# Ontario Mental Health Surveillance Report (April 2019)

**Provincial coverage: 161 hospitals reporting to ACES (10 hospitals outstanding)**

For more information on the Acute Care Enhanced Surveillance (ACES) system, click here.

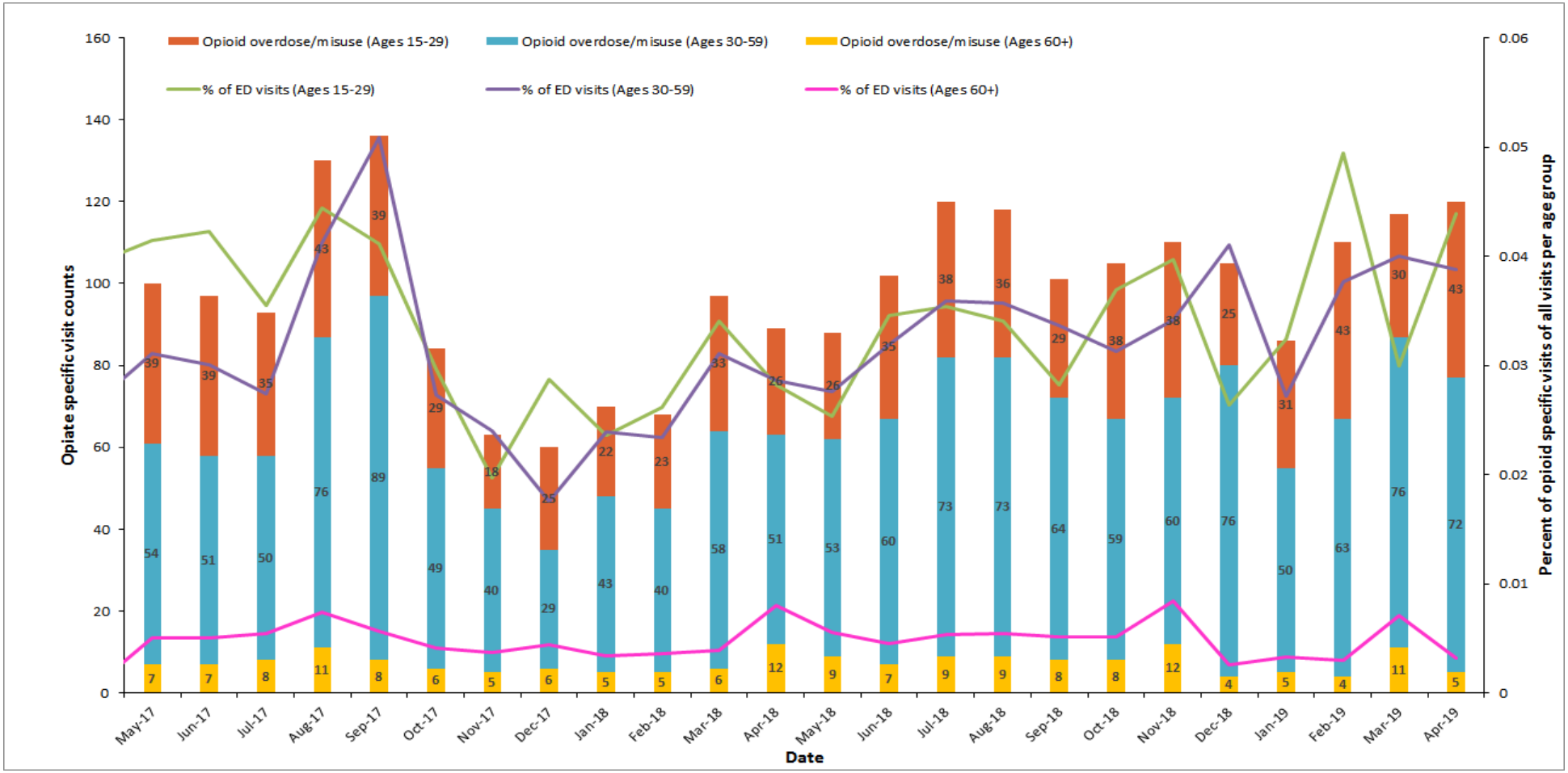
Report created by the
Kingston, Frontenac and Lennox & Addington
Public Health Knowledge Management Team

## ACES Hospital Emergency Department (ED) Activity

The purpose of this report is 1) to describe the healthcare seeking behaviours of Ontarians (over the age of 14) with a complex range of mental health disorders that are poorly captured by any current active surveillance system; 2) to capture any changing trends in acute care hospital utilization and demographics to illustrate the evolving state of mental health in Ontario; and 3) to inform policy and practice at all levels of healthcare.

