CANADA

MENTAL STATISTICS

HANDBOOK

SECOND EDITION

DOMINION BUREAU OF STATISTICS
Health and Welfare Division
Institutions Section

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MENTAL STATISTICS HANDBOOK

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PREFACE

At the beginning of 1954 more than 65,000 patients were recorded on the books of Canadian mental hospitals or in psychiatric units, 11,000 more than all the patients in all the public hospitals of the country on the same date.

The growing numbers of annual admissions to mental hospitals, the increasing outlay of public funds for institutional accommodation, the perennial shortage of beds, all point up the importance of mental illness as a continuing health problem of the first magnitude. Advances in combatting infective diseases, in prolonging life expectancy and in the general improvement of physical health have not been matched by comparable reductions in the incidence of mental disorders. Indeed, the successful control of a number of deadly diseases has served rather to accentuate the seriousness of mental illness as a cause of much suffering and unhappiness, and, from another viewpoint, of great wastage of our human resources.

There is little doubt that the complex problems involved in the prevention and treatment of mental illness will continue to confront Canadian health and welfare authorities in undiminished measure in the forseeable future. There is equally little doubt that an indispensable prerequisite to the proper understanding of these problems is the provision of reliable current statistical information on mental illness and on the institutional and other services provided. The task of compiling and publishing such statistics is the statutory responsibility of the Dominion Bureau of Statistics, exercised in collaboration with federal and provincial mental health authorities.

The present second edition of the Mental Statistics Handbook sets out the definitions and instructions to be followed by mental hospital authorities in making statistical returns which will be both accurate and uniform. It includes, however, additional material designed to enhance its usefulness for purposes of reference, teaching, and general information. Thus it contains, in addition to specific instructions for completion of the Bureau schedules, separate sections outlining the operation of the statistical system, a selected bibliography, a list of commonly used statistical terms and rates, and several other features.

Tne Bureau gratefully acknowledges the assistance received from many sources in the preparation of the material. Special acknowledgement is due to Dr. C.A. Roberts, Chief of the Mental Health Division of the Department of National Health and Welfare, and to the Subcommittee on Statistics of the Advisory Committee on Mental Health under the chairmanship of Dr. G.E. Hobbs, Professor, Department of Psychiatry and Preventive Medicine, University of Western Ontario. The Bureau is also indebted to Dr. E.S. Goddard of the Committee on Nomenclature and Statistics of the American Psychiatric Association for assistance in preparing the descriptions of the characteristics of mental disorders contained in Section 3. The handbook was prepared in the Health and Welfare Division of the Bureau.

H. Marshall,
Dominion Statistician.

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SECTION 1

Canada's national system of mental illness statistics

Canada's "constitution" the British North America Act, allocates responsibility for "the census and statistics" to the federal government in setting out the division of governmental jurisdiction between the Dominion and the provinces.

Out of that early statutory responsibility has evolved the unified system of national statistics now centralized in the Dominion Bureau of Statistics. Operating as a branch of the federal Department of Trade and Commerce, the Bureau's authority to collect, compile and publish statistics on virtually all aspects of national life is based on the Statistics Act of 1948 and sustained by a network of co-operative agreements with other federal departments, provincial governments and non-governmental agencies.

In the field of health, including the special area of mental illness, the events and situations being measured are in the main the constitutional concern of the 10 provincial governments rather than of the federal government. Accordingly, the source data are collected and compiled within the framework of working arrangements between the Bureau and provincial health departments.

System started in 1931

The present system of mental illness statistics originated in 1931. In that year the general population census was supplemented by a special census of mental institutions which provided comprehensive statistics on patients in mental hospitals. The next year, in response to a growing demand for detailed information on the institutional care of the mentally ill, the system was placed on an annual basis. The Bureau undertook to publish an annual report on the mental institutions operating in Canada, based on data compiled from two types of return – a schedule completed and submitted yearly by each institution and an individual reporting card on each patient, prepared at the time of admission, transfer, discharge or death.

Few changes have since been made in the basic methods of collecting the source data, although improvements have been introduced from time to time in simplifying the reporting documents, eliminating unnecessary questions, extending the coverage, and consolidating the liaison with provincial health departments and institutions. In recent years supplementary schedules have been designed for mental health clinics and out-patient services, and the individual card system has been broadened to include psychiatric units in general hospitals.

The reporting schedules and cards are basically uniform for all provinces, though not entirely so. The minor differences designed to meet special requirements in several provinces in no way affect nationwide comparability – indeed they tend to strengthen the reporting system by providing the flexibility necessary for full co-operative effort. Similar uniformity in the terms and definitions which underlie the reported data is achieved through the present handbook and its predecessors.

Four main objectives

The purpose of the system is to make available reliable statistical information on four main aspects of mental illness:

- the amount, nature and utilization of hospital accommodation and facilities available for treatment of the mentally ill.
- the operating costs, revenues and financial condition of mental hospitals.
- the incidence and nature of hospitalized mental illness and the characteristics of patients.
- the nature, duration and results of hospital treatment.

The first two of these are fulfilled by tabulation of the data reported to the Bureau on the two brief schedules completed by mental hospitals at the end of each calendar year. The latter two are compiled from the individual card completed for each patient and from the patient-inventory card file built up from the cards and maintained currently in the Bureau. A third, special schedule reports the yearly volume of service given by mental health clinics.

Provincial liaison

The returns are not in all cases sent directly from the institution to the Dominion Bureau of Statistics. In several provinces the provincial health department acts as an intermediate link by distributing blank forms to the institutions, collecting them when completed and sending the returns forward in bulk to the Bureau. This system offers mutual advantages—the Bureau reaps the benefit of having the receipt and editing of returns carried out by a division of the provincial health department in close professional and administrative touch with the hospitals while the province secures a more current picture of patient movement and other data than can be provided by the statistics subsequently compiled by the Bureau. In one other province the cards are routed through the provincial department but the schedules are submitted directly. In the remaining provinces the Bureau, with provincial concurrence, deals directly with the individual hospitals.

System tuned to current needs

The contents and layout of the reporting forms are determined by a number of factors. First and foremost are the requirements of consumers of the data, primarily professional health personnel concerned with various aspects of mental illness but including also social welfare workers, educators, and persons in a number of professions outside the purely psychiatric field. Officers of the Bureau seek constantly to keep in touch with consumer needs through membership in professional organizations, direct consultation with such groups as the Advisory Committee on Mental Health and the Medical Advisory Committee to the Dominion Statistician, and by personal contact with responsible provincial authorities and hospital administrators.

The consultative group most directly involved in giving professional guidance on the psychiatric requirements is the Advisory Committee on Mental Health, which, by including Directors of the Mental Health Divisions of the provinces as members, accurately reflects current provincial and institutional statistical needs.

The requirement factor must, however, be influenced strongly by expediency. The answers to many questions which might be asked are either not available or would be subject to considerable bias and must therefore be excluded in the interests of limiting the returns to data which can be expected to be provided with reasonable completeness and accuracy. Finally, further modification is frequently prompted by the desire to avoid imposing an undue burden on the administrative and clerical staffs of mental hospitals, a hazard which commonly gives rise to delinquent or deficient returns. The net result sought is a compromise between these factors, worded and arranged so as to cause a minimum of inconvenience in completion while affording maximum facility for tabulation.

Returns confidential

Since much of the information collected concerning individual patients is of a highly confidential nature, great care is taken to ensure complete protection of the particulars reported. Not only is strict secrecy specifically enjoined upon all staff by oath, but extra vigilance is exercised to guard against the inadvertent disclosure of identity through very small frequencies in published figures. Experience has amply demonstrated the importance of such confidentiality in securing the full confidence of respondents.

Obviously, the contribution of the individual hospital to the success of the statistical system is all-important. Little effort is needed by the Bureau or provincial authorities to promote institutional co-operation since almost all hospitals appear anxious to give complete and willing compliance with the requirements of reporting. A growing appreciation by hospital personnel of the practical benefits to be derived from comparison of individual hospital experience with provincial and national norms is no doubt partly responsible for this commendable outlook. Unfortunately, however, a multitude of pressing administrative problems not infrequently separates the intention from the deed. The maintenance by mental hospitals of current accurate records and accounts, while much more widespread in recent years, is still by no means universal. Yet such practices, recognized by most institutions as indispensable to sound administration, can at the same time reduce the task of periodic statistical reporting to negligible proportions.

Punctual returns important

Lateness in reporting is still a perennial obstacle to the publication of timely statistics. Figures more than a year old lose much of their value in an era of such rapid growth and change as the present. Although modern equipment and improved methods have greatly accelerated the processes of tabulation, the statistical machine cannot be set in motion until the returns are checked in. Each individual procrastination not only withholds much-needed information from all mental health workers but also, by causing a tightening of deadlines all along the assembly line, reduces substantially the time available for the analysis, interpretation and graphic illustration which enhance the usefulness of statistical publications. **The most significant single contribution an institution can make to the advancement of mental illness statistics in Canada is the simple matter of completing and submitting its returns punctually.** Specifically, individual cards should

be sent in immediately after the close of each month; the annual Schedule 1 should be sent in by the middle of January each year, the financial return, Schedule 2, as soon as the closing of accounts makes the data available.

The achievement of such prompt reporting, permitting the publication of national and provincial statistics within six months of the end of each year, is an objective of both federal and provincial mental health authorities as well as of the Bureau. Hospital administrators and officials are urged to participate in its early attainment, no less from self-interest than as a public service. They are invited to refer any difficulties promptly to the appropriate provincial authority or to the Bureau and to take full advantage of the advice and assistance available from these sources in establishing accurate, punctual reporting.

Future improvements

What may mental health personnel, in hospitals and in government, expect in return for wholehearted voluntary co-operation in this nation-wide statistical network? The indispensability of reliable statistics for planning bed accommodation, for providing specialized treatment services, for sound hospital administration and financing, for initiation of preventive measures and for a wide range of similar practical problems provides the answer. Canada now takes second place to no other country in the comprehensiveness and reliability of its mental health statistics. The task of maintaining this position, of consolidating the improvements being made, and of improving still further the practical usefulness of the statistics, requires above all the voluntary acknowledgement by mental hospitals of their key role in the co-operative effort which can yield such rewarding results.

SECTION 2

Statistics of mental health services

The previous Section mentions the two types of return made to the Dominion Bureau of Statistics or to the provincial department of health by Canadian mental hospitals:

(a) **The annual return,** made at the end of each calendar year in the form of a completed schedule. The annual return yields information about the hospital, its characteristics and year's activities.

(b) **The individual card,** sent in monthly for each admission or separation which occurred during the month. The cards, described in Section 3, provide the basis for statistics of hospitalized mental illness.

This Section outlines the procedure to be followed in making the annual return; listing, where necessary, the definitions or interpretations to be used in cases where some doubt might exist as to the precise intent of a question.

There are two basic annual schedules. Each is a simple, one-page form especially designed for easy completion, –

(a) Schedule 1 gives general information about the hospital, including personnel and services.

(b) Schedule 2 is a brief summary of the financial activities of the hospital during the year.

In addition to these two basic schedules, a third schedule covers the annual activities of psychiatric units and a fourth relates to mental health clinics and out-patient departments.

Schedule 1

Schedule 1, shown below in facsimile, is to be completed at the end of the calendar year by mental hospitals and training schools operated solely for the care of in-patients and which are recognized as such by a federal government agency or by the government of the province in which they are located.

When completed fully the Schedule should be returned to Institutions Section, Dominion Bureau of Statistics, Ottawa (or, where a special arrangement exists, to the appropriate provincial government department) not later than January 15 each year.

1. Ownership and type

(a) **Ownership.** Check the appropriate box to show what type of agency owns the hospital. Ownership ordinarily means the persons, corporation or government agency under whose name the lease or deed to the real estate of the hospital is registered or held.

ANNUAL RETURN OF MENTAL HOSPITALS – SCHEDULE I

Name of hospital and address .....

