Hospital Mental Health Database, 2014–2015: User Documentation

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Production of this document is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6

Phone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca
copyright@cihi.ca

Cette publication est aussi disponible en français sous le titre *Base de données sur la santé mentale en milieu hospitalier, 2014-2015 : documentation de l'utilisateur*.

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1 Introduction

This document provides users of the Hospital Mental Health Database (HMHDB) with information on its history and composition, as well as on the limitations of the data and the fitness of the data for various uses.

The HMHDB is an annual (fiscal year), pan-Canadian, event-based database that contains information on inpatient separations for psychiatric conditions from both general and psychiatric hospitals. The current database contains information on admission and separation dates, as well as diagnosis and demographic information. Since the HMHDB is event-based rather than person-based, a client who had more than 1 hospital separation for a psychiatric condition in the fiscal year will appear in the database multiple times. In addition, the HMHDB is created based on information regarding separations from hospitals, which can occur through either discharge or death. Some clients who are hospitalized in a given fiscal year are not separated until a subsequent fiscal year. In these cases, records are included in the database in the year of separation, not the year of admission to hospital.

Prior to 1994, Statistics Canada's Mental Health Statistics program was responsible for collecting data on hospitalizations for mental disorders via the Hospital Mental Health Survey (HMHS). Historical data for 1930 to 1994 is maintained by Statistics Canada. The Canadian Institute for Health Information (CIHI) assumed responsibility for collecting, compiling, analyzing and disseminating data on mental health hospitalizations as of the 1994–1995 fiscal year. This includes responsibility for administering the HMHS, which continues to contribute a portion of records to the HMHDB.

CIHI's first annual report on hospital mental health services was released in 2003, and was based on the data contained in the HMHDB for 2000–2001. The report focused on lengths of stay and separations for psychiatric conditions and contained results of analyses by province/territory, mental health diagnosis categories and selected demographic characteristics. Since 2010–2011, the most recent statistics on hospital mental health services have been available through the Quick Stats application on CIHI's website. A historical series of reports on hospital mental health services can be found on CIHI's website as well.

In 2006–2007, a client identifier (person's encrypted health card number) was added to HMHDB records, thereby allowing for the linkage of separations belonging to the same client. This identifier is available for all records except those that were extracted from the HMHS; these constitute a small proportion of the database (less than 0.5% per fiscal year). For item non-response rates for encrypted Health Card Number (HCN) by hospital type, please refer to Table 6.

As of October 1, 2006, Ontario facilities with designated adult mental health beds were mandated by the Ontario Ministry of Health and Long-Term Care (MOHLTC) to report psychiatric data to CIHI through the Ontario Mental Health Reporting System (OMHRS). Thus OMHRS has been integrated into the HMHDB since 2006–2007.

The current HMHDB has 2 primary components:

- General hospital data based on psychiatric separations, which is extracted as a subset of the Discharge Abstract Database (DAD)/Hospital Morbidity Database (HMDB)[i] and OMHRS; and
- Psychiatric hospital data, which is extracted from the DAD/HMDB, the HMHS and OMHRS.

