardous Use)	12-17 years	OSDUHS
3.	Prenatal Class Attendance	Prenatal (First Time Parent)	BORN
3.	Any Mental Health Concern During Pregnancy	Prenatal	BORN
3.	Any Alcohol and/or Drug Use During Pregnancy	Prenatal	BORN
3.	Adolescent Pregnancy Rate	15-19 years	IntelliHealth + Others*
6, 3, 4.	Neonatal Abstinence Syndrome Incidence Rate	Infants <28	DAD
6, 3.	Low Birth Weight Rate	Live Births	BORN or IntelliHealth
3, 5.	Domestic/Intimate Partner Violence	Prenatal	BORN
4, 5.	Parent/Caregiver Self-Rated Mental Health	1-17 years	CHSCY 2019/2023
4.	Parent/Caregiver Self-Rated Life Stress	1-17 years	CHSCY 2019/2023
5, 4.	Parent/Caregiver Distress	1-17 years	CHSCY 2023
4.	People to Count On	Parents 18+ years	CCHS 2019-2020, 2023-2024
4.	Parent-Child Interaction – Laughs with Child	1-11 years	CHSCY 2019/2023
4.	Parent-Child Interaction – Plays with Child	1-11 years	CHSCY 2019/2023
4.	Spanking	1-17 years	CHSCY 2023
4.	Supportive Family	1-17 years	CHSCY 2023

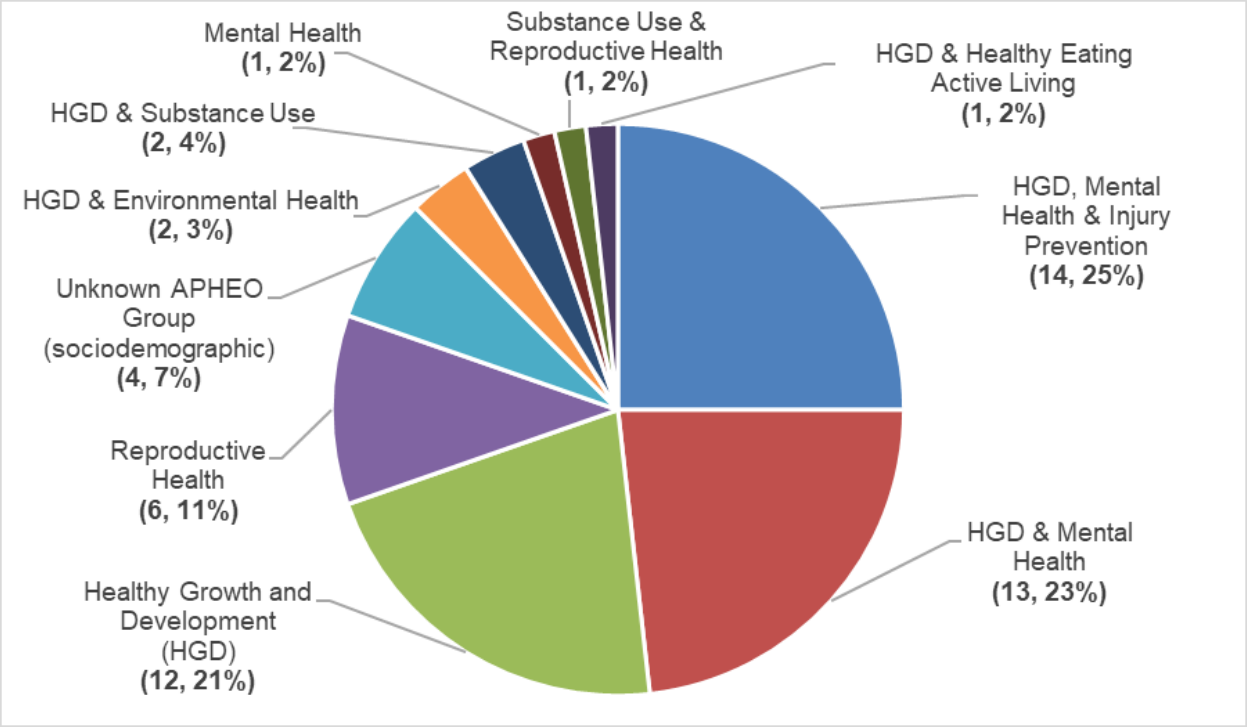
Focus Area(s)	Indicator	Population	Data Source(s)
5.	Physical Abuse	1-17 years	CHSCY 2023
5.	Sexual Abuse	15-17 years	CHSCY 2023
5.	Emotional Abuse	1-17 years	CHSCY 2023
5.	Physical Neglect	1-17 years	CHSCY 2023
5, 4.	Exposure to Physical IPV in Home	1-17 years	CHSCY 2023
5, 4.	Exposure to Emotional IPV in Home	15-17 years	CHSCY 2023
5, 4.	Witnessed Violence Against Sibling	1-14 years	CHSCY 2023
5, 4.	Experienced Separation/Divorce of Parents	1-17 years	CHSCY 2019/2023
5, 4.	Experienced Parent/Caregiver Mental Illness	1-17 years	CHSCY 2019/2023
5, 4.	Experienced Any ACE (Child/Youth)	1-17 years	CHSCY 2023
5, 4.	ACE Score (Child/Youth)	1-17 years	CHSCY 2023
5, 4.	Parent/Caregiver Substance Use	Parents 18+ years	CCHS 2015-2018, 2019-2021, 2022-2024
5.	Witnessed a Parent Hit Another Adult as a Child (Adults)	25+ years	CCHS 2019
5.	Experienced Physical Abuse as a Child (Adults)	25+ years	CCHS 2019
5.	Experienced Sexual Abuse as a Child (Adults)	25+ years	CCHS 2019
5.	Experienced Any ACE (Adults)	25+ years	CCHS 2019
5.	ACE Score (Adults)	25+ years	CCHS 2019
5, 7.	Market Basket Measure – Poverty Rate	Census Family	Census
5, 7.	Household Food Insecurity	Household	Canadian Income Survey (PHO Snapshot)

* Live Births & Stillbirths (Vital Statistics, DAD or BORN); Therapeutic Abortion Summary; IC/ES Derived Cohorts (Medical Abortion Data) & Population Estimate

The 58 prioritized indicators included 13 (22%) which were existing APHEO Core Indicators. The distribution of indicators by existing APHEO Core Indicator Working Groups (CIWG) or Core Data Advisory Collaboratives (CDAC) are summarized in Figure 4. The majority of OEAR indicators map onto the APHEO Healthy Growth and Development, Mental Health & Injury Prevention Core Indicator Working Groups. However, the OEAR indicators cross multiple public health topic areas.



FIGURE 4: OEAR indicators by APHEO Core Indicator Working Group (CIWG) or Core Data Advisory Collaborative (CDAC) topic area



Additional Indicators

Additional indicators were identified as supplementary indicators that can be used at the discretion of individual PHUs.