1. OWNERSHIP AND TYPE

(a) Ownership
- ☐ Federal
- ☐ Provincial
- ☐ Municipal
- ☐ Lay corporation
- ☐ Religious organization
- ☐ Other private

(b) Type of hospital
- ☐ Mental hospital
- ☐ Psychiatric hospital
- ☐ Epilepsy hospital
- ☐ Training school
- ☐ Other

(c) Standard bed capacity ..... _____

(d) Number of patients in hospital at December 31, 1954 ..... _____

(e) Number of patient days during 1954 ..... _____

(f) Average daily in-patient population during 1954 ..... _____

(g) Number of patients under treatment for tuberculosis at December 31, 1954 ..... _____

2. SERVICES

(a) Organized services –

Psychiatric	☐ Psychosurgery	☐ Audio-visual	☐ Psychotherapy
	☐ Psychology	☐ Occupational therapy	☐ Recreational therapy
	☐ Social service	☐ After care	☐ Children's unit
	☐ Out-patient department		
General	☐ General medical	☐ General surgery	☐ Neurosurgery
	☐ Neurology	☐ Eye, ear, nose and throat	☐ Paediatric
	☐ Geriatric	☐ Tuberculosis	☐ Other communicable diseases
	☐ Dentistry	☐ Dietetics	

(b) Service activities –

Investigation	☐ Clinical pathological	☐ Electrocardiography	☐ Electroencephalography
	☐ Psychological	☐ Social service	☐ X-ray
Treatment	☐ X-ray therapy	☐ Leucotomy	☐ ECT
	☐ Insulin	☐ Planned psychotherapeutic interviews	☐ Physiotherapy
	☐ Fever	☐ Hydro	☐ Social casework

3. EDUCATIONAL FACILITIES

		Yes	No
(a) Medical education –			
Is the hospital affiliated with a medical school for undergraduate education		☐	☐
Is the hospital approved by the Canadian Medical Association for affiliated rotating internships		☐	☐
Is the hospital approved by the Royal College of Physicians and Surgeons of Canada for residencies in –	Psychiatry	☐	☐
	Neurology	☐	☐
	Other	☐	☐
(b) Nurse education –			
Has the hospital an approved school of nursing		☐	☐
Does the school of nursing provide formal training for psychiatric nurses		☐	☐
Are graduates eligible for registration as psychiatric nurses		☐	☐
Number of nurses graduated from the school of nursing during 1954			
Is affiliation provided for general hospital student nurses		☐	☐
Does the hospital provide organized post-graduate courses in psychiatric nursing		☐	☐
Does the hospital provide formal training for – orderlies or attendants		☐	☐
– nursing aides		☐	☐

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4. PERSONNEL AT DECEMBER 31, 1954

	Part Time		Full Time	
	Male	Female	Male	Female
(a) Nursing staff –				
Psychiatric nurses				
Other graduate nurses – Registered				
– Not registered				
Student nurses (incl. affiliate) – For psychiatric				
– For other graduate				
Nursing aides – Trained				
– Untrained				
Orderlies and attendants				
Other nursing staff				

	Part Time	Full Time
(b) Other personnel –		
Administration		
Medical superintendent		
Assistant medical superintendent		
Administrator		
Matron or superintendent of nurses		
Other administrative staff		
Professional care (excl. nurses)		
Doctors – Clinical director		
– Staff – Certificated specialists		
– Physicians		
– Residents		
– Interns		
– Consulting – Certificated specialists		xxx
– Other		xxx
Dentists		
Psychologists		
Pharmacists – Registered		
– Other		
Technicians – Laboratory – Certified		
– Other		
Radiology – Registered		
– Other		
E E G technicians		
Other technicians		
Therapists – Occupational – Registered		
– Other		
– Recreational – Qualified		
– Other		
– Other therapists		
Academic teachers		
Social workers – Psychiatric		
– Other qualified		
– Other		
Dietitians – Certified		
– Qualified		
– Other		
Chaplains		
Other staff for professional care		
Other staff		
Dietary		
Laundry		
Housekeeping, bedding and linen		
Building maintenance		
Garden and farm		
All other employees		
TOTAL PERSONNEL (excl. nursing staff)		

(b) **Type of hospital.** Check the appropriate box to show the type of treatment or service which the hospital primarily gives. Use the following definitions in case of doubt—

Mental hospital – a hospital organized for the treatment of patients suffering from all types of psychiatric conditions. Most mental institutions are in this class.

Psychiatric hospital – a hospital organized for the intensive, short-term treatment of persons suffering from psychiatric conditions.

Epilepsy hospital – a hospital organized for the treatment of epilepsy.

Training school – an institution organized for the training and care of persons who are mentally defective.

Other – a hospital which falls within the general class of mental institutions but which is not covered by one of the five definitions above.

(c) **Standard bed capacity.** Give the bed capacity according to the standards shown below, regardless of the number actually provided or the number of patients accommodated. In applying the standards, psychiatric hospitals and psychiatric units should use the figures shown for "Reception and convalescent" patients.

Minimum number of square feet per bed

Type of patient	Alcoves or wards	Single rooms	Day rooms (per patient)
Reception and convalescent	60	80	50
Medical, surgical, tuberculosis	80	80	20
Infirm.....	60	80	30
Continuous care.....	50	80	50

Corridor space does not count unless it is an integral part of the sleeping or day space.

(d) **Number of patients in hospital at December 31.** Include only the patients actually in residence in the hospital on December 31.

(e) **Number of patient days during the year.** State the total number of days spent in the hospital by all patients during the year.

(f) **Average daily in-patient population during the year.** A quick way of calculating this figure is to divide the number of days in question (e) by 365 (for a leap year divide by 366).

(g) **Number of patients under treatment for tuberculosis at December 31.** State the number of patients who were under treatment for any tuberculous condition on December 31.

2. **Services:**

(a) **Organized services.** Check the appropriate boxes to indicate the services available to patients. To qualify, the service must be provided within the hospital under the direction of a properly qualified person.

(b) **Service activities.** Check those activities which were carried out at any time during the year.

3. **Educational facilities**

(a) **Medical education**

Is the hospital affiliated with a medical school for undergraduate education. Check "yes" only where the hospital and a university with a medical faculty have entered into an agreement whereby a doctor who is on the teaching staff of the university is also on the active attending staff of the hospital, and whereby undergraduate students of the medical faculty are assigned to the hospital to receive practical experience in the treatment of patients in the hospital as a regular part of their curriculum.

Is the hospital approved by the Canadian Medical Association for affiliated rotating internships. Check "yes" if the hospital is a participating member of a group of hospitals approved as a part of a rotating program for the training of interns.

Is the hospital approved by the Royal College of Physicians and Surgeons of Canada for residencies. Check "yes" if the hospital has been approved for the specialized training of doctors as residents in psychiatry, neurology or other specialties.

(b) **Nurse education**

Has the hospital an approved school of nursing. An approved school of nursing is one which meets the legal requirements of the province in which it is located. It refers only to schools whose graduates are eligible to take the qualifying examination for Registered Nurse. It does not include schools for nursing assistants.

Does the school of nursing provide formal training for psychiatric nurses. Formal training means an organized program of study and practice in psychiatric nursing.

Are graduates eligible for registration as psychiatric nurses. Check "yes" where the graduates are eligible under a provincial statute for a licence as psychiatric nurse or the equivalent.

Is affiliation provided for general hospital student nurses. Check "yes" if the hospital has entered into an agreement whereby undergraduate students of an approved school of nursing are assigned to the hospital to receive practical experience in the treatment of patients in the hospital as a regular part of their curriculum.

4. Personnel

Insert the number of paid personnel, of each type, employed by the hospital at December 31. Include as paid personnel members of religious orders who are working in the hospital as staff members without pay. Do not include other unpaid voluntary workers.

(a) **Nursing staff**

Psychiatric nurses are persons who have satisfactorily completed a formal course in psychiatric nursing, have graduated from an approved school of psychiatric nursing and have completed the necessary qualifying examination.

Other graduate nurses – Registered are persons who have graduated from an approved school of nursing and who are registered with the provincial Nurses' Association.

– Not registered are those who have graduated from an approved school of nursing but who are **not** registered with the provincial Nurses' Association.

Student nurses – For psychiatric are those who are taking a specialized formal course of training, leading to a qualifying examination for psychiatric nurse, in the hospital's school of nursing, and those who are taking a similar course of training in another approved school of nursing but who are temporarily attached to the mental institution at December 31 for training purposes.

– For other graduate are those who are taking a formal course of training, leading to a qualifying examination for graduate nurse, in the hospital's approved school of nursing, and those who are taking a formal course of training in another approved school of nursing but who are temporarily attached to the mental institution for training purposes.

Nursing aides – Trained are persons who have completed a formal course of training below the level of the course for psychiatric or other graduate nurse. This includes nursing assistants, practical nurses and persons of similar status.

– Untrained are persons who have enrolled for, but have not yet completed a formal course of training as defined above.

Orderlies and attendants are persons who perform nursing duties but who have neither enrolled for nor completed a formal course of training.

Other nursing staff includes all other nursing personnel employed by the hospital at December 31.

(b) **Other personnel**

Administration

Other administrative staff includes such personnel as the controller, secretary, business manager and general office personnel.

Professional care

Doctors – Clinical director is a qualified psychiatrist freed from administrative responsibilities who is responsible for the professional care of the patients and the training of professional staff.

– *Staff – Certified specialists* are those who are certificated in a specialty by the Royal College of Physicians and Surgeons of Canada.

Physicians include all paid full-time and part-time physicians and surgeons on the payroll, including doctors under contract to the hospital, but not including residents.

Residents are those who are training in the specialties offered by the hospital.

Interns are interns actually training in the hospital.

– *Consulting – Certified specialists* are consulting physicians who have been certificated in a specialty by the Royal College of Physicians and Surgeons of Canada.

Other includes consulting physicians who are not certificated specialists.

Pharmacists – Registered includes only those who are registered as pharmacists under the Pharmacy Act of the province in which the hospital is located.

– *Other* includes employees who are carrying out the duties of a pharmacist although not registered as above.

Technicians – Laboratory – Certified are those who possess a graduation certificate from an approved school for laboratory technologists. Approval is by a committee of the Canadian Medical Association in cooperation with the Canadian Society of Laboratory Technologists.

– *Radiology – Registered* are those who are registered with the Canadian Society of Radiological Technicians or the American Registry of Radiological Technicians.

– *EEG technicians* include only those who are registered as EEG technicians.

Therapists – Occupational – Registered include only persons who are registered as occupational therapists.

– *Recreational – Registered* are those who have satisfactorily completed a postgraduate course in recreational therapy.

Social Workers – Psychiatric are persons who have graduated from a school of social work approved by the Canadian Association of Social Workers and who have had psychiatric field experience, or those who have had five years experience in social work under qualified supervision, at least one year of which has been under psychiatric supervision.

– *Other qualified* are persons who have graduated from a school of social work approved by the Canadian Association of Social Workers, or those who have had five years experience in social work under qualified supervision.

Dietitians – Certified are persons who have satisfactorily completed a postgraduate course in hospital dietetics approved by the Canadian Dietetics Association.

– *Qualified* are persons who have satisfactorily completed a postgraduate course in hospital dietetics.

– *Other* includes those who, though having graduated in Home Economics, are neither "Certified" nor "Qualified" as defined above but who are carrying out the functions of a dietitian.

Other staff

Dietary includes all persons employed in the dietary department, if not enumerated above, such as cooks, pantry maids, kitchen help, etc. Student dietitians will be included here.

Laundry—all persons employed in the laundry department.

Housekeeping, bedding and linen—all persons in the housekeeping, bedding and linen departments, including cleaning helpers, ward aides, ward maids, etc.

Building maintenance—all persons engaged in the repair and maintenance of hospital property including engineers, carpenters, painters, furnace men, etc.

Garden and farm—all persons employed in the hospital farm or garden in the production of produce for use or sale.

All other employees includes all personnel employed at December 31 who are not enumerated above.

Schedule 2

Schedule 2, the financial schedule, is to be completed as soon as possible after the end of the fiscal year by mental hospitals, psychiatric hospitals and training schools.

When completed fully the schedule should be returned to Institutions Section, Dominion Bureau of Statistics, Ottawa, or, where a special arrangement exists, to the appropriate provincial government department.

The first section, OPERATING STATEMENT, records in summary form the main items of revenue and expenditure for current operation of the hospital. The second section, SOURCE AND APPLICATION OF PLANT FUNDS, records the amounts of **capital funds** provided from various sources for new construction or retirement of debt, and the manner in which capital funds expended during the year have been spent.

Before completing the schedule, read the following instructions and definitions carefully.

A. REVENUE includes all revenue which accrued (or became receivable) to the hospital during the year for the operation and maintenance of the hospital.