**Opioid surveillance:** Using real-time ED visit data for opioid-related surveillance is difficult given that hospital triage staff may not have a clear idea of what the patient has overdosed on/misused. This is plainly shown when looking at the graph below compared to the non-specific drug graph on page two. Non-specific drug overdoses/misuse visits account for nearly 1% of all ED visits whereas opioid-related visits account for a negligible amount of overall visits to ACES hospitals.

### Opioid-related ED Visits to Participating Hospitals




NOTE: Further details can be obtained by contacting Adam van Dijk at adam.vandijk@kflapublichealth.ca or 613-549-1232 x1510 (All feedback is welcome and appreciated)

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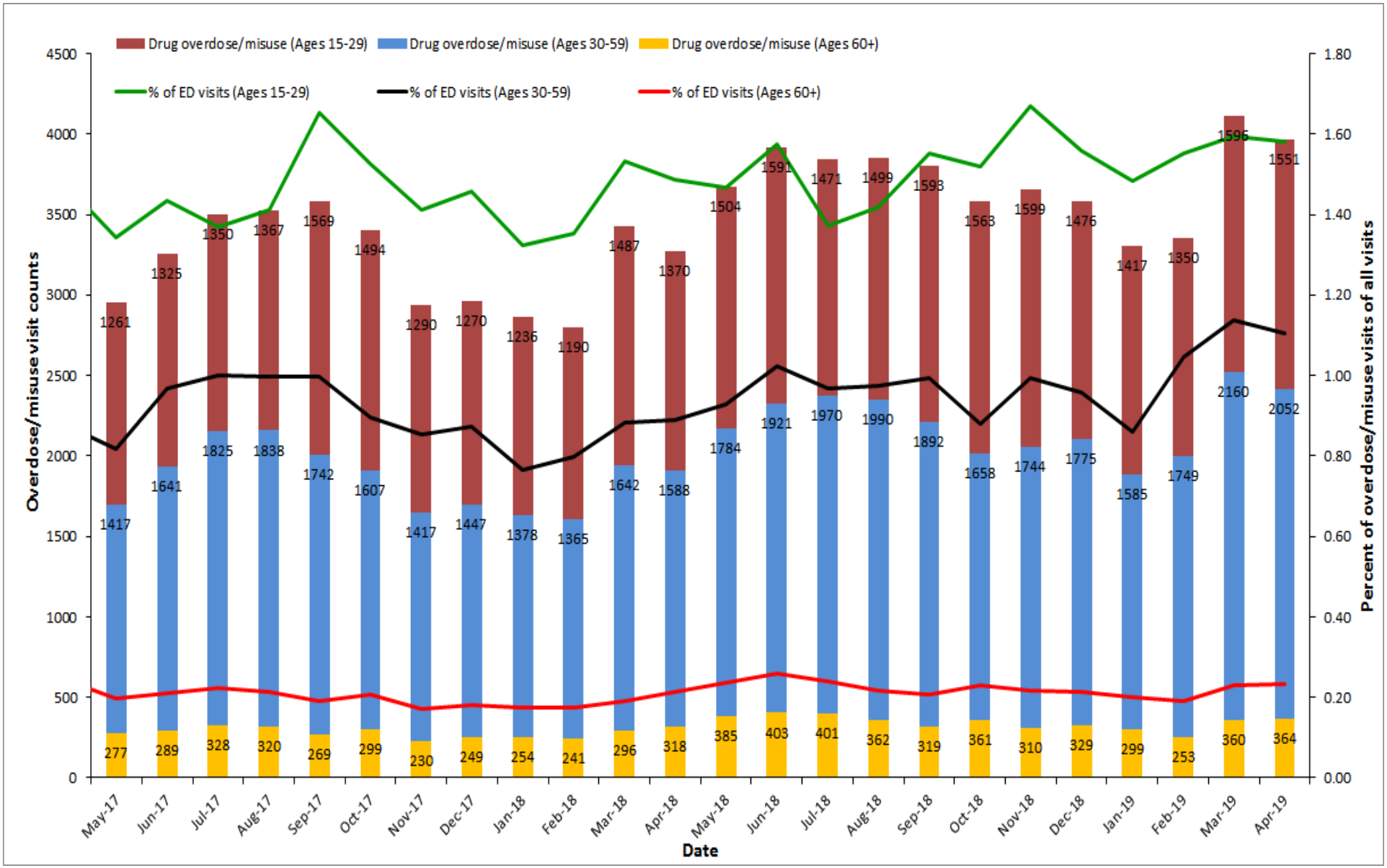
## Non-specific Drug-related ED Visits by Age Group to Participating Hospitals



