Ontario Mental Health System Reporting

DATA SOURCES AND METHODOLOGY



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Ontario Mental Health System Reporting

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Data were linked using unique encoded identifiers and analyzed at ICES.

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Abbreviations

CA Census Agglomeration

CMA Census Metropolitan Area

DA Dissemination Area

DAD Discharge Abstract Database

DSM-5 Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

ED Emergency department

FP/GP Family physician/general practitioner

ICD-8-CM International Classification of Diseases, 8th Revision, Clinical Modification

ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification

ICD-10-CA International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Canada

ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification

IPPE Income per single-person equivalent

MHA Mental health and addictions

MHAP Mental Health and Addictions Program Framework Research Team

NACRS National Ambulatory Care Reporting System

OHIP Ontario Health Insurance Plan

OMHRS Ontario Mental Health Reporting System

PC Primary care

PCCF Postal Code Conversion File

RPDB Registered Persons Database

Data Sources

Discharge Abstract Database (DAD)

The DAD is compiled by the Canadian Institute for Health Information and contains administrative, clinical (diagnoses and procedures/interventions), and demographic information for all admissions to acute care hospitals and rehabilitation, chronic care and day surgery facilities in Ontario. At ICES, consecutive DAD records are linked together to form "episodes of care" among the hospitals to which patients have been transferred after their initial admission.

National Ambulatory Care Reporting System (NACRS)

NACRS is compiled by the Canadian Institute for Health Information and contains administrative, clinical (diagnoses and procedures), and demographic information for all patient visits made to hospital- and community-based ambulatory care centres (emergency departments, day surgery units, hemodialysis units and cancer care clinics).
At ICES, NACRS records are linked with other data sources (DAD, OMHRS) to identify transitions to other care settings, such as inpatient acute care or psychiatric care.

Ontario Health Insurance Plan (OHIP)

The OHIP claims database contains information on inpatient and outpatient services provided to Ontario residents eligible for the province's publicly funded health insurance system by fee-for-service health care practitioners (primarily physicians) and "shadow billings" for those paid through non-fee-for- service payment plans. The main data elements include patient and physician identifiers (encrypted), codes for service provided, date of service, associated diagnosis and fee paid.

Ontario Mental Health Reporting System (OMHRS)

OMHRS is compiled by the Canadian Institute for Health Information and contains administrative, clinical (diagnoses and procedures), demographic and administrative information for all admissions to adult designated inpatient mental health beds. This includes beds in general hospitals, provincial psychiatric facilities and specialty psychiatric facilities. Clinical assessment data is ascertained using the Resident Assessment Instrument for Mental Health (RAI-MH), but different amounts of information are collected using this instrument depending on the length of stay in the mental health bed. Multiple assessments may occur during the length of a mental health admission.

Postal Code Conversion File (PCCF)

The PCCF database will link to postal codes within a given cohort and determine other census geographic identifiers, such as dissemination/ enumeration area, census division, longitude/latitude, urban/rural flag and neighbourhood income quintile.

Registered Persons Database (RPDB)

The RPDB provides basic demographic information (age, sex, location of residence, date of birth, and date of death) for those issued an Ontario health insurance number. The RPDB also indicates the time periods for which an individual was eligible to receive publicly funded health insurance benefits and the best-known postal code for each registrant on July 1 of each year.

Contents

vi Abbreviations
v Data Sources

1 1.0 Mental health and addictions indicators reported in this dashboard

3 2.0 Indicator methodology
4 2.1 General instructions for indicator creation
7 2.2 Indicator calculation
22 2.3 Diagnostic groupings used in indicator calculation

1.0 Mental health and addictions indicators reported in this dashboard

EXHIBIT 1.1 Mental health and addictions system performance indicators[1]

Quality Dimension Indicators[2]			Health Service Use Indicators
Effective	**Timely**	**Efficient**	
• Rates of emergency department visits for intentional self-injury • Rates of eating disorder-related hospitalizations • Rates of eating disorder-related emergency department visits	• Rates of emergency department visits as first point of contact for mental health and addictions–related care	• Rates of outpatient visits within 7 days following a mental health and addictions–related hospital discharge • Rates of 30-day hospital readmission following a mental health and addictions–related hospital discharge • Rates of 30-day emergency department revisits following a mental health and addictions-related emergency department visit	• Rates of mental health and addictions–related outpatient visits • Rates of mental health and addictions–related emergency department visits • Rates of mental health and addictions–related hospitalizations • Length of stay for psychiatric hospitalizations • Rates at which individuals were seen by a psychiatrist, primary care provider or paediatrician for mental health and addictions care

[1] Indicators will be assessed through five stratifications: age group, sex, diagnostic category, neighbourhood income quintile and health region.
[2] Quality dimension indicators were identified by the Institute of Medicine in 2001 and subsequently adopted by Health Quality Ontario (now Ontario Health Quality).

2.0
Indicator methodology

2.1 General instructions for indicator creation

2.1.1 General exclusion criteria for indicators

Unless otherwise stated, the following numerator and denominator exclusion criteria were consistent for all indicators (for additional indicator-specific exclusions, see **Section 2.2**):

- Age older than 105 years
- Non-residents of Ontario
- Individuals with an invalid health card number
- Missing sex information

For indicators that use the Ontario population as the denominator, additional exclusions were applied. These include:

- Individuals who were born after or died before the midpoint of the calendar year (July 1)
- Individuals who were not eligible for OHIP at the midpoint of the calendar year
- Individuals whose date of last contact with the health care system was equal to or greater than 8 years from the midpoint of the calendar year

For indicators that used a general Ontario population denominator, exclusion criteria were applied to the numerator independently, as the denominator is a population estimate at the midpoint of the year (i.e., the numerator is not a subset of the population denominator).

2.1.2 Indicator stratifications

These variables are used for the stratification of indicators. Please note that stratifications may vary across indicators. For indicator-specific calculations, **see Section 2.2**.