1. **Grants and payments** include revenue from governments to cover operating deficits or to maintain specific patients but excluding capital grants or payments. Show the amount received or becoming receivable during the year from each type of government authority, federal, provincial and municipal.
2. **Received from or on behalf of paying patients** show all revenue accruing to the hospital from paying patients or from other persons such as relatives or friends on behalf of paying patients. Do **not** include amounts paid by governments on behalf of patients,—these should be shown in item A1.
3. **Received from other sources** include here all other operating revenues of the hospital such as revenue from ancillary operations, interest income, contributed services of personnel, cash discount on purchases, etc.

DOMINION BUREAU OF STATISTICS

ANNUAL RETURN OF MENTAL HOSPITALS – SCHEDULE 2

Name of hospital and address ..... Year ended .....19.....

OPERATING STATEMENT

A. Revenue –

1. Grants and payments: Federal .....
   Provincial .....
   Municipal .....
2. Received from or on behalf of paying patients .....
3. Received from other sources .....
4. **Total Operating Revenue** .....

B. Expenditure –

5. Gross salaries and wages .....
   Less: deductions for board, etc. .....
6. Provisions (food) .....
7. Fuel, power, light and water .....
8. Other operating expenditures .....
9. **Total Operating Expenditures** .....

SOURCE AND APPLICATION OF PLANT FUNDS

	For new construction or additions to plant	For retirement of debt
A. Funds provided –		
1. Grants: Federal		
Provincial		
Municipal		
2. Mortgages or other long-term borrowings		
3. Other sources		
4. **Total Plant Funds Provided**		

B. Funds expended –

5. Land and improvements to grounds .....
6. Buildings (including permanent fixtures) .....
7. New furniture and equipment .....
8. Retirement of long-term debt .....
9. **Total Plant Funds Expended** .....

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B. EXPENDITURE is the actual accrued cost of operating and maintaining the hospital during the year. All operating expenses should be included whether or not payment has actually been made. Do **not** include any capital expenditures.

5. **Gross salaries and wages** include all wages and salaries earned by personnel during the fiscal year including the value of contributed services by unpaid personnel such as members of religious orders.

   Less deductions for board, etc.—subtract here the known or estimated value of board, lodging, laundry and similar perquisites supplied to the staff by the hospital, regardless of whether the value of these is normally included in staff salaries or not. Include also the value of the perquisites supplied to unpaid staff. Show on the right the difference between gross salaries and deductions.

6. **Provisions (food)** includes the cost of food used in the hospital during the fiscal year.

7. **Fuel, power, light and water** includes the cost of electricity, coal, oil or other sources of energy and of water consumed during the fiscal year.

8. **Other operating expenditures** includes all items of operating expenditure not enumerated above, such as the cost of drugs and medicines, depreciation of fixed assets, cleaning costs, etc.

The following definitions apply to the second section of the schedule, the SOURCE AND APPLICATION OF PLANT FUNDS.

A. FUNDS PROVIDED includes the amounts of funds provided from the sources listed and the purpose of each.

1. **Grants** show the amounts provided by each type of government authority on the basis of the **original** source of the funds, e.g. where funds provided by a federal grant are received by the hospital through the provincial government such amounts should be included as federal.

2. **Mortgages or other long-term borrowings** includes the funds raised for capital purposes through mortgages, debenture loans or bonded debt.

3. **Other sources** includes all other receipts of capital funds such as endowments or bequests.

B. FUNDS EXPENDED includes all expenditures made during the year, regardless of when the funds were provided, for the purposes listed in each item.

5. **Land and improvement to grounds** includes all expenditures made to acquire additional land or to improve land and grounds presently owned.

6. **Buildings (including permanent fixtures)** includes the cost of new construction of buildings or of permanent fixtures of buildings, and of all permanent improvements to existing buildings and fixtures.

   Expenditure for the **maintenance** of buildings, equipment or fixtures should not be shown here but as an operating expenditure under item 8 of the OPERATING STATEMENT.

7. **New furniture and equipment** includes the cost of all acquisitions of new furniture and new equipment.

8. **Retirement of long-term debt** includes all expenditures made for the purpose of retiring outstanding debt, such as principal repayments and sinking fund requirements.

ANNUAL RETURN OF PSYCHIATRIC UNITS

This return is designed to give a summary picture of patient movement, bed capacity, service activities, educational facilities, and personnel of psychiatric units.

The schedule is to be completed at the end of the calendar year by organized psychiatric units of general hospitals. When fully completed the Schedule should be returned to the Institutions Section, Dominion Bureau of Statistics, Ottawa, (or, where a special arrangement exists to the appropriate provincial government department) not later than January 15 each year.

1. **Ownership.** Check the appropriate box to show what type of agency owns the Hospital of which this psychiatric unit is a part. Ownership refers to the persons, corporation or government agency under whose name the lease or deed to the real estate of the hospital is registered or held.

2. **Standard bed capacity.** This should be calculated according to the standards set out in paragraph (c) on page 14.

3. **Movement of patients.** The terms first admission, readmission, transfer, discharge and death can be found on pages 25 and 28.

4. **Service activities.** The services available within the unit or the parent hospital should be checked. Services available in another hospital should not be reported.

6. **Personnel.** The definition of the various classes of personnel are given on pages 16, 17, 18. "Total hours worked per week" is the hours worked by all personnel in the stated group in a normal work week.

ANNUAL RETURN OF MENTAL HEALTH CLINICS AND OUT-PATIENT DEPARTMENTS

This special schedule obtains an annual measure, in broad terms, of the growing volume and utilization of clinic and out-patient services in combating mental illness.

The schedule is distributed by provincial authorities to the clinics and out-patient departments recognized as such by provincial government, and is returned to the Dominion Bureau of Statistics through provincial channels.

1. **Type of patient served** – A child is a person aged 0-14 years.

2. **Number of sessions held per week** – A session is of approximately a half day's (or 3 to 4 hours) duration. For example, a clinic or department operating five full days per week would report ten sessions.

3. **Personnel** – number of personnel includes both full-time and part-time.

4. **Patients during this year**— this question is to be answered in terms of individual patients rather than visits. Thus 2 visits by the same person would count as one in question 4. The 2 visits would, however, count as 2 interviews in question 3.
4 (c) Total number of patients during this year – this question is the total of 4 (a) and 4 (b).

DOMINION BUREAU OF STATISTICS

Institutions Section

ANNUAL RETURN OF PSYCHIATRIC UNITS

Name

Address

Year ended Dec. 31, 195

Name of the hospital of which this unit is a part

1. Ownership: ☐ Federal ☐ Provincial ☐ Municipal
☐ Lay corporation ☐ Religious organization ☐ Other and/or private

2. Standard bed capacity

3. Movement of patients:
(a) Patients in the unit at January
(b) First admissions during the year
(c) Re-admissions during the year
(d) Transfers received from other psychiatric institutions during the year
(e) Discharges during the year
(f) Deaths during the year
(g) Transfers sent to other psychiatric institutions during the year
(h) Patients in the unit at December 31

4. Patient days during the year

5. Average daily population

6. Service activities within the unit or the parent hospital:

☐ Out-patient department	☐ Psychological investigation	☐ Leucotomy
☐ Occupational therapy	☐ Social service	☐ Planned psychotherapeutic interviews
☐ After care	☐ Electroencephalography	☐ Hydro
☐ Recreational therapy	☐ Insulin coma	☐ ECT
☐ Children's unit	☐ Insulin sub-coma	☐ Physiotherapy

7. Educational facilities:

	Yes	No
For physicians –		
(a) Is the hospital affiliated with a medical school for undergraduate education?	☐	☐
(b) Is the unit utilized by the medical school for undergraduate education?	☐	☐
(c) Is the unit utilized for affiliated rotating internships?	☐	☐
(d) Is the hospital approved by the Royal College of Physicians and Surgeons of Canada for residencies in psychiatry?	☐	☐
For psychologists –		
(e) Is the unit affiliated with a university department of psychology for formal supervised training of student psychologists?	☐	☐

(f) Number of such students receiving training during the year

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(OVER PLEASE)

7. Educational facilities: (continued)

For nurses –

	Yes	No.
(g) Is the unit utilized for formal psychiatric training of undergraduate nurses?	☐	☐
(h) Number of student nurses trained in the unit during the year		
(i) Does the hospital provide organized post-graduate courses in psychiatric nursing?	☐	☐
(j) Number of graduate nurses completing post-graduate courses during the year		

For social workers –

(k) Is the unit approved by a school of social work for training?	☐	☐
(l) How many such students received such training during the year?		

8. Personnel:

	Number at December 31	
	Male	Female
(a) Nursing staff –		
Psychiatric nurses		
Other graduate nurses – Registered		
Not registered		
Student nurses (incl. affiliate) – For psychiatric		
For other graduate		
Nursing aides – Trained		
Untrained		
Orderlies and attendants		
Other nursing staff		

	Number at December 31	Hours worked per week
(b) Medical and technical personnel		
Doctors – Certificated specialists		
Other physicians		
Residents		
Interns		
Psychologists		
Therapists – Occupational – Registered		
Other		
Recreational – Qualified		
Other		
Other therapists		
Social workers – Psychiatric		
Other qualified		
Other		
(c) Clerical staff		

DOMINION BUREAU OF STATISTICS

Institutions Section

ANNUAL RETURN OF MENTAL HEALTH CLINICS AND OUT-PATIENT DEPARTMENTS

Name

Address

Year ended Dec. 31, 195 _____

Auspices under which operated

1. Type of patient served: ☐ Adults only ☐ Children only
☐ Adults and children

2. Number of sessions held per week ..... _____

3. Personnel:	Number	Hours per week	Total interviews during year
(a) Psychiatrists			
(b) Psychologists.....			
(c) Social workers			
(d) Nurses			
(e) Special therapists			
(f) Clerical workers.....			x x x

4. Patients during the year:

(a) Number of this year's patients who had attended this clinic or department in a previous year ..... _____

(b) Number who had not done so ..... _____

(c) Total number of patients during this year ..... _____

9002-6.1: 15-10-54

(OVER PLEASE)

SECTION 3

Statistics of mental illness

General

Information about the patients in Canadian mental hospitals, and those entering and leaving each year, constitutes the only large-scale source of knowledge concerning the incidence and nature of mental illness in the general population of Canada.

Under an arrangement with provincial mental health authorities, the Dominion Bureau of Statistics compiles statistics on hospitalized mental illness derived from individual reporting cards which are submitted by mental hospitals, psychiatric hospitals, mental deficiency institutions and psychiatric units or wards in other hospitals. Two cards are employed—one for each admission (which includes first admission, readmission or transfer in) and the other for each separation (which includes discharge, death or transfer out).

The completed cards are returned in monthly batches either directly to the Bureau in the envelope provided or, where a special arrangement has been made, to the provincial department of health. Each monthly batch is accompanied by an advice in the form of the Monthly Statement of Population Movement.

In the Bureau the particulars of each patient and illness are transferred to punched cards for statistical tabulation. The reporting cards are then maintained in the fashion of a perpetual inventory of hospitalized patients to provide a continuous census for relationship with general population data and with annual patient movement.

Admission card

First Admission refers to a patient admitted for the first time to any hospital for mental diseases or to the psychiatric unit of a hospital.
Readmission refers to a patient admitted who has previously been under treatment in a hospital for mental diseases or in the psychiatric unit of a hospital, wherever situated, and who is not merely being transferred.
Transfer refers to a patient transferred in from another hospital for mental diseases or from the psychiatric unit of a hospital, wherever situated.

Name of patient — print or type the surname first, followed by the given names in full.

Date of Admission — give the month, day and year of the present admission, whether this be a first admission, readmission or a transfer in.

Case number should be the serial number allocated to the patient on admission. The one case number should remain with a patient throughout any one stay in the institution and should thus appear on both his admission and separation card. It is essential that the admission and separation cards for any one hospital stay should bear an identical case number.

