



Canadian Centre
on **Substance Abuse**
Centre canadien de **lutte**
contre les **toxicomanies**

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National Treatment Indicators Report

2012–2013 Data

April 2015

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Executive Summary

Background

Substance abuse is a significant health, economic and social issue in Canada. One way to reduce the burden of substance abuse is through evidence-informed treatment. Such an approach requires reliable data to inform decisions about effective system and service planning.

In 2012, the Canadian Community Health Survey (CCHS) found that 4.4% of Canadians age 15 and older (approximately 1.3 million persons) met the criteria for a substance use disorder (Statistics Canada, 2014a). However, several sources, including the National Treatment Indicators (NTI) project, indicate a gap between individuals who could benefit from treatment services and those accessing them.

Variations in the way substance use treatment data are collected across Canada has made it difficult to describe a complete picture of the use of treatment services, the people accessing these services, and the trends among jurisdictions and over time. These information gaps also restrict Canada's ability to provide comprehensive treatment services data to initiatives addressing the health and social impacts of substance abuse at the international level.

Project Purpose and Contribution

The NTI project was developed to work towards collecting consistent information across jurisdictions to fill the information gaps and help improve the quality, range and accessibility of the treatment system in Canada. The NTI report presents information about treatment services for use by researchers, analysts, decision makers, advisors and program administrators looking to support system and service planning, development and communications.

NTI data contributes to the system-level information required by decision makers to plan, implement, monitor and evaluate evidence-informed services and supports for the treatment of substance abuse in Canada by:

- Providing a multi-jurisdictional picture of treatment system use through data collected according to a set of common indicators;
- Providing a central, accessible source of information that allows those within and outside the substance use field to discover what national treatment system data exists;
- Building Canada's capacity to provide meaningful, reliable information on substance use treatment services to support evidence-based decision making at regional, provincial, territorial and national levels; and
- Facilitating collaboration and knowledge-sharing between Canada and other countries and international organizations by providing a central source for national-level data.

Limitations

It is important to note that the NTI report captures data from publicly funded, treatment services only and does not include information from sources such as privately-funded specialized treatment centres, community supports (e.g., Alcoholics Anonymous) or primary care services (e.g. those offered by family physicians). Variation in data collection and reporting mean that direct comparisons between jurisdictions should not be made. It is also important to mention that not all information collected from the jurisdictions could be presented in this report; rather, only a subset of indicators



agreed upon by the NTI Working Group (NTIWG) is included. This decision was made to ensure the report remains as succinct yet informative as possible.

Results

This fourth NTI report provides 2012–2013 fiscal-year data from six provinces, one territory and one provincial association and has expanded its scope to include information on the primary substance for which treatment was sought. The report also includes information on the total number of hospital stays related to substance use disorders and their associated costs.¹

As the fourth in the series, this report looks at trends in the data from 2009–2010 to 2012–2013. The results show a great deal of variability in service use trends across Canada. Many jurisdictions have seen a substantial increase in the number of individuals accessing specialized treatment services in their respective jurisdiction. However, the ratio of episodes to individuals has remained relatively consistent across most of Canada.

Key Findings

- Between April 1, 2012, and March 31, 2013, a total of 155,210 unique individuals² from six Canadian provinces and one territory accessed publicly funded substance use treatment services. In total, these unique individuals accounted for nearly 225,000 treatment episodes.³
- On average, individuals accessing publicly funded treatment services account for approximately 1% of a jurisdiction's entire population.
- Non-residential treatment accounted for the majority (between 61% and 77%) of treatment episodes in every participating jurisdiction.
- On average, most individuals accessing residential treatment, non-residential treatment and non-residential withdrawal management only access these services once throughout the year; most individuals attending residential withdrawal management programs, however, access the service twice or more throughout the year.
- Many jurisdictions have seen a substantial increase in the number of individuals accessing specialized treatment services in their respective jurisdiction over the past four fiscal years.
- As much as 13% of unique individuals accessing substance use treatment accessed treatment because of someone else's substance use (e.g., they accompanied a family member or friend to treatment, or they accessed treatment services themselves to help them cope with a friend or family member's problem). This rate has remained consistent since 2009–2010.
- With the exception of the Yukon, males accounted for the majority of all individuals accessing specialized treatment services during 2012–2013.

¹ A stay is defined as a departure from hospital through discharge or death.

² A "unique individual" refers to a single person. One unique individual might have several treatment episodes over the course of a year.

³ An "episode" refers to admission to a specific treatment service. One person might access several services over the course of a year (for example, by transferring from withdrawal management to non-residential treatment or leaving and re-entering services) and so have multiple episodes.



- Males accounted for nearly two-thirds of all individuals accessing treatment services for injection drug use (IDU) in three of the five jurisdictions that provided data. For the remaining two jurisdictions, the gender ratio for IDU clients was approximately equal.
- Males accounted for the majority of individuals accessing opioid substitution treatment in four of the six jurisdictions that provided data.
- Persons between the ages of 25 and 34 accounted for the majority of individuals accessing specialized treatment services in 2012–2013. These individuals accounted for roughly one-third of all individuals accessing specialized treatment services.
- Youth (ages 15–24) accounted for a considerable proportion (between 13% and 33%) of all individuals accessing specialized treatment services.
- Alcohol was cited as the most common reason for seeking treatment in the two jurisdictions that contributed data.
- The majority (between 37.4% and 55.8%) of all treatment episodes were accessed by individuals who listed “unemployed” as their employment status at the time of treatment.

Conclusions and Next Steps

The NTI project has made and continues to make a significant contribution to our understanding of substance use treatment service use in Canada. This fourth report has contributed new information on publicly funded substance use treatment services in Canada and has identified common patterns and trends in treatment service use. Through the development and implementation of data collection protocols, the NTI project has improved the quality, consistency and comprehensiveness of treatment data being collected at the jurisdictional levels.

Building on the project’s progress to date, the long-term goal of NTIWG is to continue to expand and strengthen data collection and provide a truly comprehensive national picture that will better serve system planning needs. To this end, NTIWG has been working with a number of partners to enhance the comprehensiveness of the report. For example, CCSA has partnered with Canadian Institute for Health Information (CIHI) to assess the feasibility of collecting client-level treatment data. CCSA is also currently in discussions with representatives from the North West Territories, British Columbia, and the First Nations and Inuit Health Branch of Health Canada to obtain treatment-related information from their jurisdictions’ respective treatment providers.

The expansion and improvement of information provided over time and through additional sources will lead to the realization of the goal of the NTI project: to produce a comprehensive picture of service use to inform effective policy, resourcing and development for substance use treatment in Canada. Achieving this goal further contributes to the overall goal of CCSA’s treatment initiatives: to improve the range, quality and accessibility of services and supports for substance use problems.



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List of Acronyms

General

DWI	Driving while impaired
RWM	Residential withdrawal management
NRWM	Non-residential withdrawal management
RT	Residential treatment
NRT	Non-residential treatment
IDU	Injection drug use

Canadian organizations

ACRDQ	Association des centres de réadaptation en dépendance du Québec
AFM	Addictions Foundation of Manitoba
AHS	Alberta Health Services
CCSA	Canadian Centre on Substance Abuse
CIHI	Canadian Institute for Health Information
CSC	Correctional Service Canada
NNADAP	National Native Alcohol and Drug Abuse Program
NYSAP	National Youth Solvent Abuse Program
VAC	Veterans Affairs Canada

Canadian data collection

ADG	Alcohol, Drugs and Gambling System
AIMS	Addictions Information Management System
AMIS	Addiction and Mental Health Information System
ASIST	Addiction System for Information and Service Tracking
ASsist	Addiction Services Statistical Information System Technology
CADUMS	Canadian Alcohol and Drug Use Monitoring Survey
CRMS	Client Referral Management System
DATIS	Drug and Alcohol Treatment Information System
ISM	Integrated System Management
MHIS	Mental Health Information System
MRR	Minimum Reporting Requirements
NTI	National Treatment Indicators
NTIWG	National Treatment Indicators Working Group
OMS	Offender Management System
RASS	Regional Addiction Service System
SIC-SRD	Système d'information clientèle pour les services de réadaptation en dépendance
SPSS	Statistical Package for the Social Sciences
STORS	Service Tracking and Outcome Reporting System



Introduction

Substance abuse is a significant health, economic and social issue in Canada. According to Rehm et al. (2006), substance abuse cost Canadians an estimated \$39.8 billion in 2002, of which 20% (\$4.2 billion) was attributed to direct healthcare costs. The 2012 Canadian Community Health Survey (CCHS) (Statistics Canada, 2014a) estimates that 4.4% of Canadians (approximately 1.3 million people) age 15 and older meet the criteria for a substance use disorder.

According to the 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS), 10.6% of Canadians 15 years of age and older have used an illegal drug⁴ in the past 12 months (Health Canada, 2013). Of these individuals, nearly 20% reported experiencing one or more types of harm from their own drug use in the preceding 12 months (Health Canada, 2013). One way to reduce the risks and harms associated with alcohol and other drug use is to ensure Canadians have access to a comprehensive system of effective, evidence-based services and supports.

The National Treatment Indicators (NTI) project addresses the need for better data. It implements a set of measures to collect treatment system data according to common categories across Canada. Better, more consistently collected data at all levels will:

- Support the business case for investing in substance use treatment services;
- Illustrate the size of the system and its client base;
- Better assess the capacity of systems at all levels to respond to demand;
- Identify underserved populations;
- Measure and monitor the impact of system change;
- Facilitate the evaluation of specific strategies or programs at regional, provincial/territorial or national levels;
- Identify trends in the characteristics of people seeking services;
- Indicate trends and patterns;
- Inform system planning and development;
- Increase collaboration and communication among jurisdictions;
- Enable valid comparisons between national and jurisdictional data; and
- Contribute reliable, pan-Canadian information to international data-collection.

The NTI report is the only accessible source of information on publicly funded substance use treatment centres in Canada. It illustrates the type of treatment information that is currently being collected, and helps to identify information gaps. Currently the NTI report collects information on four treatment categories: residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management. The NTI report also helps indicate whether the treatment system is responding to the latest trends and evolving knowledge in the substance use field. For a complete list of indicators collected for this report, please see Appendix A.

The NTI report is intended for a broad audience that includes researchers, analysts, leaders, decision makers and advisors looking for information to support service planning, development and

⁴ Illegal drugs include cannabis, cocaine, ecstasy, speed, hallucinogens, salvia and heroin.



communications. The components of this report present varying levels of detail to meet the needs of these different audiences.

National Treatment Indicators

The NTI project was established in 2009 and was built on previous work by the Canadian Institute for Health Information (Canadian Institute for Health Information, 2001), the Canadian Centre on Substance Abuse (Thomas, 2005) and the National Treatment Strategy Working Group (2008). Its primary purpose is to work towards providing a comprehensive picture of substance use treatment use in Canada by reporting on data collected from a common set of treatment indicators.

The project is led by the National Treatment Indicators Working Group (NTIWG), which was formed in 2009. As of February 2015, NTIWG includes representatives from seven provinces, one territory, federal and provincial departments with treatment delivery responsibility and the Canadian Institute for Health Information (CIHI). For a complete list of current NTIWG members, please see Appendix B. NTIWG intends to continue expanding its membership to obtain complete cross-Canada representation.

Funding for the NTI project is provided through Health Canada's Drug Treatment Funding Program.

Progress to Date

The NTIWG has made significant progress since its creation in 2009. The project's first report, published in March 2012, presented 2009–2010 fiscal year data on nine indicators provided by six provinces. Since then, the NTIWG has increased both the number of indicators it collects, as well as the number of jurisdictions and sources that contribute data to the report.

Quality improvement is important to the NTIWG. In 2013, a secure online data collection tool was developed to improve the data collection process and minimize data entry errors and inconsistencies. This year, a new report format is being used. The new format is designed to provide jurisdiction-specific context, reduce reporting errors, mitigate cross-jurisdictional comparisons, and improve the utility and relevancy of information being presented.

The NTIWG has also been working with a number of partners to enhance the comprehensiveness of the report. For example, CCSA has partnered with CIHI to assess the feasibility of collecting client-level treatment data. CCSA is also currently in discussions with representatives from the North West Territories, British Columbia, and the First Nations and Inuit Health Branch of Health Canada to obtain treatment-related information from their jurisdiction's respective treatment providers.

The Road Ahead

Building on the project's progress to date, the long-term goal of the NTIWG is to continue to expand and strengthen data collection and provide a truly comprehensive national picture that will better serve system planning needs. Improvements will include obtaining data:

- From all provinces, territories, and national agencies with substance use service delivery responsibility;
- On services provided in hospital settings;
- On non-specialized services offered by community and private sector partners; and
- On an expanded set of indicators.



Administrative Context: Contributing to a National and International Picture

In Canada, the administration and delivery of healthcare services is the responsibility of each province or territory, guided by the provisions of the *Canada Health Act*. The provinces and territories fund these services with assistance from the federal government. Treatment for substance use and gambling is included under the umbrella of healthcare services. There are also federal agencies that provide treatment for specific populations: Correctional Service of Canada for federally incarcerated offenders; Veterans Affairs Canada for veterans, Canadian Forces members and the Royal Canadian Mounted Police; and Health Canada's First Nations and Inuit Health Branch, which funds the National Native Alcohol and Drug Abuse Program (NNADAP) and National Youth Solvent Abuse Program (NYSAP) for First Nations and Inuit.