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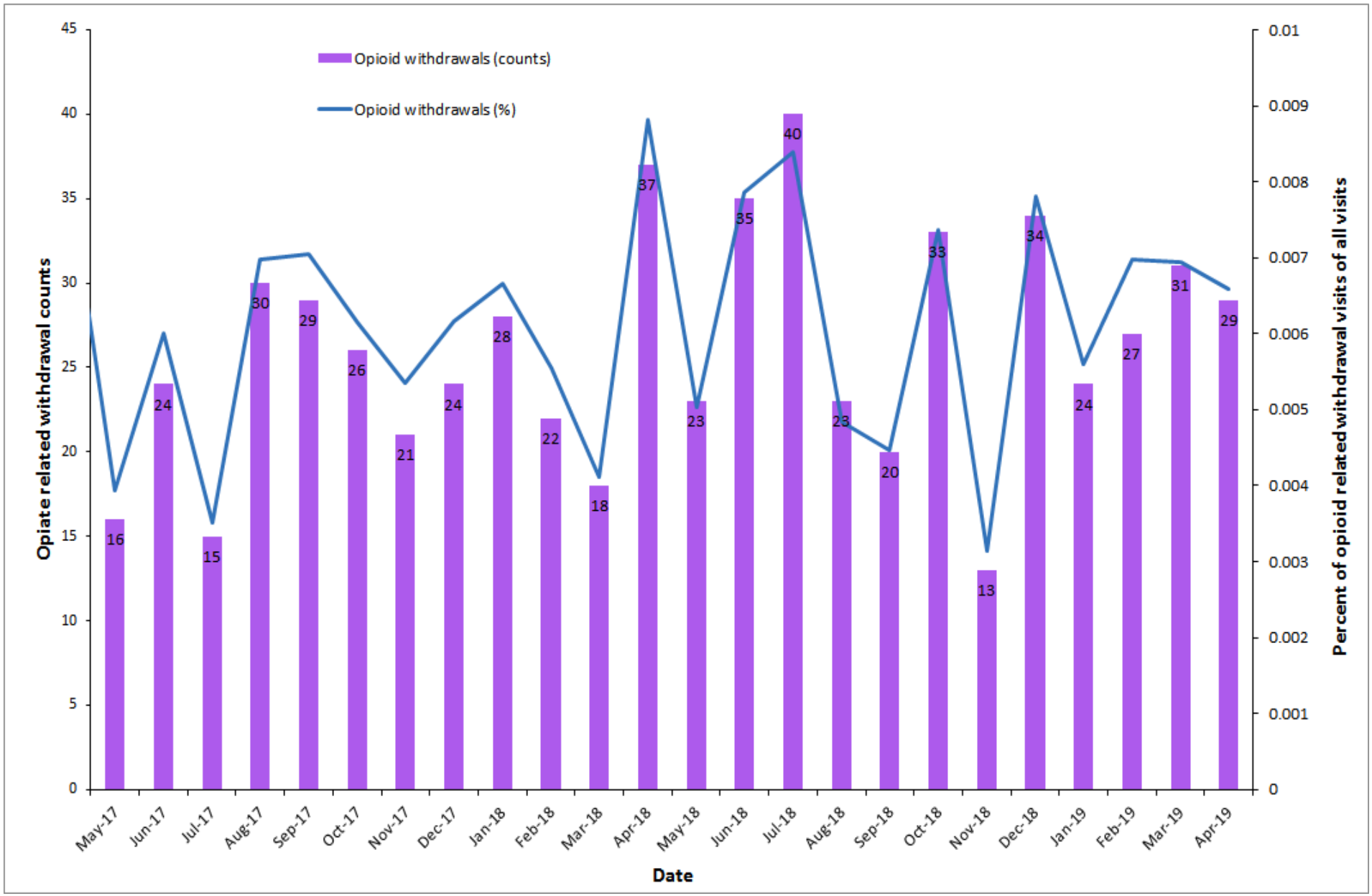
## Opioid-related Withdrawal ED Visits to Participating Hospitals