Stratification	Definition	Categories
Age group[1]	Age group cut-offs were defined in order to examine transitions between youth and adult services.	• 0–9 years • 10–13 • 14–17 • 18–21 • 22–24 • 25–44 • 45–64 • 65–84 • 85–105
Sex	Sex of a person – male or female – is determined based on demographic information available in the existing databases. In almost all cases, sex is collected as a binary male/female variable, which is not inclusive of intersex people. When sex is derived from administrative data, this is most often the sex assigned at birth.	• Male • Female
Diagnostic category	Some indicators were stratified by diagnosis. These diagnostic groups do not add up to the overall MHA category since the presented diagnostic categories do not include all available diagnostic codes. For more information on diagnostic codes and definitions, see **Section 2.3**.	• Substance use disorder • Schizophrenia spectrum and other psychotic disorders • Mood disorders • Anxiety disorders • Trauma- and stressor-related disorders • Obsessive compulsive and related disorders • Personality disorders • Intentional self-injury (residual)
Neighbourhood income quintile	In the absence of individual-level income data, neighbourhood-based income was calculated according to methods developed by Statistics Canada. Individuals' postal codes were first matched to Dissemination Areas (or DAs, the smallest census areas), where the average household income per single-person equivalent (IPPE) (adjusted for household size), was obtained from the Census of Canada for 2016/2021. DAs within each Census Metropolitan Area (CMA), Census Agglomeration (CA), or provincial residual area not in any CMA or CA were ranked and assigned to five groups, or quintiles, of approximately equal population based on the DA average IPPE. The corresponding neighbourhood income quintile of that DA was assigned to the individual.	• Quintile 1 (lowest) • Quintile 2 • Quintile 3 • Quintile 4 • Quintile 5 (highest)
Health region	Areas of the province established by Ontario Health to regionally manage, plan, support, and co-ordinate the delivery of health services. Health regions are based on consolidated geographical boundaries previously used to define the Local Health Integration Networks (LHINs).[2] Effective April 1, 2023, Ontario Health realigned the borders of its Central, East, and Toronto regions with the City of Toronto's municipal boundaries.	• Central (formerly Mississauga Halton, Central West, Central, and North Simcoe Muskoka LHINs; realigned with City of Toronto municipal boundaries) • East (formerly Central East, South East, and Champlain LHINs; realigned with City of Toronto municipal boundaries) • North East (formerly North East LHIN) • North West (formerly North West LHIN) • Toronto (formerly Toronto Central LHIN ; realigned with City of Toronto municipal boundaries) • West (formerly Erie St. Clair, South West, Hamilton Niagara Haldimand Brant, and Waterloo Wellington LHINs)

[1] Select indicators have different age group categories for stratification due to exclusions and/or sample size considerations.

[2] https://www.ontariohealth.ca/about-us/our-programs/ontario-health-regions

2.1.3 Indicator rates that were calculated

Method	Calculation	Categories
Indicator/rate calculation	Quarterly from January 2017 to the current available date	• Ontario (Overall) • Age group • Sex • Diagnostic category • Neighbourhood income quintile • Health region
Standardization	Direct standardization method	• Ontario
	Standard population	2021 Ontario population standardized by age and sex: • Males: 0–9, 10–13, 14–17, 18–21, 22–24, 25–44, 45–64, 65–84, 85–105 years • Females: 0–9, 10–13, 14–17, 18–21, 22–24, 25–44, 45–64, 65–84, 85–105 years

2.2 Indicator calculation

For a list of the diagnostic codes used to calculate indicators, see **Section 2.3**.

2.2.1. Rates of mental health and addictions–related outpatient visits

Data sets	OHIP, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of mental health and addictions (MHA)–related outpatient visits from OHIP • Family physicians/general practitioners, psychiatrists, paediatricians For a definition of MHA-related outpatient visits based on physician specialties and diagnostic codes, see Section 2.3.1. MHA-related outpatient visits are presented by provider specialty: • Any specialty • Family physician/general practitioner • Psychiatrist • Paediatrician
Exclusions	See general exclusions in Section 2.1.1
Stratifications	• In addition to indicator stratifications in Section 2.1.2, numerators were also stratified by: Visit modality • In-person • Virtual
Index	Date of OHIP claim
Additional specifications/notes	• The numerator was derived separately from the denominator. • Exclusions have been pre-applied to the denominator. • Exclusions for the numerator were applied at index. • Presented as rates, which includes multiple visits per person per quarter. • When reporting on visits rather than unique individuals, the numerators for different physician specialties add up to "any specialty." • A visit is, at most, one claim per patient per physician per service date (individuals may contribute more than one visit to various physician specialties in a quarter).
Limitations	• Rates may be undercounted because some specialists only "shadow bill" (i.e., they submit claims for services provided to patients that are funded through sources other than fee-for-service). • Data did not capture most non-physician mental health and addictions services. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.2. Rates of mental health and addictions–related hospitalizations

Data sets	DAD, OMHRS, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of mental health and addictions (MHA)-related hospitalizations
Exclusions	See general exclusions in Section 2.1.1
Stratifications	See indicator stratifications in Section 2.1.2
Index	Hospital discharge date
Additional specifications/notes	• Hospitalizations were constructed as episodes of care: – A DAD-OMHRS episode of care is a series of inpatient admissions to acute care inpatient hospitals (records including DAD and OMHRS) that are linked because the patient was transferred from one hospital to another. • The numerator was derived separately from the denominator. • Exclusions were pre-applied to the denominator. • Exclusions were applied to the numerator at index. • Presented as rates, which includes multiple hospitalizations per person per quarter. • Diagnoses-specific numerators do not add up to the overall numerator (see Section 2.3). • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual intentional self-injury, i.e., the presence of a self-injury diagnosis where the main reason for the hospital admission is non-MHA-related.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.3. Rates of mental health and addictions–related emergency department visits

Data sets	NACRS, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of mental health and addictions (MHA)-related ED visits
Exclusions	In addition to general exclusions in Section 2.1.1, also excluded were: • Scheduled ED visits
Stratifications	See indicator stratifications (Section 2.1.2)
Index	Date of ED visit
Additional specifications/notes	• Includes suspect diagnoses, visits with admissions to hospital and those who left without being seen. • The numerator was derived separately from the denominator. • Exclusions have been pre-applied to the denominator. • Exclusions for the numerator were applied at index. • Presented as rates, which includes multiple visits per person per quarter. • Emergency department visit episodes were constructed to avoid double counting visits that were transfers between multiple institutions and to better identify ED episode discharges. • Diagnoses-specific numerators do not add up to the overall numerator (see Section 2.3). • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual intentional self-injury, i.e., the presence of a self-injury diagnosis where the main reason for the ED visit is non-MHA-related.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

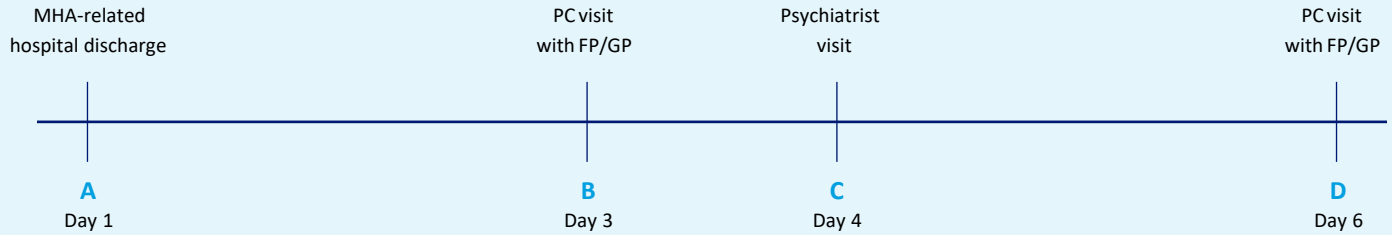
2.2.4. Rates of emergency department visits for intentional self-injury