Jurisdictions are free to tailor their healthcare systems to best meet the unique needs of their populations. However, autonomy also results in a number of inter-jurisdictional differences in how services are funded and delivered, affecting the range of available treatment options across the country. For example, provinces and territories may contract services through regional health authorities or directly with service agencies. Substance use systems can be completely distinct from or fully integrated with mental health systems, or somewhere in between. Although all jurisdictions collect information to monitor system activities and performance, the nature and sophistication of these efforts varies substantially. As a result of these variations, the data collected are often not comparable across jurisdictions, but brought together they begin to form a pan-Canadian picture of substance use treatment utilization that can inform system planning, resourcing and development.

Canada also has international reporting responsibilities. The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), the Pan-American Health Organization (PAHO) and the Inter-American Drug Abuse Control Commission (CICAD) all have annual or semi-annual reporting requirements. The reports produced by these organizations all include national treatment data. Prior to the NTI project, much of the information Canada provided on substance use services was based on partial data from some provinces and territories, or estimates derived by taking data from a small number of jurisdictions and extrapolating to the national level. By building Canada's capacity to provide meaningful, reliable information on national substance use services to the international level, the NTI project is facilitating collaboration and knowledge sharing between Canada and other countries and international organizations.



Methods

This report provides aggregate-level descriptive information on clients who accessed publicly-funded substance use treatment services in Canada during 2012–2013.⁵ Data for this report were submitted to CCSA by members of NTIWG using a secure online data collection tool. NTIWG is comprised of individuals representing Canadian jurisdictions that have treatment service delivery responsibilities (see Appendix B for NTIWG members). Working group members were asked to provide information on 35 indicators (see Appendix A); however, not all jurisdictions were able to provide information on each indicator.

The data presented in this report are the outcome of a multi-stage process. First, service providers enter client level data, which are then submitted at the regional or provincial level according to reporting requirements. The data are then analyzed at the provincial level according to the definitions and data-collection protocols developed by the Canadian Centre on Substance Abuse (CCSA) in consultation with the NTIWG.⁶ Next, data are entered into a secure online platform specially designed for the NTI project. Finally, CCSA conducts data analysis and produces the report in close consultation with the NTIWG.

Not all information collected from the jurisdictions could be presented in this report; only a subset of indicators agreed upon by NTIWG is included. This decision was made to ensure the report remains as succinct yet informative as possible.

Jurisdictional Data Collection

This fourth NTI report provides information from six provinces, one territory, and one provincial association on clients who accessed publicly-funded specialized treatment services during 2012–2013. Specifically, provincial-level treatment service data were provided by Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, and Newfoundland and Labrador; territorial-level data were provided by the Yukon. The Association des centres de réadaptation en dépendance du Québec (ACRDQ) also provided data on driving-while-impaired programs in Quebec.

A variety of different systems, methods and processes are currently used to collect information about treatment services across Canada. There is generally a substantial amount of service and client information collected during the screening and assessment or intake process. In most provinces and territories, regional health authorities manage the collection of this information and then provide summary information to the provincial Ministry of Health or other funding and oversight bodies. However, funding for substance use treatment is sometimes provided in a single envelope with no specific accountability for individual services. Requirements for the type and quality of data submitted to funders also vary. Across the provinces, there are a number of differences in terms of the quality and quantity of the information being collected, the format in which it is recorded and its availability. Appendix C provides a summary of the data-collection systems in place across Canada as well as information on their administrative context (such as the service delivery structure and provincial ministry responsible).

⁵ While information on gambling treatment services was collected, it is not presented in this report.

⁶ Data collection protocols are available from CCSA on request. See Appendix C for more information on the data-collection process.



Limitations

Developing a list of common core indicators presents many challenges. The general limitations to the current data are described below and noted in explanations throughout the report. Limitations specific to each jurisdiction's data are included in each jurisdiction's respective summary. Because of these limitations the data are not completely comparable across jurisdictions. Fortunately, the limitations are expected to diminish with time as data-collection capacity develops and jurisdictions identify new methods to report information more directly in line with the NTI data-collection protocols. At this time, however, the following limitations must be considered when reviewing the data:

- **Services included:** The data represent only publicly funded and specialized services. Private treatment⁷ and rapid detoxification data are not included. Many clients with substance use problems also have a multitude of other health-related issues that may be the cause of their contact with the healthcare system. The report presents some information regarding hospital separations; however, it does not capture most substance use treatment in primary care or hospital contexts. As the NTI project evolves, CCSA hopes to better capture data reflecting the full continuum of substance use treatment services provided in Canada (e.g., community supports, primary care).
- **Jurisdictional participation:** This report is based on data submitted by 8 of a possible 16 administrative jurisdictions across Canada. Unfortunately, not all jurisdictions were able to participate in this year's annual report. CCSA and the NTIWG will continue to work with all jurisdictions to improve and enhance data collection as well as identify additional sources of information to include in future reports (e.g., privately-funded treatment centre data).
- **Reliability:** The accuracy of aggregate data depends on the accuracy and consistency of the individual case data being entered at the frontline level. In many provinces and territories, there are different data-collection systems in place across regions, creating inconsistencies in data definitions and data-entry practices. Service-level data-collection capacity is developing and will help improve consistency in future reports.
- **Service definitions:** The collection of consistent information relies on the use of a standard, agreed-upon set of definitions. However, service delivery models vary widely across Canada. The core indicator definitions can be revisited as the project progresses to ensure that they best reflect the work of the field.
- **Administrative variation:** Small differences in how cases are recorded can result in tremendous variations at the aggregate level. For example, some jurisdictions consider a case to be "open" at first contact, whereas others wait until the formal treatment intake.
- **Comparability:** The limitations listed above mean that although all jurisdictions are using the same data collection protocols, the data being provided across jurisdictions are not yet comparable.

⁷ Privately funded treatment providers operate independently and are under no obligation to provide data to the jurisdictions or any federal authority.



Results

This report contains information from the 2012–2013 fiscal year on indicators related to substance use treatment services submitted by eight jurisdictions (Yukon, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Newfoundland and Labrador, and Association des centres de réadaptation en dépendance du Québec).

The findings from this year’s analysis are presented in two parts. The first part contains treatment information specific to jurisdictions, while the second provides a national picture of treatment service use and related trends. Data presented in this report are limited to publicly funded treatment centres and data **should not be compared across jurisdictions**.

The interpretation of these results should also be guided by recognition that the number of people receiving substance use services is the result of many combined factors, and is not an accurate measure of need in the population. Factors influencing service numbers include the rate of a given problem in the population; the structure, availability and accessibility of services within the system; and various other health and social factors.

Finally, the results include the ratio of service episodes to individuals, recognizing that a single individual can have several episodes in a given year. The ratio, however, indicates an average that can be affected by variations in how an episode is measured between jurisdictions⁸ or by a small number of individuals with a high number of episodes.

Definitions	
Episode	An episode refers to admission to a specific treatment service. A person can access several different services or re-enter the same service more than once in a given year, and so have multiple episodes.
Unique Individual	A unique individual refers to a single person. One unique individual might have several treatment episodes over the course of a year.

⁸ Some systems count a new episode when a new system component or category of service is accessed; others limit new episodes to individuals entering the system as a whole. Resolving this inconsistency is one of the goals of the NTIWG for future reports.



Yukon

Population estimate (July 1, 2012): 36,402 (Statistics Canada, 2014b)

Overview and Summary

The Yukon joined the NTIWG in 2009 and has contributed specialized treatment data to three of the four annual reports that have been published to date. Substance use treatment in the Yukon consists of the three distinct services: detoxification services, outpatient treatment services and a 28-day residential treatment program.

The Ministry of Health and Social Services is responsible for the delivery of specialized treatment services in the Yukon. All treatment data are manually entered into a Microsoft Excel file and managed using Microsoft Access. Data are reported to the Ministry on a monthly basis.

The first section of this summary includes information on outpatient treatment services as well as residential treatment services. Detoxification services in the Yukon include rapid detoxification, which falls outside the scope of the NTI project. For this reason, information on detoxification services is presented separately at the end of this jurisdictional summary.

Important Considerations and Limitations

- Data in this summary is limited to information on new clients who accessed publicly funded treatment services between April 1 and December 31, 2012, for this reason data should not be compared to years previous nor to other jurisdictions.
- A new client is defined as “a person who does not have a client file number for treatment services in the database. This is because they have not accessed treatment services (RT or NRT) before.” Every client is given a treatment file number that follows them throughout their use of treatment services. Please note that these definitions were changed in 2013 to reflect the definitions provided in the NTI data collection protocols.
- The Yukon is currently unable to provide data on all indicators, but has been working towards expanding the information they collect.

Results

Total number of treatment episodes and unique individuals

Between April 1 and December 31, 2012, 168 unique individuals accessed publicly funded outpatient and residential treatment services in the Yukon for the first time (n=113 and n=55, respectively). In total, these 168 unique individuals accounted for 222 episodes. On average, each outpatient services client accessed the service 1.48 times throughout the year, while residential treatment clients only accessed the program once during the year.

Total number of episodes and unique individuals by treatment category

Non-residential treatment accounted for approximately 75% (n=167) of the 222 specialized treatment episodes accessed by new clients in the Yukon between April 1 and December 31, 2012, while residential treatment accounted for the remaining 25% (n=55).



The ratio of episodes to individuals for each of the treatment categories is presented in Table 1.

Table 1. Ratio of episodes to individuals (Yukon)

Residential Treatment	1.0
Non-residential treatment	1.5

Total number of episodes and unique individuals by gender and treatment category

Of the 168 new clients who accessed specialized treatment in the Yukon, 95 (56.5%) were female, while 73 (43.5%) were male. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 65.8%; females: 68.4%).

Detoxification Data

Yukon offers detoxification treatment services; however, these services include brief detoxification, which does not fall within the scope of the current national treatment indicators. For this reason data on detoxification services offered in the Yukon is presented separately.

In 2012–2013, a total of 559 unique individuals accessed detoxification services in the Yukon. These 559 individuals accounted for 780 episodes. This means that on average each individual accessed detoxification services approximately 1.4 times throughout the year. The majority of episodes were accounted for by males (67.3%).

Overall, First Nation’s people accounted for 78.6% of all detoxification episodes in the Yukon during fiscal year 2012–2013 (males: 75.4%; females: 85.1%). According to the 2006 census, persons of Aboriginal descent account for approximately 25% of the Yukon’s total population indicating that First Nation’s people are disproportionately overrepresented among Yukon’s detoxification services clientele.

Based on 2012–2013 data, 54.1% of all detox episodes had a length of stay of 12 or more hours.

In total, 229 individuals were refused treatment during the fiscal year 2012–2013. Of these refusals, 66.8% were attributed to the facility being “full.”

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in the Yukon between April 1 and December 31, 2012. Importantly, the information contained within this summary was limited to new clients only, representing only a portion of all clients accessing publicly funded treatment services during 2012.

Due to the limitations of this year’s data collection, patterns and trends in treatment service use in the Yukon cannot be discussed. Similarly, the information provided in this summary should not be compared to data from previous years or to other jurisdictions.

It is important to note that the limited data summarized in this report are the result of changes made to the Yukon’s treatment definitions. These changes are intended to ensure treatment definitions match those outlined in the national treatment indicators data collection protocols. These changes are an important step that will not only improve the quality and consistency of treatment data in the Yukon, but will also contribute to a more accurate national picture of publicly funded, specialized treatment service use in Canada. It is anticipated that these changes will be completed in time for the next round of data collection, which will take place in the summer of 2015.



Alberta

Population estimate (July 1, 2012): 3,888,600 (Statistics Canada, 2014b)

Overview and Summary

Alberta joined the NTIWG in 2009 and has contributed specialized treatment data to each of the four annual reports that have been published to date. Substance use treatment services in Alberta include residential treatment, non-residential treatment and withdrawal management.

Alberta Health is the Ministry responsible for specialized treatment services in Alberta. Alberta Health Services (AHS) is primarily responsible for delivering specialized services both directly and through AHS community contracted services. Mental Health services are integrated with substance use services at the administrative level. Two data systems are currently being used to collect treatment data in Alberta. AHS uses the Addiction System for Information and Service Tracking (ASIST), while AHS contracted agencies use the Service Tracking and Outcome Reporting System (STORS). It is important to note that ASIST is a browser-based system,⁹ while STORS is an electronic database formed using paper-based data capture. Provincial-level data are reported on an annual basis.

Important Considerations and Limitations

- Although the vast majority of AHS services, both direct and contracted, are captured through STOR and ASIST, some parts of the province (i.e., health zones) have additional addiction programs that do not report to STOR or ASIST. These data are not included in this analysis.
- For the following results, a new case is defined as a unique client admitted during the fiscal year. This excludes clients who received service in previous years whose treatment carried over in 2012–2013. This includes clients who received services in previous years, but whose service did not carry-over into 2012–2013.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 33,650 unique individuals accessed publicly funded specialized treatment services in Alberta; of which 83.5% were new cases. In total, these 33,650 individuals accounted for 51,692 episodes meaning that, on average, each unique individual accessed treatment services 1.5 times throughout the year.

The majority of individuals accessing treatment services (87.2%) were seeking treatment for their own substance use problems. However, 4,311 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year, which accounts for 12.8% of the entire population of unique clients.