Indicators that reflect priority areas of the OEAR Framework readily available for local regions within some PHUs, but not all, were noted by the group. These included built environment indicators from HealthyPlan.City, data sources from community partners such as childcare centres, police, and children's aid societies, indicators in development by researchers, as well as HBHC universal postpartum screening data. Although the latter is available to all PHUs, due to wide discrepancies in population coverage these indicators were categorized as supplementary.

HealthyPlan.City

Indicators from HealthyPlan.City are recommended for PHUs who have local regions captured within the data tool. Indicators that may be of relevance to the *Socially Connected, Equitable and Inclusive Communities* Focus Area of the OEAR Framework include:

Greenspace Provision

- The available greenspace (in m^2) per person within a 500 m walk. Greenspaces are composed of parks, open spaces, large natural areas, outdoor recreation spaces, forests, and other similar land uses. The number of people within 500 m of a greenspace was determined using the Statistics Canada Geographic Attribute File at the dissemination block level and transportation data from OpenStreetMap. Components of greenspace provision were extracted from the OpenStreetMap database.

Recreation and Sports Facilities

- The number of recreational and sports facilities such as arenas, swimming pools, gyms, aquariums, bowling alleys, fitness centers and bingo halls within a 1 km radius. Recreational and sports facilities were extracted from the OpenStreetMap database.



Air Pollution

- A modeled estimate of nitrogen dioxide air pollution (a marker of traffic-related air pollution) for the year 2016 developed by Hystad et al.[20]

Average Summer Temperature

- The average land surface temperature from May to September 2019-2021 derived from LandSat 8 satellite data in Google Earth Engine. This data was obtained using an adapted code shared on StackExchange by Edwin Osei (April 22, 2020). The average of values within each dissemination block is reported.

Community Partner Data Sources

Additional potential data sources that have been acquired at the discretion of PHUs were also noted by the group, with an opportunity for sharing lessons learned to support future data development including:

- Local childcare data related to licensed childcare centre's wait list data are available to some PHUs through local municipalities.
- Verified maltreatment incidence data from local child welfare agencies.
- Intimate partner violence incidents with children present are available to some PHUs through local police data. Appendix B presents lessons learned and shared by Durham Region Public Health on requesting data related to domestic violence incidents locally to support knowledge sharing.

Indicators in Development by Researchers

Some indicators were identified that are currently in development by researchers that may be important to consider as they are further developed. Examples:

- The Canadian Perinatal Opioid Project (CPOP) project,[21] whose goal is to develop a national public health surveillance system to look at perinatal opioid exposure among all mother-infant pairs and investigate associated impacts on maternal and child health in Canada. These indicators may provide local public health unit level data, with potential for review and integration locally. These indicators would fall under Focus Areas 3 and 4.
- The Canadian Database for Development, Infancy to Six (CanDDIS) Project[22] is the first Canadian database of child development for children under the age of 6, created through partnership between the Infant and Early Mental Health Promotion at the Hospital for Sick Children, Queen's University and community-based agencies across Canada. This database houses anonymous data from the Ages and Stages Questionnaire (ASQ),[23] which is securely stored in a REDCap Server maintained by the Centre for Advanced Computing at Queen's University. Data ownership is retained by the agency/community that collects the data. Developmental milestone data would be beneficial for Focus Area 2, especially in the preschool (2-5 year) age range.

Healthy Babies Healthy Children Universal Postpartum Screening Data

Some indicators related to early adversity and resilience across the OEAR Framework were identified from the HBHC Screening Questionnaire. There was extensive discussion in the subgroup about the quality and consistency of this data source across PHUs. While several HBHC questions align with concepts of early adversity and resilience, the subgroup ultimately decided not to include HBHC screening data in the prioritized indicator set for the following key reasons:

Coverage Rate for Population-Level Data Requirement

Most PHUs in Ontario do not meet the ≥80% universal screening threshold that would support population-level use. Only 38% of PHUs reached ≥80% in 2023.[24] Because of this low and variable completion rate, HBHC Screen data are generally not representative of the broader population, but rather of those who complete the screen.

Variation in Data Collection

PHUs have different models for data collection and are resourced and organized differently, resulting in variable screen completion quality.

Question Validity and Consistency



Some questions may not be capturing important concepts consistently, such as parenting and caring for baby support questions.

Due to these reasons, other population-based sources such as BORN or census data were prioritized and the HBHC Screen was not included as a core data source. This data source remains referenced as a *secondary data source,* meaning that HBHC-derived population indicators could still be used at the discretion of individual PHUs when no other population-level data source exists and when local HBHC screen data collection is sufficiently standardized, with a screen completion of 80%. In particular, the following HBHC Screen questions may be of relevance:

Q 22) Father/partner/support person is NOT involved with care of baby/child

Q 23) Client cannot identify a support person to assist with parenting of the baby/child?

Q 24) Client cannot identify a support person to assist with care of the baby/child?

Q 27) Client or parenting partner has a history of depression, anxiety, or other mental illness?

Data Gaps and Future Indicator Development Priorities

Several relevant areas were identified where data gaps exist or where further development is needed. These gaps relate to either the absence of data, limitations in data quality or timeliness, or restricted availability at the local PHU level. In some cases, existing indicators require further development and refinement because current data sources are not sufficiently specific or representative of the target population. This may involve data sharing agreements with partner organizations with more appropriate data sources (e.g., Police data for intimate partner violence or child protection data from the Children's Aid Society).

As progress is made in addressing these data gaps, there will be opportunity to refine and update these priority indicators in future iterations of this work.

Absence of Data

In each Focus Area, there were key indicators that had no known data source. These include access to low cost of free recreation programs, connection to culture, spirituality, identity and land-based practices, social and emotional development and resilience indicators in youth, parenting strengths-based measures, and two traditional ACEs (incarceration of someone in the household and emotional neglect).

Some of these indicators would require PHUs to independently collect this data through surveys or strengthen partnerships and obtain data from other sectors locally such as youth justice. Additional data related to the social determinants of health would further strengthen equity-focused planning and decision-making, especially at the local level.

There is a need for ongoing Indigenous data engagement to ensure that data collection activities and interpretations are culturally appropriate, relevant, and aligned with Indigenous data governance principles, such as OCAP® (Ownership, Control, Access, and Possession).[25] Ongoing Indigenous data engagement refers to the continuous and meaningful involvement of Indigenous communities throughout all stages of the data lifecycle, including the design, collection, interpretation, and application of data. Sustained collaboration is particularly relevant when measuring community adversity and relational well-being in Indigenous populations.[26]

Limitations to Data Quality or Timeliness

There are two key areas where data exists, but the quality of the data source is a limitation; gender-based violence and intimate partner violence (IPV), and protective parenting indicators. Firstly, the available indicators for gender-based violence and IPV are based on health administrative data including emergency department visits and hospitalizations, however these data critically underrepresent the true burden as not all cases would result in a hospital outcome. The other IPV indicators identified as ACEs Prevalence Indicators among children and youth are available through CHSCY, providing self-reported exposure to both emotional and physical IPV. However, there is uncertainty on the appropriate cut-offs for emotional IPV; other ACE prevalence questions use an "ever vs never" dichotomy; for emotional IPV that would result in an overestimate of the true burden. The rate of IPV cases reported to police services would be a key indicator that better describes the burden, however PHUs would be responsible for obtaining this data locally per police service.