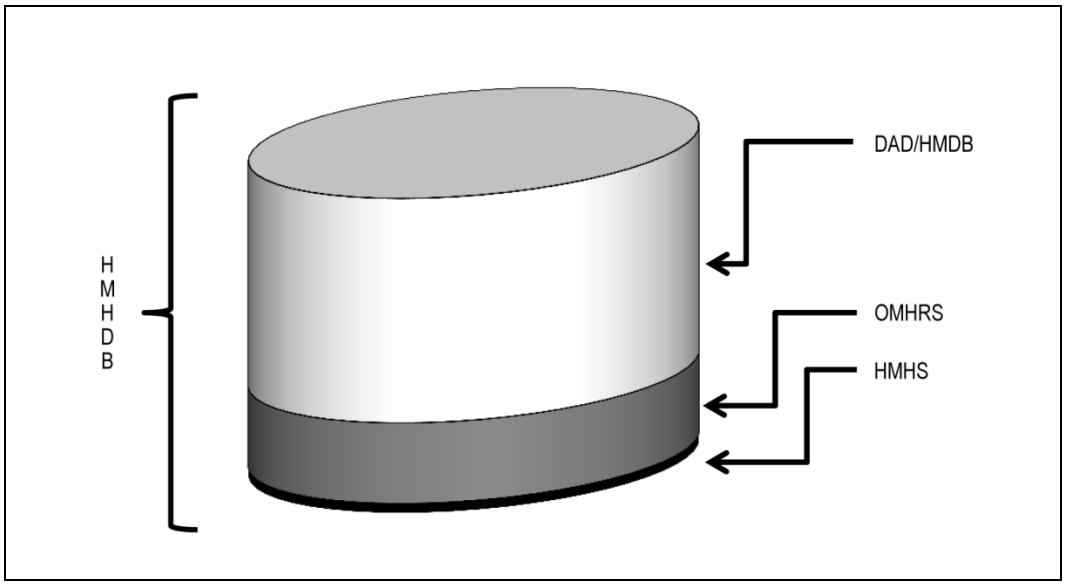
For DAD/HMDB facilities, hospital type is based on the Analytical Institution Type Code, a CIHI-defined data element used to identify the level of care for facilities in the DAD/HMDB. Prior to assigning this value, CIHI consults and confirms the level of care with the institutions and the provincial and territorial ministries or departments of health. For OMHRS facilities, hospital type is based on the OMHRS Peer Group. OMHRS Peer Group is based on the nature of the services, the type of hospital in which the service is located, the provincial or regional designation and/or the self-assignment of the facility. The 2 HMHS facilities are psychiatric facilities.

The data sources for the HMHDB are illustrated in Figure 1, with jurisdiction-specific details in Table 1. The process for creating the HMHDB is discussed in greater detail below.

Quality assessment for the 2014–2015 data, of which the present document is a summary, was conducted in August 2016.

i. The DAD receives data directly from acute care facilities or from their respective health/regional authority or ministry/department of health. Facilities in all provinces and territories except Quebec are required to report. Data from Quebec is submitted to CIHI directly by the ministère de la Santé et des Services sociaux du Québec. This data is appended to the DAD to create the HMDB.

Figure 1 Data sources for the Hospital Mental Health Database



Notes
HMHDB: Hospital Mental Health Database.
DAD: Discharge Abstract Database.
HMDB: Hospital Morbidity Database.
OMHRS: Ontario Mental Health Reporting System.
HMHS: Hospital Mental Health Survey.

Table 1 Data sources for general and psychiatric hospitals in the Hospital Mental Health Database

Province/territory	Data source
British Columbia	DAD
Alberta	DAD
Saskatchewan	DAD HMHS
Manitoba*	DAD HMHS OMHRS
Ontario†	DAD OMHRS
Quebec	HMDB
New Brunswick	DAD

Province/territory	Data source
Nova Scotia	DAD
Prince Edward Island	DAD
Newfoundland and Labrador	DAD
Yukon	DAD
Northwest Territories	DAD
Nunavut	DAD

Notes

* A Manitoba psychiatric facility, Selkirk Mental Health Centre, started submitting data to OMHRS in 2013–2014.

† Ontario general and psychiatric hospitals report separations from designated adult mental health beds to OMHRS. Ontario general and psychiatric hospitals report separations from non-OMHRS beds to the DAD.

DAD: Discharge Abstract Database.

HMHS: Hospital Mental Health Survey.

OMHRS: Ontario Mental Health Reporting System.

HMDB: Hospital Morbidity Database.

2 Concepts and definitions

2.1 Purpose

The purpose of the HMHDB is to compile and provide pan-Canadian information on separations from psychiatric and general hospitals for clients who have a primary diagnosis of mental illness or addiction.

2.2 Population

The population of reference is defined as all separations that have a most responsible diagnosis of a psychiatric condition, from psychiatric and general hospitals in Canada that were *expected to submit* data to the DAD/HMDB, the HMHS or OMHRS, between April 1, 2014, and March 31, 2015. This definition reflects a change from years prior to 2014–2015. Previously, the population of reference was based on separations from hospitals that *submitted* data to the DAD/HMDB, the HMHS or OMHRS in the given fiscal year. Statistics in this report are based on the revised definition of the population of reference.