⁹ Refers to the ability to connect to a central data-collection system that allows all users to enter data directly from various locations and for the generation of summary reports



Total number of episodes and unique individuals by treatment category

Of the total number of episodes for individuals seeking treatment for themselves (n=46,721), the majority (60.8%) were episodes for non-residential treatment. Approximately 25.6% of the total episodes were for residential withdrawal management, and 13.6% for residential treatment.

The ratio of episodes to individuals for each of the treatment categories is presented in Table 2.

Table 2. Ratio of episodes to individuals (Alberta)

Residential withdrawal management	2.2
Residential Treatment	1.9
Non-residential treatment	1.1

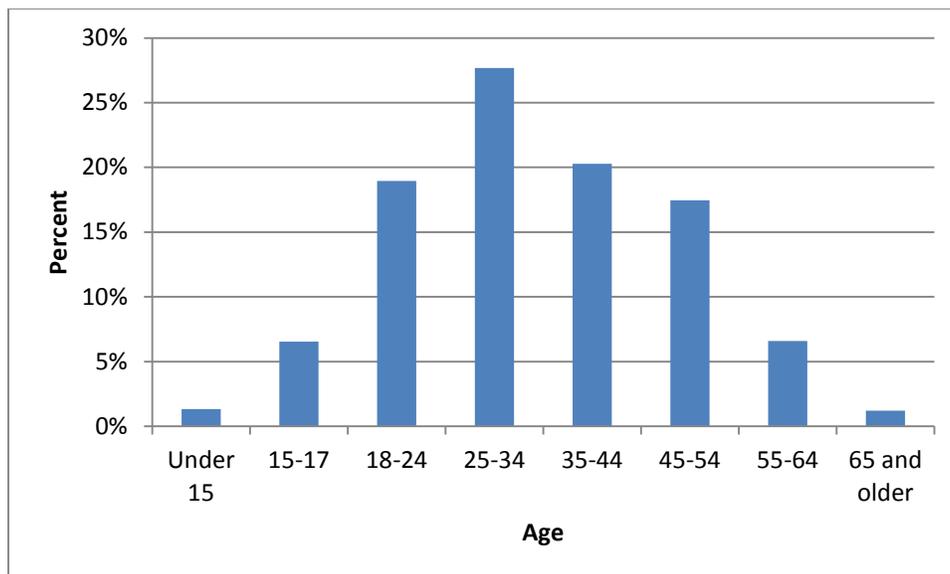
Total number of episodes and unique individuals by gender and treatment category

Of the 46,716 episodes¹⁰ accessed by individuals seeking treatment for themselves, 30,507 (65.3%) were accounted for by males, while 16,056 (34.4%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 59.5%; females: 63.2%) in Alberta followed by residential withdrawal management (males: 27.1%; females: 22.8%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 1 and Figure 2, people aged 25–34 accounted for the highest percentage of specialized treatment episodes as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of both individuals accessing treatment and total treatment episodes. As shown in Figure 3, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 1. Treatment episodes by age (Alberta)



¹⁰ This figure excludes five cases where the gender was unknown.



Figure 2. Unique individuals by age (Alberta)

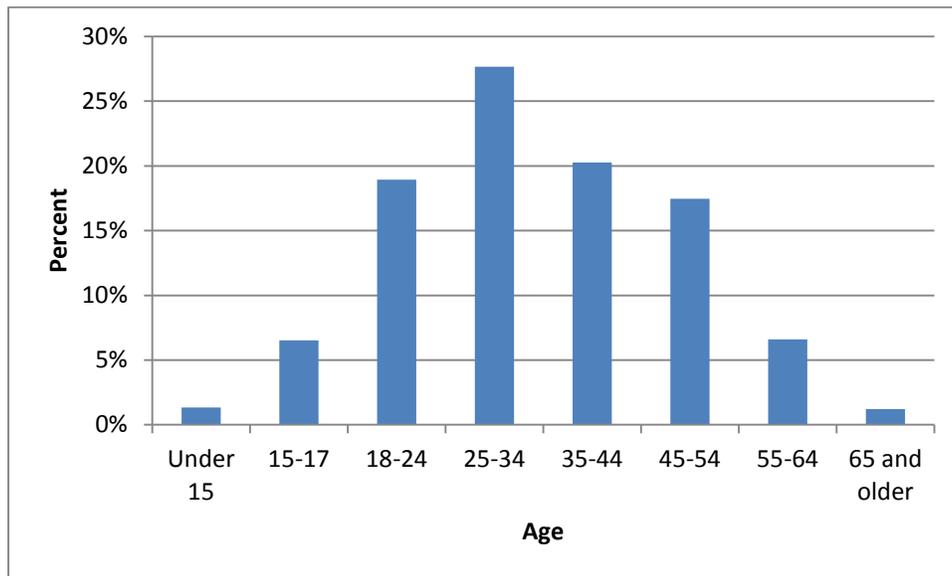
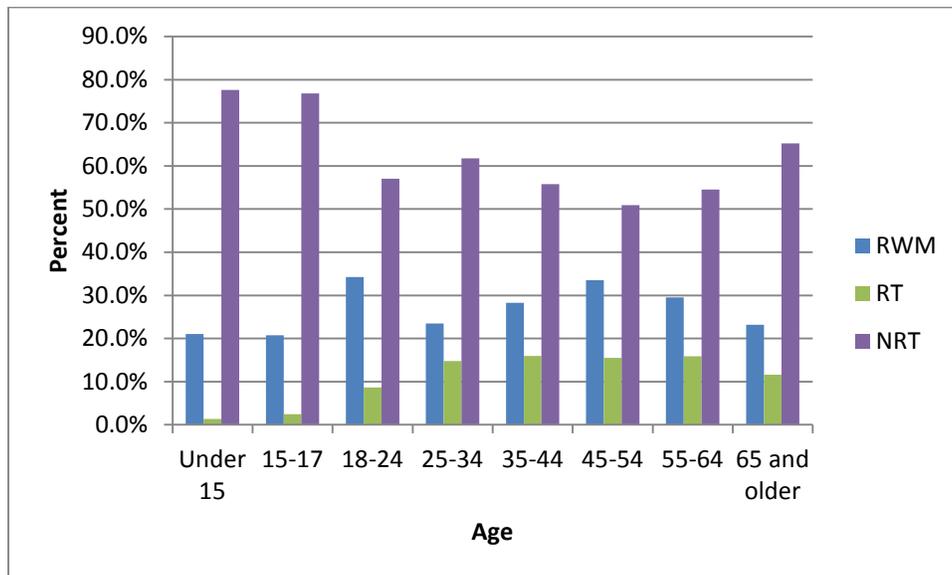


Figure 3. Episodes by age and treatment type (Alberta)



Total number of episodes and unique individuals that have used drugs by injection within the 12 months prior to treatment

Males accounted for the majority (63.1%) of all episodes related to treatment for injection drug use. The ratio of episodes to individuals (1.9) was the same for both males and females.

Total number of unique individuals accessing opioid substitution treatment

In total, 1,129 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 59.9% of all clients.



Past-year substance use among unique individuals seeking treatment

In fiscal year 2012–2013, among individuals accessing treatment services, alcohol was the most commonly used substance in the 12 months preceding treatment, followed by cannabis, cocaine and opioids.

Treatment episodes by employment status

Of 51,692 episodes, 55.8% were accessed by individuals who reported their employment status as “unemployed” at the time of treatment; 33.4% were accessed by individuals who reported “employed full-time”; 7.2% by individuals who reported “employed part-time”; and 3.5% who reported “other” as their employment status.

Discussion

The summary for this jurisdiction has presented aggregate-level information on select publicly funded specialized treatment service use in Alberta between April 1, 2012, and March 31, 2013.

Overall, the results revealed relatively consistent patterns and trends in service use when compared to data from previous years. For example, between 2009–2010 and 2012–2013, the number of episodes per individual remained stable at approximately 1.5 episodes per individual, averaged across all service types. In the same time period, non-residential treatment remained the most commonly accessed treatment service in Alberta, accounting for 61% of all treatment episodes in 2012–2013. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment is typically the most accessible and cost-effective treatment service available. Interestingly, the total number of episodes for non-residential treatment decreased 7.5% (2,303 episodes), while the total number of episodes for residential treatment increased 20.4% (1,075 episodes) between 2009–2010 and 2012–2013. Changes in service volume could be due to a number of factors, including service demand and capacity, shifts in service use and referral practices, population change, policy and legislation, and the use of services not captured in this report.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past four years of data collection, between 9.2% and 13.1% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

Unsurprisingly, alcohol was identified as the most commonly reported substance used by clients in the 12 months preceding treatment. Although data on the primary substance for which treatment was sought was not collected for this report, the most common treatment focus for clients was alcohol followed by treatment for other drugs, excluding alcohol, and treatment for both alcohol and other drugs.

In addition to monitoring service use, AHS tracks other indicators related to care, including client satisfaction, access times and client outcomes. More information related to addiction and mental health services performance monitoring can be found in the annual System Level Performance Report for Alberta Health Services (<http://www.albertahealthservices.ca/2773.asp>).



Saskatchewan

Population estimate (July 1, 2012): 1,087,300 (Statistics Canada, 2014b)

Overview and Summary

Saskatchewan joined the NTIWG in 2009 and has contributed specialized treatment data to each of the four annual reports that have been published to date. Substance use treatment services in Saskatchewan include residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management.

The Saskatchewan Ministry of Health is responsible for publicly funded treatment services in Saskatchewan. These services are delivered directly through 12 regional health authorities, one unique health authority in northern Saskatchewan, and through community-based organizations. Saskatchewan is currently in the process of integrating mental health services with substance misuse services, at the administrative and clinical level. The Province of Saskatchewan uses one data collection system, the Alcohol, Drug and Gambling (ADG) system; however, there is one regional health authority that does not participate in this system and reports data to the Ministry of Health annually.

Important Considerations and Limitations

- All regional health authorities and community-based organizations funded by the Ministry of Health to provide alcohol and drug treatment services in the province submit data through the ADG system, except for one of the larger health regions as noted above. Saskatchewan's ADG data system tracks service events rather than new admissions, therefore this does not reflect the number of "discrete" (i.e., new) cases for the fiscal year of interest.
- Not all treatment providers were able to submit data on each of the indicators. For this reason data discrepancies may be present in the data provided below.
- Saskatchewan does not collect information on the primary substance for which treatment is being sought. For this reason, information on substances used in the 12 months preceding treatment is provided.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 15,119 unique individuals accessed publicly funded specialized treatment services in Saskatchewan. In total, these 15,119 individuals accounted for 21,113 episodes meaning that, on average, each unique individual accessed treatment services 1.4 times throughout the year.

The majority of individuals accessing treatment services (90.8%) were seeking treatment for their own substance use problems. However, 1,174 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year, accounting for 7.8% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of 19,318 episodes accessed by individuals seeking treatment for themselves, 70.3% were episodes for non-residential treatment. Approximately 18.6% of the total episodes were for residential withdrawal management, 8.6% for residential treatment and 2.4% for non-residential withdrawal management.



The ratio of episodes to individuals for each of the treatment categories is presented in Table 3.

Table 3. Ratio of episodes to individuals (Saskatchewan)

Residential withdrawal management	1.3
Non-residential withdrawal management	1.3
Residential Treatment	1.0
Non-residential treatment	1.1

Total number of episodes and unique individuals by gender and treatment category

Of 19,324 episodes 12,637 (65.4%) were accounted for by males, while 6680 (34.6%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 71.8%; females: 67.5%) in Saskatchewan followed by residential withdrawal management (males: 19.6%; females: 23.8%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 4 and Figure 5, people aged 25–34 accounted for the highest percentage of specialized treatment episodes as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of episodes while, people aged 18–24 accounted for the second highest percentage of individuals. As shown in Figure 6, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 4. Treatment episodes by age (Saskatchewan)

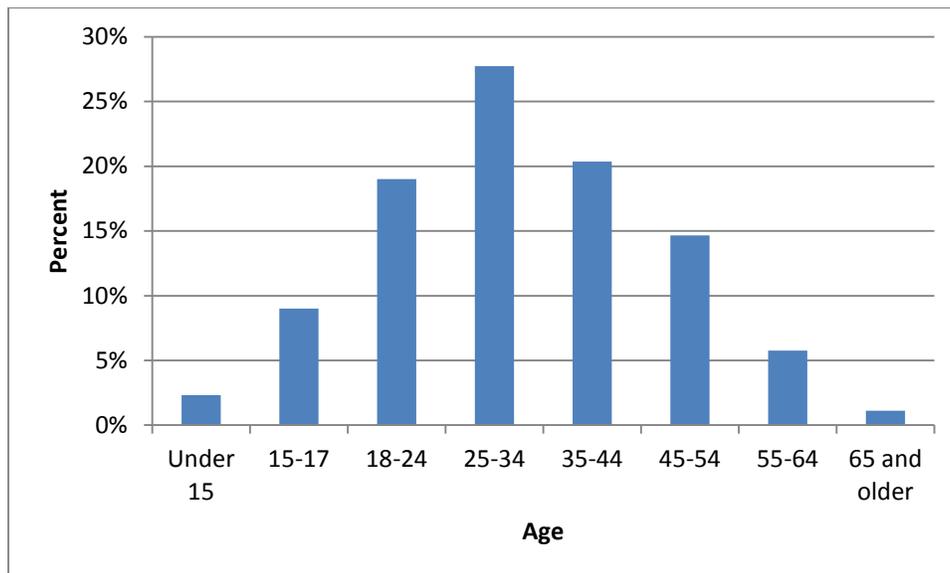




Figure 5. Unique individuals by age (Saskatchewan)