Data sets	DAD, NACRS, OMHRS, PCCF, RPDB
Denominator	Quarterly Ontario population aged 10–105 years from January 2017 to the current available date
Numerator	Quarterly number of emergency department (ED) visits for intentional self-injury identified using two methods: 1) ED visits with a diagnosis of intentional-self injury. ICD-10-CA (NACRS) codes: X60.x–X84.x, Y10.x–Y19.x, Y28.x as a secondary diagnosis, regardless of whether the primary diagnosis is mental health-related (primary diagnosis of F06.x–F99.x, excluding F06.7) or not mental health-related (primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x). 2) ED visits without a diagnosis of intentional self-injury, but where the patient is subsequently hospitalized (in DAD or OMHRS) with a diagnosis of intentional self-injury recorded during the admission. ICD-10-CA (DAD) codes: X60.x–X84.x, Y10.x–Y19.x, Y28.x as a secondary diagnosis, regardless of whether the primary diagnosis is mental health-related (primary diagnosis of F06.x–F99.x, excluding F06.7) or not mental health-related (primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x). ICD-10-CA (OMHRS) codes: X60.x–X84.x, Y10.x–Y19.x, Y28.x in any non-psychiatric diagnostic code field (variables i11h - i11m) in OMHRS.
Exclusions	In addition to general exclusions in Section 2.1.1, other exclusions include: • Age <10 years • Scheduled ED visits
Stratifications	In addition to indicator stratifications in Section 2.1.2, numerators were also stratified by: • Disposition of ED visit for intentional self-injury: – Visits resulting in hospital admission – Visits resulting in admission to ICU/Death during ED visit or hospitalization • Method of self-injury: – Self poisoning only – Self-cutting only – Other – Multiple
Index	Date of ED visit
Additional specifications/notes	• The numerator includes suspect diagnoses, unscheduled ED visits, patients who were admitted, and the first ED visit in the case of ED to ED transfers. • The numerator was derived separately from the denominator. • Exclusions have been pre-applied to the denominator. • Exclusions for the numerator were applied at index. • Presented as rates, which includes multiple visits per person per quarter. • For all exhibits, rates of ED visits for intentional self-injury are presented where this diagnosis was made as a secondary reason for the ED visit, regardless of the main reason for the visit.
Limitations	• Individuals who self-injure but do not present to the ED were not included. • Self-injury treated in a non-hospital setting cannot be assessed. • Whether the individual who self-injured had suicidal or non-suicidal intent cannot be determined. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.5. Rates of outpatient visits within 7 days following a mental health and addictions–related hospital discharge

Data sets	DAD, OMHRS, OHIP, RPDB, PCCF
Denominator	Quarterly number of mental health and addictions (MHA)–related hospitalizations with a status of discharged alive among Ontario residents aged 0–105 years from January 2017 to the current available date
Numerator (subset of denominator)	Outpatient visit within 7 days following index hospital discharge (an outpatient visit occurring on the same day as discharge was not counted towards the numerator) • Family physicians/general practitioners, psychiatrists, paediatricians Outpatient visits within 7 days following index hospital discharge are presented by provider specialty: • Any specialty • Family physician/general practitioner • Psychiatrist • Paediatrician
Exclusions	In addition to general exclusions in Section 2.1.1, also excluded were those with a hospital readmission within 7 days
Stratifications	See indicator stratifications in Section 2.1.2.
Index	• Index hospital discharge date
Additional specifications/notes	• Hospitalizations were constructed as episodes of care. – A DAD-OMHRS episode of care is a series of inpatient admissions to acute care inpatient hospitals (records including DAD and OMHRS) that are linked because the patient was transferred from one hospital to another. • The final discharge of the index hospital episode must have resulted in one of the following: – a discharge home (with or without supportive services) – a transfer to a long-term or continuing care facility or to other ambulatory care, palliative care/hospice, addiction treatment centre, jail or social service agency – a sign-out against medical advice/absent without leave • Index hospital discharges were restricted to calendar quarters, but the 7-day follow-up could cross over into the next calendar quarter. • MHA diagnostic codes are not specified for outpatient visits (only for hospitalization); the follow-up outpatient visit could have been for any reason, and not necessarily related to MHA care. • Numerators are not mutually exclusive: a maximum of one numerator per specialty per follow-up per period. • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual intentional self-injury, i.e., the presence of a intentional self-injury diagnosis where the main reason for the hospital admission is non-MHA-related. • Diagnoses-specific denominators do not add up to the overall denominator (see Section 2.3).
Limitations	• Data did not capture most non-physician MHA services (i.e., psychologists, counsellors and social workers) that may have been provided post-discharge. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

For example, this diagram shows the events that would be considered in the numerator following an MHA-related hospital discharge:



- Denominator includes MHA-related hospital discharge **A**.
- Numerator includes **B**, **C**.

  A index → **B** Follow-up visit with a PC provider within 7 days. Only the first visit counts toward follow-up (i.e., **B** but not **D**).

  A index → **C** Follow-up visit with a psychiatrist within 7 days.

  A index → No follow-up visit with a paediatrician within 7 days.
- This individual contributed in the calendar quarter to (independently):

  Any specialty = 1/1; PC provider = 1/1; Psychiatrist = 1/1; Paediatrician = 0/1

Abbreviations: PC = primary care; FP/GP = family physician/general practitioner

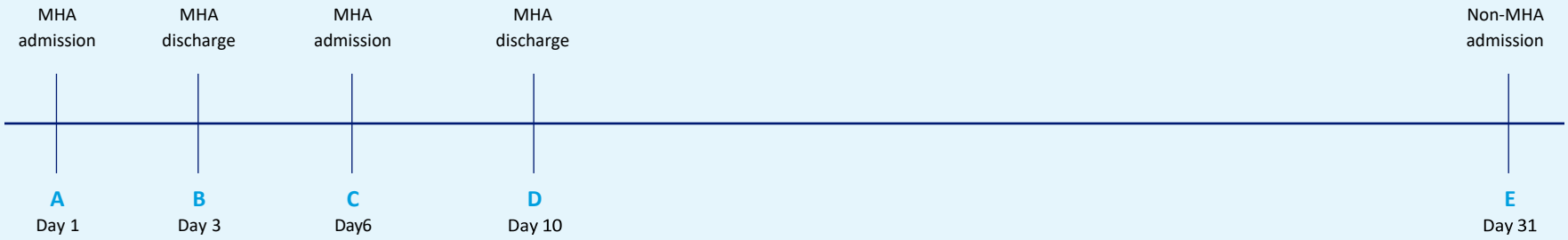
2.2.6. Rates of emergency department visits as first point of contact for mental health and addictions–related care