All records from psychiatric facilities and OMHRS facilities are extracted for the HMHDB. Separations with diagnosis codes not attributable to a psychiatric condition are classified to the category Non–Mental Health (non-MH) disorders. Statistics in this report exclude separations for non-MH disorders.

In 2014–2015, 165,671 separations (74.4%) were extracted from the DAD/HMDB; 56,617 separations (25.4%) were from OMHRS; and 317 separations (0.14%) were from the HMHS.

Table 2 shows the number of facilities that reported data, the number of separations and the total length of stay for general and psychiatric hospitals. In 2014–2015, the HMHDB contained data on 222,605 separations. Of these separations, 196,225 (88.1%) were psychiatric separations from general hospitals; the remaining 26,380 (11.9%) separations were from psychiatric hospitals. These separations came from a total of 805 hospitals located across Canada.

Table 2 Separations and length of stay by hospital type,* Hospital Mental Health Database, 2014–2015

Type of hospital	Number of submitting facilities	Number of separations	Length of stay (total days)
General	751	196,225	3,460,798
Psychiatric	54	26,380	1,910,107
Total	**805**	**222,605**	**5,370,905**

Note

* The generic term "hospital" is used throughout this report, while the analysis is based on reporting facilities. It is possible that a hospital may have more than 1 reporting facility.

It is important to note that the number of facilities included in the HMHDB may vary from one fiscal year to the next for various reasons, including reorganization that results in some hospitals reporting under 2 separate facility numbers, where previously they reported under only 1; the reappearance in the database of a facility that previously had separation counts at or around 0; and the exclusion of facilities from the HMHDB due to data quality issues or reporting constraints. As well, a facility may be free-standing, a unit or a collection of beds within a hospital. As such, a hospital may have more than 1 reporting facility.

2.3 Data elements and concepts

The data elements in the HMHDB focus primarily on hospital separations and lengths of stay and are based on admission and separation dates. In addition, the data elements include a client identifier (i.e., encrypted HCN), diagnoses, age at admission, age at separation, sex and discharge disposition.

Table 3 provides a list of the key data elements in the HMHDB data file. Extended descriptions of these and additional data elements (e.g., primary diagnosis) are available in the document *Hospital Mental Health Database Data Dictionary for Fiscal Year 2014–2015*, which can be found on the HMHDB metadata web page.

Table 3 Main data elements, Hospital Mental Health Database

Data element	Description	Type (length)
HMHDB_DATA_YEAR	The fiscal year the person was separated (April 1 to March 31)	Num (8)
PROV	The code for the province/territory in which the reporting facility is located	Char (2)
HOSP	The facility identification number as assigned by the province/territory	Char (5)
BIRTHDATE	Birthdate of person	Num (8)
SEX	Sex of person	Char (1)
PATIENT_POSTALCODE	Residential postal code of person	Char (6)
ADMITAGE	The age of the person at admission	Num (8)
SEPAGE	The age of the person at separation	Num (8)
ADMITDATE	The date the person was admitted to the facility	Num (8)
SEPDATE	The date the person was formally separated from the facility	Num (8)
LOS	The total number of days the person was hospitalized	Num (8)
DATA_SOURCE	Indicates the original data source for the record (DAD/HMDB, HMHS or OMHRS)	Num (8)
ENCRYPTED_HCN	Encrypted health card number	Char (12)
HEALTH_CARD_PROV_CODE*	The province/territory issuing the health card number	Char (2)
PSYCH_HOSP	Indicates whether a record is from a general or psychiatric facility	Num (8)
DIAGCATEGORY†	The mental health diagnosis category	Char (40)
HOMELESS	Indicates whether a person was homeless on admission	Num (8)
ADMITTED_VIA_ED	Indicates whether a person was admitted via the emergency department	Num (8)
HOSP_POSTALCODE	The reporting facility's postal code	Char (6)
DISCHARGE_DISPOSITION	Location to which the person was discharged or the status of the person on discharge	Num (8)

Notes

* Not available for records from Quebec and the HMHS.