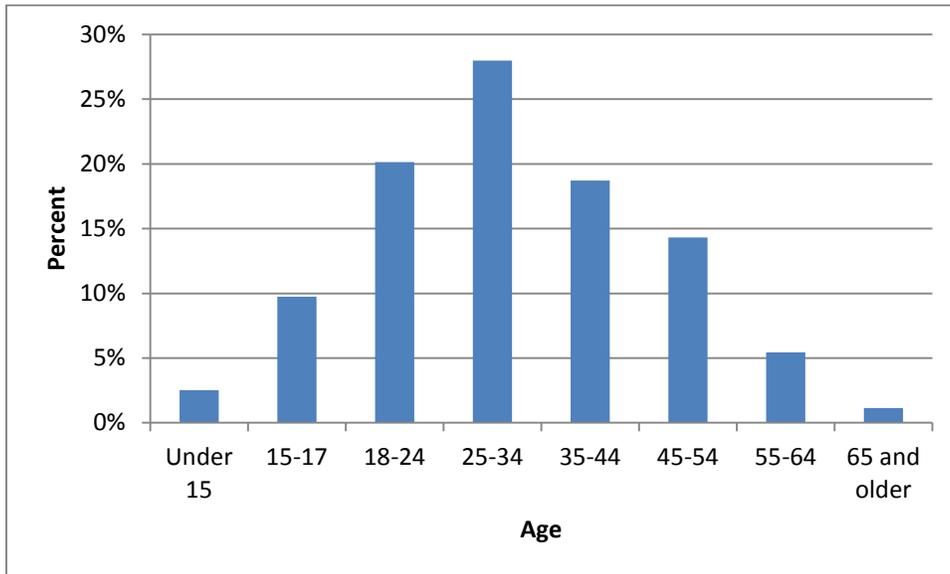
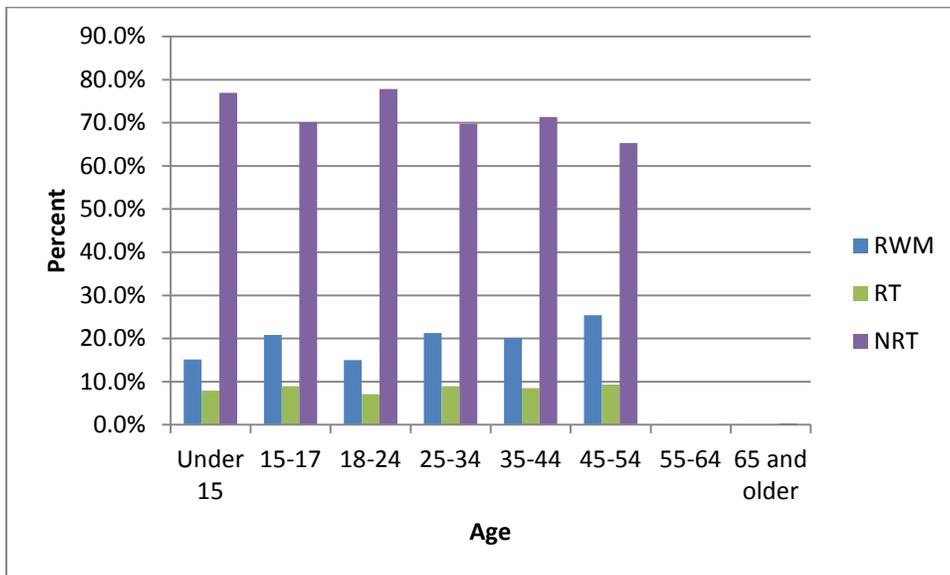


Figure 6. Episodes by age and treatment type (Saskatchewan)



Total number of episodes and unique individuals that have used drugs by injection within the 12 months prior to treatment

Males and females each accounted for approximately half of all episodes related to treatment for injection drug use. Similarly, the average ratio of episodes to individuals was 1.6 for both males and females.

Total number of unique individuals accessing opioid substitution treatment

In total, 393 individuals accessed publicly funded opioid substitution treatment, of which females accounted for 56.2% of all clients. The majority (41.5%) of opioid substitution clients were ages 25–34 followed by individuals 35–44 (28.2%).



Past-year substance use among unique individuals seeking treatment

As noted, Saskatchewan does not collect information on the primary substance for which treatment is being sought. For this reason, information on substances used in the 12 months preceding treatment is provided.

In fiscal year 2012–2013, the top three substances unique individuals reported having used in the past 12 months were alcohol (84.6%), cannabis (47.0%) and opioids (28.2%). Past-year use of hypnotics was also reported by 25.9% of the client population.

Treatment episodes by employment status

Of 19,397 episodes, 36.9% were accessed by individuals who reported “unemployed” as their employment status at the time of treatment; 33.9% reported being employed “full-time”; 12.1% identified as a student; 11.1% were employed “part-time”; and 5.9% fell into the “other” employment status category.¹¹

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in Saskatchewan between April 1, 2012, and March 31, 2013.

Overall, treatment use has remained relatively constant since 2009–2010 with approximately 15,000 individuals accessing publicly funded specialized services in Saskatchewan each year. Between 2009–2010 and 2012–2013, the number of episodes per individual also remained stable at approximately 1.4 episodes per individual, averaged across all service types. In the same time period, non-residential treatment remained the most commonly accessed treatment service in Saskatchewan, accounting for approximately 70% of all treatment episodes in 2012–2013. This finding is also consistent across other jurisdictions and is unsurprising given that non-residential treatment is accessible in all regional health authorities and is typically the starting point for families and individuals concerned about their own or others use of alcohol or drugs. Furthermore, individuals returning home from a residential treatment program are encouraged to access non-residential treatment.

Interestingly, the total number of episodes for non-residential treatment increased nearly 6.0% (761 episodes), while the total number of episodes for residential treatment decreased 13.0% (250 episodes) between 2009–2010 and 2012–2013. These changes might be explained by the fact that individuals will often choose to seek treatment for alcohol and drug misuse in their home community. Typically, there are no wait times for non-residential treatment and individuals are able to self-refer to service. In Saskatchewan, there are approximately 50 centres that provide non-residential treatment services. For these reasons, non-residential treatment is often the first and easiest point of entry into the system in Saskatchewan.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past four years of data collection, between 6.1% and 8.7% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

As mentioned, most individuals accessing services in Saskatchewan are doing so on a non-residential basis. As such, it is important to highlight the work being done to monitor wait times of adult and youth accessing these non-residential treatment services in Saskatchewan. The Ministry of Health, in collaboration with the regional health authorities, developed wait time benchmarks for

¹¹ “Other” includes retired, homemaker and seasonal worker.



clients accessing outpatient services. Benchmarks were established for four categories: very severe, severe, moderate and mild. These benchmarks outline the maximum length of time a client should wait to see a clinician, based upon their level of need. Following the development of these benchmarks, regional health authorities began to collect wait time data to assess how often these benchmarks are met; metrics were created and regional health authorities began to submit quarterly data to the ministry of health in the very severe and severe categories.



Manitoba

Population estimate (July 1, 2012): 1,250,500 (Statistics Canada, 2014b)

Overview and Summary

Manitoba joined the NTIWG in 2009 and has contributed specialized treatment data to three of the four annual reports that have been published to date. Substance use treatment services in Manitoba include residential treatment, non-residential treatment and residential withdrawal management.

The Department of Healthy Living and Seniors and the Department of Health are the ministries responsible for specialized treatment services in Manitoba. Specialized services are delivered through Addictions Foundation Manitoba (AFM) and 11 provincial grant-funded agencies. Adult residential withdrawal services and one residential treatment program are delivered through two regional health authorities. Mental health services are not currently integrated with substance use services at the administrative level. Two data systems (Healthy Living, Youth and Seniors and an Excel-based system) are currently being used to collect provincial aggregate treatment data. Data are provided monthly to the Addictions Policy and Support Branch by AFM and other provincially grant-funded addictions agencies. Adult residential withdrawal management data are requested annually.

Important Considerations and Limitations

- Manitoba does not offer non-residential withdrawal management.
- Manitoba does not distinguish between full- and part-time employment status.
- Some agencies were unable to provide data for certain indicators of interest; refer to the respective footnotes. Agencies might have been able to report on some indicators, but not on others, creating inconsistencies in the data. Manitoba is currently improving agency-level data collection processes.
- There are limited common data collection processes in Manitoba, making it difficult to fully validate the data provided by agencies.
- Because Manitoba's publicly funded agencies do not share data from agency to agency, new cases can only be tracked for a specific agency, not at a system level.
- Manitoba does not collect information on the primary substance for which treatment is being sought. For this reason, information on substances used in the 12 months preceding treatment is provided.
- Carry over data (i.e., cases that began in 2011–2012 and continued into 2012–2013) are not reported by all agencies in Manitoba.
- In Manitoba, a new case is defined as clients with no treatment experience within the fiscal year and does not include the same client being transferred to a new program within the same agency.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 9,045 unique individuals accessed publicly funded specialized treatment services in Manitoba; of which 93.8% were new cases. In total, these 9,045 individuals accounted for 15,697



episodes, meaning that, on average, each unique individual accessed treatment services 1.7 times throughout the year.

The majority of individuals accessing treatment services (92.4%) were seeking treatment for their own substance use problems. However, 707 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year which accounts for 7.8% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the approximately 15,000 treatment episodes in Manitoba, the majority (71.6%) were episodes for non-residential treatment. Approximately 16.5% were for residential treatment, and 11.9% for residential withdrawal management.

The ratio of episodes to individuals for each of the treatment categories is presented in Table 4.

Table 4. Ratio of episodes to individuals (Manitoba)

Residential withdrawal management	4.6
Residential Treatment	1.1
Non-residential treatment	1.5

Total number of episodes and unique individuals by gender and treatment category

Not all treatment centres were able to provide information on gender; however, of the 14,347 episodes where gender was reported, 8,909 (62.0%) were accounted for by males, while 5,435 (38.0%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 71.5%; females: 75.2%) in Manitoba followed by residential treatment (males: 15.2%; females: 20.5%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 7 and Figure 8, people aged 25–34 accounted for the highest percentage of specialized treatment episodes as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of both individuals accessing treatment and total treatment episodes. As shown in Figure 9, non-residential treatment accounted for the majority of episodes for all age categories.



Figure 7. Treatment episodes by age (Manitoba)

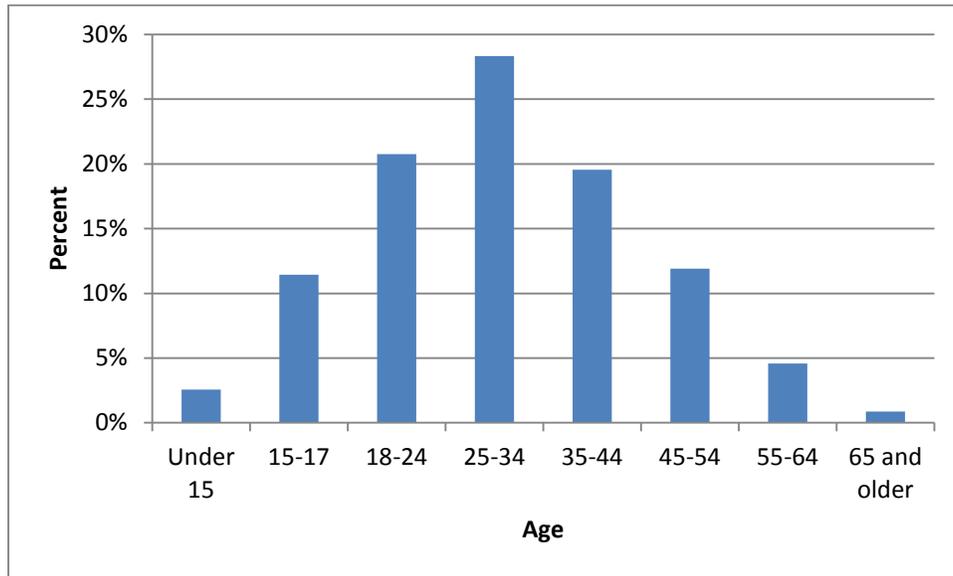


Figure 8. Unique individuals by age (Manitoba)