Data sets	DAD, OMHRS, NACRS, OHIP, RPDB, PCCF
Denominator	Quarterly number of unique Ontario residents aged 0–105 years with an incident (first in a calendar quarter) unscheduled mental health and addictions (MHA)–related emergency department (ED) visit from January 2017 to the current available date
Numerator (subset of denominator)	Number of individuals in Ontario without an MHA-related service contact in a 2-year look-back period; includes only those who did not have an MHA-related outpatient visit to a psychiatrist, primary care provider or pediatrician, or an MHA-related ED visit (scheduled or unscheduled) or an MHA-related hospitalization in the 2 years preceding the index ED visit (see Section 2.3).
Exclusions	In addition to general exclusions in Section 2.1.1, also excluded were scheduled ED visits (from denominator only).
Stratifications	See indicator stratifications in Section 2.1.2.
Index	Date of incident ED visit
Additional specifications/notes	• Index ED visit includes individuals who left without being seen and those admitted to hospital. • Visits on the same day as the index are not considered prior contact. • Look-back can include scheduled ED visits. • Person-level indicator: one index visit per person per quarter. • Diagnostic categories represent the reason for the incident ED visit (i.e., the denominator). • Diagnoses-specific denominators do not add up to the overall denominator (see Section 2.3). • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual intentional self-injury, i.e., the presence of a self-injury diagnosis where the main reason for the ED visit is non-MHA-related.
Limitations	• Data did not capture most non-physician mental health and addictions services (i.e., psychologists, counsellors and social workers). • General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.7. Rates of 30-day hospital readmission following a mental health and addictions–related hospital discharge

Data sets	DAD, OMHRS, RPDB, PCCF
Denominator	Quarterly number of mental health and addictions (MHA)–related hospitalizations with a status of discharged alive among Ontario residents aged 0–105 years from January 2017 to the current available date
Numerator (subset of denominator)	Number of individuals in Ontario with a hospital admission for any MHA-related reason within 30 days following the index hospital discharge.
Exclusions	In addition to general exclusions in Section 2.1.1, also excluded were individuals who: • Died on or prior to index hospital discharge
Stratifications	See indicator stratifications in Section 2.1.2.
Index	Index hospital discharge date
Additional specifications/notes	• Index discharges (i.e., the denominator) were restricted to calendar quarters but hospital readmission can cross over to the next calendar quarter, can be for a different MHA diagnosis than index, and does not have to result in a status of discharged alive. • Count only the first readmission per person per follow-up period. • Hospitalizations were constructed as episodes of care: – A DAD-OMHRS episode of care is a series of inpatient admissions to acute care inpatient hospitals (records including DAD and OMHRS) that are linked because the patient was transferred from one hospital to another. • The final discharge of the index hospital episode must result in one of the following: – a discharge home (with or without supportive services) – a transfer to a long-term or continuing care facility or to other ambulatory care, palliative care/hospice, addiction treatment centre, jail or social services agency – a sign-out against medical advice/absent without leave • Diagnoses-specific denominators do not add up to the overall denominator (see Section 2.3). • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual deliberate self-injury, i.e., the presence of a self-injury diagnosis where the main reason for the hospital admission is non-MHA-related.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

For example, this diagram shows which events would be considered in the numerator following an MHA-related admission and which other admissions would be considered in the denominator:

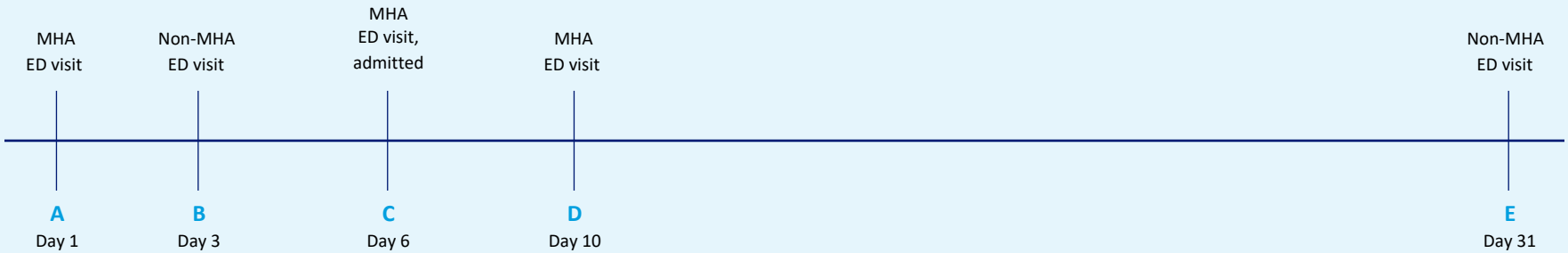


- Denominator includes **A**—**B** and **C**—**D** episodes.
- Numerator includes **C**—**D**.
  A—**B** index → **C**—**D** readmission within 30 days.
  There is no MHA readmission after **C**—**D** discharge.
- This individual contributed denominator = 2, numerator = 1 in this calendar quarter.

2.2.8. Rates of 30-day emergency department revisits following a mental health and addictions–related emergency department visit

Data sets	NACRS, RPDB, PCCF
Denominator	Quarterly number of unscheduled mental health and addictions (MHA)–related emergency department (ED) visits that were discharged home among Ontario residents aged 0–105 years from January 2017 to the current available date
Numerator (subset of the denominator)	Number of individuals in Ontario with an unscheduled ED visit for any MHA-related reason within 30 days following the index ED visit
Exclusions	In addition to general exclusions in Section 2.1.1, also excluded were: • Left index ED visit without being seen • Died in the ED • Admitted to hospital through the ED • ED length of stay > 2 days
Stratifications	See indicator stratifications in Section 2.1.2.
Index	Index ED visit date
Additional specifications/notes	• Index ED visits were restricted to calendar quarters, but ED revisits can cross over to the next calendar quarter, result in a hospital admission, include those who left without being seen, or be for a different MHA diagnosis than the index diagnosis. • Count only the first revisit per person per follow-up period. • For ED to ED transfers, the last record was kept, and transfers were not counted as ED revisits. • Diagnoses-specific denominators do not add up to the overall denominator (see Section 2.3). • Intentional self-injury may be present as a secondary diagnosis in any of the other diagnostic types. Intentional self-injury refers to residual deliberate self-injury, i.e., the presence of a self-injury diagnosis where the main reason for the ED visit is non-MHA-related. • Data did not capture non-physician mental health and addictions care that may have been provided in the period between ED discharge and repeat visit.
Limitations	• General limitations of health administrative data include potential coding errors and lack of clinical detail.