Other data sources to measure the proportion of self-reported IPV cases include the General Social Survey on Victimization (GSS)[27] or the Survey of Safety in Public and Private Spaces (SSPPS),[28] although these data are only collected every 5 years and not sampled at the PHU-level to support local monitoring of trends.

Secondly, although a few indicators related to parent support were prioritized and are measured in the CCHS, there are important limitations. These include small sample sizes of parents within the dataset and limited variability in responses, with more than 95% of parents reporting strong social support and emotional well-being. There is likely an opportunity to develop more sensitive and informative indicators to better assess early relational health and parenting support. Other parenting support related questions are also available in the HBHC Postpartum Screening Questionnaire, however there is concern about the validity of these questions to adequately measure the burden in communities, as previously described.

Restricted Availability at the Local PHU Level

Sample size limitations in CHSCY oversampling for smaller populations, as well as anticipated reductions in child and youth local data availability, particularly following the discontinuation of CHSCY oversampling after 2023, is anticipated to potentially further constrain the ability to design responsive, equity-informed programming and public health action and monitor local trends over time. In addition, significant gaps persist in local data on youth substance use and youth mental health. While data does exist in these areas from the Ontario Student Drug Use and Health Survey (OSDUHS), not all PHUs are able to consistently acquire this data source, limiting the ability to monitor trends over time at a local level. Further, there is some evidence that self-reported data collected in a school setting is more accurate than data collected in the home setting when reporting on more sensitive or socially undesirable behaviours, where youth may be hesitant to report on these behaviours in the home setting.[29] As such, there is ongoing work to improve the availability of local data related to child and youth health and well-being. This includes:

- Exploring the feasibility of oversampling in population-based surveys such as:
    - Canadian Health Survey on Children and Youth (CHSCY)
    - Ontario Student Drug Use and Health Survey (OSDUHS)
- Identifying opportunities for collaboration with local school boards to enhance data collection and sharing (examples include the Icelandic Prevention Model[30] and through School Climate Surveys)

In the absence of local child and youth health due to sample size restrictions, discontinuation of CHSCY oversampling as of the CHSCY 2023 cycle, PHUs can adopt the following strategies:

- investigate combining CHSCY cycles from CHSCY 2023 with future CHSCY cycles to support local or regional trend monitoring (and increasing sample size); and
- use of regional and provincial estimates.

DISCUSSION

A total of 58 indicators were prioritized aligning with the OEAR Framework and across the life course. Forty-six indicators aligned with the four OEAR Focus Areas, with the greatest concentration in Responsive and Culturally Safe Parenting/Caregiving, followed by Social and Emotional Development and Resilience, Socially Connected, Equitable and Inclusive Communities, and Reproductive Health and Parenting/Caregiver Readiness. In addition, 22 indicators captured the prevalence of ACEs and 12 reflected important child and youth outcomes, underscoring the Framework's emphasis on both exposure and impact. Key social determinants of health, including housing, food insecurity, and early childhood development, were integrated across relevant focus areas. The prioritized indicator set was well balanced across early years, middle years, and youth populations, with complementary indicators addressing prenatal populations, parents, and broader household or adult/community contexts. Notably, 70% of indicators were deficit-framed, reflecting both the availability of existing data and the predominance of ACE and outcome-based measures, and highlighting an important gap in strengths-based indicators needed to more fully capture resilience and protective factors.



These indicators are meant to provide population-level surveillance data to local PHUs to understand the distribution of ACEs and resilience factors across their communities. With this data, PHUs can prioritize public health interventions and activities suggested in the OEAR Framework and use these indicators to benchmark Framework implementation. **Although many of the prioritized indictors may fall outside the direct influence of PHUs, this data can enable discussion and partnership with community partners and cross-sectoral collaborations.**

This work also aligned with concurrent indicator identification and prioritization efforts specific to parenting and early relational health, which helped to validate indicators identified in Focus Area 4. In the Parenting Indicators Project, 12 indicators were prioritized, all except two were also prioritized in this project (reading with child was kept instead of plays with child, and child maltreatment data from administrative data was included).[31]

The prioritization of 58 indicators reflects the broad scope of the OEAR Framework, which spans multiple areas of public health action across the life course, including the prenatal, early years, child and youth populations, as well as parents, adults and the general community. While this comprehensive set of indicators supports a wide range of surveillance needs, it also presents limitations. Not all indicators will be equally relevant or feasible for every PHU to implement. It is anticipated that PHUs will select and apply the indicators that align most closely with their local program areas, priorities, and initiatives. As such, the full set of 58 indicators should be viewed as a menu of options rather than a required package. Local prioritization, guided by the results generated from these indicators, will be essential to ensure meaningful, context-specific application and to support strategic decision-making within each PHU.

Data from the Canadian Health Survey for Children and Youth (CHSCY)[7] were identified as a particularly valuable data source of population-level data for all PHUs in Ontario, especially for children ages 1-11 years and their parents. Prior to 2019, there had been no representative health survey data for children under 12 years since the National Longitudinal Survey of Children and Youth in 2009. CHSCY was identified as a robust dataset for children and youth, with known funding by Statistics Canada up to 2027. As of 2023, the survey will be conducted annually (to 2027). However, oversampling at the PHU region will not be available from 2024 onward. This limits the ability to produce reliable local estimates beyond 2023 and is expected to create a future data gap for many recommended CHSCY indicators at the local PHU-level.

Previous work on ACEs prevalence estimates in Ontario and Canada have focused on adult populations relying on historical recall.[32–35] In this work, data sources that focused on the child and parent population were prioritized to reflect more timely and actionable indicators for public health practice. Adult outcomes were excluded to keep the indicator set focused on the immediate and actionable impacts of adversity and resilience during childhood, middle years, and youth, which are the primary populations of interest within the OEAR Framework. Including adult outcomes may shift the focus toward long-term consequences that are influenced by many additional factors beyond early adversity, making attribution less clear and limiting their usefulness for timely public health planning and prevention strategies. Excluding these outcomes also helped maintain feasibility and consistency of indicators that best support early intervention and monitoring within the public health mandate.

Our indicator identification process built on previous work by local public health including Southwestern Public Health,[36] North Bay and Parry Sound District Health Unit,[37] Region of Waterloo Public Health,[38] as well as an environmental scan of indicators used by other public health units through the APHEO Healthy Growth and Development Core Indicator Working Group. These PHUs provided a baseline list of potential indicators that were then augmented with additional data sources.