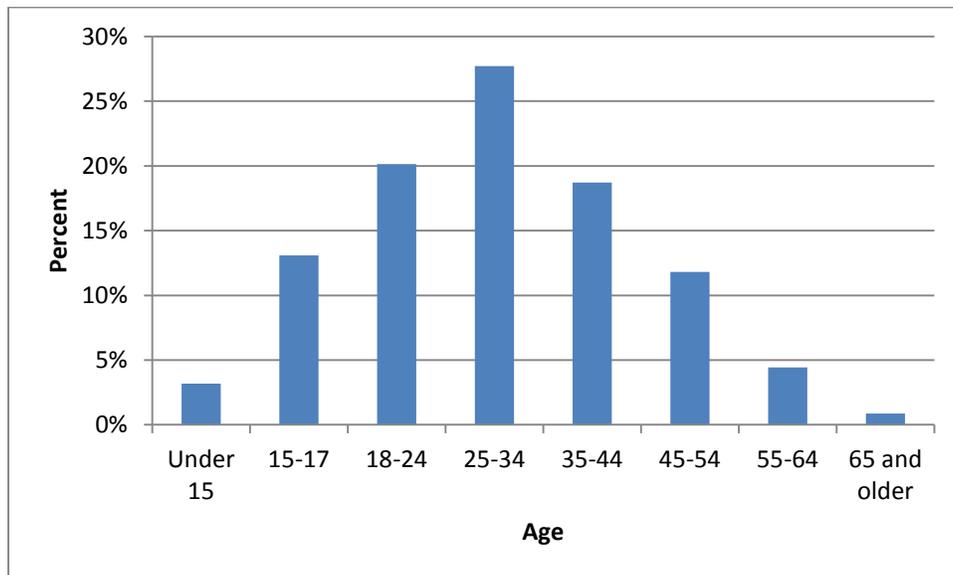
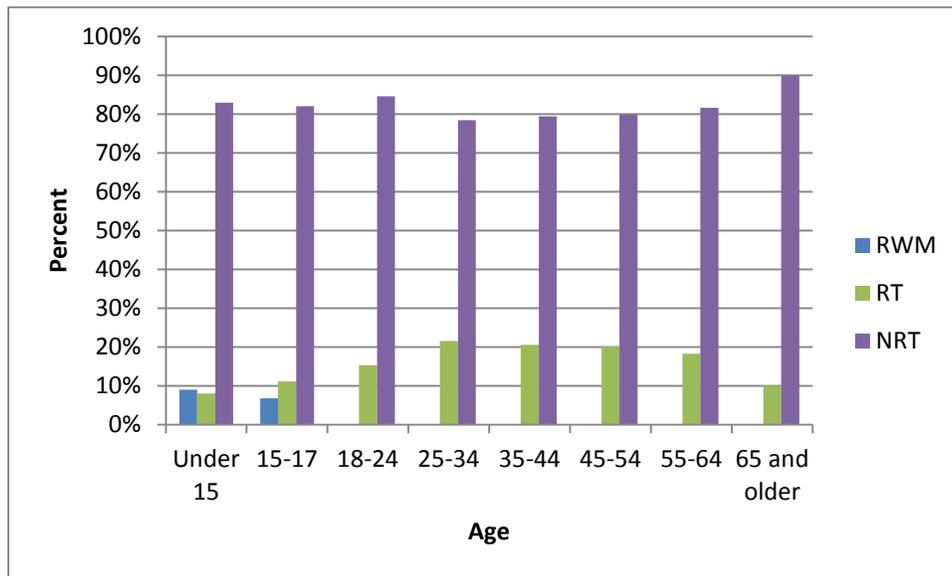




Figure 9. Episodes by age and treatment type (Manitoba)



Total number of episodes and unique individuals that have used drugs by injection within the 12 months prior to treatment

Males accounted for the majority (53.7 %) of all episodes related to treatment for injection drug use. The ratio of episodes to individuals was approximately even among males (1.0) and females (1.1).

Total number of unique individuals accessing opioid substitution treatment

In total, 100 individuals accessed publicly funded opioid substitution treatment, of which females accounted for 58.0% of all clients.

Total number of people served within driving-while-impaired programs

In total, 1,795 individuals attended driving while impaired (DWI) programs in Manitoba during the 2012–2013 fiscal year. The vast majority of these individuals were male (83.1%). Nearly one-third (29.3) of all DWI clients were between the ages of 25 and 34. Individuals ages 18–24 made up the second highest percentage of DWI clients (23.3%), followed by 35–44 year olds (19.8%) and 45–54 year olds (18.2%). Approximately 91% of all DWI clients were between the ages of 25 and 54.

Past-year substance use among unique individuals seeking treatment

As noted, Manitoba does not collect information on the primary substance for which treatment is being sought. For this reason, information on substances used in the 12 months preceding treatment is provided. In fiscal year 2012–2013, the top three substances unique individuals reported having used in the past 12 months were alcohol (63.9%), cannabis (43.2%) and cocaine (26.5%). Past-year use of opioids was also reported by 25.6% of the client population.

Employment status of unique individuals seeking treatment

Of 7,203 unique individuals who accessed treatment, where employment data was tracked, 46.3% reported “unemployed” as their employment status at the time of treatment; approximately 16.9% of these clients reported “student” as their employment status, while 26.9% reported being



“employed.”¹² “Other” categories including unpaid work (i.e., homemaker) or retired made up the remaining 9.9%.

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in Manitoba between April 1, 2012, and March 31, 2013.

Overall, Manitoba experienced an 8.4% decrease in the total number of treatment episodes between 2011–2012 and 2012–2013. The difference in these numbers might be explained by some agencies being able to report on indicators in 2011–2012, but not in 2012–2013. Another factor that could underlie the decrease are changes to agency level reporting protocols. That is, agencies reported total numbers from all programs in 2011–2012, but in 2012–2013 only reported numbers from the programs that are funded by Manitoba Health, Healthy Living and Seniors. Agency-level changes to intake and admission processes could also account for the decrease in people accessing the treatment system.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past three years of data collection, between 7.7% and 9.0% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

Between 2010–2011 and 2012–2013, the number of episodes per individual remained stable at approximately 1.7 episodes per individual, averaged across all service types. In the same time period, non-residential treatment remained the most commonly accessed treatment service in Manitoba, accounting for nearly 72% of all treatment episodes in 2012–2013. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment services are accessible from many sites province wide, whereas the majority of residential services are located in Winnipeg. Furthermore, best practice suggests that the majority of individuals seeking treatment for addiction issues do not require specialized residential treatment services and therefore non-residential treatment is the most appropriate service type.

In 2011–2012, publicly funded treatment services in Manitoba began the process of implementing common data collection and reporting processes. As a result, six agencies now use a common data collection and reporting process, however, data collection in several large agencies remains inconsistent. Changes internally to data collection and data definitions likely impact overall numbers as compared to previous years.

¹² This category includes both full- and part-time employment statuses.



Ontario

Population estimate (July 1, 2012): 13,410,100(Statistics Canada, 2014b)

Overview and Summary

Ontario joined the NTIWG in 2007 and has contributed specialized treatment data to each of the four annual reports that have been published to date. Substance use treatment services in Ontario include residential treatment, non-residential treatment, residential withdrawal management, and non-residential withdrawal management.

The Ministry of Health and Long-Term Care is the ministry responsible for specialized treatment services in Ontario. Treatment services in Ontario are delivered through 14 Local Health Integration Networks as well as through community agencies. Mental health services are integrated with substance use services at the administrative level. Ontario uses the Drug and Alcohol Treatment Information System (DATIS), a browser-based system,¹³ to collect its treatment data. DATIS figures are reported quarterly and annually.

Important Considerations and Limitations

In Ontario, a new case is defined as a unique individual with no previous admissions to a participating agency or program.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 83,103 unique individuals accessed publicly funded specialized treatment services in Ontario; of which, 74.9% were new cases. In total, these 83,103 individuals accounted for 119,001 episodes meaning that, on average, each unique individual accessed treatment services 1.4 times throughout the year.

The majority of individuals accessing treatment services (93.1%) were seeking treatment for their own substance use problems. However, 5,743 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year which accounts for 6.9% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of 112,918 treatment episodes in Ontario, the majority (58.6%) were episodes for non-residential treatment. Approximately 32.0% were for residential withdrawal management, 8.1% for residential treatment, and 1.3% for non-residential withdrawal management.

The ratio of episodes to individuals for each of the treatment categories is presented in Table 5.

¹³ Refers to the ability to connect to a central data-collection system that allows all users to enter data directly from various locations and for the generation of summative reports.



Table 5. Ratio of episodes to individuals (Ontario)

Residential withdrawal management	2.4
Non-residential withdrawal management	1.1
Residential Treatment	1.2
Non-residential treatment	1.2

Total number of episodes and unique individuals by gender and treatment category

Of 112,918 episodes accessed by individuals seeking treatment for themselves, 74,891 (66.3%) were accounted for by males, while 37,992 (33.6%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 54.6%; females: 66.5%) in Ontario, followed by residential withdrawal management (males: 36.1%; females: 24.0%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 10 and Figure 11, people aged 25–34 accounted for the highest percentage of specialized treatment episodes as well as the highest percentage of unique individuals. People aged 45–54 accounted for the second highest percentage of treatment episodes, while people aged 35–44 accounted for the second highest percentage of unique individuals accessing treatment. With the exception of individuals 65 years of age and older, non-residential treatment accounted for the majority of episodes for all age categories (see Figure 12).

Figure 10. Treatment episodes by age (Ontario)

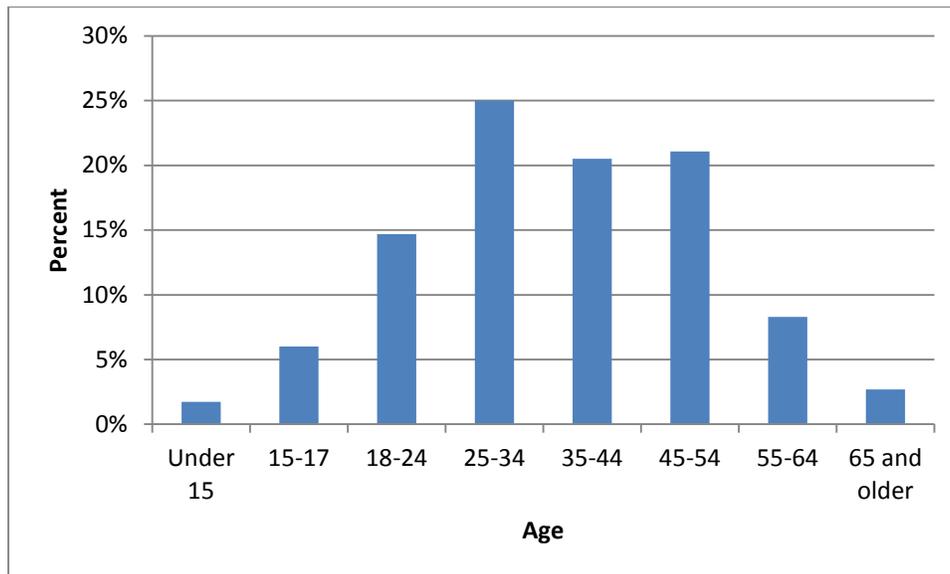




Figure 11 Unique individuals by age (Ontario)

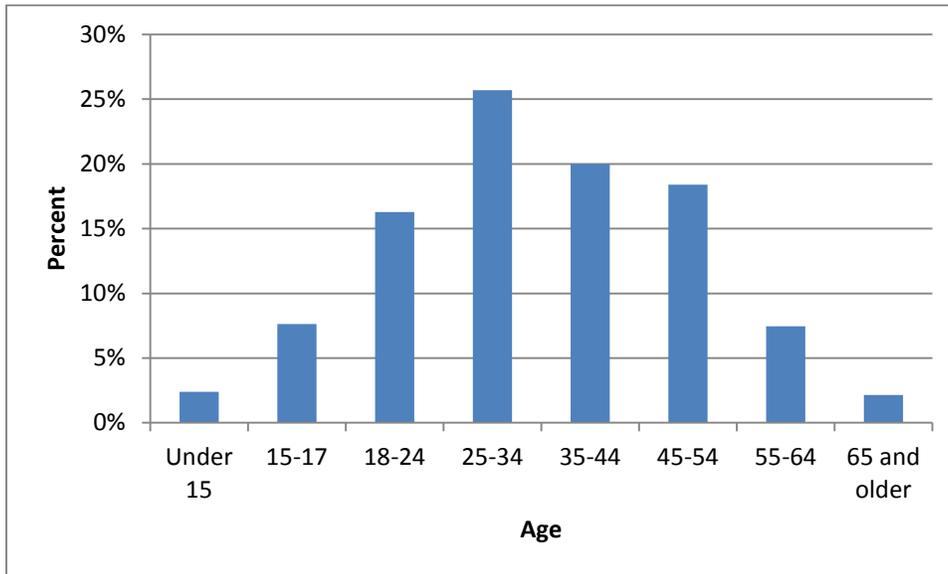
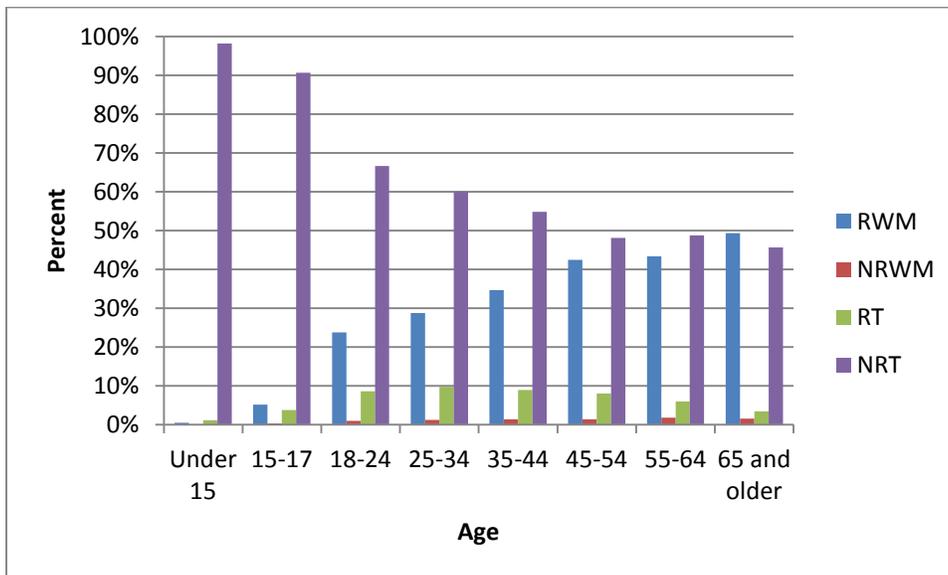


Figure 12. Episodes by age and treatment type (Ontario)



Total number of episodes and unique individuals that have used drugs by injection within the 12 months prior to treatment

Males accounted for the majority (64.8%) of the 12,020 episodes related to treatment for injection drug use. Based on the number of individuals accessing treatment for each respective gender, the ratio of episodes to individuals was slightly higher among males (1.7) than females (1.5).