For example, this diagram shows which events would be considered in the numerator following an MHA-related ED visit and which other visits would be considered in the denominator:



- Denominator includes **A**, **D**.
  C resulted in a hospital admission and thus is not in the denominator.

- Numerator includes **C**.
  A index → **C** revisit within 30 days, regardless of hospital admission.
  For **A** index, **D** is not the numerator (count only one numerator [the first applicable] per denominator follow-up).
  There is no MHA-related ED revisit after **D**.

- This individual contributed denominator = 2, numerator = 1 in this calendar quarter.

2.2.9. Length of stay for mental health and addictions-related hospitalizations

Data sets	DAD, OMHRS, RPDB, PCCF
Indicator calculation	Median length of stay (in days) for quarterly mental health and addictions (MHA)–related hospitalizations among individuals aged 0–105 years in Ontario from January 2017 to the current available date
Exclusions	See general exclusions in Section 2.1.1
Stratifications	See indicator stratifications in Section 2.1.2
Index	Hospital discharge date
Additional specifications/notes	• Hospitalizations were constructed as episodes of care: – A DAD-OMHRS episode of care is a series of inpatient admissions to acute care inpatient hospitals (records including DAD and OMHRS) that are linked because the patient was transferred from one hospital to another.
Limitations	General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.10. Rates at which individuals were seen by a psychiatrist, primary care provider or paediatrician for mental health and addictions care

Data sets	OHIP, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of unique individuals who received mental health and addictions (MHA)-related service from a care provider, including primary care providers, psychiatrists and paediatricians, in an outpatient setting. Unique individuals seen for an MHA-related service are presented by provider specialty: • Any specialty • Family physician/general practitioner • Psychiatrist • Paediatrician
Exclusions	See general exclusions in Section 2.1.1
Stratifications	• See indicator stratifications in Section 2.1.2.
Index	Date of OHIP claim
Additional specifications/ notes	• The numerator was derived separately from the denominator. • Exclusions have been pre-applied to the denominator. • Exclusions for the numerator were applied at index. • If a patient had multiple OHIP claims, only the first claim for each physician specialty was considered (i.e., each patient was counted once per specialty).
Limitations	• Rates may be undercounted because some specialists only “shadow bill” (i.e., they submit claims for services provided to patients that are funded through sources other than fee-for-service). • Data did not capture most non-physician mental health and addictions services. • General limitations of health administrative data include potential coding errors and lack of clinical detail.

2.2.11 Rates of eating disorder-related hospitalizations

Data sets	DAD, OMHRS, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of eating disorder–related hospitalizations ICD-10-CA (DAD) codes: F50.0, F50.1, F50.2, F50.3, F50.8, F50.9, F98.2, F98.3 ICD-9-CM (OMHRS, 2016/17 to 2018/19) codes: 307.10, 307.50, 307.51, 307.52, 307.53, 307.59 or a provisional diagnosis = 10 ICD-10-CM (OMHRS, 2019/20 onward) codes: F50.0, F50.1, F50.2, F50.3, F50.8, F50.9, F98.2, F98.3 or a provisional diagnosis = 10
Exclusions	See general exclusions in Section 2.1.1
Stratifications	• By age group (0–17, 18–24, 25–64, and 65–105 years)
Index	Hospital discharge date
Additional specifications/ notes	• Hospitalizations were constructed as episodes of care: A DAD-OMHRS episode of care is a series of inpatient admissions to acute care inpatient hospitals (records including DAD and OMHRS) that are linked because the patient was transferred from one hospital to another. • We include ALL diagnosis codes in DAD (except where diagnosis type = 3) and OMHRS records • The numerator was derived separately from the denominator. • Exclusions were pre-applied to the denominator. • Exclusions were applied to the numerator at index. • Presented as rates, which includes multiple visits per person per quarter.
Limitations	• These codes may undercount the true estimate of eating disorders in adult populations as acute care visits may not be appropriately coded as eating disorders if presenting for medical issues such as bradycardia, electrolyte abnormalities, gastroparesis, etc. • There are fewer adult hospital beds dedicated to eating disorders in the province, and it is rare for these patients to be admitted to general psychiatry units.
References	Smith S. A. (2023) Characteristics of Children and Adolescents Hospitalized with Eating Disorder Diagnoses in Ontario Over Time [MSc Thesis, Institute of Health Policy, Management and Evaluation, University of Toronto]. TSpace Repository (https://tspace.library.utoronto.ca/handle/1807/126918), accessed on May 25, 2023.

2.2.12 Rates of eating disorder-related emergency department visits

Data sets	NACRS, RPDB, PCCF
Denominator	Quarterly Ontario population aged 0–105 years from January 2017 to the current available date
Numerator	Quarterly number of eating disorder–related ED visits ICD-10-CA (NACRS) codes: F50.0, F50.1, F50.2, F50.3, F50.8, F50.9, F98.2, F98.3
Exclusions	See general exclusions in Section 2.1.1
Stratifications	• By age group (0–17, 18–24, 25–64, and 65–105 years)
Index	Date of ED visit
Additional specifications/ notes	• The numerator includes suspect diagnoses, unscheduled ED visits, visits with admissions to hospital, and those who left without being seen. • Includes ALL diagnosis codes in NACRS • Removed duplicates and kept first visit in the case of transfers. • The numerator was derived separately from the denominator. • Exclusions have been pre-applied to the denominator. • Exclusions for the numerator were applied at index. • Presented as rates, which includes multiple visits per person per quarter. • Emergency department visit episodes were constructed to avoid double counting visits that were transfers between multiple institutions and to better identify ED episode discharges.
Limitations	• These codes may undercount the true estimate of eating disorders in adult populations as ED visits may not be appropriately coded as eating disorders if presenting for medical issues such as bradycardia, electrolyte abnormalities, gastroparesis, etc.
References	Smith S. A. (2023) Characteristics of Children and Adolescents Hospitalized with Eating Disorder Diagnoses in Ontario Over Time [MSc Thesis, Institute of Health Policy, Management and Evaluation, University of Toronto]. TSpace Repository (https://tspace.library.utoronto.ca/handle/1807/126918), accessed on May 25, 2023.