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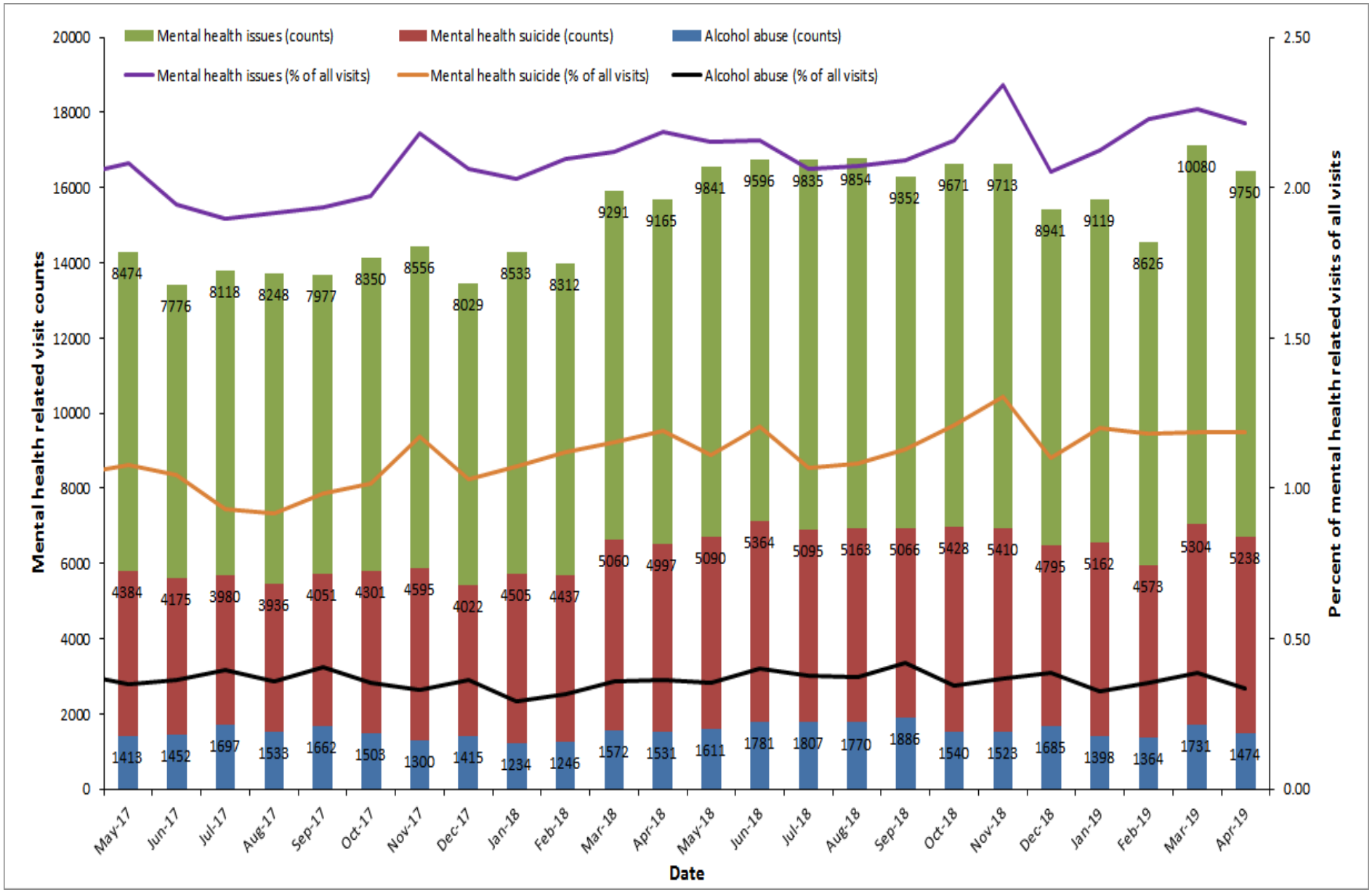
## Mental Health and Alcohol-related ED Visits to Participating Hospitals