Total number of unique individuals accessing opioid substitution treatment

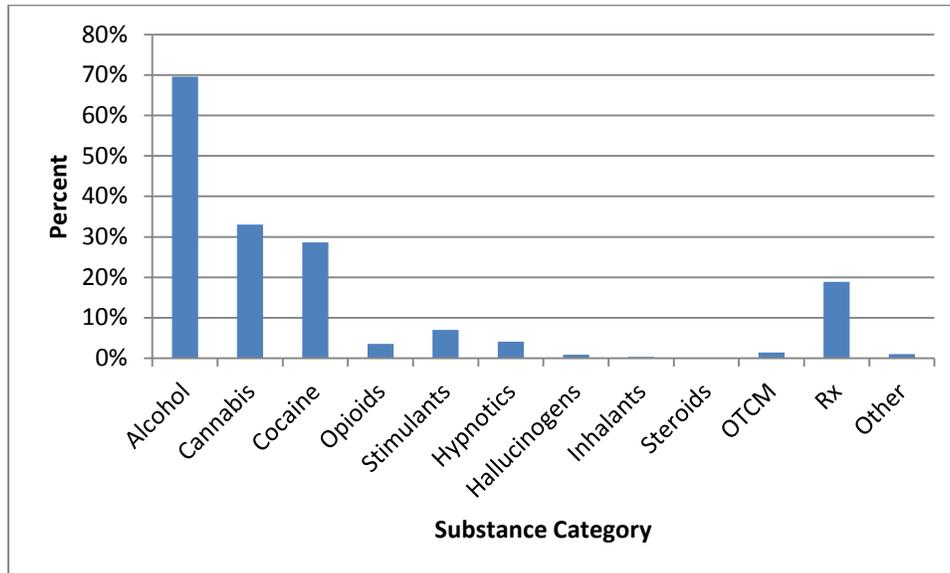
In total, 5,127 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 52.8% of all clients. The majority (43.3%) of opioid substitution clients were ages 25–34 followed by individuals 35–44 (21.9%) and then 18–24 year olds (18.6%).



Total number of episodes by primary substance for which treatment was being sought

As shown in Figure 13, alcohol was the substance most commonly reported as a client’s reason for seeking treatment.

Figure 13. Episodes by primary substance for which treatment was sought (Ontario)¹⁴



Note: A complete list of substance categories and examples can be found in Appendix G.

Treatment episodes by employment status

Of the 119,001 episodes, 37.4 were accessed by individuals who reported “unemployed” as their employment status at the time of treatment; 27.0% were identified as “other” and 21.2% were employed full-time.

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in Ontario between April 1, 2012, and March 31, 2013.

Overall, Ontario experienced a 10.4% increase in the total number of treatment episodes between 2009–2010 and 2012–2013. The difference in these numbers might be explained by the increase in data quality vigilance from DATIS and by the increase in data scope obtained by interfacing DATIS proprietary software with software commonly used in multi-sectorial agencies.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past four years of data collection, between 4.9% and 7.2% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

Between 2009–2010 and 2012–2013, the number of episodes per individual fluctuated between 1.4 and 1.6 episodes per individual, averaged across all service types. In the same time period, non-residential treatment remained the most commonly accessed treatment service in Ontario,

¹⁴ Note that individuals can present up to two primary substances.



accounting for nearly 60% of all treatment episodes in 2012–2013. This finding is also consistent across other jurisdictions and is likely explained by the fact that non-residential treatment is typically the most accessible and cost-effective treatment service available.

Alcohol-related issues were the most common reason individuals sought treatment in Ontario during 2012–2013. However, in the last five years, Ontario has seen a noticeable rise in the number of admissions listing prescription opioids as the client’s primary reason for seeking treatment. This trend might be the result of a limited supply of these medications as a result of delisting some popular brand prescription opioids.



Quebec

Population estimate (July 1, 2012): 8,084,800 (Statistics Canada, 2014b)

Overview and Summary

Association des centres de réadaptation en dépendance du Québec (ACRDQ) joined the NTIWG in 2009 and has contributed data to three of the last four annual reports. Substance use treatment services in Quebec include residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management. Currently, data on Quebec treatment services is limited to DWI programs. These data are submitted by the ACRDQ.

The Ministry of Health and Social Services is the ministry responsible for specialized treatment services in Quebec. Treatment services in Quebec are delivered through 16 addiction rehabilitation centres, 95 community health and social service centres, and more than 100 inpatient private and community resources. Mental health services are not currently integrated with substance use services at the administrative level. Quebec uses the *Système d'information clientele pour les services de réadaptation en dépendance* to collect its treatment data. Treatment data are submitted annually.

Important Considerations and Limitations

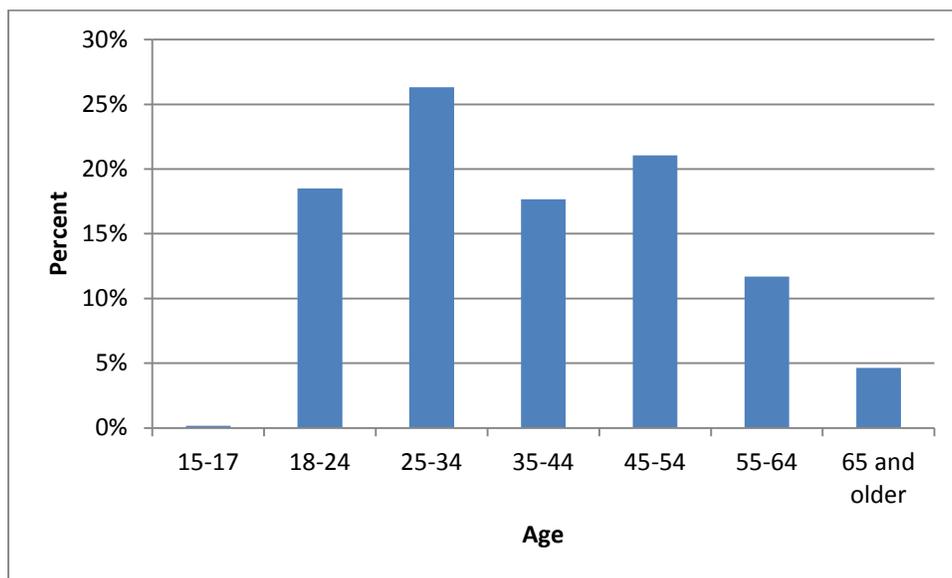
Only data on individuals accessing DWI programs is included.

Results

Total number of people served within driving-while-impaired programs

In total, 10,058 individuals accessed DWI programs in Quebec during the 2012–2013 fiscal year. The vast majority of these individuals were male (83.2%). Roughly one quarter of all DWI individuals were between the ages of 25 and 34. More than 80% of all DWI clients were between the ages of 18 and 54.

Figure 14. Percentage of individuals served within driving-while-impaired programs by age (Quebec)





Discussion

For over 15 years, ACRDQ has been managing and implementing a driver assessment program, Programme d'évaluation des conducteurs automobiles, based on standards set out in an agreement between Société de l'assurance automobile du Québec, ACDRQ and the addiction rehabilitation centres.

The protocols used by ACRDQ had not changed since 2002. In 2011–2012, protocols were developed based on best practices following legislative changes to the highway safety code in 2010. Fiscal year 2012–2013 presented the considerable challenge of implementing related measures. Through the years, ACRDQ has found that the evolution of administrative measures and laws has encouraged the use of assessments, which went from 5,250 in 2003–2004 to 11,987 in 2012–2013, representing an increase of almost 130%.



Nova Scotia

Population estimate (July 1, 2012): 944,800 (Statistics Canada, 2014b)

Overview and Summary

Nova Scotia joined the NTIWG in 2009 and has contributed specialized treatment data to each of the four annual reports that have been published to date. Substance use treatment services in Nova Scotia include residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management.

The Department of Health and Wellness is the ministry responsible for specialized treatment services in Nova Scotia. Treatment services in Nova Scotia are delivered through nine district health authorities and the IWK Health Centre. Nova Scotia is currently in the process of integrating mental health services with substance use services at the administrative level. Nova Scotia uses the Addiction Services Statistical Information System Technology (ASsist) system to collect its treatment data. ASsist is a browser-based system¹⁵ and data are submitted in real-time.

Important Considerations and Limitations

- In Nova Scotia, a new case is defined as a client who did not previously exist within ASsist. The system searches for a case number or a combination of first and last name and date of birth. If that is not found, then a new client is created.
- The employment category “other” includes those who indicated disabled/disability pension, employed seasonally, retired or did not report.
- In Nova Scotia, the number of individuals shown throughout this summary refers to those who were actively participating in a program within the given timeframe.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 11,835 unique individuals accessed publicly funded specialized treatment services in Nova Scotia; of which, 21.9% were new cases. In total, these 11,835 individuals accounted for 13,743 episodes meaning that, on average, each unique individual accessed treatment services 1.2 times throughout the year.

The majority of individuals accessing treatment services (94.6%) were seeking treatment for their own substance use problems. However, 644 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year, which accounts for 5.4% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the total number of episodes for individuals seeking treatment for themselves (n=13,081), the majority (61.5%) were episodes for non-residential treatment. Approximately 25.5% of the total episodes were for residential withdrawal management, 9.0% for residential treatment, and 4.0% for non-residential withdrawal management.

¹⁵ Refers to the ability to connect to a central data-collection system that allows all users to enter data directly from various locations and for the generation of summative reports.



The ratio of episodes to individuals for each of the treatment categories is presented in Table 6.

Table 6. Ratio of episodes to individuals (Nova Scotia)

Residential withdrawal management	1.7
Non-residential withdrawal management	1.2
Residential Treatment	1.1
Non-residential treatment	1.0

Total number of episodes and unique individuals by gender and treatment category

Of the 13,743 episodes 9,229 (67.2%) were accounted for by males, while 4,490 (32.7%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 63.3%; females: 63.1%) in Nova Scotia followed by residential withdrawal management (males: 24.6%; females: 23.5%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 15 and Figure 16, people aged 25–34 accounted for the highest percentage of specialized treatment episodes as well as the highest percentage of unique individuals. People aged 45–54 and individuals ages 35–44 accounted for approximately the same percentage of respective episodes and individuals.

As shown in Figure 17, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 15. Treatment episodes by age (Nova Scotia)

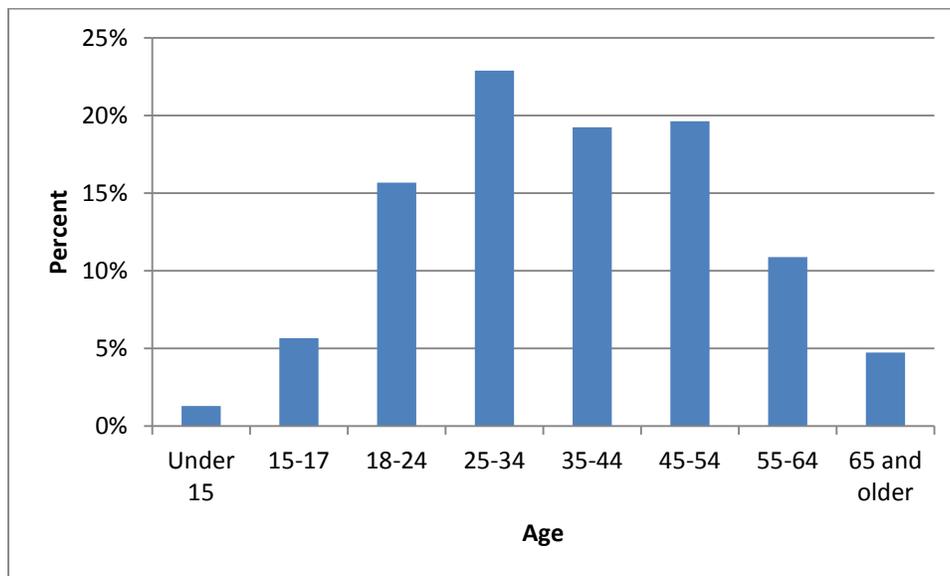




Figure 16. Unique individuals by age (Nova Scotia)