9002-8
2-9-52

☐ First Admission ☐ Readmission ☐ Transfer ☐ Male ☐ Female

Mental Institution Admission Card

Name of Patient _____ Date of Admission _____ 19___ Case No. _____

1. Residence _____

_____
(City, town, village, rural municipality) (County)

2. Age _____ Date of Birth _____

3. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

4. Number of Children _____

	Patient	Father	Mother
5. Country of Birth — Canada	☐	☐	☐
5. Country of Birth — Other	☐	☐	☐

6. Year of Arrival in Canada _____

7. Citizenship ☐ Canadian Born ☐ Canadian by Naturalization ☐ Other British ☐ Other

8. Origin ☐ English ☐ French ☐ Irish ☐ Scottish Other (Specify) _____

9. Years of Schooling _____ 10. Religion _____

11. Occupation _____ 12. Industry _____

13. Method of Admission ☐ Voluntary ☐ Warrant of Lieut.-Governor ☐ Certification ☐ Other

14. Source of Admission (Check one only)

☐ Private Physician ☐ Clinic Agency ☐ General Hospital
☐ Welfare Institution ☐ Penal Institution ☐ Other
☐ Transfer from other Mental Hospital

(a) Name of Hospital _____

(b) Date of Last Admission _____ 19___
(Other than by Transfer)

15. Diagnosis: (a) Describe Fully _____

_____

_____

_____

(b) International Statistical Classification No. _____

(c) Is the Patient — Mentally Defective ☐ Yes ☐ No; Epileptic ☐ Yes ☐ No

16. Number of Previous Admissions _____

17. Particulars of Last Previous Admission

Hospital _____

Date Admitted _____ 19___

Date Discharged _____ 19___

Hospital _____ Location _____

9002–8: 7-11-58

☐ First admission ☐ Readmission ☐ Transfer ☐ Male ☐ Female

Mental Institution Admission

Name of patient _____ Date of admission _____ Case no. _____
(month) (day) (year)

1. Residence _____
(City, town, village, rural municipality) (County)

2. Age _____ Date of birth _____

3. Marital status ☐ Single ☐ Married, separated ☐ Widowed ☐ Divorced

4. Number of children _____

	Patient	Father	Mother
5. Country of birth — Canada	☐	☐	☐
5. Country of birth — Other	☐	☐	☐

6. Year of arrival in Canada _____

7. Citizenship ☐ Canadian born ☐ Canadian by naturalization ☐ Other British ☐ Other

8. Origin ☐ English ☐ French ☐ Irish ☐ Scottish
Other (specify) _____

9. Years of schooling _____ 10. Religion _____

11. Occupation _____ 12. Industry _____

13. Method of admission ☐ Voluntary ☐ Warrant ☐ Certification ☐ Other

14. Source of admission –
☐ Private physician ☐ Clinic agency ☐ General hospital
☐ Welfare institution ☐ Penal institution ☐ Mental institution
If admitted or transferred from a mental institution or other psychiatric in-patient service, complete (i) and (ii) below. ☐ Other
(i) Name of Institution _____
(ii) Date of admission this treatment period, not considering transfer(s) as breaking treatment _____

15. Diagnosis: (a) _____
(describe fully) _____
_____
_____
(b) International Classification of Diseases No. _____
(c) Associated conditions –

Mental deficiency	Epilepsy	Addiction to alcohol	Addiction to drugs
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

16. Number of previous admissions _____

17. Particulars of last previous admission:
Institution _____
Date admitted _____
Date discharged _____

Institution _____ Location _____

1. **Residence** is the last regular home address of the patient before admission. Do not report a temporary address which a patient may have had pending admission.

4. **Number of children** means the number ever born to this patient, including any stillborn or illegitimate children.

5. **Country of birth** – check the appropriate box for the patient and his natural parents, or, if these are not known, his foster parents. Persons born in Newfoundland prior to its confederation with Canada are to be considered as having been born in Canada.

6. **Year of arrival in Canada** applies to persons born elsewhere than in Canada. For Canadian-born state the age in years.

7. **Citizenship** or "nationality" refers to the country to which the patient owes allegiance. "Canadian" refers to a person who was born in Canada or who is a Canadian citizen by marriage or naturalization in accordance with the provisions of the Canadian Citizenship Act. Include as "Canadian" persons who were Newfoundland citizens prior to its confederation with Canada.

8. **Origin** refers to the people, race or ethnic group from which the patient is descended, as traced through the father. The terms "Canadian" or "American" should not be recorded as origins since they refer to citizenship. The following list suggests suitable terms for reporting origin:

Austrian	Esthonian	Indian (Native)	Roumanian
Belgian	Finnish	Italian	Russian
Bulgarian	German	Japanese	Swedish
Chinese	Greek	Latvian	Syrian
Czech and Slovak	Jewish	Lithuanian	Turkish
Danish	Hungarian	Negro	Ukrainian
Dutch	Icelandic	Norwegian	Welsh
Eskimo	Indian (Asia)	Polish	Yugoslavic

9. **Years of schooling** means the number of completed school years beyond Kindergarten. Where, for example, two years were spent in the same school grade they are to be counted as one completed school year. Part-time attendance and private study should count for the number of years of formal schooling to which they are equivalent.

10. **Religion** is the specific religious body, denomination, sect, or community of which the patient is a member or which he adheres to or favours. Avoid such broad terms as Christian, Protestant, or Believer. If the patient has no religious affiliation, record "none".

11. **Occupation** is the trade, profession or kind of work in which the patient was engaged as his usual occupation prior to admission, for example, carpenter, stenographer, sales clerk, office clerk, housewife, etc.

12. **Industry** means the kind of business or industry in which the patient followed his occupation, such as coal mining, retail grocery, dairy farming, textile manufacturing, etc.

13. **Method of admission** – Check the appropriate box to indicate whether the patient has been admitted on his own application, or a warrant of the Lieutenant-Governor, or on the certificate of one or more doctors in accordance with provincial law.

14. **Source of admission** – indicate, by checking the appropriate box, the agency, institution or person by whom the patient was referred for committal. In the case of transfer from another mental hospital, a training school or a psychiatric unit, state the name of the hospital. In a general hospital the movement of a patient from a general unit to a psychiatric unit should not be reported as a transfer but a first admission or re-admission as the case may be. In such a case check the space for General Hospital.

When the patient is admitted by transfer, give also the date of his last admission other than by transfer, that is, the date on which continuous hospitalization began. For example, where a patient is admitted to hospital A on January 2 and transferred to hospital B on March 11, the latter hospital will show January 2 as the date of last admission other than by transfer.

15. **Diagnosis**

(a) State the complete diagnosis using, so far as possible, terminology of the International Statistical Classification (1948) or of the Standard Nomenclature.

(b) Insert the International Statistical Classification number for the diagnosis.

(c) Where mental deficiency and/or epilepsy are present, either alone or in addition to the primary diagnosis, check the appropriate boxes as applicable. For example, suppose a patient is admitted with hebephrenic schizophrenia and is also mentally defective. In 15(a), both the mental disorder and the mental deficiency would be reported; in 15(b) the International Statistical Classification number, 300.1, would be reported; and in 15(c) the box "yes" would be checked for mental deficiency.

In cases where a combination of mental deficiency and epilepsy forms the diagnosis, describe both conditions in 15(a), reporting the primary condition first; then check "yes" for both conditions in 15(c).

Separation card

Discharge refers to a patient released from the supervision of the hospital authorities. A patient on parole or boarded out is not considered as discharged until he has been officially discharged from the books of the institution.

Death refers to a patient who dies in the hospital or institution, or while boarding out or on parole or while otherwise on the books of the institution.

Transfer refers to a patient who is transferred out from the hospital to another hospital for mental diseases, wherever situated.

Name of patient – print or type the surname first, followed by the given names in full.

Date of separation – give the month, day and year of discharge, death or transfer out. If a patient is on parole do not report as a separation until the patient is actually written off the books.

3. **Date of last admission other than by transfer** – give the date on which the patient last entered a mental hospital or institution as a

9002–7: 7-11-58 ☐ Discharge ☐ Death ☐ Transfer ☐ Male ☐ Female

Mental Institution Separation

Name of patient _____ Date of separation _____ Case No. _____
(Month) (day) (year)

1. Residence _____

_____
(City, town, village, rural municipality) (County)

2. Age at separation _____ Date of birth _____

3. Date of admission this treatment period, not considering transfer(s) as breaking treatment _____

4. Date of leaving hospital or beginning of last probation period _____

5(a) Final admission diagnosis in full _____

_____

_____

International Classification of Diseases No. _____

(b) Associated conditions –

Mental deficiency	Epilepsy	Addiction to alcohol	Addiction to drugs
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6. Nature of discharge – ☐ On medical advice ☐ Against medical advice

7. Condition on separation – ☐ Recovered ☐ Much Improved ☐ Improved ☐ Unimproved

8. Discharge or transfer to –

☐ Home ☐ Clinic agency
☐ General hospital ☐ Welfare institution
☐ Mental institution* ☐ Other*

*Name of Institution _____

9. Cause of death –

		Approximate interval between onset and death
I (a) Disease or condition directly leading to death		
Due to (or as consequence of)		
I (b) Antecedent causes		
Due to (or as consequence of)		
I (c)		
II Other significant conditions		

10. Was an autopsy performed? ☐ Yes ☐ No

Findings _____

_____

_____

Institution _____ Location _____

9002-7

☐ Discharge ☐ Death ☐ Transfer ☐ Male ☐ Female

Mental Institution Separation Card

Name of Patient _____ Date of Separation _____ 19___ Case No. _____

1. Residence _____

(City, town, village, rural municipality) (County)

2. Age at Separation _____ Date of Birth _____

3. Date of last Admission other than by Transfer _____

4. Date of finally leaving Hospital _____

5. Final Diagnosis: (a) Describe fully _____

(b) International Statistical Classification No. _____

(c) Was the Patient { Mentally Defective ☐ Yes ☐ No / Epileptic ☐ Yes ☐ No }

6. Nature of Separation ☐ On Medical Advice ☐ Against Medical Advice

7. Condition on Separation { ☐ Recovered ☐ Much Improved / ☐ Improved ☐ Unimproved }

8. Disposition to:

☐ Home ☐ Clinic Agency

☐ General Hospital ☐ Welfare Institution

☐ Other ☐ Transfer to other Mental Hospital

Name of Hospital _____

9. Cause of Death

			Approximate interval between onset and death
I	Disease or Condition Directly leading to Death	(a) _____	
		Due to (or as consequence of)	
	Antecedent Causes	(b) _____	
		Due to (or as consequence of)	
		(c) _____	
II	Other Significant Conditions	_____	

10. Was an Autopsy Performed ☐ Yes ☐ No

Findings _____

Hospital _____ Location _____

first admission or readmission. If the patient now being separated came in as a transfer, report the date admitted to the mental hospital from which he was transferred.

4. **Date of finally leaving hospital** – give the date on which the patient physically left the hospital prior to the recorded separation. In the majority of cases this will be the date on which probation commenced.

5. **Final diagnosis** – this will not, in most cases, differ from the diagnosis reported on the admission card. In some instances, however, additional diagnostic information may have become available after the admission card had been sent in which may amplify or alter the diagnosis originally reported. The question is **not** intended to reflect any change brought about by treatment or to give any indication of the patient's diagnosis or condition at the time of separation. The final diagnosis should be expressed in terms similar to those used to answer question 15 of the Admission Card.

6. **Nature of separation** – for patients being discharged check the appropriate space to indicate whether the discharge was on or against medical advice.

7. **Condition on separation** – for purposes of statistical comparability, use the following definitions to determine which space should be checked:

   Recovered – a restoration to that degree of social adjustment which obtained before the illness.

   Much improved – a near restoration to that degree of social adjustment which obtained before the illness.

   Improved – a partial restoration to that degree of social adjustment which obtained before the illness.

   Unimproved – no restoration to that degree of social adjustment which obtained before the illness.

8. **Disposition to:** – indicate by checking the appropriate box, the agency, institution or person to whom the patient was referred on discharge. In the case of a transfer to a mental hospital, training school or psychiatric unit, give the name of the institution. In a general hospital, the movement of a patient from a psychiatric unit to a general unit of the hospital should not be reported as a transfer but as a discharge.

9. **Cause of death** – the disease or condition directly leading to death, together with the antecedent cause and other significant conditions should be stated in the same form as on the official registration of death required by the province.

   In Part I enter on line (a) the condition leading directly to death and, on lines (b) and (c), the antecedent conditions which gave rise to the direct cause, with the underlying cause being stated last. If the condition on line (a) completely describes the sequence of events no further entries are needed on lines (b) or (c).

   In Part II enter any other significant condition which unfavourably influenced the course of the morbid process, and thus contributed to the fatal outcome, but which was not related to the disease or condition directly causing death.

   The terms used in describing the death should correspond to those contained in the 6th Revision of the International Statistical

Classification of Diseases, Injuries and Causes of Death, 1948. Canadian physicians will find the Physicians' Pocket Reference, (Dominion Bureau of Statistics, 1950) convenient for selecting acceptable terms to be used.