2.3 Diagnostic groupings used in indicator calculation

2.3.1. Outpatient visits

Outpatient visits	OHIP algorithm
Any physician specialty	Psychiatrist, paediatrician or family physician/general practitioner, as defined below
Psychiatrist	Any outpatient OHIP-funded visit/consultation held at a psychiatrist's office, patient's residence, long-term care facility, or virtually
Paediatrician	Any outpatient OHIP-funded visit/consultation held at a paediatrician's office, patient's residence, long-term care facility, or virtual, with a mental health diagnostic code listed below (exclude all laboratory fee codes G.x) OR Any OHIP-funded visit/consultation with a paediatrician held at an undefined location, with a mental health diagnostic code listed below and one of the following fee codes: • K122 Developmental and/or behavioural care – individual developmental and/or behavioural care • K123 Developmental and/or behavioural care – family developmental and/or behavioural care • K704 Paediatric outpatient case conference
Primary care provider	Any OHIP-funded visit/consultation held at a FP/GP's office, patient's residence, long-term care facility, or virtual, with a mental health diagnostic code listed below (exclude all laboratory fee codes G.x)
Mental health diagnostic codes	OHIP diagnostic codes: 291–292, 295–299, 300–304, 306–307, 309, 311, 313–315, 897–902, 904–906, 909 Virtual care codes: B099, B100, B200, B103, B203, B209, K080, K081, K082, K083

Note: In September 2022, we changed the algorithm of identifying MHA outpatient visits by applying the MHA diagnosis codes to ALL age groups. Previously the diagnosis codes 291, 292, 299, 307, 313, 314, and 315 were only applied to a) those aged 24 or under, or b) those aged over 24 and seen by psychiatrists. Now, we include all these diagnosis codes submitted by GP/FP, paediatrician, or psychiatrist regardless of the patient's age. With this update, the overall change is about 4% higher. However, in the 85+ group, we see significant increase in rate, and relatively small increase in absolute counts. The diagnosis code 307 (Habit spasms, tics, stuttering, tension headaches, anorexia nervosa, sleep disorders, enuresis) is the driving force; many of these diagnoses are made in individuals who also have a history of dementia or stroke, suggesting that perhaps they are in these cases neurological sequelae of the dementia/stroke or another medical condition and not mental disorders per se. This caveat should be considered when the algorithm is being used in the context of specific research studies.

2.3.2. Hospitalizations

DIAGNOSTIC CODES FROM 2016/17 TO 2018/19 (DSM-5)

Category	ICD-9-CM code (OMHRS)	ICD-10-CA (DAD/NACRS)
Any mental health disorders and addictions	Any diagnosis (including missing, except for 290.x, 294.x in primary diagnosis). If primary diagnosis missing and provisional = 17, exclude	Primary diagnosis F06.x–F99.x (excluding F06.7) or secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x
Substance use disorder	291.x, 292.x, 303.x, 304.x, 305.x, 312.31. Provisional = 16	F10.x–F19.x, F55.x, F63.0
Schizophrenia spectrum and other psychotic disorders	293.81, 293.82, 295.x, 297.x, 298.x. Provisional = 2	F06.0, F06.1, F06.2, F20.x, F22.x–F29.x, F53.1
Mood disorders	293.83, 296.x, 300.4x, 301.13, 311.x, 625.4x. Provisional = 3, 4	F06.3, F30.x–F34.x, F38.x, F39.x, F53.0
Anxiety disorders	293.84, 300, 300.0x, 300.2x, 309.21, 313.23. Provisional = 5	F06.4, F40.x, F41.x, F93.0, F93.1, F93.2, F94.0
Trauma- and stressor-related disorders	308.3x, 309, 309.0x, 309.24, 309.28, 309.3x, 309.4x, 309.81, 309.89, 309.9x, 313.89. Provisional = 7	F43.x, F94.1, F94.2
Obsessive-compulsive disorder and related disorders	300.3x, 312.39, 698.4x. Provisional = 6	F42.x, F63.3
Personality disorders	301, 301.0x, 301.2x, 301.4x, 301.5x, 301.6x, 301.7x, 301.81, 301.82, 301.83, 301.89, 301.9x, 310.1x. Provisional = 18	F07.x, F21.x, F60.x, F61.x, F62.x, F68.8, F69.x
Intentional self-injury (residual)	A diagnosis of X60.x–X84.x, Y10.x–Y19.x, Y28.x in any non-psychiatric diagnostic code field (variables i11h - i11m) in OMHRS[1]	Secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x

[1] Only applicable when last hospital record within the episode of care was in DAD and did not have a primary diagnosis at discharge of F06.x–F99.x (excluding F06.7) or secondary diagnosis of X60.x–X84.x, Y10.x–Y19.x, Y28.x. Non-psychiatric diagnostic fields use ICD-10-CA codes in OMHRS.

Note: For more details on standard mental health and addictions diagnostic codes, see Section 2.3.4.

Note: Unless specified otherwise, we use the primary discharge diagnosis (or the main provisional diagnosis at discharge if the primary discharge diagnosis is missing) of the hospitalization to place the event into a single diagnostic category.

DIAGNOSTIC CODES FROM 2019/2020 ONWARD (BASED ON DSM-5 WITH ICD-10-CM DIAGNOSTIC CODES)

Category	ICD-10-CM code (OMHRS)	ICD-10-CA
Any mental health disorders and addictions	Any diagnosis (including missing, except for neurocognitive disorders in primary diagnosis: A81.9x, F01.x, F02.x, F03.x, F05.x, F06.7x, G10.x, G20.x, G30.x, G31.09, G31.83, G31.84, G31.9x, G35.x, R41.0x, R41.9x, S06.2X9S) If primary diagnosis missing and provisional = 17, exclude	Primary diagnosis F06.x–F99.x (excluding F06.7) or secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x
Substance use disorder	F10.x–F19.x, F55.x, F63.0x, Z72.0, F63.0. Provisional = 16	F10.x–F19.x, F55.x
Schizophrenia spectrum and other psychotic disorders	F06.0x, F06.1x, F06.2x, F20.x, F22.x–F29.x, F53.1x. Provisional = 2	F06.0, F06.1, F06.2, F20.x, F22.x–F29.x, F53.1
Mood disorders	F06.3x, F30.x–F34.x, F39.x, F53.0x. Provisional = 3, 4	F06.3, F30.x–F34.x, F38.x, F39.x, F53.0
Anxiety disorders	F06.4x, F40.x, F41.x, F93.0x, F94.0x. Provisional = 5	F06.4, F40.x, F41.x, F93.0, F93.1, F93.2, F94.0
Trauma- and stressor-related disorders	F43.0x, F43.1x, F43.2x, F43.8x, F43.9x, F94.1x, F94.2x. Provisional = 7	F43.x, F94.1, F94.2
Obsessive-compulsive disorder and related disorders	F42.2x, F42.3x, F42.4x, F42.8x, F42.9x, F45.22, F63.3x. Provisional = 6	F42.x, F63.3
Personality disorders	F07.x, F21.x, F60.x, F68.8x, F69.x. Provisional = 18	F07.x, F21.x, F60.x, F61.x, F62.x, F68.8, F69.x
Intentional self-injury (residual)	A diagnosis of X60.x–X84.x, Y10.x–Y19.x, Y28.x in any non-psychiatric diagnostic code field (variables i11h - i11m) in OMHRS[1]	Secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x