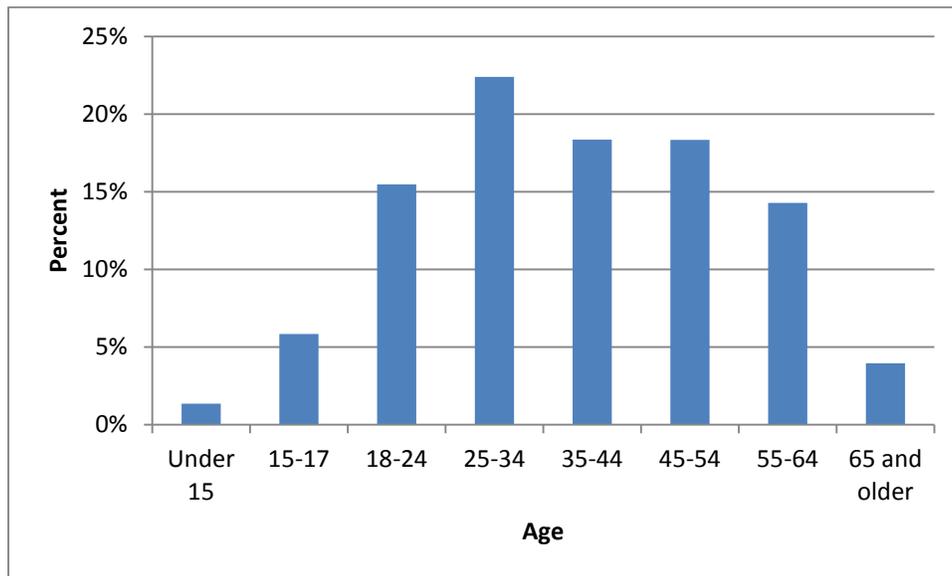
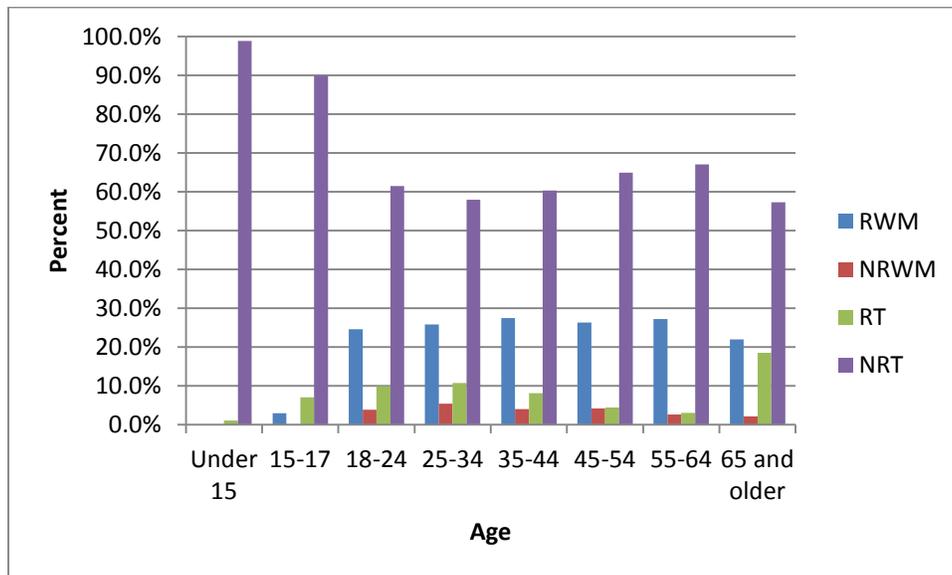


Figure 17. Episodes by age and treatment type (Nova Scotia)



Total number of episodes and unique individuals that have used drugs by injection within the 12 months prior to treatment

Males accounted for the majority (65.2%) of all episodes related to treatment for injection drug use. However, based on the number of individuals accessing treatment for each respective gender, the ratio of episodes to individuals was slightly higher among females (2.0) than males (1.9).

Total number of unique individuals accessing opioid substitution treatment

In total, 623 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 65.2% of all clients. The majority (41.6%) of opioid substitution clients were ages 25–34 followed by individuals 18–24 (29.4%). Of those unique individuals accessing methadone

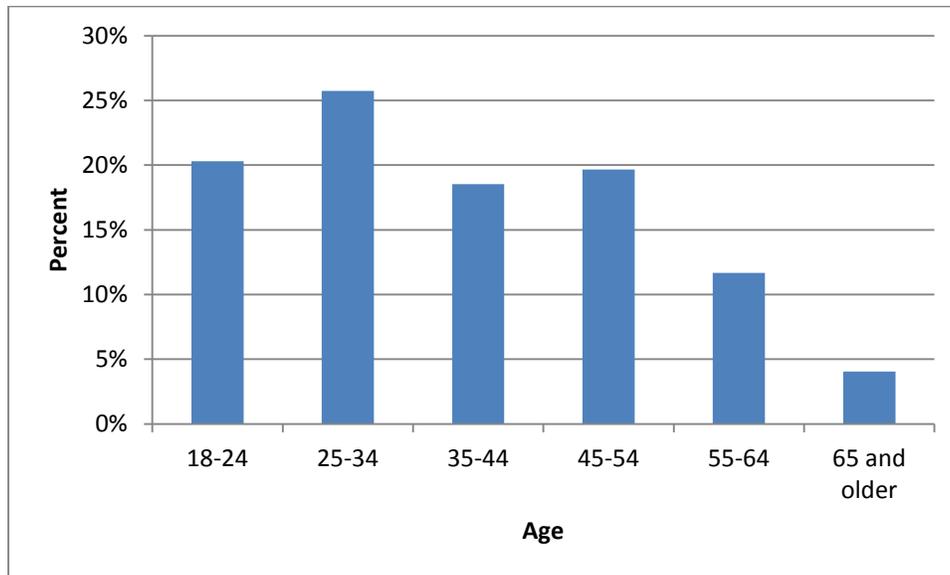


treatment in Nova Scotia during 2012–2013, 50% were male and 50% were female. More than half (56.3%) of these individuals were between the ages 25 and 34.

Total number of people served within driving-while-impaired programs

In total, 1,749 individuals accessed DWI programs in Nova Scotia during the 2012–2013 fiscal year. The vast majority of these individuals were male (82.5%). Roughly one quarter of all individuals in DWI programs were between the ages of 25 and 34. More than 80% of all DWI clients were between the ages of 18 and 54.

Figure 18. Percentage of individuals served within driving-while-impaired programs by age (Nova Scotia)

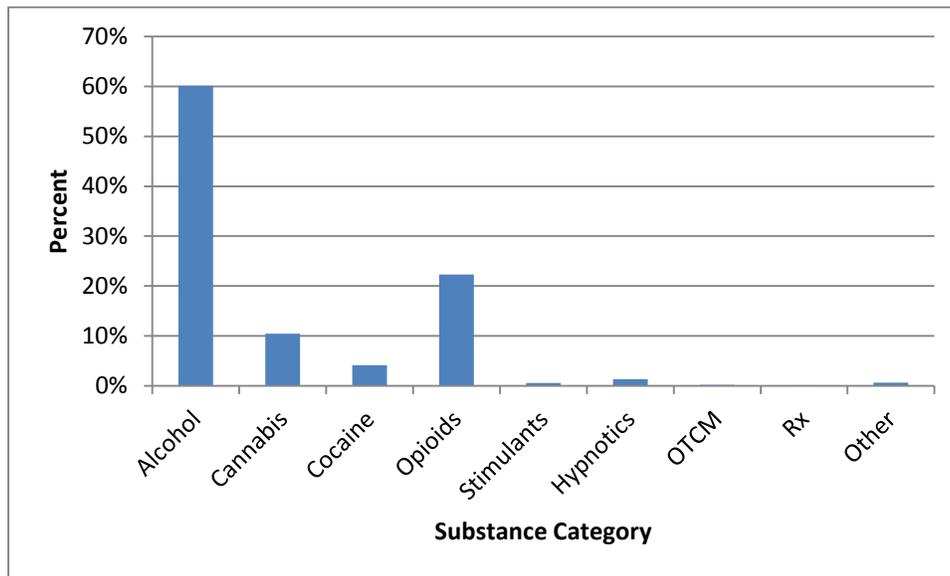


Total number of episodes by primary substance for which treatment was being sought

As shown in Figure 19, alcohol was the substance most commonly reported as a client's reason for seeking treatment.



Figure 19. Episodes by primary substance for which treatment was sought (Nova Scotia)



Note: A complete list of substance categories and examples can be found in Appendix G.

Treatment episodes by employment status

Of the 13,743 episodes, 45.2% were accessed by individuals who reported “unemployed” as their employment status at the time of treatment; 26.9% were employed full-time; 22.4% listed “other” as their employment status at the time of treatment; and 5.4% were employed part-time.

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in Nova Scotia between April 1, 2012, and March 31, 2013.

Overall, treatment use patterns and trends in Nova Scotia have been fluctuating over the past four years. For example, in 2009–2010 Nova Scotia experienced nearly 15,000 treatment episodes; however, these numbers fell to 12,535 and 12,935 in 2010–2011, and 2011–2012, respectively. In 2012–2013 the total number of treatment episodes climbed to nearly 14,000. Interestingly, the 6.2% increase in treatment episodes between 2011–2012 and 2012–2013 was eclipsed by a 60% increase in unique individuals during the same time period. As a result, the ratio of episodes to individuals decreased from 1.7 to 1.2 episodes per individual. Overall, fluctuation in the total number of treatment episodes over the past four years for which data was collected is difficult to explain as there have been no major changes to staffing or programming throughout the province.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past four years of data collection, between 3.5% and 8.3% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

Since 2009–2010, non-residential treatment has remained the most commonly accessed treatment service in Nova Scotia, accounting for 61.5% of all treatment episodes in 2012–2013. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment offers the least intrusive form of intervention and is often more accessible (i.e., same community, town, etc.) than other service types.



Alcohol-related issues were the most common reason individuals sought treatment in Nova Scotia during 2012–2013. However, it is important to note that the total number of individuals seeking treatment for opioid-related issues has increased over the last few years. To address this trend, the Mental Health and Addiction Services Strategy has helped expand opioid replacement treatment by funding 70 additional treatment spots; sponsoring training sessions that allow family physicians to receive their exemption to prescribe methadone for dependency purposes; providing supplies used in the assessment of opioid misuse; and recruiting 50 additional physicians (Government of Nova Scotia, 2013).

Nova Scotia is also currently developing a new service delivery model. The goal of this new model is to provide access to timely and safe addictions care, linking clients to the least intrusive level of service that matches their individual needs and to ensure that inpatient withdrawal management is integrated with other components of addiction and mental health services so clients experience the best chance for coordinated, effective care that leads to improved health.

In addition to the changes mentioned above, Nova Scotia recently implemented the Choice and Partnership Approach, a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling, and demand and capacity management (York & Kingsbury, 2007). This improvement is expected to enhance access to appointments, and ensure clients receive services from the appropriate clinicians.



Newfoundland and Labrador

Newfoundland and Labrador population estimate (July 1, 2012): 526,900 (Statistics Canada, 2014b)

Overview and Summary

Newfoundland and Labrador joined the NTIWG in 2009 and have contributed specialized treatment data to three of the four annual reports that have been published to date. Substance use treatment services in Newfoundland and Labrador include residential treatment, non-residential treatment and residential withdrawal management.

The Department of Health and Community Services is the ministry responsible for specialized treatment services in Newfoundland and Labrador. Treatment services are delivered through four regional health authorities. Mental health services are integrated with substance use services at the administrative level. Newfoundland and Labrador use the Client Referral Management System (CRMS) to collect treatment data.

Important Considerations and Limitations

- There are data quality concerns with the CRMS such that numbers reported might not be reflective of actual numbers.
- Newfoundland and Labrador does not offer non-residential withdrawal management.
- A client can be active in more than one of the treatment services throughout the year. Therefore they would be counted as a unique individual in each treatment service, which might result in counting them more than once.
- A client can access a treatment service for themselves as well as a family member, which might result in data discrepancies.
- In Newfoundland and Labrador, a case is considered new if the client has never been treated before in public community mental health and addictions treatment services.

Results

Total number of treatment episodes and unique individuals

In 2012–2013, 2,290 unique individuals accessed publicly funded specialized treatment services in Newfoundland and Labrador, of which 80.8% were new cases (n=1851). In total, these 2,290 individuals accounted for 3,489 episodes meaning that, on average, each unique individual accessed treatment services 1.5 times throughout the year.

The majority of individuals accessing treatment services (96.5%) were seeking treatment for their own substance use problems. However, 105 individuals accessed specialized treatment services for a friend or family member during the 2012–2013 fiscal year, which accounts for 4.6% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the total treatment episodes (n=3,489), the majority (77.3%) were for non-residential treatment. Approximately 16.3% of the total episodes were for residential withdrawal management, while the remaining 6.3% were for residential treatment. Newfoundland and Labrador does not offer non-residential withdrawal management services.



The ratio of episodes to individuals for each of the treatment categories is presented in Table 7.

Table 7. Ratio of episodes to individuals (Newfoundland and Labrador)

Residential withdrawal management	1.8
Residential Treatment	1.1
Non-residential treatment	1.3

Total number of episodes and unique individuals by gender and treatment category

Of the 3,489 episodes 2,142 (61.4%) were accounted for by males, while 1,252 (35.9%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males: 75.6%; females: 79.9%) in Newfoundland and Labrador followed by residential withdrawal management (males: 18.3%; females: 13.3%).

Total number of episodes and unique individuals by age and treatment category

As shown in Figure 20 and Figure 21, people aged 25–34 accounted for the highest percentage of specialized treatment episodes, as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of both individuals accessing treatment and total treatment episodes, followed closely by people aged 45–54.