There were significant indicators and data gaps identified during this project across key early adversity and resilience Focus Areas. Major data gaps persist in areas such as Indigenous data and community engagement, culturally grounded connections (including culture, spirituality, and land-based practices), and community-level indicators on built environment and social connection. Other data gaps persist, including parental stress and strength-based measures such as relationships with caring, trusted adults and protective factors for parents. In other areas, indicators with major limitations such as poor data sources, unvalidated questionnaires were identified such as gender-based and intimate partner violence, parental substance use, parental incarceration, and births to unhoused parents. While some indicators, such as youth substance use intensity (or hazardous use), youth crime and incarceration, infant feeding duration, and child welfare investigations are available only to some PHUs and often lack local granularity. Inconsistent data availability across PHUs was an important consideration in the selection and prioritization of the OEAR Indicators.



Existing data sources, including Healthy Babies Healthy Children (HBHC), provided conceptually relevant indicators related to caregiver support, but these were not optimized for population-level surveillance in many PHUs as screening coverage did not reach over 80% of live births. Collectively, these gaps underscore the need for continued coordinated data development, equity-informed approaches, and consistent provincial access to strengthen monitoring of early adversity, relational health, and resilience, and to support targeted, evidence-informed public health action across Ontario.

Strengths and Limitations

This work had multiple strengths. Indicator selection was informed by a review of measures identified by other public health units undertaking similar work, as well as relevant Ministry data sources and established public health frameworks from related institutions (e.g., Healthy Cities initiatives). These sources helped ensure alignment with existing best practices and comparability across jurisdictions. A defined set of prioritization criteria was applied to guide decision-making and promote transparency and consistency in indicator selection.[19] The composition of the working group, with an equal number of program content experts and epidemiologists, further strengthened the process by balancing conceptual relevance with practical considerations related to data quality, availability, and feasibility, resulting in more robust and actionable indicators. Furthermore, the Subgroup included representatives from a wide geographic area and diverse organizational public health contexts, spanning large urban, rural, and northern public health units. This broad representation supported a balanced and comprehensive approach to indicator development.

Several limitations should be considered when interpreting this work. Data availability varied substantially across public health units, reflecting differences in local budgets, priorities, and geographic contexts, which in turn influenced access to certain data sources. For example, not all PHUs had access to enhanced datasets such as the OSDUHS oversample, limiting comparability across jurisdictions. In addition, anticipated reductions in child and youth local data availability, particularly following the end of CHSCY oversampling after 2023, may further constrain the ability to design responsive, equity-informed programming and public health action and monitor local trends over time. In addition, variability in existing relationships and data-sharing agreements with external partners, particularly school boards and municipalities, posed challenges for acquiring consistent local-level data. Future efforts would benefit from broader system-level support to strengthen and standardize data-sharing agreements between PHUs and these partners. Finally, this indicator list is not intended to be exhaustive or static in time. A set of “headliner” indicators was selected to highlight key variables within each focus area; however, depending on local context and priorities, additional indicators from the broader list may be more appropriate or informative for specific PHUs. In addition, indicators may be further refined as new data sources emerge, or additional research or indicator development work continues to advance.

Further, the prioritized indicators were based on existing data sources available to PHUs in Ontario. Given the absence of a single, comprehensive data source monitoring child health, adversity and wellbeing relies on a patchwork of indicators collected across multiple data sources. Each dataset captures only part of the picture, with varying levels of completeness, frequency and geographic coverage. As a result, identifying meaningful trends depends on the triangulation of these data from these different sources - including examining where these indicators align, diverge and how they collectively inform understanding of population-level patterns. This triangulation approach helps to fill existing data gaps, supports more robust interpretation and strengthens confidence in emerging trends despite limitations in any single dataset.

Lastly, the ACE prevalence indicators capture only a narrow subset of early adversity. The “traditional” ACEs represent specific categories of traumatic experiences, while many other forms of adversity can contribute to toxic stress. Attempts were made to include a broader subset of early adversity contributing to toxic stress; however, the calculation of the overall ACE Score indicator follows the available “traditional” 10 ACEs where data is available. This likely underrepresents the true burden of adversity in children and youth. In addition, Canada does not have a standardized or widely implemented tool to measure the full set of 10 ACEs. While a comprehensive ACE survey has been piloted, it has not been adopted consistently across jurisdictions.



CONCLUSIONS/SIGNIFICANCE

The set of population-based indicators provides an opportunity for standardized measurement of early adversity and resilience across PHUs in Ontario. This is the first collaborative effort among staff from PHUs, including both program staff and epidemiologists, and Public Health Ontario to systematically identify and prioritize population level indicators to align with the Ontario Early Adversity and Resilience (OEAR) framework. These indicators align with the Population Health Assessment and Surveillance Protocol of the Ontario Public Health Standards, addressing cross-cutting public health priorities such as mental health, social health, and health equity. As implementation of the OEAR Framework progresses, additional indicators may be identified that highlight opportunities for future measurement.

APHEO Core Indicator Working Groups are encouraged to consider integration of these indicators into the indicator life cycle of APHEO Core Indicators in relation to early adversity and resilience indicators as core or model indicators where appropriate. Public Health Units are encouraged to consider local implementation of these APHEO recommended OEAR indicators where possible as part of routine population health assessment and surveillance.



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Appendix A: Prioritized Ontario Early Adversity and Resilience (OEAR) indicators and definitions, by OEAR framework focus area

Legend

1. Focus Area 1) Socially Connected, Equitable and Inclusive Communities
2. Focus Area 2) Social and Emotional Development and Resilience
3. Focus Area 3) Reproductive Health and Parenting/Caregiving Readiness
4. Focus Area 4) Responsive and Culturally Safe Parenting/Caregiving
5. Prevalence of Adverse Childhood Experiences
6. Child/Youth Outcomes related to Early Adversity and Resilience
7. Social Determinants of Health

Focus Area 1: Socially Connected, Equitable and Inclusive Communities

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
1.	**Neighbourhood Safe for Outdoor Play**	Percentage of children and youth, aged 1-17 years, whose neighbourhood was reported as “very safe”, “reasonably safe”, or “somewhat or very unsafe” for children to play outside during the day, as reported by the person most knowledgeable of the child or youth.	CHSCY 2019 and 2023	1-17 years (PMK report)
1.	**Outdoor Play**	Percentage of children aged 1-11 years, who played outside during their free time for 3 or more hours a week in the past 7 days, as reported by the person most knowledgeable of the child.	CHSCY 2019 and 2023	1-11 years (PMK report)
1.	**Youth Experienced Any Discrimination**	Percentage of youth, aged 12 to 17 years, who self-reported ever experiencing any type of discrimination in their day-to-day life. Any type of discrimination includes being treated with less courtesy or respect than others, receiving poorer service than others at restaurants or stores, people act like they think they are not smart, or they were threatened or harassed.	CHSCY 2023	12-17 years (self-report)
1.	**Community Belonging**	Percentage of adults, aged 18 years and older, who experienced a sense of belonging to their local community as “very or somewhat strong” or “very or somewhat weak”	CCHS 2015-2018, 2019-2021, 2022-2024	18+ years