[1] Only applicable when last hospital record within the episode of care was in DAD and did not have a primary diagnosis at discharge of F06.x–F99.x (excluding F06.7) or secondary diagnosis of X60.x–X84.x, Y10.x–Y19.x, Y28.x. Non-psychiatric diagnostic fields use ICD-10-CA codes in OMHRS.

Note: For more details on standard mental health and addictions diagnostic codes, see Section 2.3.4.

Note: Unless specified otherwise, we use the primary discharge diagnosis (or the main provisional diagnosis at discharge if the primary discharge diagnosis is missing) of the hospitalization to place the event into a single diagnostic category.

2.3.3. Emergency department visits

DIAGNOSTIC CODES FROM 2016/17 ONWARD (BASED ON DSM-5)

Emergency department visits	ICD-10-CA (NACRS)
Any mental health disorders and addictions	Primary diagnosis field = F06.x–F99.x (excluding F06.7) or secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x
Substance use disorder	F10.x–F19.x, F55.x, F63.0
Schizophrenia spectrum and other psychotic disorders	F06.0, F06.1, F06.2, F20.x, F22.x–F29.x, F53.1
Mood disorders	F06.3, F30.x–F34.x, F38.x, F39.x, F53.0
Anxiety disorders	F06.4, F40.x, F41.x, F93.0, F93.1, F93.2, F94.0
Trauma- and stressor-related disorders	F43.x, F94.1, F94.2
Obsessive compulsive disorder and related disorders	F42.x, F63.3
Personality disorders	F07.x, F21.x, F60.x, F61.x, F62.x, F68.8, F69.x
Intentional self-injury (residual)	Secondary diagnosis = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x

Note: Unless specified otherwise, we use the primary diagnosis of the ED visit to place the event into a single diagnostic category.

2.3.4 Standard mental health and addictions diagnostic codes

DIAGNOSTIC CODES FROM 2016/17 TO 2018/19

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), Canadian Enhancement codes	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) codes[1]
Substance use disorder	F10: Mental and behavioural disorders due to use of alcohol F11: Mental and behavioural disorders due to use of opioids F12: Mental and behavioural disorders due to use of cannabinoids F13: Mental and behavioural disorders due to use of sedatives or hypnotics F14: Mental and behavioural disorders due to use of cocaine F15: Mental and behavioural disorders due to use of other stimulants, including caffeine F16: Mental and behavioural disorders due to use of hallucinogens F17: Mental and behavioural disorders due to use of tobacco F18: Mental and behavioural disorders due to use of volatile solvents F19: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances F55: Abuse of non-dependence-producing substances F63.0: Pathological Gambling	291.x, 292.x, 303.x, 304.x, 305.x, 312.31. Provisional = 16
Schizophrenia spectrum and other psychotic disorders	F06.0-2: Other mental disorders due to brain damage and dysfunction and to physical disease F20: Schizophrenia F22: Persistent delusional disorders F23: Acute and transient psychotic disorders F24: Induced delusional disorder F25: Schizoaffective disorders F28: Other nonorganic psychotic disorders F29: Unspecified nonorganic psychosis F53.1: Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified	293.81, 293.82, 295.x, 297.x, 298.x. Provisional = 2
Mood disorders	F06.3: Organic mood disorders F30: Manic episode F31: Bipolar affective disorder F32: Depressive episode F33: Recurrent depressive disorder F34: Persistent mood [affective] disorders F38: Other mood [affective] disorders F39: Unspecified mood [affective] disorder F53.0: Mild mental and behavioural disorders associated with the puerperium, not elsewhere classified	293.83, 296.x, 300.4x, 301.13, 311.x, 625.4x. Provisional = 3, 4

[1] For descriptions of DSM-5 codes, see the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. Arlington, VA: American Psychiatric Association; 2013.

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), Canadian Enhancement codes	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) codes[1]
Anxiety disorders	F06.4: Organic anxiety disorder F40: Phobic anxiety disorders F41: Other anxiety disorders F93.0-2: Emotional disorders with onset specific to childhood F94.0: Elective mutism	293.84, 300, 300.0x, 300.2x, 309.21, 313.23. Provisional = 5
Trauma- and stressor-related disorders	F43: Reaction to severe stress and adjustment disorders F94.1: Reactive attachment disorder of childhood F94.2: Disinhibited attachment disorder of childhood	308.3x, 309, 309.0x, 309.24, 309.28, 309.3x, 309.4x, 309.81, 309.89, 309.9x, 313.89. Provisional = 7
Obsessive-compulsive disorder and related disorders	F42: Obsessive-compulsive disorder F63.3: Trichotillomania	300.3x, 312.39, 698.4x. Provisional = 6
Personality disorders	F07: Organic personality disorder F21: Schizotypal disorder F60: Specific personality disorders F61: Mixed and other personality disorders F62: Enduring personality changes, not attributable to brain damage and disease F68.8: Other disorders of adult personality and behaviour F69: Unspecified disorder of adult personality and behaviour	301, 301.0x, 301.2x, 301.4x, 301.5x, 301.6x, 301.7x, 301.81, 301.82, 301.83, 301.89, 301.9x, 310.1x. Provisional = 18
Intentional self-injury (residual)	X60: Intentional self-poisoning by and exposure to non-opioid analgesics, antipyretics and antirheumatics X61: Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, NOS X62: Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], NOS X63: Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system X64: Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances X65: Intentional self-poisoning by and exposure to alcohol	Not applicable