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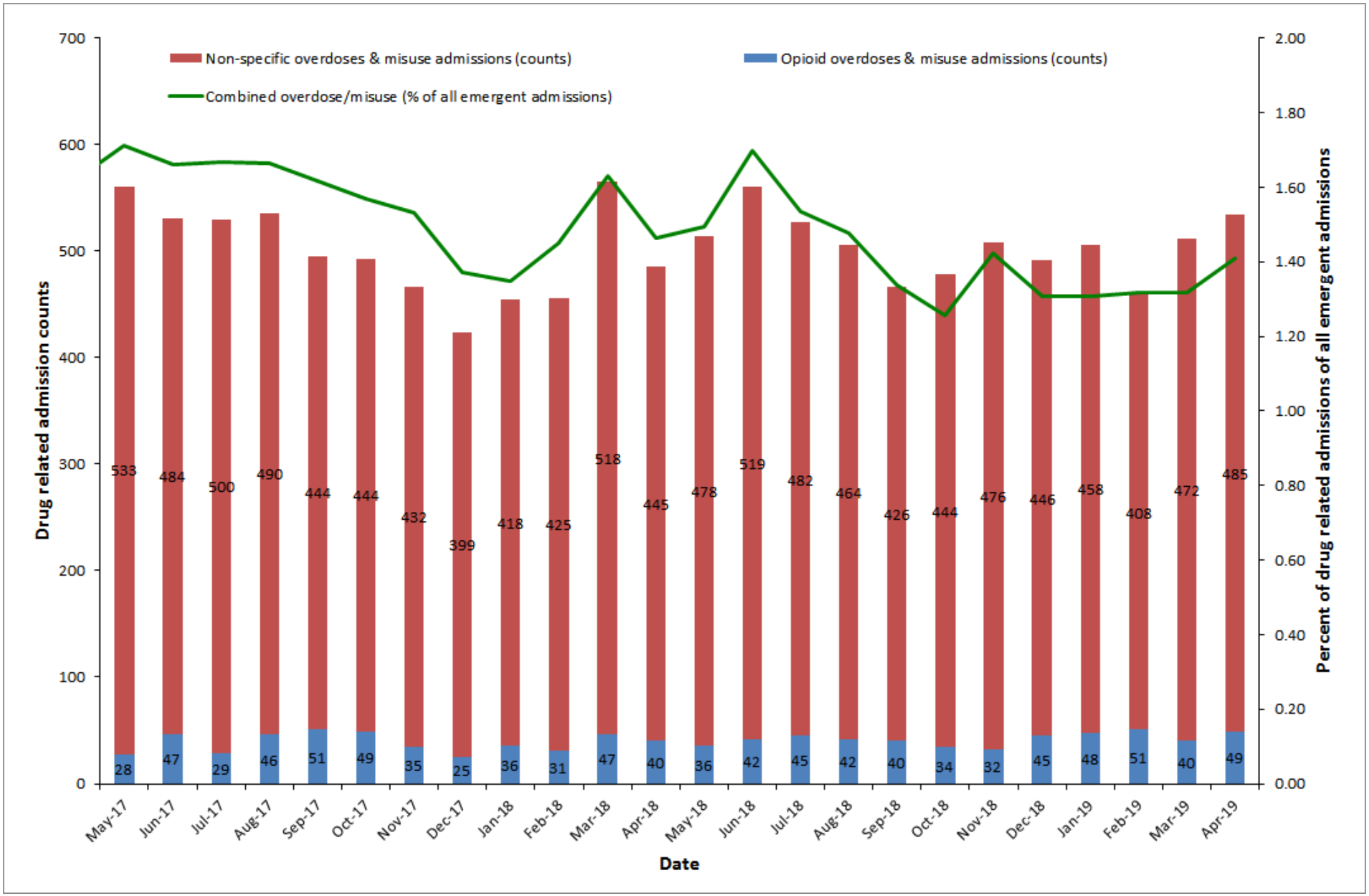
## Combined Opioid and Non-specific Drug-related Admissions to Participating Hospitals