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
1.	**Has a Regular Primary Care Provider**	Percentage of children and youth, aged 1-17 years, who had a regular family doctor or health professional to consult with for care of or advice on the health of the child/youth, as reported by the person most knowledgeable of the child/youth	CHSCY 2023	1-17 years (PMK-report)
1,7.	**Core Housing Need**	Percentage of households where the household's housing falls below at least one of the indicator thresholds for housing adequacy[b], affordability[c] or suitability[d]	Census	Household Level
1,7.	**Housing Affordability**	Percentage of households spending 30% or more of their total before-tax household income on shelter costs	Census	Household Level

CHSCY – Canadian Health Survey on Children and Youth; CCHS – Canadian Community Health Survey ; PMK – Person Most Knowledgeable of the Child/Youth

Focus Area 2: Social and Emotional Development and Resilience

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
2.	**Child Functioning and Disability**	Percentage of children and youth, aged 2 to 17 years, who experienced a functional difficulty on any functional domain (and by specific domain) [e], as reported by the person most knowledgeable of the child/youth	CHSCY 2019 and 2023	2-17 years (PMK report)

[b] Housing Adequacy: Reported by residents as inadequate housing, where the home needs major repairs (including defective plumbing or electrical wiring or structural repairs to walls, floors or ceilings);

[c] Housing Affordability: Affordable housing refers to those with shelter costs equal to or less than 30% of the total before-tax household income, as defined by the Canada Mortgage and Housing Corporation. Unaffordable housing is greater than the 30% before-tax household income threshold.

[d] Housing Suitability: Suitable housing includes enough bedrooms for the size and composition of resident households according to the National Occupancy Standard (NOS), developed by the Canada Mortgage and Housing Corporation and provincial and territorial representatives. Unsuitable housing indicates that the number of bedrooms and the size of the home is insufficient for the current dwellers.

[e] Can report by specific functional domain (no functional difficulty and with functional difficulty) including:

- Any functional domain (2-17 years) (WSHDVFC3) and for 2–4-year-olds (WSHDVFD1) and 5–17-year-olds (WSHDVFC2)

By Domain:

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
2.	**Youth Social Connections***	Mean summary score of the summation of the Social Provisions Scale (derived variable from CHSCY) In addition, reporting by specific Social Provision: Percentage of youth, aged 12 to 17 years, who identified the following often/always, sometimes, rarely/never: a) have close relationships that provide a sense of emotional security and well-being b) have someone they can talk to about important decisions in their life c) have relationships where their competence and skill are recognized d) feel part of a group of people who share their attitudes and beliefs e) people they can count on in an emergency	CHSCY 2023	12-17 years (self-report)
2.	**Attend Licensed Child Care**	Percentage of children, aged 1 to 3 years, who regularly attend licensed childcare facilities, as reported by person most knowledgeable of the child	CHSCY 2019 and 2023	1-3 (PMK report)
2.	**Attend Before or After School Care**	Percentage of school-aged children, aged 4 to 11 years, who regularly attended before or after school care programs, as reported by person most knowledgeable of the child	CHSCY 2019 and 2023	Children who attend school <12 years (PMK report)
2.	**Participated in Sports, Clubs or Community Groups**	Percentage of children and youth, aged 3 to 17 years, who participated in physical activities with a coach or instructor, who participated in music, drama, art clubs/lessons, or participated in other organized	CHSCY 2019 and 2023	3-17 years (PMK report)

i) Accepting Change
- Accepting change (5-17 years) (WSHDVAC)

ii) Emotion
- Anxiety (5-17 years) (WSHDVANX)
- Depression (517 years) (WSHDVDEP)

iii) Communication
- Communication (2-4 years) (WSHDVCM1)
- Communication (5-17 years) (WSHDVCM2)

iv) Concentrating
- Concentrating (5-17 years) (WSHDVCON)

v) Behaviour
- Controlling behaviour (2-4 years) (WSHDVCB1)
- Controlling behaviour (5-17 years) (WSHDVCB2)

vi) Learning
- Learning (2-4 years) (WSHDVLE1)
- Learning (5-17 years) (WSHDVLE2)

vii) Relationships
- Making friends (5-17 years) (WSHDVMF)

viii) Remembering
- Remembering (5-17 years) (WSHDVREM)

ix) Dexterity and Playing
- Playing (2-4 years) (WSHDVPLA)

x) Self-Care
- Self-care (5-17 years) (WSHDVSC)

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
		clubs/community groups in the past 12 months, as reported by the person most knowledgeable of the child and youth		
2.	**Connectedness at School****	Percentage of Grade 7 to 12 students who responded that they somewhat agree or strongly agree to feeling safe in their school, close to people at the school, and feeling like they are part of the school	OSDUHS	Students in Grades 7-12
2.	**Youth Experienced Any Bullying**	Percentage of youth, aged 12 to 17 years, who reported ever experiencing any type of bullying in the past 12 month	CHSCY 2019 and 2023	12-17 years (self-report)
2,6.	**Youth Self-Rated Life Stress**	Percentage of youth, aged 12 to 17 years, who reported their life stress as quite a bit to extremely stressful, a bit stressful or not very to not at all stressful	CHSCY 2019 and 2023	12-17 years (self-report)
2,6.	**Vulnerable on Social Competence**	Percentage of children in Senior Kindergarten identified as vulnerable on the Social Competence domain of the Early Development Instrument. This includes children's overall social competencies, capacity for respect and responsibility, approaches to learning and readiness to explore new things.	EDI	SK Students
2,6.	**Vulnerable on Emotional Maturity**	Percentage of children in Senior Kindergarten identified as vulnerable on the Emotional Maturity domain of the Early Development Instrument. This includes children's prosocial and helping behaviours, as well as hyperactivity and inattention, aggressive, anxious and fearful behaviours.	EDI	SK Students

CHSCY - Canadian Health Survey of Children and Youth; **EDI** - Early Development Instrument; **OSDUHS** - Ontario Student Drug Use and Health Survey; **PMK** - Person Most Knowledgeable of the Child/Youth; **SK** - Senior Kindergarten

*** Youth Social Provisions include** emotional security and well-being, social support, competence and skills recognized, shared beliefs, people to count on

** **OSDUHS** may not be available for local reporting for all public health units. This is a priority data gap, as no other known data sources are available on this topic.