† Please refer to the appendix Mental illness diagnosis categories and subcategories in the HMHDB Data Dictionary for Fiscal Year 2014-2015, which can be found on the HMHDB metadata web page.

3 Major data limitations

Prior to 2006–2007, the HMHDB did not include encrypted HCN or any other variable designed to uniquely identify a client. For those years, a client's records cannot be linked across time. As mentioned previously, clients who have had multiple separations appear in the database on multiple occasions. For 2006–2007 onward, the HMHDB includes both encrypted HCN and the province/territory that issued the HCN, which can be used in combination to identify unique clients and link their records within the HMHDB and with other CIHI data.

Changes to the database frame occur each year for a number of reasons, as noted in Section 2.2 — Population. Frame changes result in some limits on comparability, particularly for more detailed analyses. For example, changes in the number of psychiatric hospitals in a jurisdiction (due to re-typing, closure, etc.) will have a greater impact on analyses that provide a breakdown by facility type. Large changes to length of stay or number of separations may partly reflect changes such as mergers, closures and splits as well as non-frame changes such as bed numbers.

HMHDB extraction criteria were modified in 2011–2012, as described in Section 5.1 — Data collection/abstraction. The changes result in some limits on comparability with prior years, particularly for more detailed analyses.

Finally, the integration of OMHRS into the HMHDB resulted in data limitations that are important to note. As of 2006–2007, OMHRS data has been integrated into the HMHDB for designated adult inpatient mental health beds in Ontario. The major limitations that persist from 2006–2007 are summarized as follows:

- 2 types of mental health diagnostic codes are captured in an OMHRS record: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) codes and DSM-IV-TR Diagnostic Categories. About 20% and 18% of OMHRS records in the HMHDB for 2006–2007 and 2007–2008, respectively, had neither provisional diagnostic category nor DSM-IV-TR codes. This missing diagnostic information will affect some estimated indicators that were generated for diagnosis-specific groupings. For 2008–2009, the proportion of records with missing diagnostic information decreased substantially to less than 1%. Since 2009–2010, the proportion has dropped to 0.
- There is a potential data quality issue in the HMHDB for 2007–2008 onward due to the issue of OMHRS open episodes of care. Open episodes are those for which an admission record was submitted to CIHI but not a subsequent record. These are cases for which a quarterly, change-in-status or discharge assessment was expected during the current reporting quarter but was not received and accepted into the OMHRS database at CIHI. By the end of 2014–2015, open episodes represented less than 0.1% of the total number

of episodes in the OMHRS database (based on a June 1, 2015, snapshot) and no longer presented a significant data quality issue. A portion of these open episodes may be the result of persons being discharged from the facility without a discharge assessment being submitted to CIHI. Consequently, these clients are not included in the HMHDB (as it is based on separations).

- When the Ontario MOHLTC mandated reporting to OMHRS, each facility that reported to OMHRS was assigned a new facility number to report discharges from designated adult mental health beds; however, discharges related to mental health treatment for clients in undesignated mental health beds in these facilities were still reported with the previous facility number. As a result, some facilities have at least 2 different facility numbers over time and more than 1 number in a given year. In some instances, 2 facility numbers may be used to represent a single facility. Any analysis at the facility level should be conducted after considering the source of the facility number.

4 Coverage

4.1 HMHDB frame

All hospital separations that were treated in designated adult mental health beds in Ontario have been captured in OMHRS as of 2006–2007. Since that time, there have been separations for psychiatric illness in Ontario that were treated in non-OMHRS beds; these were captured in the DAD/HMDB and extracted from there for inclusion in the HMHDB.

The frame of the HMHDB includes all facilities that were expected to submit data on psychiatric separations to the DAD/HMDB, the HMHS or OMHRS. A hospital was expected to submit data for inclusion in the HMHDB if that hospital contributed any records to the HMHDB in the 3-year period ending March 31, 2015. Data on separations for psychiatric conditions was submitted by hospitals from all provinces and territories. The proportion of data from general hospitals as compared with psychiatric hospitals has remained relatively stable over time (Table 4).