Monthly statement of patient movement

This monthly summary of the movement of patients should accompany the monthly batch of admission and separation cards sent in by each hospital, institution or psychiatric unit. It constitutes a check on the cards actually submitted and received, since the figure for item 2 will agree with the admission cards received, and that for item 4 with the separation cards.

Where, in a smaller hospital, no patients have been admitted or separated in a particular month, a statement should nevertheless be sent with items 1, 3 and 5 completed for the number of patients in the hospital.

To: Dominion Bureau of Statistics, Institutions Section, Ottawa

STATEMENT OF POPULATION MOVEMENT: For the Month of .....19....

	Males	Females
1. On books at beginning of month	.....	.....
2. Admissions (Cards enclosed)	.....	.....
3. Total under care (Items 1 and 2)	.....	.....
4. Separations (Cards enclosed)	.....	.....
5. On books at end of month	.....	.....

HOSPITAL 9002-16

Report submitted by 30-10-53

SECTION 4

Classification of mental disorders

Statistics of mental illness are the facts, in numerical form, which are used to appraise the mental health conditions and needs of the people of Canada. To be used with confidence they must be built up from individual diagnostic particulars recorded and classified in a comparable manner. To be intelligible they must bring together these individual diagnoses into groupings which permit scientific generalization and deduction. These fundamental attributes of the statistics provide the basis for the employment of a uniform classification of mental disorders.

Such a classification should not be confused with a medical or psychiatric nomenclature. The function of a nomenclature is to provide a completely specific list or catalogue of approved terms for every disease entity which is clinically recognizable. On the other hand a statistical classification, while it encompasses the full range of psychiatric conditions, accommodates these within a more limited number of titles, chosen and arranged to facilitate the statistical study of mental disease phenomena.

Canada, as one of the member nations of the World Health Organization, has adopted the International Statistical Classification of Diseases, Injuries and Causes of Death (6th revision) as the basis for statistics of mortality and morbidity since 1950. The classification as a whole provides 612 numbered categories of diseases and morbid conditions, arranged in 17 main sections. One of these major groups is entitled Mental, Psychoneurotic and Personality Disorders and contains the 26 categories or rubrics which are used to classify most of the diagnoses reported by mental hospitals and psychiatric units. Each category is identified by a three-digit number, several being further broken down by decimal subdivision for greater specificity.

Since the scheme of classification followed could not be expected to include within these 26 categories all the conditions involving admission to mental hospitals, certain conditions such as tabes dorsalis and puerperal psychosis are contained in other major groups of the Classification. Syphilis, for example, is included in the section covering Infective and Parasitic Diseases.

The following pages list twice the categories of the International Statistical Classification which are used to classify the diagnostic information reported by Canadian mental hospitals and psychiatric units. The first list contains the three-digit categories in summary form for convenience of reference. The second contains fourth-digit categories where they exist, together with the diagnostic terms which are included within each category and also describes briefly the characteristics of each mental disorder as an aid in making correct assignments.

Summary list of categories

Psychoses

300 Schizophrenic disorders (dementia praecox)
301 Manic-depressive reaction
302 Involutional melancholia
303 Paranoia and paranoid states
304 Senile psychosis
305 Presenile psychosis
306 Psychosis with cerebral arteriosclerosis
307 Alcoholic psychosis
308 Psychosis of other demonstrable etiology
309 Other and unspecified psychoses

Psychoneurotic disorders

310 Anxiety reaction without mention of somatic symptoms
311 Hysterical reaction without mention of anxiety reaction
312 Phobic reaction
313 Obsessive-compulsive reaction
314 Neurotic-depressive reaction
315 Psychoneurosis with somatic symptoms (somatization reaction) affecting circulatory system
316 Psychoneurosis with somatic symptoms (somatization reaction) affecting digestive system
317 Psychoneurosis with somatic symptoms (somatization reaction) affecting other systems
318 Psychoneurotic disorders, other, mixed, and unspecified types

Disorders of character, behaviour, and intelligence

320 Pathological personality
321 Immature personality
322 Alcoholism
323 Other drug addiction
324 Primary childhood behaviour disorders
325 Mental deficiency
326 Other and unspecified character, behaviour, and intelligence disorders

Other

020.1 Juvenile neurosyphilis (congenital)
024 Tabes dorsalis
025 General paralysis of insane
026 Other syphilis of central nervous system
083 Late effects of acute infectious encephalitis
353 Epilepsy
648.3 Psychosis arising from pregnancy
688.1 Puerperal psychosis
793 Observation, without need for further medical care

Detailed list of categories, inclusions and characteristics of Mental, Psychoneurotic, and Personality Disorders

Psychoses

In the psychotic disorders will be found varying degrees of personality disintegration, and failure to test and evaluate correctly external reality in various spheres. In addition, individuals with such disorders fail in their ability to relate themselves effectively to other people or to their own work.

300 SCHIZOPHRENIC DISORDERS (Dementia Praecox)

This term is synonymous with the formerly used term dementia praecox. In this group of psychotic reactions there is disturbance in reality relationships and concept formations with affective, behavioural and intellectual disturbances in varying degrees and mixtures. The disorders are marked by strong tendency to retreat from reality by emotional disharmony, unpredictable disturbances in stream of thought, aggressive behaviour and, in some, by a tendency to deterioration.

This group of psychoses is further subdivided because of the prominence of the various symptoms in individual cases. The distinctions are only relative and transitions from one sub group to another are common.

300.0 Simple type

Under this heading will be shown those reactions which display some defective interest with gradual development of an apathetic state and indifference but without other strikingly peculiar behaviour and without expression of delusions or hallucination. It manifests a type of reaction with an increasing severity of symptoms over a long period of time with some apparent mental deterioration.

Inclusions –

Dementia:	Schizophrenia:
primary	primary
simplex	simple

300.1 Hebephrenic type (apathetic type)

These reactions are characterized by a shallow effect, unpredictable, silly behaviour which appears inconsistent with the ideas expressed; neologisms; bizarre ideas; and coining of words or phrases are common. Hallucinations and delusions are quite common in this type of reaction and the regressive type of behaviour is fairly rapid.

Inclusions –

Dementia, paraphrenic:	Schizophrenia:
Hebephrenia	hebephrenic
Paraphrenia	paraphrenic

300.2 Catatonic type

These reactions are characterized by usually a conspicuous alternating state with either marked generalized inhibition (stupor, mutism, negativism and waxy flexibility) or excessive motor

activity and excitement. The latter shows marked impulsiveness and belligerence. In retrospect it is usually found that the sensorium has remained clear. Regression to a vegetative state may occur.

Inclusions –

Catatonia
Dementia, catatonic
Schizophrenia, catatonic

300.3 Paranoid type

This group is characterized by prominence of delusional ideas generally of a persecutory or grandiose nature. A consistent emotional reaction of aggressiveness due to persecutory delusions is most frequent. The hallucinations occur in various fields to which the patient frequently responds. Excessive religiosity or expansive delusional system of omnipotence, genius or special ability are also found here. The systematized paranoid hypochondriacal states are included in this group.

Inclusions –

Dementia, paranoid
Schizophrenia, paranoid

300.4 Acute schizophrenic reaction (Acute undifferentiated type)

This classification is reserved for the acute undifferentiated cases of schizophrenic reaction. The symptoms usually clear in a few weeks but there is a tendency to recur. If the condition progresses it usually falls into one of the more clearly defined types.

Inclusions –

Schizophrenic reaction, acute

300.5 Latent schizophrenia

This classification is reserved for chronic undifferentiated cases, those referred to usually as "latent", "incipient", "pre-psychotic" schizophrenia, etc.

Inclusions –

Latent schizophrenic reaction
Schizophrenia, latent
Schizophrenic residual state (Restzustand)

300.6 Schizo-affective psychosis

This group covers those cases exhibiting a mixture of schizophrenic and affective reactions. It includes those main groups of schizophrenic reactions with schizophrenic-like thinking or bizarre behaviour. It can also include those cases where the pre-psychotic personality is at variance or inconsistent with the presenting psychotic symptoms. On prolonged observation, all these usually prove to be basically schizophrenic in nature.

Inclusions –

Mixed schizophrenic and manic-depressive psychosis
Schizo-affective psychosis
Schizothymia

300.7 Other and unspecified

Occasionally other schizophrenic reactions may occur which cannot be classified in the previous groups – only such cases should be placed in this group.

Inclusions –

Dementia praecox
Schizophrenia
Schizophrenic reaction

} Not otherwise specified, or any type not classifiable under 300.0 - 300.6

301 MANIC-DEPRESSIVE REACTION

This term is synonymous with manic-depressive psychosis. These conditions are characterized by marked changes in mood and a tendency to remission and recurrence. Many other symptoms such as illusions, delusions and hallucinations may be present in addition to the marked affective changes.

301.0 Manic and circular (Manic type)

This group is characterized by elation or irritability with overtalkativeness or flight of ideas and increased motor activity. Occasional brief periods of depression may occur but this should not change the diagnosis from the manic type of reaction.

Inclusions –

Alternating insanity
Circular:
  insanity
  stupor
Cyclothymia
Hypomania
Insanity or psychosis, manic-depressive:
  circular
  manic
Mania NOS
Manic-depressive reaction:
  agitated
  circular
  manic

301.1 Depressive

In this group will be found those cases with marked depression of mood and with mental and motor retardation. Agitation, apprehension and anxiety may also be present in this group. Perplexed and stuporous reactions should also be included in this sub-classification.

Inclusions –

Insanity or psychosis, manic-depressive, depressive
Manic-depressive reaction, depressive
Melancholia NOS

301.2 Other

Under this heading will be included those with marked mixture of 301.0 plus 301.1, where the alteration is frequent and where it is difficult to say which phase predominates. The alteration of the two phases may be rapid and constitute the circular type. In addition other manic-depressive reactions which are not in 301.0 and 301.1 should be classified here.

Inclusions –

Affective psychosis
Insanity or psychosis, manic-depressive:
  NOS any type except circular, depressive, or manic
Manic-depressive reaction:
  NOS stuporous

302 INVOLUTIONAL MELANCHOLIA

This group includes psychotic reactions characterized by depression during the involutional period, generally without previous history of manic-depressive reaction and occurring usually in individuals of the compulsive personality type. These reactions tend to have a prolonged course and may be manifested by worry, intractability, insomnia, guilt, anxiety, agitation, delusional ideas and somatic complaints. Agitation and depression are common in many of these cases while others may present a paranoidal idea. Somatic pre-occupation to a delusional degree is common in this group. Manic-depressive reactions occurring in the involutional period should not be included in this group nor should other psychotic reactions which have an onset in this involutional period.

Inclusions –

Insanity, climacteric
Melancholia:
climacteric
involutional
menopausal
Psychosis, involutional
(any type)

303 PARANOIA AND PARANOID STATES

In this group will be included those cases showing characteristics of a paranoid state, paranoid condition and those more commonly known under the old classification as paranoia.

These reactions show fixed suspicions and logically elaborated ideas of persecution generally as the result of false interpretation of an actual occurrence. Emotional reactions are usually consistent with the ideas held. Hallucinations are usually not present. The patients are prone to take action against their suspected persecutors. The abnormal ideas are frequently isolated from the normal ideas of the individual and may be difficult to elicit. Intelligence is usually good. The course is prolonged and chronic but deterioration is not a marked feature.

All cases of paranoid schizophrenia and other psychotic reactions showing paranoid symptoms should be excluded from this category.

Inclusions –

Paranoia
Paranoid conditions, other than in dementia and schizophrenia
Paranoid state, NOS

304 SENILE PSYCHOSIS

This group is to include only those who are having a psychotic reaction and exhibit such symptoms as exaggeration of normal senile mental changes, marked loss of memory for recent events, inability to concentrate, misidentification, fabrication and faulty orientation. Determination, irritability, confusion, delusions or depression or excitement may predominate.

A degree of self-centering of interests, reminiscence and difficulty in adjustment in character of old persons should be classified under 794. Deterioration may be minimal or it may progress to a state of vegetative existence.