Focus Area 3: Reproductive Health and Parenting/Caregiver Readiness

FOCUS AREA(S)	INDICATOR	DEFINITION	DATA SOURCE	POPULATION
3.	**Prenatal Class Attendance**	Percentage of individuals who gave birth for the first time who attended a prenatal class either in person or online during that pregnancy	BORN	Prenatal (first time parents)
3.	**Any Mental Health Concern During Pregnancy**	Percentage of individuals who gave birth who self-reported any mental health concern during pregnancy	BORN	Prenatal
3.	**Any Alcohol Use During Pregnancy**	Percentage of individuals who gave birth who self-reported the use of any alcohol and/or drug and substance exposures during pregnancy (excluding cannabis from April 2019 onwards)	BORN	Prenatal
3.	**Adolescent Pregnancy Rate**	Number of pregnancies including those resulting in live births, still births, surgical induced abortions and medical induced abortions per 1,000 women aged 15-19 years per year	Vital Statistics, BORN, IntelliHealth, IC/ES Derived Cohorts & Population Estimates	15-19 years
3,5.	**Domestic or Intimate Partner Violence (Prenatal)***	Percentage of individuals who gave birth, who reported threat of or actual physical, sexual, psychological, verbal, emotional or financial abuse in their current relationship	BORN	Prenatal

BORN – Better Outcomes Registry Network; **DAD** – Discharge Abstract Database; **IC/ES** – Institute for Clinical Evaluative Sciences

*Also included in Prevalence of Adverse Childhood Experiences Indicators

Focus Area 4: Responsive and Culturally Safe Parenting/Caregiving

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
4,5.	**Parent/ Caregiver Self-Rated Mental Health**	Percentage of children and youth, aged 1 to 17 years, whose parent/caregiver reported their own mental health status as excellent/very good, good, or fair/poor. Parent/caregiver refers to the person most knowledgeable of the child.	CHSCY 2019 and 2023	PMK of 1-17 years
4.	**Parent/ Caregiver Self-Rated Life Stress**	Percentage of children and youth, aged 1 to 17 years, whose parent/caregiver reported their own life stress was quite a bit or extremely stressful, a bit stressful, or not very to not at all stressful. Parent/caregiver refers to the person most knowledgeable of the child.	CHSCY 2019 and 2023	PMK of 1-17 years
4.	**People to Count On**	Percentage of parents/caregivers who reported having people they can count on in an emergency. Parents include respondents who were 18+ years old who had at least one child <18 years living in their household.	CCHS 2019-2020, 2023-2024	Parents 18+ years of <18-year-olds in household
4.	**Parent-Child Interaction – Laughs with Child**	Percentage of children, aged 1 to 11 years, whose parent/caregiver reported laughing with the child many times each day, one to two times per day or a few times a week or less. Parent/caregiver refers to the person most knowledgeable of the child.	CHSCY 2019 and 2023	PMK of 1-11 years
4.	**Parent-Child Interaction – Plays with Child**	Percentage of children, aged 1 to 11 years, whose parent/caregiver reported playing with the child many times each day, one to two times per day or a few times a week or less. Parent/caregiver refers to the person most knowledgeable of the child.	CHSCY 2019 and 2023	PMK of 1-11 years
4.	**Spanking**	Percentage of children, aged 1 to 14 years and youth, aged 15 to 17 years, who were spanked by hand by a parental figure at least once in their life, as reported by the person most knowledgeable of the child (aged 1- 14 years) and self-reported by youth (15-17 years).	CHSCY 2023	PMK of 1-14 years (PMK report); PMK of 12-17 years (youth report)
4.	**Supportive Family**	Percentage of children and youth, aged 1 to 17 years, who can Turn to one another for support in times of trouble, as reported by the person most knowledgeable of the child (aged 1-11 years) and reported by youth (aged 12-17 years)	CHSCY 2023	1-11 years (PMK report); 12-17 (youth-report)

CHSCY – Canadian Health Survey on Children and Youth; **CCHS** – Canadian Community Health Survey; **PMK** – Person Most Knowledgeable of Child/Youth
* Parent substance use includes – heavy drinking, cannabis use and/or “illicit drug” use (when data available in CCHS, may not be in more recent modules); also included in Prevalence of Adverse Childhood Experience indicators