Table 4 Proportion of separations by hospital type, Hospital Mental Health Database, 2006–2007 to 2014–2015

Fiscal year	General	Psychiatric
2006–2007	86.9%	13.1%
2007–2008	86.7%	13.3%
2008–2009	87.1%	12.9%
2009–2010	87.1%	12.9%
2010–2011	86.4%	13.6%
2011–2012	87.7%	12.3%
2012–2013	86.1%	13.9%
2013–2014	86.9%	13.1%
2014–2015	88.1%	11.9%

4.2 Frame maintenance procedures

The DAD/HMDB and OMHRS teams at CIHI have kept all internal users of their data apprised of changes affecting those facilities that report to the DAD/HMDB and OMHRS.

4.3 Impact of the frame maintenance procedures

As changes to the HMHDB frame occur yearly, the major impact of such changes will be on the comparability of the data over time. In some jurisdictions, restructuring of health services has meant that institutions have been reclassified. Often the changes involve psychiatric facilities becoming part of a general hospital or part of a larger hospital system. As such, in addition to an impact on temporal comparisons, provincial comparisons of indices, such as average length of stay, will be affected because of variations in the amount of reclassification between psychiatric and general hospitals.

CIHI provides guidance to each ministry of health on how to manage DAD submissions when 2 acute care facilities amalgamate. CIHI recommends that a single DAD abstract be submitted when the patient is formally discharged, using the facility number that is in effect at that time. For the period of the stay when a prior facility number was in effect, CIHI recommends that a separate abstract should not be submitted.

When OMHRS Ontario facility closures, mergers and splits happen, based on current direction from the MOHLTC, OMHRS Ontario facilities should discharge patients from the old facility number and admit them under the new facility number, with the new admit date being the same as the old discharge date. As the HMHDB takes a snapshot of OMHRS and is based on separations, this will result in false separations in the HMHDB for the given fiscal year, followed by real separations at the actual discharge and a splitting of the true length of stay for that episode of care.

5 Collection and non-response

5.1 Data collection/abstraction

The 4 data sources for the HMHDB are the DAD, the HMDB, the HMHS and OMHRS (see Figure 1). Data from the DAD/HMDB for general hospitals was included in the HMHDB when the most responsible diagnosis was a psychiatric condition. Data from psychiatric hospitals and OMHRS facilities was included regardless of diagnosis. However, separations for non-MH disorders are excluded from the statistics in this report.

For 2014–2015, diagnostic data was submitted to the DAD/HMDB using the ICD-10-CA coding format, to OMHRS using the DSM-IV-TR coding format and to the HMHS using the DSM-IV-TR coding format for 1 psychiatric facility in Saskatchewan and the ICD-9-CM coding format for 1 psychiatric facility in Manitoba.

Extraction of the data files for the HMHDB was conducted according to the diagnostic classification system in which the data was originally coded. Separations were then grouped into broad mental health categories[ii] based on the primary diagnosis code (or the provisional category assigned in OMHRS, where specific diagnosis codes were not available). Starting in 2011–2012, additional codes were included in the extraction criteria (O99.3, R41.0 and R41.3 in ICD-10-CA). R41.0 and R41.3 were subsequently excluded from the extraction criteria as of the 2014–2015 fiscal year.

The OMHRS database is longitudinal in nature — late data is accepted as long as it meets the current submission specifications. This means that later data cuts may include records from a previous quarter that were submitted after the submission deadline for that previous quarter. Typically, late submissions account for less than 1.5% of overall OMHRS records, but this rate may vary by facility. The HMHDB uses a June 1 snapshot of the OMHRS database for the previous fiscal year and does not make revisions thereafter.

ii. Please refer to the appendix Mental illness diagnosis categories and subcategories in the HMHDB Data Dictionary for Fiscal Year 2014-2015, which can be found on the HMHDB metadata web page.

The data that comprised the HMHS was received from provincial providers in electronic format. Table 5 identifies jurisdictions and classification systems used to report their data.