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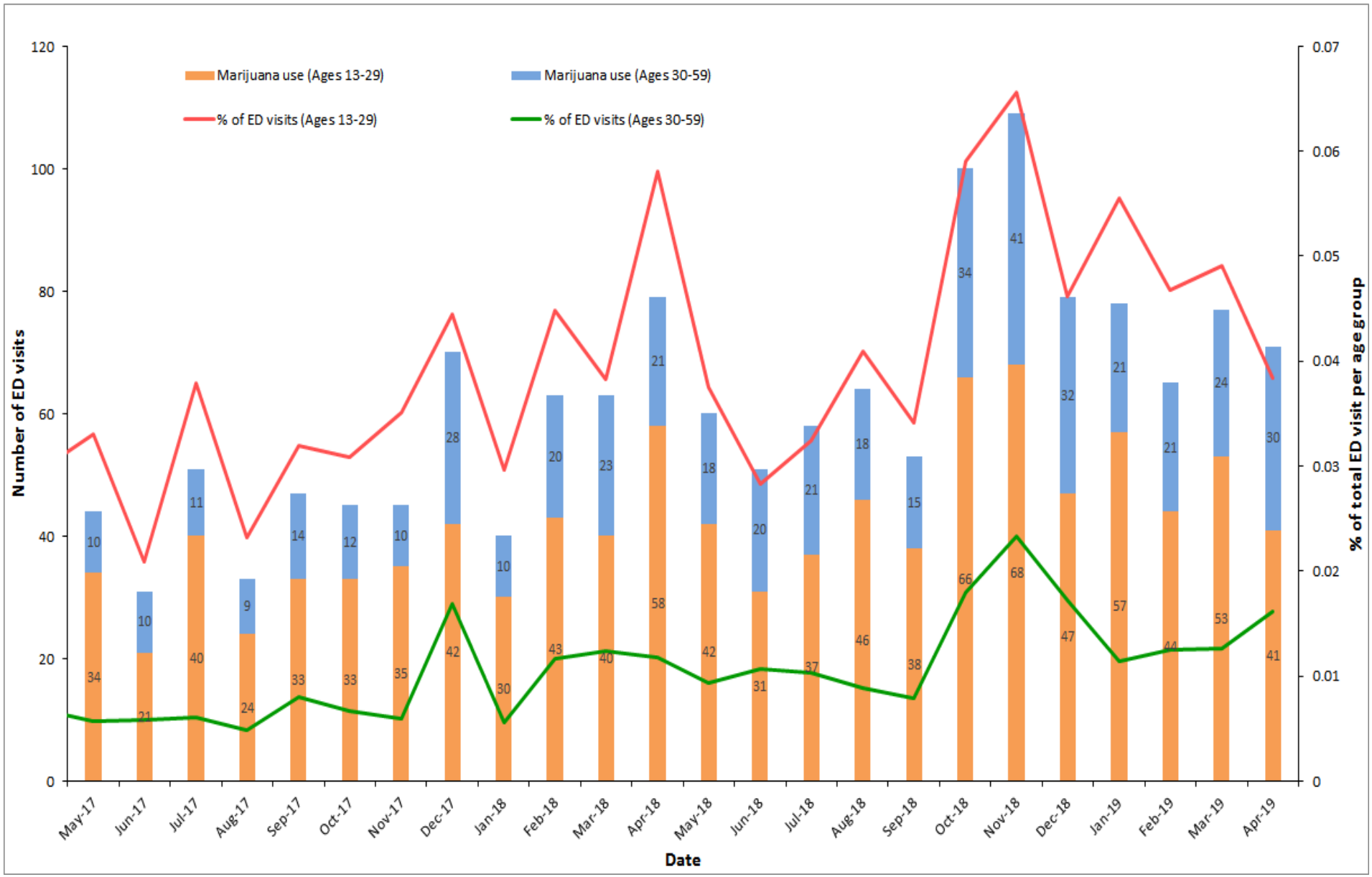
## Cannabis-related ED Visits to Participating Hospitals



## NOTES

1. There are inherent limitations to emergency department triage data. Overdose specificity can be limited due to the potential for polydrug overdoses. Chief complaints recorded at patient intake may be different to the discharge diagnosis which can overestimate broad syndrome classifications like mental health issues while underestimating very specific syndromes such as opioid or alcohol abuse.

2. Opioid-related visits include any mention of methadone, fentanyl, codeine, morphine, hydromorphone, hydromorph, carfentanil, dilaudid, heroin, oxycodone, opium, percocet and opioids (and their misspellings).

3. Non-specific drug related visits include instances of overdose, substance misuse or withdrawal that do not specifically mention an opioid; it does not include accidental, alcohol-related or insulin overdoses.

4. Opioid-related withdrawals include any mention of the opiates outlined in note #2 above along with various spellings of withdrawal. Opiate withdrawals have been included in this report due to the ever changing climate of the opiate epidemic and the thought that crackdowns on prescribing rates will lead to more patient withdrawals in the future.

5. The denominator in the admission graph uses emergent admissions only because combining them with elective admissions would give a false underestimate of the impact of these overdose and misuse cases.

6. Cannabis-related visits include any mention of pot, marijuana, weed, cannabis and edible (and their misspellings). There is a small chance that some of these cannabis-related visits are also being counted in the non-specific drug related visits graph. More specifically, when the word ‘overdose’ is included with one of the above key words (which is not frequent).