Inclusions –

Cerebral atrophy or degeneration with psychosis at ages 65 and over	Senile: dementia imbecility insanity melancholia psychosis (any type)
Dementia of old age	

305 PRESENILE PSYCHOSIS

This classification is reserved for those who show severe progressive brain syndrome in the comparatively early age period. There is a gradual loss of memory, changes in perception, changes in personal habits and disorientation. Intellectual impairment appears fairly early whereas loss of sleep and often debility are later features. Deterioration is a prominent feature. Onset usually occurs between 40 and 60 years of age but earlier cases have been reported. Included in this group is Pick's disease, Alzheimer's disease and diffuse convolutional atrophy.

Inclusions –

Alzheimer's disease	Presenile: dementia psychosis sclerosis
Circumscribed atrophy of brain	
Pick's disease of brain	

306 PSYCHOSIS WITH CEREBRAL ARTERIOSCLEROSIS

Here are to be classified those chronic progressive mental disturbances occurring in connection with cerebral arteriosclerosis. This will constitute a comparatively large group of middle age and old persons who show evidence of interference with cerebral circulation. Such symptoms are difficulty in sustained mental cerebration, confusion, loss of memory and general impairment of the intellectual functions in varying degrees. Preservation of the personality and insight into the defects may be present in early or mild cases but in severe circulatory disturbance with cerebral destruction, mental enfeeblement may be advanced to a high degree. In elderly persons hypertension may or may not be found in the presence of severe vascular disease. Cases with essential hypertension or with arteriosclerosis without demonstrable degenerative changes in the larger vessels, but showing psychotic symptoms of the arteriosclerotic type, should be classified here. Differentiation from the senile psychoses is sometimes difficult as the pathological changes lying at the basis of the two psychotic reaction types may be associated. The age, history, and a careful survey of the symptoms will often assist in determining which is the predominant type of reaction; where such a determination is not clearly possible, preference should continue to be given, for statistical purposes, to the arteriosclerosis classification.

Inclusions –

Dementia, arteriosclerotic
Organic brain disease with psychosis
Psychosis due to arteriosclerosis (cerebral)

3340 Cerebral arteriosclerosis without psychosis

307 ALCOHOLIC PSYCHOSIS

Under this heading will be included all degrees of brain damage resulting from the use of alcohol ranging from very mild, up to and including very severe. In this group will be those cases which can be reasonably concluded to have alcohol as the main etiological factor. This includes pathological intoxication, delirium tremens, Korsakoff's psychosis and alcoholic hallucinosis.

Excessive alcoholism may be a symptom of some other psychosis or psychopathological condition. It may aggravate and bring to notice an already existing psychosis of a non-alcoholic nature. Such cases are to be carefully distinguished by the previous history, by the symptomatology and course, and should be grouped elsewhere under their proper categories. Alcoholic addiction without psychosis should be classified under 322.

Inclusions –
Delirium tremens
Hallucinosis, alcoholic
Korsakoff's psychosis or syndrome, unless specified as non-alcoholic
Polyneuritic psychosis, alcoholic
Psychosis, alcoholic (any type)

308 PSYCHOSIS OF OTHER DEMONSTRABLE ETIOLOGY

The psychoses of other organic etiology constitute a class which result from relatively permanent more or less irreversible diffuse impairment of cerebral tissue function. These disorders are classified according to the cause of impairment of brain function. There may be varying degrees of progress but some disturbance of memory, judgment, orientation, comprehension and affect persist permanently.

308,0 Resulting from brain tumour

Psychoses developing during the course of intracranial neoplasms (brain tumour) should be classified here whether the brain tumour is primary or secondary. Personality change with defect in judgment and deterioration may often be the presenting symptom in a brain tumour.

Inclusions –
Psychosis:
resulting from brain tumour
with intracranial neoplasm

308,1 Resulting from epilepsy and other convulsive disorders

Here should be classified only cases which show psychosis in connection with idiopathic epilepsy. This includes epileptic deterioration, epileptic clouded states and epileptic confusion. Most commonly found in epilepsy with psychosis are those who show a gradual development of mental dullness, slowness of associated thinking, impairment of memory and other intellectual functions as well as apathy.

If the convulsive manifestation is symptomatic of another disease, it should be classified under the other disease heading. Epilepsy without psychosis is to be classified under 353.

Inclusions –

Epileptic:
clouded state
deterioration

Psychosis with:
any condition classifiable under 353
other convulsive disorders

308.2 Secondary or due to infective or parasitic diseases

Classify here only those psychoses due to severe general systemic infections – e.g., pneumonia, typhoid. Do not include other disorders which may be manifest during an infectious or parasitic disease.

Exclude psychosis due to tuberculosis of central nervous system (010), syphilis of the central nervous system (025, 026) and acute infectious encephalitis (083).

308.3 Secondary or due to allergic, endocrine, metabolic and nutritional diseases

Include only those psychoses due to such disease. Do not classify here psychoses occurring coincidentally with such conditions.

308.4 Secondary or due to diseases of the blood, blood-forming organs and circulatory system

Here are to be classified those chronic organic mental disturbances occurring in connection with circulatory disturbance other than cerebral arteriosclerosis. In each case specify the condition such as cerebral embolism, cerebral hemorrhages, arterial hypertension and other chronic vascular disease.

Do not include here syphilis (see 020, 024, 026) or cerebral arteriosclerosis (306).

308.5 Secondary or due to diseases of the nervous system and sense organs

Classify here only those conditions due to diseases of the nervous system and sense organs and not those seen together with these conditions.

308.6 Secondary or due to drugs and other exogenous poisons

Classify here those psychoses due to drugs, noxious foodstuffs or poisoning by other substances.

308.7 Secondary or due to accidents and violence

Here will be classified only those cases of acute psychosis occurring immediately after injury or violence of an external nature. If an injury to another part of the body produces mental disturbance, it should not be classified here. Also psychoses in which head trauma acts as a contributing or precipitating cause should be diagnosed under proper heading and not included in this group.

308.8 Secondary or due to other diseases

This category is intended for those cases where there is demonstrable etiology which does not properly fit in the above groups or is not elsewhere classifiable as an organic psychosis. The disease, however, will be specified. It is also permissible to use this category for incomplete diagnoses.

309 OTHER AND UNSPECIFIED PSYCHOSES

Here will be classified those cases that show abnormal reactions essentially of an emotional and volitional nature apparently on the basis of constitutional defect, which are not to be classified under the groups already described.

309.1 Psychoses with Psychopathic Personality

Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage and sexual perversion. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may he present.

The abnormal reactions which bring psychopathic personalities into the group of psychoses are varied in form but usually of an episodic character. Most prominent are attacks of irritability, excitement, depression, paranoid episodes, transient confused states, etc. True prison psychoses belong in this group.

A psychopathic personality with a manic-depressive attack should be classified in the manic-depressive group. Likewise a psychopathic personality with a schizophrenic psychosis should go into the appropriate classification. Psychopathic personalities without episodic mental attack or psychotic symptoms should be placed in the group "Without psychosis". Cases of intellectual defect (feeble-mindedness, mental deficiency) are not to be included in this group.

309.2 Psychoses, other and unspecified

In this group should be placed the cases in which a satisfactory diagnosis cannot be reasonably made and in which the psychosis must therefore be regarded as an unclassified one. Most frequently this may be due to lack of history, inaccessibility of the patient, or too short a period of observation. On the other hand, the clinical picture may be so obscured and the symptoms so unusual that a reasonably accurate classification cannot be made.

The number of undiagnosed psychoses may reflect the attitude of physicians, indicating either inadequacy of careful collection of facts and insufficient observation or may indicate a rigid tendency for absolute accuracy. It may be mentioned that reasonable accuracy and not absolute accuracy is looked for in statistical classification of medical conditions. This does not mean guessing at a classification or forcing one into a group without reasonable facts to substantiate the decision.

Psychoneurotic Disorders

These disorders usually present evidence of periodic or constant maladjustment of varying degrees from early life. There is usually neither gross distortion of external reality nor gross disorganization

of the personality. The chief features are anxiety and tension which may be directly felt and expressed or unconsciously and automatically controlled by the utilization of various psychological defence mechanisms. The reaction to stress may bring about acute symptomatic expression of such disorders and manifest itself by varying types of reaction in the psychoneurotic group.

310 ANXIETY REACTION WITHOUT MENTION OF SOMATIC SYMPTOMS

This term is synonymous with the former term 'anxiety state' and 'anxiety neurosis' These cases show more or less continuous diffuse anxiety and apprehension. Feelings of acute panic and acute tension are extremely common and emotional tension is high.

When somatic symptoms are definite the condition should be classified under 315, 316, 317 or 318.

Inclusions –

Anxiety:
- neurosis NOS
- reaction NOS
- state NOS

Anxiety reaction with any condition in 311 without mention of somatic symptoms

311 HYSTERICAL REACTION WITHOUT MENTION OF ANXIETY REACTION

In these cases the anxiety is 'converted' into functional symptoms and expressed in organs or parts of the body, usually those that are mainly under voluntary control. These are to be differentiated from the psychoneuroses with somatic symptoms which should be classified under 315, 316, 317 and 318. Conversion reaction is synonymous with conversion hysteria and hysterical neurosis.

Inclusions –

Anorexia nervosa
Compensation neurosis
Dissociative reaction (any)
Hysteria, hysterical:
- NOS
- amnesia
- anaesthesia
- anorexia
- anosmia
- aphonia
- blindness
- catalepsy
- conversion

} without mention of anxiety reaction

Hysteria, hysterical:
- convulsions
- dyskinesia
- fugue
- mutism
- paralysis
- postures
- somnambulism
- tic
- tremor
- other manifestations

Hystero-epilepsy

} without mention of anxiety reaction

312 PHOBIC REACTION

In these cases the anxiety is usually attached to some specific fear – syphilis, dirt, high places, etc. The patient tries to avoid these specific situations in the effort to overcome his anxiety. The former terms phobia and anxiety hysteria belong in this group.

Inclusions –

Fear reaction
Phobia NOS

Phobic reaction

313 OBSESSIVE-COMPULSIVE REACTION

In these conditions there is obsessive rumination or pre-occupation with ideas, and repetitive impulses to perform certain acts. The acts may be recognized by the patient as unreasonable but the desire cannot be controlled.

Inclusions –

Neurosis:	Obsessional:
compulsive	ideas and mental images
impulsive	impulses
obsessional	phobias
obsessive-compulsive	ruminations
	state
	Obsessive-compulsive reaction

314 NEUROTIC-DEPRESSIVE REACTION

Here are to be classified those cases which show depression in reaction to obvious external causes such as bereavement, sickness, financial and other worries. The reaction of a more marked degree and of longer duration than normal sadness, may be looked upon as pathological. The anxiety in this reaction is replaced to some extent by depression and self-deprecation. Feelings of guilt are common.

This term is synonymous with the former term "reactive depression". Differentiation from manic-depressive reactions are on the basis of a life history and absence of such malignant symptoms as severe psychomotor retardation. Manic-depressive Reaction will be classified under 301.

Inclusions –

Neurotic-depressive reaction	Reactive depression
Psychogenic depression	

315 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING CIRCULATORY SYSTEM

This group is different from other psychoneurotic reactions in that there is persistent attachment to the cardiovascular system.

315.0 Neurocirculatory asthenia

Inclusions –

Cardiac asthenia	Effort syndrome
Da Costa's syndrome	Neurocirculatory asthenia
Disordered action of heart, specified as psychogenic	"Soldier's heart"

315.1 Other heart manifestations specified as of psychogenic origin

Inclusions –

Functional heart disease, Paroxysmal tachycardia, Angina } specified as psychogenic

315.2 Other circulatory manifestations of psychogenic origin

Inclusions –

Hypertension, Vascular spasm, Migraine } specified as psychogenic

316 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING DIGESTIVE SYSTEM

This title excludes ulcer of stomach and of duodenum. It excludes functional disorders of oesophagus, of stomach and of intestines unless specified as psychogenic. The condition will be classified according to the sub-groups below:

316.0 Mucous colitis specified as of psychogenic origin

Inclusions –
Mucous colic, Mucous colitis } specified as psychogenic

316.1 Irritability of colon specified as of psychogenic origin

Inclusions –
Functional diarrhoea, Enterospasm, Spastic colon } specified as psychogenic

316.2 Gastric neuroses

Inclusions –
Cyclical vomiting
Functional dyspepsia, specified as psychogenic
Gastric neurosis
Functional disorders of stomach, specified as psychogenic

316.3 Other digestive manifestations specified as of psychogenic origin

Inclusions –
Aerophagy
Globus
Disorders of digestive system specified as psychogenic, but not classifiable under 316.0 to 316.2.