Table 5 Diagnosis classification coding systems, by province/territory

Province/territory	Diagnosis classification coding system
British Columbia	ICD-10-CA
Alberta	ICD-10-CA
Saskatchewan	ICD-10-CA/DSM-IV-TR*
Manitoba	ICD-10-CA/ICD-9-CM*/DSM-IV-TR
Ontario	ICD-10-CA/DSM-IV-TR
Quebec	ICD-10-CA
New Brunswick	ICD-10-CA
Nova Scotia	ICD-10-CA
Prince Edward Island	ICD-10-CA
Newfoundland and Labrador	ICD-10-CA
Yukon	ICD-10-CA
Northwest Territories	ICD-10-CA
Nunavut	ICD-10-CA

Note

* Applicable only to facilities that submitted to CIHI through the HMHS.

5.2 Data quality control

Controls on data quality for the HMHDB are based on protocols developed for the DAD, the HMDB, the HMHS and OMHRS.

Data from the DAD is subjected to a series of data quality steps that are intended to ensure data accuracy, to maintain the frame and to identify problem areas. In 2010–2011, the most recent reabstraction study on the contents of the DAD indicated that the level of overall error was minimal. You can find information about data quality for the DAD, HMDB and OMHRS on the following web pages:

- On the page Discharge Abstract Database (DAD) Metadata, under Data Quality, look for the PDF *Current-Year Information, 2014–2015*.

- On the page Hospital Morbidity Database (HMDB) Metadata, under Data Quality, look for the PDFs *Current-Year Information, 2014–2015* and *Quality Assurance Processes Applied to the DAD and HMDB, December 2007*.
- On the page Ontario Mental Health Reporting System (OMHRS) Metadata, under Data Quality, look for the PDF *2014–2015*.
- In CIHI's online store of health care system products, look for "Discharge Abstract Database (DAD) Re-abstraction Studies."

5.3 Non-response

Analyses in this section are based on the population of reference, as defined in Section 2.2 — Population and Section 4.1 — HMHDB frame.

Unit non-response occurs when entire records are missing from the database. The unit non-response rate at the record level was 0.27% in 2014–2015 due to the following issues:

- Lakeshore General Hospital in Quebec did not submit data in time for inclusion in the DAD/HMDB, which resulted in an estimated 597 separations not being included in the HMHDB.
- Glengarry Memorial Hospital in Ontario submitted partial data to the DAD, which resulted in an estimated 3 separations not being included in the HMHDB.

The unit non-response rate at the hospital level was 0.12%, due to the above-noted facility in Quebec that did not submit 2014–2015 data.

Item non-response usually occurs when a record that is received has some missing data elements that should not be missing. Item non-response differs from unit non-response in that unit non-response deals with the number of units or records that are missing, while item non-response deals with the number of data elements that are missing within a record.

Item non-response for a data element is calculated as follows and expressed as a percentage:

(1 − (number of records for which the data element was reported ÷ number of records for which the data element should have been reported)) × 100

Within the HMHDB data, certain data elements are available for only 1 of the data sources. Partial reporting can also be a function of provincial practices; an example is the 2-letter postal abbreviation that is used for Quebec separations instead of the 6-digit postal code. Item non-response rates for some of the key data elements in the HMHDB are listed in Table 6.

Table 6 Item non-response rates (percentage), Hospital Mental Health Database, 2014–2015

Data element	Psychiatric hospitals N = 26,380	General hospitals N = 196,225	All hospitals N = 222,605
Patient Postal Code*	1.6	0.5	0.6
Discharge Disposition	1.2	0.0	0.1
Encrypted HCN†	2.5	1.0	1.1
Patient Date of Birth	27.3	21.0	21.7

Notes

* The percentages listed reflect missing values only. Quebec provides the 2-letter postal abbreviation (QC). A method is in place to map these separations to their appropriate health region. Additionally, jurisdictions may use a 2-letter postal (or other) abbreviation or the 3-digit forward sortation area code instead of the full postal code. For example, XX may be used in the postal code field in the DAD/HMDB to indicate that the patient is homeless. These instances are not counted above as true non-responses, as data has been reported.