Prevalence of Adverse Childhood Experiences

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5.	**Physical Abuse**	Percentage of children aged 1 to 14 years and youth, aged 15-17 years, who ever experienced any of the following types of physical abuse, as reported by the person most knowledgeable of the child, aged 1 to 14 years, and self-reported by youth, aged 15 to 17 years: • slapped in the face, head or ears or hit with something hard by an adult to hurt them • pushed, grabbed, shoved or had something thrown at them by an adult to hurt them • kicked, bit, punched, choked, burnt, or physically attacked by an adult Reported separately for children (1 to 14 years) and youth (15 to 17 years)	CHSCY 2023	1-14 years (PMK report); 15-17 years (self-report)
5.	**Sexual Abuse**	Percentage of youth, aged 15 to 17 years, who reported experiencing at least one of the following forms of sexual violence by an adult at any point in their lifetime: • Being forced or experienced an attempt to force them into any unwanted sexual activity by threatening them, holding them down or hurting them in some way; or • Being touched in a sexual way against their will by an adult, including unwanted touching, grabbing, kissing or fondling.	CHSCY 2023	15-17 years (self-report)
5.	**Emotional Abuse**	Percentage of children aged 1to 14 and youth aged 15 to 17 years who experienced at least one form of emotional abuse by an adult in their life, specifically being scared or feeling really bad because a grown-up called them names, said mean things to them, or said they did not want them. This information is reported by the person most knowledgeable of the child (1 to 14 years) and reported by youth (15 to 17 years). Reported separately for children (1 to 14 years) and youth (15 to 17 years)	CHSCY 2023	1-14 years (PMK report); 15-17 years (self-report)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5.	**Physical Neglect**	Percentage of children aged 1 to 14 years and youth, aged 15 to 17 years, who reported experiencing at least one form of physical neglect by a parent, step-parent, or guardian at any point in their lifetime, including an experience where their basic needs - such as being kept clean or being provided with food or clothing - were not taken care of. This information is reported by the person most knowledgeable of the child (1 to 14 years) and reported by youth (15 to 17 years). Reported separately for children (0 to 14 years) and youth (15 to 17 years)	CHSCY 2023	1-14 years (PMK report); 15-17 years (self-report)
5,4.	**Exposure to Physical Intimate Partner Violence in Home**	Percentage of children aged 1 to 14 years and youth, aged 15 to 17 years, who reported experiencing exposure to physical intimate partner violence in their home at least once in their lifetime, specifically, seeing or hearing a parent, step-parent or guardian hit each other or another adult in their home. This information is reported by the person most knowledgeable of the child (1 to 14 years) and reported by youth (15 to 17 years).	CHSCY 2023	1-14 years (PMK report); 15-17 years (self-report)
5,4.	**Exposure to Emotional Intimate Partner Violence in Home**	Percentage of youth, aged 15 to 17 years, who reported experiencing exposure to emotional intimate partner violence in their home at least once in their lifetime, specifically, seeing or hearing a parent or caregiver say hurtful or mean things to each other or to another adult in their home.	CHSCY 2023	15-17 years (self-report)
5,4.	**Witnessed Violence Against Sibling**	Percentage of children and youth aged 1 to 14 who experienced violence in the home at least once in their lifetime, specifically seeing or hearing a parent hit, beat, kick, or otherwise physically hurt their sibling, not including spanking on the bottom. This information is reported by the person most knowledgeable about the child or youth.	CHSCY 2023	1-14 years (PMK report)
5,4.	**Experienced Separation/ Divorce of Parents**	Percentage of children and youth aged 1 to 17 years who experienced the separation or divorce of a parent/caregiver, or as reported by the person most knowledgeable of the child/youth.	CHSCY 2019 and 2023	1-17 years (PMK report); 12-17 years (self-report)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5,4.	**Experienced Parent/ Caregiver Mental Illness**	Percentage of children and youth, aged 1 to 17 years, whose parents/caregivers (person most knowledgeable of the child or youth) reported that they themselves were diagnosed by a health care professional with a mental health condition that has lasted or is expected to last six months or more. Reported by the person most knowledgeable of the child and youth.	CHSCY 2023	1-17 years (PMK report)
5,4.	**Experienced Any Adverse Childhood Experience (Child/Youth)**	Percentage of children and youth, aged 1 to 14 years, who experienced any type of adverse childhood experience at least once in their lifetime. Reported by the person most knowledgeable of the child and youth. This includes the following six types of adverse childhood experiences: 1) Physical Abuse 2) Emotional Abuse 3) Physical Neglect 4) Exposure to Physical Intimate Partner Violence or Witnessed Violence Against Sibling 5) Parent/Caregiver Separation/Divorce, or 6) Parent/Caregiver Diagnosed with a Mental Illness. Percentage of youth, aged 15 to 17 years, who experienced any type of adverse childhood experience at least once in their life. This includes the following seven types, as reported by the youth (for all except Separation/Divorce of their Parents and Parent Diagnosed with a Mental Illness, which was reported by the person most knowledgeable of the youth): 1) Physical Abuse 2) Emotional Abuse 3) Sexual Abuse 4) Physical Neglect 5) Exposure to Physical or Emotional Intimate Partner Violence 6) Parent/Caregiver Separation/Divorce, or 7) Parent/Caregiver Diagnosed with a Mental Illness.	CHSCY 2023	1-14 years (reported by PMK) 15-17 years (reported by youth, except for Parent/Caregiver Separation/Divorce and Parent/ Caregiver Mental Illness, reported by PMK)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
		This is a dichotamous indicator and reported as Yes or No. This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with other jurisdictions/populations, which may include different ACE factors.		
5,4.	**Adverse Childhood Experiences Score (Child/Youth)**	ACE Score (Child) (0-6): Percentage of children and youth, aged 1 to 14 years, who experienced the following number of types of adverse childhood experiences (at least once in their lifetime): 0, 1, 2, 3 or 4 or more. This includes the following six types of adverse childhood experiences as reported by the person most knowledgeable of the child: 1) Physical Abuse 2) Emotional Abuse 3) Physical Neglect 4) Exposure to Physical Intimate Partner Violence or Witnessed Violence Against Sibling 5) Parent/Caregiver Separation/Divorce, or 6) Parent/Caregiver Diagnosed with a Mental Illness. ACE Score Youth (0-7): Percentage of youth, aged 15 to 17 years, who experienced the following number of adverse childhood experiences (at least once in their lifetime): 0, 1, 2, 3 or 4 or more. This includes the following seven types of adverse childhood experiences as reported by the youth (for all except Parent/Caregiver Separation/Divorce and Parent/Caregiver Diagnosed with Mental Illness, which was reported by person most knowledgeable of the youth): 1) Physical Abuse 2) Emotional Abuse 3) Sexual Abuse 4) Physical Neglect 5) Exposure to Physical or Emotional Intimate Partner Violence 6) Parent/Caregiver Separation/Divorce, or 7) Parent/Caregiver Diagnosed with a Mental Illness.	CHSCY 2023	1-14 years (reported by PMK), except for Experienced Separation/Divorce of Parent, reported by youth, aged 12-14) 15-17 years (reported by youth, except for Separation/Divorce of Parents, Parent Mental Illness, reported by PMK)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
		An ACEs score is the total number of categories of adverse childhood experiences an individual faced before age 18. Research suggests that a higher ACE score is associated with an increased risk of negative health and well-being outcomes in adulthood.[39-41] Adults with 4 or more ACEs were substantially more likely to experience substance use disorder, depression, and suicide attempts.[2] The ACE Score does not reflect the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/ populations, which may include differences in how ACEs are defined and measured, as well as how many ACE categories are included. Due to only having six items for children (aged 1-14 years) and seven items for youth (aged 15-17 years) in the set, prevalence of higher scores may be lower than what has been reported in the literature.		
5,4.	**Parent/ Caregiver Substance Use**	Percentage of parents/caregivers, aged 18 years or older, who were: • heavy drinkers - had 5 or more drinks (for men) or 4 or more drinks (for women) one occasion at least once a month in the previous 12 months; OR • used cannabis more than once in the past 12 months. Parents include respondents who had at least one child <18 years living in their household.	CCHS	Parents 18+ years of <18-year-olds in household
5.	**Experienced Physical Abuse as a Child (Adult)**	Percentage of adults, aged 25 years or older, who experienced being slapped, hit or spanked, or pushed, grabbed or shoved or physically attacked by an adult prior to the age of 16 years. This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/populations, including with CHSCY indicators, which may include differences in how ACEs are defined and measured.	CCHS 2019	Adults 25+ years

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5.	**Experienced Sexual Abuse as a Child (Adult)**	Percentage of adults, 25 years of age or older, who reported being forced into sexual activity or touched sexually against will by an adult before 16 years of age. This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/populations, including with CHSCY indicators, which may include differences in how ACEs are defined and measured.	CCHS 2019	Adults 25+ years
5.	**Wtinessed Parent Hitting Another Parent as a Child (Adult)**	Percent of adults, 25 years of age or older, who report experiencing seeing or hearing a parent/caregiver hit each other or another adult in their home before age 16 years. This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/populations, including with CHSCY indicators, which may include differences in how ACEs are defined and measured.	CCHS 2019	Adults 25+ years
5.	**Experienced Any Adverse Childhood Experience (Adult)**	Percentage of adults aged 25 years or older, who experienced any of the following three types of adverse childhood experiences prior to the age of 16 years: 1) Physical Abuse; 2) Sexual Abuse; and/or 3) Exposure to Physical Intimate Partner Violence in the Home This is a dichotamous indicator and reported as Yes or No. This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/populations, including with CHSCY indicators, which may include differences in how ACEs are defined and measured, as well as how many ACE categories are included.	CCHS 2019	Adults 25+ years