317 PSYCHONEUROSIS WITH SOMATIC SYMPTOMS (SOMATIZATION REACTION) AFFECTING OTHER SYSTEMS

317.0 Psychogenic reactions affecting respiratory system

Inclusions –
Disorder of respiratory system, specified as psychogenic
Psychogenic asthma

317.1 Psychogenic reactions affecting genito-urinary system

Inclusions –
Disorder of:
genito-urinary system, micturition, sexual function } specified as psychogenic

317.2 Pruritus of psychogenic origin

Inclusions –
Pruritus, specified as psychogenic

317.3 Other cutaneous neuroses

Inclusions –
Disorder of skin specified as psychogenic, excluding pruritus

317.4 Psychogenic reactions affecting musculoskeletal system

Inclusions –
Disorder of:
articulation (joint)
joint
limb
muscle
musculoskeletal system
Paralysis
} specified as psychogenic

317.5 Psychogenic reactions affecting other systems

Inclusions –
Disorders of parts of body not classifiable under 315-317.4, specified as psychogenic

318 PSYCHONEUROTIC DISORDERS, OTHER, MIXED, AND UNSPECIFIED TYPES

318.0 Hypochondriacal reaction

Under this heading are to be classified those cases that show essentially an obsessive preoccupation with the state of their health or of various organs, with a variety of somatic complaints which are not relieved by demonstration of a lack of pathology. Occurring frequently in the involutional period, they are to be differentiated from involutional melancholia by the absence of marked depression with agitation and self-condemnation. Hypochondriacal complaints may be a symptom of dementia praecox and this reaction type should be eliminated before classifying cases here.

Inclusions –
Hypochondria
Hypochondriasis

318.1 Depersonalization

In this condition there is a loss of affective response with a feeling that everything, including the patient, is unreal. Stupor, fugues, amnesias may occur.

318.2 Occupational neurosis

This classification is only to be used when the occupation is a definite causative factor in the development of the neurosis.

Inclusions –
Craft neurosis
Miners' nystagmus
Occupational neurosis

318.3 Asthenic reaction

To be designated under this heading are those cases in whom organic disease is ruled out and who complain of motor and mental fatigability, diminished power of concentration and pressure in the

head, scalp, neck or spine. Early dementia praecox or mild depressions of the manic-depressive type not infrequently have to be considered in the differential diagnosis.

Inclusions –

Asthenic reaction
Nervous:
debility
exhaustion
prostration
Neurasthenia
Psychogenic:
asthenia
general fatigue

318.4 Psychoneurotic disorders, mixed

This group excludes mixed anxiety and hysterical reactions (310). Include only those whom it is not possible to classify according to the predominant factor.

318.5 Other and unspecified types

Include here only those psychoneurotic disorders which cannot be classified elsewhere.

Inclusions –

Nervous breakdown
Neurosis NOS
Psychasthenia
Psychoneurosis:
NOS
other specified types not classifiable under 310-318.4

Disorders of character, behaviour and intelligence

320 PATHOLOGICAL PERSONALITY

320.0 Schizoid personality

These cases show shyness, sensitiveness, seclusiveness, unsociability, etc., often associated with eccentricity. Exclude schizophrenia (300).

320.1 Paranoid personality

Frequently have schizoid personality together with suspiciousness, envy, jealousy and difficulty in maintaining interpersonal relationships.

320.2 Cyclothymic personality

These cases exhibit alternating moods of elation and sadness. The changes of mood seem to be precipitated from within rather than by external factors.

320.3 Inadequate personality

Are characterized by an inability to meet life's demands – they do not exhibit severe defeat in any field but are generally unable to adapt to specific situations such as marriage, home life, or occupation.

320.4 Antisocial personality

These cases are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. Impulsive reactions are common as are mood changes and rationalization. Intelligence may be normal or superior but, not infrequently, is borderline.

Inclusions –

Antisocial personality	Psychopathic personality:
Constitutional psychopathic state	NOS
	with antisocial trend

320.5 Asocial personality

These cases frequently develop in an abnormal moral environment and they disregard the usual social codes and as a result are in conflict with the environment. Other than the apparent inability to appreciate norms of behaviour they show little personality deviation.

Inclusions –

Asocial personality	Pathologic liar
Moral deficiency	Psychopathic personality with amoral trend

320.6 Sexual deviation

This diagnosis is reserved for cases where the sexual deviation is not symptomatic of some other psychiatric disorder.

Inclusions –

Exhibitionism	Pathologic sexuality
Fetishism	Sadism
Homosexuality	Sexual deviation

320.7 Other and unspecified

Include only those cases of personality pathology which cannot be classified elsewhere.

321 IMMATURE PERSONALITY

321.0 Emotional instability

These cases show undue excitement and become ineffective even when faced by very minor stress situations. Judgment under stress is usually faulty and emotional conflicts are handled poorly.

321.1 Passive dependency

Here the patient is dependent, with helplessness and indecisiveness being the predominant characteristic.

321.2 Aggressiveness

Characterized by temper tantrums, irritability, and destructive behaviour.

321.3 Enuresis characterizing immature personality

Classify here only those cases where enuresis is the predominant symptom of the personality disorder.

321.4 Other symptomatic habits except speech impediments

Classify here habits other than enuresis and speech impediments which are symptomatic of the personality disorder.

321.5 Other and unspecified

Inclusions –

Immature personality NOS	Immaturity reaction NOS

322 ALCOHOLISM

Do not classify here alcoholic psychosis (307), acute poisoning by alcohol or cirrhosis of the liver with alcoholism.

322.0 Acute

Classify here those cases of temporary disturbance caused by excessive use of alcohol.

322.1 Chronic

Those cases where there is repeated and long continued use of alcohol, i.e., addiction to alcohol without recognizable underlying disorder.

Inclusions –

Alcoholic addiction
Alcoholism, chronic
Ethylism, chronic

322.2 Unspecified

Only those cases which cannot be classified in 322.0 or 322.1.

323 OTHER DRUG ADDICTION

As drug addiction is usually symptomatic of some underlying disorder, this category should only be used where the underlying condition is not determined.

Inclusions –

Addiction to, or chronic poisoning by:
- amphetamine
- barbituric acid (and compounds)
- benzedrine
- bromides
- cannabis indica
- chloral
- cocaine
- codeine
- demerol
- diacetylmorphine
- diamorphine
- ethylmorphine
- hashish
- heroin
- Indian hemp
- morphine
- opium
- paraldehyde
- pethedine
- thebaine
- other narcotic, analgesic, and soporific drugs

Drug addiction
Morphinism

324 PRIMARY CHILDHOOD BEHAVIOUR DISORDERS

Do not classify here behaviour disorders associated with pathological personality (320), immature personality (321), mental deficiency (325), or due to any physical illness. It is expected that the group of children with personality disorders not classifiable elsewhere will be placed in this group. These conditions are usually transient.

Inclusions –

Behaviour disorder of childhood not identified with psychopathic personality, mental deficiency, or any physical illness:
- jealousy
- masturbation
- tantrum

Juvenile delinquency

325 MENTAL DEFICIENCY

Exclude cerebral spastic infantile paraplegia, birth injury, epiloia, tuberous sclerosis, gargoylism, hydrocephalus, hypertelorism, juvenile general paralysis of the insane. If there is concomitant deficiency the appropriate box for mental deficiency should be checked on the admission card.

Psychosis with mental defect should be classified under the appropriate psychosis or in "psychosis unspecified" and the appropriate box for mental deficiency checked on the admission card. If there is mental deficiency and epilepsy it should be classified under the predominant condition and the appropriate boxes for epilepsy and deficiency checked on the admission card. Here will be classified primary intellectual defect existing from birth when there is no demonstrated organic brain condition or other cause.

325.0 Idiocy
Adult of mental age 0-35 months
Child with I.Q. under 20

325.1 Imbecility
Adult of mental age 36-83 months
Child with I.Q. of 20-49

325.2 Moron
Adult of mental age 84 months
Child with I.Q. of 50-74

325.3 Borderline intelligence
Some vocational limitation; I.Q. of 75-85

325.4 Mongolism
Characterized by anomalies of the skull, eyes and tongue. The eyes are oblique, narrow and slit-like, and other eye anomalies are common. Cause is obscure.

325.5 Other and unspecified types

Inclusions –

Amaurotic family idiocy	Oligophrenia
Cerebromacular degeneration	Phenylpyruvic oligophrenia
Mental deficiency NOS	Tay-Sachs disease
Mental retardation NOS	

326 OTHER AND UNSPECIFIED CHARACTER, BEHAVIOUR AND INTELLIGENCE DISORDERS

This group is to be used where the specific symptom is the outstanding feature of the case. If the specific symptom is secondary to some other condition it should be classified under the primary condition.

326.0 Specific learning defects
Specific defects such as reading, mathematics, etc.

326.1 Stammering and stuttering of non-organic origin

Inclusions –
Balbutio
Stammering or stuttering:
NOS
due to specified non-organic cause

326.2 Other speech impediments of non-organic origin

326.3 Acute situational maladjustment

To include only transient conditions directly due to stress, situational difficulties, combat or other operations. If the condition falls into any other definite psychiatric group it should be so classified.

326.4 Other and unspecified

Inclusions –
Simple adult maladjustment
Primary behaviour disorders and psychoneurotic personalities not classifiable under 083, 310-318, 320-326.3

326.0 Cerebral arteriosclerosis without psychosis

Other mental disorders

020.1 JUVENILE NEUROSYPHILIS

This group is to include all cases of congenital neurosyphilis whether psychotic or not, i.e., juvenile neurosyphilis, dementia paralytica juvenilis, juvenile general paresis, juvenile tabes and juvenile taboparesis.

Inclusions –
Dementia paralytica juvenilis
Juvenile:
general paralysis
tabes
taboparesis

024 TABES DORSALIS

Include all such cases without psychosis. Cases with psychosis should be classified according to the primary psychosis.

Inclusions –

Arthritic syphilitica deformans (Charcot)	Posterior spinal sclerosis
Cerebrospinal tabes	Progressive spinal ataxia
Charcot's joint disease	Spastic ataxia
Locomotor ataxia (progressive)	Tabes dorsalis
Neurosyphilis, tabes (dorsalis)	Tabetic arthropathy

025 GENERAL PARALYSIS OF INSANE (SYPHILITIC MENINGO-ENCEPHALITIS)

Under this heading are to be classified cases showing rapidly or slowly progressive organic intellectual and emotional defects with

physical signs and symptoms of parenchymatous syphilis of the nervous system and completely positive serology, including the paretic gold curve. Cases showing symptoms suggestive of manic-depressive reaction, schizophrenia or of other constitutional psychotic reactions, but showing also physical signs and symptoms of syphilis of the nervous system and positive serology, particularly the paretic gold curve, are to be listed here rather than under other headings. It is to be remembered that with the modern methods of treatment a number of paretics may be found with negative serology. Here the history, particularly that of the length and nature of treatment, must be taken into consideration in making the final classification.

026 OTHER SYPHILIS OF CENTRAL NERVOUS SYSTEM

026.0 Without psychosis

Include here cases of C.N.S. syphilis not classifiable in 020, 024 or 025.

026.1 With psychosis

It is expected that all such cases will be as far as possible classified under 020, 025 or other primary diagnosis. A classification under this heading is only to be made after failure of every reasonable effort to determine the predominating pathological process.

083 LATE EFFECTS OF ACUTE INFECTIOUS ENCEPHALITIS

083.1 Postencephalitic personality and character disorders

Include here only those cases due to and occurring with or following acute infectious encephalitis.

083.2 Postencephalitic psychosis

Include here only those psychoses due to and occurring with or following acute infectious encephalitis.

353 EPILEPSY

This title excludes epilepsy with psychosis (308.1), focal and Jacksonian epilepsy. In cases of epilepsy and mental defect classify under the predominating diagnosis and check the other condition in the appropriate box on the admission card.

353.0 Petit mal

Inclusions –

Minor epilepsy — Petit mal (idiopathic)

353.1 Grand mal

Inclusions –

Grand mal (idiopathic) — Major epilepsy

Haut mal

353.2 Status epilepticus

353.3 Other and unspecified

Inclusions –
Epilepsy (idiopathic) not specified as major or minor
Epileptic:
automatism
convulsions or fits, not specified as major or minor
Pykno-epilepsy

648.3 PSYCHOSIS ARISING FROM PREGNANCY

Include here only those cases directly attributable to the pregnancy; those occurring with pregnancy should be classified under the appropriate diagnosis.