† The percentages listed reflect blank values and specific codes used in OMHRS and the DAD/HMDB to indicate unknown or invalid values. HCN is not provided by the 2 facilities that report via the HMHS (317 psychiatric hospital separations [0.14% of the HMHDB or 1.2% of psychiatric hospital separations] for 2014–2015). For details on non-response rates for source data holdings (DAD/HMDB and OMHRS), please refer to their respective user documentation (links provided in Section 5.2 — Data quality control).

5.4 Adjustment for non-response

Imputation was used to populate the diagnosis category (the broad mental health category that is based on the primary separation diagnosis code) when the primary diagnosis value from OMHRS or the HMHS was missing.

6 Revision history

Since the HMHDB was acquired from Statistics Canada, the main changes to the database have involved the frame, diagnostic coding and the addition of a client identifier. Diagnostic coding using the International Classification of Diseases has changed from using version ICD-9-CM[iii] to version ICD-10-CA. Another classification system, DSM-IV-TR, is used for OMHRS data. In 2006–2007, a client identifier consisting of a person's encrypted HCN was added. Additionally, the data element of the province/territory issuing the HCN was added in 2012–2013 (and retrospectively included back to 2006–2007) to improve the accuracy of linkage of client separations.

iii. 1 Manitoba psychiatric facility reporting to the HMHS still uses the ICD-9-CM classification system.

Since 2006–2007, information on health regions and mental health categories has been added to the database to facilitate mapping data to specific groupings. However, this information has not resulted in any major revisions to the data set.

In 2011–2012, the following major changes were made:

- Additional mental health codes were added to the extraction criteria for the DAD/HMDB.
- Extraction criteria for OMHRS records were modified to include all separations.
- The broad mental health category diagnostic grouping table was further refined and now includes additional ICD-10-CA and DSM-IV-TR codes.
- New data elements (Homeless and Admitted via Emergency indicators, Facility Postal Code and Discharge Disposition) were included.

As stated in Section 5.1 — Data collection/abstraction, mental health codes R41.0 and R41.3 were added to the extraction criteria in 2011–2012 and were removed from the extraction criteria in 2014–2015.

Although the population of reference was redefined as of 2014–2015, as noted in Section 2.2 — Population, there was no change to the HMHDB extraction criteria. As of 2014–2015, records that do not meet the criteria for the population of reference remain in the database but are excluded from data quality analyses, such as those included in this report.

7 Comparability

The HMHDB makes a number of comparisons possible for indicators such as hospital length of stay and number of separations. When making comparisons over time (using previous iterations of the database) or across provinces/territories, users should be aware that certain limitations might apply. In particular, comparisons over time might be affected by changes in the frame that result in changes to the number of reporting facilities, and by changes to the extraction criteria for the HMHDB.

The HMHDB synthesizes data on hospital separations from several sources. As such, it is a unique resource for pan-Canadian information on and comparison of separations that have a most responsible diagnosis of a psychiatric condition. Provincial comparisons for separations and lengths of stay were provided in the *Hospital Mental Health Services in Canada* report series; as well, a dynamic presentation of the latest mental health statistics is provided through the Quick Stats application on CIHI's website. The data set also allows for comparisons among mental health diagnosis categories, between general and psychiatric hospitals, as well as among provinces, territories and health regions.

8 Contact

For more information about the HMHDB, email the Mental Health and Addictions program area or visit CIHI's Mental Health and Addictions web page.

Talk to us

CIHI Ottawa
495 Richmond Road
Suite 600
Ottawa, Ont.
K2A 4H6
613-241-7860

CIHI Toronto
4110 Yonge Street
Suite 300
Toronto, Ont.
M2P 2B7
416-481-2002

CIHI Victoria
880 Douglas Street
Suite 600
Victoria, B.C.
V8W 2B7
250-220-4100

CIHI Montréal
1010 Sherbrooke Street West
Suite 602
Montréal, Que.
H3A 2R7
514-842-2226

13665-0965

cihi.ca help@cihi.ca