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5.	**Adverse Childhood Experiences Score (Adult)**	ACE Score Adults (0-3): Percentage of adults aged 25 years or older, who experienced the following number of types of adverse childhood experiences prior to the age of 16 years: 0, 1, 2 or 3. This includes the following 3 types of adverse childhood experiences experienced prior to the age of 16 years: 1) Physical Abuse; 2) Sexual Abuse; and/or 3) Exposure to Physical Intimate Partner Violence in the Home This does not account for the severity or frequency of experiencing an adverse childhood experience. Exercise caution when comparing with ACE Prevalence Scores in other jurisdictions/populations, including CHSCY indicators, which may include different ACE factors. Due to only having 3 items in the set, prevalence of higher scores may be lower than what has been reported in the literature.	CCHS 2019	Adults 25+ years
5,4.	**Parent/ Caregiver Distress**	Percentage of children and youth, aged 1 to 17 years, whose parent/caregiver had serious distress (scores of 13 or higher of 24 on the 6-item distress scale) Can also be reported by specific type of distress as Percentage of children and youth, aged 1 to 17 years, whose parent/caregiver experienced feeling the following types of distress most of the time, some of the time or none of the time: a) depressed b) everything was an effort c) hopeless d) nervous e) restless f) worthless	CHSCY	1-17 years (PMK report)
5,7.	**Market Basket Measure (Poverty Rate)**	Percentage of children and youth, aged 0 to 17 years, who are living below the Market Basket Measure Threshold for poverty (as defined by Statistics Canada).	Census	Census Family

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
5,7.	**Household Food Insecurity**	Percentage of households who experience some level (marginal, moderate or severe) of household food insecurity, by family type (including lone parent households, couples with children)	Canadian Income Survey (via PHO Household Food Insecurity Snapshot)	Household Level and by Family Type

BORN – Better Outcomes Registry Network; **CHSCY** – Canadian Health Survey on Children and Youth; **CCHS** – Canadian Community Health Survey; **PHO** – Public Health Ontario; **PMK** – Person Most Knowledgeable of Child/Youth

Child/Youth Outcomes related to Early Adversity and Resilience

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
6,2.	**Child and Youth Self-Rated Health**	Percentage of children and youth, aged 1 to 17 years, whose overall health was rated as excellent/very good, good, fair/poor, as reported by the person most knowledgeable of the child (1 to 11 years) and self-reported by youth (12 to 17 years).	CHSCY	1-11 years (PMK report); 12-17 (youth-report)
6,2.	**Child and Youth Self-Rated Mental Health**	Percentage of children and youth, aged 1 to 17 years, whose mental health status was rated as excellent/very good, good, fair/poor, as reported by the person most knowledgeable of the child (1 to 11 years) and self-reported by youth (12 to 17 years).	CHSCY	1-11 years (PMK report); 12-17 (youth-report)
6,2.	**Youth Loneliness**	Percentage of youth, aged 12 to 17 years, who experienced loneliness, based on the 3-item loneliness scale scores of 6 or higher (derived variable in CHSCY) Also reporting on each aspect of loneliness: a) Percentage of youth, aged 12 to 17 years, who experienced feeling like they have no one to talk to b) Percentage of youth, aged 12 to 17 years, who experienced feeling like they were left out Percentage of youth, aged 12 to 17 years, who experienced feeling like they were alone	CHSCY	12-17 years (youth-report)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
6,7.	**Vulnerable on Two or More Domains**	Percentage of children in Senior Kindergarten identified as vulnerable on two or more domains of the Early Development Instrument	EDI	SK Students
6,2.	**Child and Youth Mental Illness Hospitalization Rate**	Age-specific rate (per 100,000) of mental illness related hospitalizations among children aged 0 to 14 years and youth aged 15 to 18 years (reported overall and by type of mental illness)	IntelliHealth (DAD, OMHRS)	<18 years
6,2.	**Child and Youth Mental Illness Emergency Department Visit Rate**	Age-specific rate (per 100,000) of mental illness related emergency department visits among children aged 0 to 14 years and youth aged 15 to 18 years (reported overall and by type of mental illness)	IntelliHealth (NACRS)	<18 years
6,2.	**Youth Substance Use Intensity**	*[Definition to be determined in consultation with APHEO Substance Use CDAC related to hazardous/harmful youth substance use indicators from OSDUHS]* *Examples related to coping could include:* • *Past year cigarette use* • *Past-month vaping* • *Past-month cannabis use* • *Past-month alcohol use* • *Past-year opioid use* • *Binge drinking (5 or more drinks at least once a month)* • *Hazardous/harmful drinking indicators* • *Drug use problem indicators* • *Cannabis dependence indicators*	OSDUHS	Grades 7-12 (TBD)

FOCUS AREA(S)	INDICATOR	DEFINTION	DATA SOURCE	POPULATION
6,3,4.	**Neonatal Abstinence Syndrome Incidence Rate**	Number of newborns less than 28 days of age hospitalized and diagnosed with neonatal abstinence syndrome per 1,000 live births	IntelliHealth (DAD)	Infants <28 days
6,3.	**Low Birth Weight Rate**	Number of live births weighing less than 2,500 grams at the time of delivery per 100 live births	BORN or IntelliHealth (Vital Statistics: Live Births, Deaths, DAD)	Live Births with Known Birth Weights

BORN – Better Outcomes Registry Network; **CHSCY** – Canadian Health Survey on Children and Youth; **DAD** – Discharge Abstract Database; **EDI** – Early Development Instrument; **NACRS** – National Ambulatory Care Reporting System; **OMHRS** – Ontario Mental Health Reporting System; **OSDUHS** – Ontario Student Drug Use and Health Survey; **PHO** - Public Health Ontario; **PMK** = Person Most Knowledgeable of Child/Youth

Appendix B: Lessons Learned and Shared by PHUs in Accessing Local Data related to Domestic Violence Incidents

Lessons learned on requesting these data were shared by Durham Region Health Department (March 2026) to support knowledge sharing.

- To produce the indicator of *domestic violence incidents with children present*, our public health unit collaborated with our local police service through their Strategic Planning/Strategic Partnerships division.
- We contacted a designated representative within the police service who served as our main liaison for data requests.
- Through this partnership, we submitted a formal request outlining:
    - the indicator definition we were looking to measure (domestic incidents, with children present), and
    - the geographical boundaries relevant to public health (in our case, the defined health neighbourhoods).
- Police extracted all incidents that met our definition within the specified geographic boundaries.
- To address privacy requirements and minimize the risk of re-identification, data were provided in aggregated multi-year periods (3-year periods) rather than single-year counts.
- Police shared count data grouped by health neighbourhood, enabling reporting at the sub-municipal level without compromising confidentiality.
- Once received, our team further processed the data to be able to include it on our Health Neighbourhoods dashboard.
- The epidemiology team used these totals to generate counts, rates, and trend information based on the multi-year aggregates.