688.1 PUERPERAL PSYCHOSIS

Inclusions –
Psychosis of the puerperium
Puerperal: dementia, insanity } after delivery
Puerperal: mania, melancholia, psychosis } after delivery

793.0 OBSERVATION WITHOUT NEED FOR FURTHER MEDICAL (PSYCHIATRIC) CARE

This title includes cases which present some evidence of an abnormal condition which requires further study, but which after examination and observation show no need for further treatment or psychiatric care.

794.0 Senility without mention of psychosis
900.0 Other non-psychotic conditions
351.0 Paraplegia, cerebral spastic infantile
760.0 Mental deficiency due to birth injury
753.1 Epilepsy; tuberous sclerosis
289.0 Paraglycosis
752.0 Hydrocephalus, congenital
344.0 Hydrocephalus, acquired
334.0 Arteriosclerosis without psychosis
758.2 Hypertelorism, (congenital malformation of skull.

SECTION 5

Index of mental disorders

An alphabetical index is a necessary tool for the use of any statistical classification. While the index which follows has been prepared primarily for the use of clerks engaged in coding diagnostic terms appearing on medical records it is felt that the persons responsible for recording such particulars may derive benefit from its inclusion in the present Handbook.

The index has been abstracted from Volume 2, the Alphabetical Index, of the International Statistical Classification of Diseases, Injuries and Causes of Death, thus assuring uniformity with the list of categories in the preceding section and with international practice. As in the case of its international counterpart, it includes many ill-defined, colloquial and even undesirable terms in order to indicate to the coder where the case should be assigned. The presence of many terms should therefore not be taken either as sanction for their usage in good medical terminology or as inferring acceptance of their adequacy for classification purposes.

For these reasons, the index should not be used alone but as auxiliary to the list of categories, which should constitute the final authority for decisions on correct assignment.

Aberration, mental, 318.5
Abnormal excitability under minor stress, 326.3; late effect, acute infectious encephalitis, 083.1.
Absence, epileptic, 353.1; with psychosis, 308.1
Absinthemia, absinthaemia, 322.2
Absinthe addiction, 322.1; with psychosis, 307
Absinthism, 322.2
Abuse, alcohol, 322.2
Acarophobia, 313
Accidents, psychosis secondary or due to, 308.7
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Narcotism, 323; with psychosis, 308.6
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Neuralgia, writers' 318.2
Neurasthenia—NOS, 318.3; cardiac, 315.0; gastric, 316.2; heart, 315.0; postfebrile, 318.3
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Neurocirculatory asthenia 315.0
Neurosis—NOS, 318.5; anxiety, 310; bladder, 317.1; cancerphobia, 313; cardiac, or cardiovascular, 315.0; compensation, 311—with anxiety reaction, 310; compulsive, 313; craft, 318.2; cutaneous, 317.3; environmental, 318.5; functional, 311—with anxiety reaction, 310; gastric or gastro-intestinal, 316.2; heart, 315.0; impulsive, 313; incoordination of larynx or vocal cords, 317.0; intestine, 316.3; larynx, 317.0; larynx, hysterical, 311—with anxiety reaction, 310; larynx, sensory, 317.0; musculoskeletal, 317.4; obsessional or obsessive-compulsive, 313; ocular, 317.5; occupational, 318.2; pharynx, 317.0; railroad, 311—with anxiety reaction, 310; rectum, 316.3; respiratory, 317.0; rumination, 316.3; senile, 318.5; sexual, 317.1; situational, 326.3—late effect, acute infectious encephalitis, 083.1; stomach, 316.2; vasomotor, 315.2; war, 326.3
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Paraphiegia—functional or hysterical, 311, with anxiety reaction 310; syphilitic 026.0, with psychosis 026.1

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Paresthesia of larynx or pharynx, hysterical 311—with anxiety reaction 310

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Parorexia 326.4

Paroxysmal tachycardia, psychogenic 315.1

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Pelizaeus—Merzbacher disease 325.5

Pellagra followed by psychosis 308.3

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Pethidine addiction 323; with psychosis, 308.6

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Phenylketonuria with mental deficiency 325.5

Phobia, phobic reaction 312; phobia, obsessional 313

Pica 326.4

Pick's brain disease 305

Pithiatism 311; with anxiety reaction 310

Pneumophagia 316.3

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opium, paraldehyde, paregoric, percaine, pernocton, pethidine, phanodorm, phanodorn, phenacetin, phenobarbital, Pitkin's solution, pontocaine hydrochloride, potassium bromide, procaine hydrochloride, propanal, pyramidon, seconal, sedative drug, sedormid, sodium amytal, sodium bromide, sodium soporific, somnifaine, soneryl, soothing syrup, soporific drug, stovaine, sulfonal, sulfonmethane, tetronal, thebaine, tribromethanol, trional, urethane, veganin, veronal, yellow jasmine
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Potatorium, chronic 322.1
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Sucking thumb, child 324
Suicidal risk or tendencies 318.5
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Unsoundness of mind, 309.2; late effect, acute infectious encephalitis, 083.2
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Unverricht's disease, 353.3; with psychosis, 308.1
Upset, psychogenic—NOS, 316.3; intestinal, 316.3; stomach, 316.2

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Vagabondage, 320.5; late effect, acute infectious encephalitis, 083.1
Vaginismus, hysterical 311; with anxiety reaction, 310
Vagrancy, 320.5; late effect, acute infectious encephalitis, 083.1
Vasovagal attack, psychogenic, 315.1
Ventricular escape, psychogenic, 315.1
Veronal addiction, 323; with psychosis, 308.6
Vesania 309.2
Vogt-Spielmeyer disease or amaurotic familial idiocy 325.5
Voluntary starvation: —65 yr., 309.2; 65 yr. +, 304
Vomiting—cyclical, or functional psychogenic, 316.2; hysterical, 311; hysterical with anxiety reaction, 310; nervous, neurotic, pernicious psychogenic, persistent psychogenic, psychic, uncontrollable psychogenic, 316.2

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Wandering, pacemaker, psychogenic, 315.1
War neurosis 326.3
Wet brain 322.2
Witzelsucht 326.4
Word-blindness—NOS, 326.0; congenital, 326.0; late effect, acute infectious encephalitis, 083.1; non-organic, 326.0—deafness, developmental, 326.0
Wry neck—hysterical, 311; hysterical with anxiety reaction, 310, psychogenic, 317.4

Note:

The following groups are abbreviated, being served by cross references:

Psychoneurosis, psychoneurotic
Psychopathic
Psychosis
Reaction

SECTION 6

Commonly used statistical terms and rates

Average or mean. The sum of the values recorded in a series of observations divided by the number of observations.

Median. The centre value in a series of observations when the observations are ranged from lowest to highest. With an even number of observations the mean of the two central observations is usually taken. The median is a useful form of average when the arithmetic mean is unduly affected by very large or very small outlying observations. It is an average of position, being affected by the number of observations rather than by the size of extreme values of observations.

Mode. The value which occurs most frequently in a series of observations. It is the maximum point on the curve which most closely describes an observed frequency distribution. While it is not possible to make an exact mathematical determination of the mode it can be calculated approximately from the formula Mode = Mean − 3 (Mean − Median).

Range. The distance between the lowest and highest values observed.

Frequency distribution. An arrangement of a number of observations to show the frequency with which each observation occurs, for example, the number of individuals in each age group of a population.

Mean deviation. The arithmetic average of all the differences between the observations and their mean, the differences being added without regard to whether they are difference above or below the mean.

Standard deviation. A special form of average deviation from the mean. It is computed by taking the square root of the arithmetic average of the squares of the differences between the observations and their mean.

Coefficient of variation. The standard deviation expressed as a percentage of the mean, or —

$$\frac{\text{Standard deviation} \times 100}{\text{mean}}$$

Standard error. A measure of the variability which a statistical value, such as a percentage or a mean, would show if repeated samples were taken from the same series of observations. In other words it shows how much variation might be expected to occur merely by chance in the various characteristics of samples drawn equally randomly from one and the same population.

Significance. If two averages (or two proportions) differ by more than twice the value of the standard error of the difference, the difference is said to be "significant", or more than is easily likely to have arisen by chance.

Probable error. The probable error of a value is 0.6745 times (or about two-thirds) its standard error. If twice the standard error is taken as the level of "significance", then three times the probable error must be taken to reach the same level.

Correlation coefficient. A measure of the degree of association or interdependence between two characteristics. Its value must be between plus 1 and minus 1. Either plus or minus 1 indicates complete dependence of one characteristic on the other; zero denotes no association whatever between them. A plus sign shows that an upward movement of one characteristic is accompanied by an upward movement in the other. A minus sign indicates that an upward movement of one is accompanied by a downward movement of the other.

Chi-square test. A test as to whether a series of values differs, between themselves or from an expected series, to a greater extent than might be expected to occur by chance.

Scatter diagram. A graphic method of ascertaining the correlation between two characteristics of a number of individuals. Each individual is entered as a point or dot on a graph, the position of each point being determined by the associated value of the two characteristics measured in that individual, for example the height of children plotted against their weight. The relationship is shown by the form of the path made by the points across the face of the diagram.

Rates and ratios

Admission rate. The total number of admissions (excluding transfers) to mental hospitals during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of admissions} \times 100{,}000}{\text{Population}}$$

First admission rate. The number of first admissions during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of first admissions} \times 100{,}000}{\text{Population}}$$

Re-admission rate. The number of re-admissions during a calendar year per 100,000 general population at the middle of the year.

$$\frac{\text{Number of re-admissions} \times 100{,}000}{\text{Population}}$$

Age-specific admission rate. The number of admissions in a specified age-group during a calendar year per 100,000 population in that age group at the middle of the year.

$$\frac{\text{Number of admissions at a specified age} \times 100{,}000}{\text{Total population at the same age}}$$

Note: Admission rates may be specific for other characteristics than age, or for combinations of characteristics, for example, sex, marital status, occupation, age-sex, etc. Similarly admission rates may be calculated for individual diagnoses either for the whole population or specific for age and other characteristics.

Hospitalization rate. The number of persons on the books of mental hospitals at a given date per 100,000 general population at the same date.

$$\frac{\text{Patients at end of year} \times 100{,}000}{\text{Population at end of year}}$$

Patients under care. The total number of persons receiving care at any time during the year, i.e. the sum of the number of patients on books at the beginning of the year and the number of admissions during the year.

Discharge rate. The number of patients discharged alive during a calendar year per 1,000 patients under care during the year.

$$\frac{\text{Discharges} \times 1{,}000}{\text{Patients under care during year}}$$

Death rate. The number of patients who died before discharge during a calendar year per 1,000 patients under care during the year.

$$\frac{\text{Number of patients died} \times 1{,}000}{\text{Patients under care during year}}$$

General death rate. The number of deaths in the general population during a calendar year per 1,000 population at the middle of the year.

$$\frac{\text{Number of deaths} \times 1{,}000}{\text{Population}}$$

Note: Death rates (either general or institutional) may be specific for age, sex, diagnosis or other characteristics subject to the proviso that both the numerator and denominator used in calculating the rate must refer to the same population characteristic.

Average daily population. The number of patients under care on an average day during the calendar year.

$$\frac{\text{Total patient days of care during the year}}{\text{Number of days in the year}}$$

Percentage occupancy. A measure of "patient turnover" which relates the average daily population to the beds available. It may be calculated either for bed capacity or the average number of beds set up.

(a) $\dfrac{\text{Average daily population} \times 100}{\text{Standard bed capacity}}$

(b) $\dfrac{\text{Average daily population} \times 100}{\text{Average beds set up}}$

Average stay. The average duration of stay, in days, weeks or months of all patients who died in, or were discharged from the hospital during the year.

$$\frac{\text{Total duration of stay of separated patients}}{\text{Number of separated patients}}$$

Personnel ratio. The ratio between the number of patients in hospital at the end of a calendar year and the number of staff, either for all personnel or for those in a particular category, at the same date, e.g.

$$\frac{\text{Patients in hospital at end of year}}{\text{Nursing staff}}$$

Average cost per patient day. The average operating cost of maintaining a patient in the hospital for one day.

$$\frac{\text{Total maintenance expenditure for the year}}{\text{Total patient days during the year}}$$

SECTION 7

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