Diagnostic category	International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), Canadian Enhancement codes	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) codes[1]
Intentional self-injury (residual)	X66: Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours X67: Intentional self-poisoning by and exposure to other gases and vapours X68: Intentional self-poisoning by and exposure to pesticides X69: Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances X70: Intentional self-harm by hanging, strangulation and suffocation X71: Intentional self-harm by drowning and submersion X72: Intentional self-harm by handgun discharge X73: Intentional self-harm by rifle, shotgun and larger firearm discharge X74: Intentional self-harm by other and unspecified firearm discharge X75: Intentional self-harm by explosive material X76: Intentional self-harm by smoke, fire and flames X77: Intentional self-harm by steam, hot vapours and hot objects X78: Intentional self-harm by sharp object X79: Intentional self-harm by blunt object X80: Intentional self-harm by jumping from a high place X81: Intentional self-harm by jumping or lying before a moving object X82: Intentional self-harm by crashing of motor vehicle X83: Intentional self-harm by other specified means X84: Intentional self-harm by unspecified means Y10: Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined intent Y11: Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent Y12: Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent Y13: Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent Y14: Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent Y15: Poisoning by and exposure to alcohol, undetermined intent Y16: Poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours, undetermined intent Y17: Poisoning by and exposure to other gases and vapours, undetermined intent Y18: Poisoning by and exposure to pesticides, undetermined intent Y19: Poisoning by and exposure to other and unspecified chemicals and noxious substances, undetermined intent Y28: Contact with sharp object, undetermined intent	Not applicable

DIAGNOSTIC CODES FROM 2019/20 ONWARD (BASED ON DSM-5)

Category	ICD-10-CM code (OMHRS)	ICD-10-CA (DAD/NACRS)
Substance use disorder	F10 – Alcohol-related disorders F11 – Opioid-related disorders F12 – Cannabis-related disorders F13 – Sedative, hypnotic, or anxiolytic-related disorders F14 – Cocaine-related disorders F15 – Other stimulant-related disorders F16 – Hallucinogen-related disorders F17 – Nicotine dependence F18 – Inhalant-related disorders F19 – Other psychoactive substance-related disorders F55 – Abuse of non-psychoactive substances F63.0 – Pathological gambling Z72.0 – Tobacco use disorder Provisional = 16	F10.x–F19.x, F55.x, F63.0
Schizophrenia spectrum and other psychotic disorders	F06.0 – Psychotic disorder due to another medical condition with hallucinations F06.1 – Unspecified catatonia F06.2 – Psychotic disorder due to another medical condition with delusions F20 – Schizophrenia F22 – Delusional disorder F23 – Brief psychotic disorder F24 – Shared psychotic disorder F25 – Schizoaffective disorders F28 – Other specified schizophrenia spectrum and other psychotic disorder F29 – Unspecified schizophrenia spectrum and other psychotic disorder F53.1 - Puerperal psychosis Provisional = 2	F06.0, F06.1, F06.2, F20.x, F22.x–F29.x, F53.1
Mood disorders	F06.3 – Bipolar and related disorder due to another medical condition F30 – Manic episode F31 – Bipolar and related disorder F32 – Major depressive disorder, single episode F33 – Major depressive disorder, recurrent episode F34 – Cyclothymic disorder F39 – Unspecific mood disorder F53.0 – Postpartum depression Provisional = 3, 4	F06.3, F30.x–F34.x, F38.x, F39.x, F53.0
Anxiety disorders	F06.4 – Anxiety disorder due to another medical condition F40 – Phobic anxiety disorders F41 – Other anxiety disorder F93.0 – Separation anxiety disorder F94.0 – Selective mutism Provisional = 5	F06.4, F40.x, F41.x, F93.0, F93.1, F93.2, F94.0

Category	ICD-10-CM code (OMHRS)	ICD-10-CA (DAD/NACRS)
Trauma- and stressor-related disorders	F43.0 – Acute stress disorder F43.1 – Posttraumatic stress disorder F43.2 – Adjustment disorder F43.8 – Other specified trauma- and stressor- related disorder F43.9 – Unspecified trauma and stressor related disorder F94.1 – Reactive attachment disorder F94.2 – Disinhibited social engagement disorder Provisional = 7	F43.x, F94.1, F94.2
Obsessive-compulsive disorder and related disorders	F42.2 – Obsessive compulsive disorders F42.3 – Hoarding disorder F42.4 – Excoriation (skin picking) disorder F42.8 – Other specified obsessive-compulsive and related disorder F42.9 – Unspecified obsessive-compulsive and related disorder F45.22 – Body dysmorphic disorder F63.3 – Trichotillomania (hair pulling disorder) Provisional = 6	F42.x, F63.3
Personality disorders	F07 – Personality and behavioural disorders due to known physiological condition F21 – Schizotypal disorder F60 – Specific personality disorders F68.8 – Other specified disorders of adult personality and behaviour F69 – Unspecified disorder of adult personality and behaviour Provisional = 18	F07.x, F21.x, F60.x, F61.x, F62.x, F68.8, F69.x
Intentional self-injury (residual)	Not applicable (Non-psychiatric diagnosis code fields in OMHRS are coded using the ICD-10-CA system)	Secondary diagnosis fields = X60.x–X84.x, Y10.x–Y19.x, Y28.x when primary diagnosis is not F06.0, F06.1, F06.2, F06.3, F06.4, F06.5, F06.6, F06.8, F06.9, F07.x–F99.x

OHIP DIAGNOSTIC CODES (BASED ON ICD-8-CM)

Category	International Classification of Diseases, Eighth Revision, Clinical Modification (ICD-8-CM) code
Any mental health disorder or addiction	Visits related to psychotic disorders 295: Schizophrenia 297: Other paranoid states 298: Other psychoses Visits related to anxiety and mood disorders 296: Manic-depressive psychoses, involutional melancholia 300: Anxiety neurosis, hysteria, neurasthenia, obsessive-compulsive neurosis, reactive depression 311: Depressive disorder Visits related to substance use disorders 291: Alcoholic psychosis, delirium tremens, Korsakov's psychosis 292: Drug psychosis 303: Alcoholism 304: Drug dependence Visits related to behavioural and neurodevelopmental disorders 299: Childhood psychoses (e.g., autism) 313: Behaviour disorders of childhood and adolescence 314: Hyperkinetic syndrome of childhood 315: Specified delays in development (e.g., dyslexia, dyslalia, motor retardation) Visits related to other mental health disorders 301: Personality disorders 302: Sexual deviations 306: Psychosomatic illness 307: Habit spasms, tics, stuttering, tension headaches, anorexia nervosa, sleep disorders 309: Adjustment reaction Visits related to social problems of childhood and adolescence 899: Parent-child problems 902: Education problems 904: Social maladjustment 909: Other problems of social adjustment Visits related to other social and family problems 897: Economic problems 898: Marital difficulties 900: Problems with aged parents or in-laws 901: Family disruption/divorce 905: Occupational problems 906: Legal problems



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