As shown in Figure 22, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 20. Treatment episodes by age (Newfoundland and Labrador)

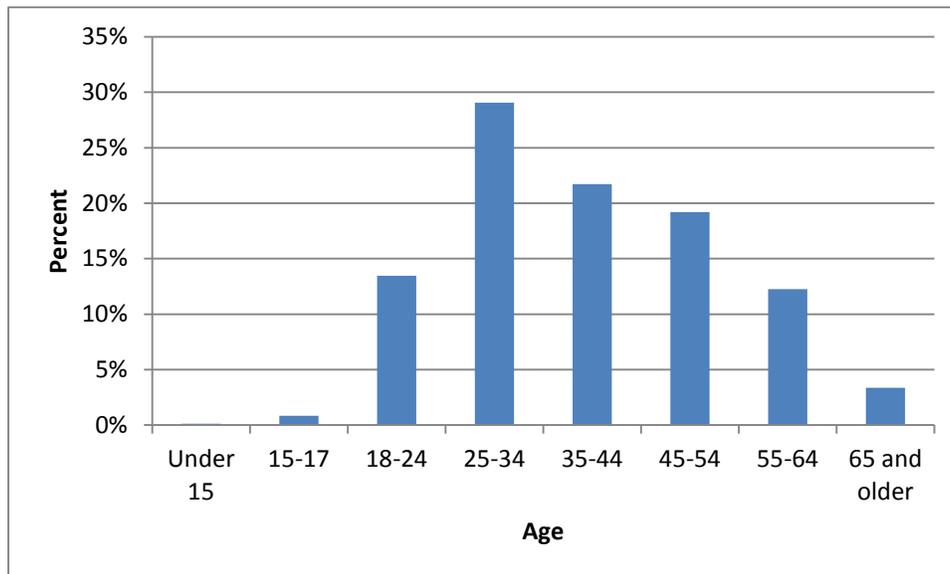




Figure 21. Unique individuals by age (Newfoundland and Labrador)

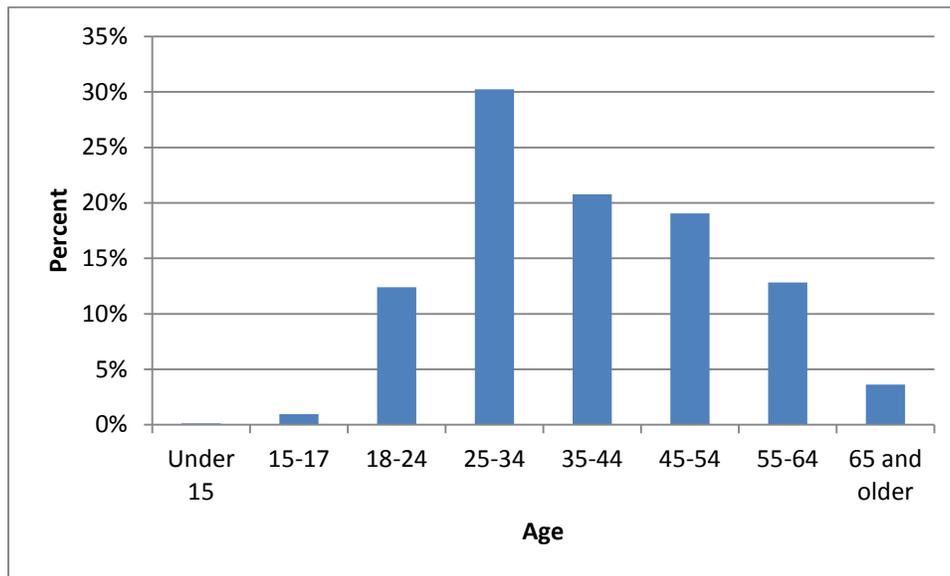
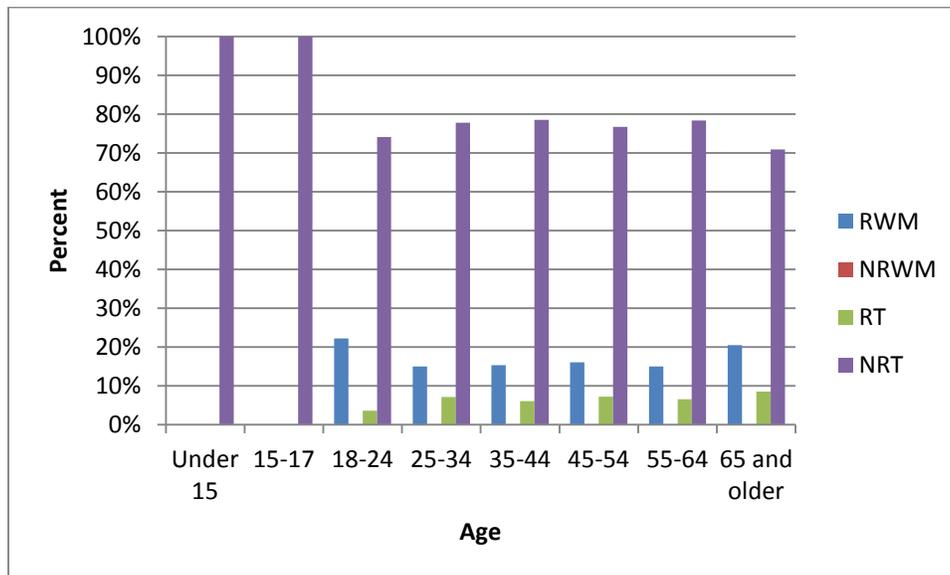


Figure 22. Episodes by age and treatment type (Newfoundland and Labrador)



Total number of episodes for opioid substitution

In total, 68 individuals accessed publicly funded opioid substitution treatment (i.e., methadone maintenance treatment), of which males accounted for 60.3% of all clients.¹⁶ The majority (50.0%) of opioid substitution clients were ages 25–34 followed by individuals 35–44 (29.4%).

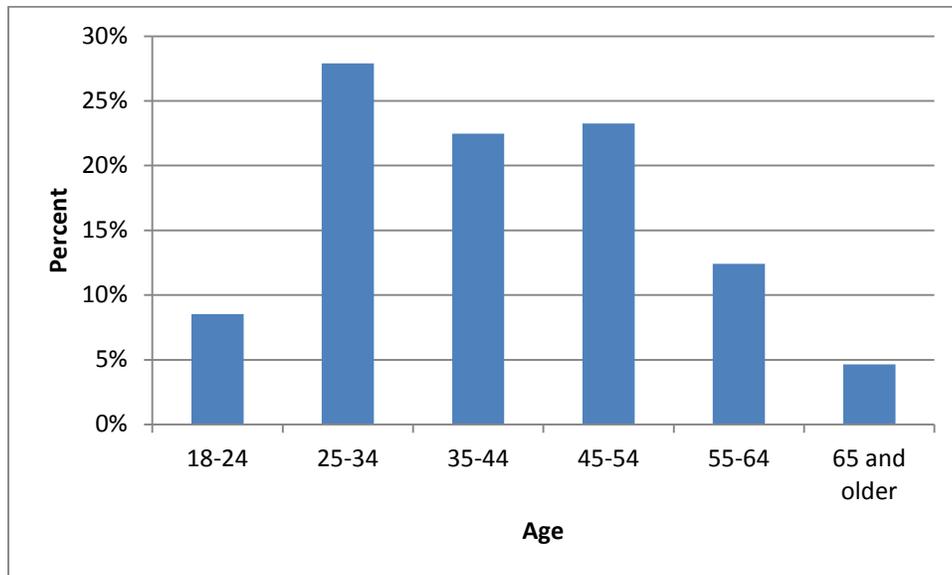
¹⁶ Note this figure is underreported. Newfoundland and Labrador currently serve approximately 1,000 methadone maintenance clients. The majority access methadone through physicians in private practice. Clients accessing methadone privately are not captured in CRMS.



Total number of people served within driving-while-impaired programs

In total, 130 individuals attended DWI programs in Newfoundland and Labrador during the 2012–2013 fiscal year.¹⁷ The majority of these individuals were male (70.0%). Nearly one-third of all DWI clients were between the ages of 25 and 34. Individuals ages 35–44 and 45–54 represented the next two highest age categories. Approximately 91% of all DWI clients were between the ages of 25 and 54.

Figure 23. Percentage of individuals served within driving-while-impaired programs by age (Newfoundland and Labrador)



Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded specialized treatment service use in Newfoundland and Labrador between April 1, 2012, and March 31, 2013.

Overall, treatment service use trends in Newfoundland and Labrador have fluctuated over the past three years. For example, the total number of unique individuals accessing specialized treatment services decreased 16% between 2010–2011 and 2011–2012 and then increased 87% between 2011–2012 and 2012–2013. However, it is important to note that these fluctuations could be attributed to variation in how data is entered in each region, as well as to refinement of the data scripts used to pull data from CRMS to better reflect the NTI data protocols.

Consistent with findings from previous years, the majority of individuals accessing treatment services were male, and over the past three years of data collection, between 3.2% and 4.6% of all treatment episodes were accessed by individuals seeking treatment due to the substance use issue of a family member or friend.

Between 2010–2011 and 2012–2013, the number of episodes per individual ranged from 1.5 to 2.4. Again this variation could be an artifact of data limitations and efforts made to improve the data collection process over time. In the same time period, non-residential treatment remained the most commonly accessed treatment service in Newfoundland and Labrador (accounting for 77.3% of all

¹⁷ Note this figure might be underreported.



treatment episodes in 2012–2013). This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment meets the needs of the broadest population base and is often the most accessible form of treatment. Moreover, access rates are also directly influenced by the treatment process in Newfoundland and Labrador whereby a client cannot access residential treatment without having first participated in non-residential treatment and/or residential withdrawal management.

Beyond the NTI project, the government of Newfoundland and Labrador has been working very closely with regional health authorities to reduce wait times for mental health and addictions services. Wait times can change from month to month; however, the province is experiencing some improvements. Access to mental health and addictions services is not an issue everywhere in the province. From time to time there are no wait lists for mental health and addictions counselling services in different parts of the province.

While CRMS is a provincial system, the manner in which regional health authorities use the system to document mental health and addictions programs and services varies. Such variation contributes to discrepancies in data quality, so caution should be exercised before drawing conclusions on service use in the province.



National Picture

This section is intended to provide a national picture of treatment service use and related trends using findings from each of the participating jurisdictions mentioned in this year's report. This section also includes additional information from reports and projects that complement the NTI project.

Total number of unique individuals and treatment episodes

The NTI data indicate that between April 1, 2012, and March 31, 2013, a total of 155,210 individuals from six Canadian provinces and one territory accessed publicly funded substance use treatment services. In total, these unique individuals accounted for nearly 225,000 treatment episodes. On average, individuals accessing publicly funded treatment services account for approximately 1% of a jurisdiction's entire population.

In many Canadian jurisdictions, the number of individuals accessing specialized treatment services has increased over the past four fiscal years. For example, Ontario provided specialized treatment services to an additional 13,337 individuals in 2012–2013 than they did in 2009–2010. During the same time period, the number of individuals accessing specialized treatment services in Nova Scotia increased by more than 2,000.

Treatment for friends and family

Problematic substance use affects not only the individual user, but also their family members and friends. In 2012–2013, as many as 13% of unique individuals accessing substance use treatment, accessed treatment because of someone else's substance use (e.g., they accompanied a family member or friend to treatment or they accessed treatment services themselves to help them cope with a friend or family member's problem). This rate has remained consistent since 2009–2010.

Gender

With the exception of the Yukon, males accounted for the majority of all individuals accessing specialized treatment services during 2012–2013. In three of the five jurisdictions that provided data, males accounted for nearly two-thirds of all individuals accessing treatment services for injection drug use; the gender ratio for clients who inject drugs was approximately equal in the remaining two jurisdictions. Males also accounted for the majority of individuals accessing opioid substitution treatment in four of the six jurisdictions that provided data.

Age

The data indicate that the majority of individuals accessing treatment services in Canada are young (between 15 and 34 years of age). For example, between 13% and 33% of all treatment clients were accounted for by youth (ages 15–24), while roughly one-third of all treatment clients were between the ages of 25 and 34.

Past 12 month substance use

Alcohol was the most common substance used in the past 12 months by clients of publicly funded treatment centres. In all jurisdictions but Nova Scotia, clients between the ages of 25 and 34 had the highest past-year prevalence of alcohol and cannabis use. However, in Nova Scotia, clients 45–54 years of age had the highest past-year prevalence of alcohol consumption, while clients between the ages of 15 and 17 had the highest past-year prevalence of cannabis use.



Reason for treatment

This year, data collection was expanded to include information on the primary substance for which an individual was seeking treatment. Ontario and Nova Scotia were able to provide this information. Their data indicate that alcohol was the most commonly reported reason for seeking treatment. In Ontario, the second most commonly reported reasons for attending treatment was cannabis followed by cocaine, while in Nova Scotia opioids were the second most commonly reported reason for seeking treatment followed by cannabis.

Employment status

Employment status is another recent addition to the NTIs. Again, not all jurisdictions have the capacity to collect and report on this indicator. However, data indicate that in each of the jurisdictions that submitted data, the majority (between 37.4% and 55.8%) of all treatment episodes were accessed by individuals who listed “unemployed” as their employment status at the time of treatment.

New clients

In most jurisdictions, new clients represent the majority of individuals accessing substance use treatment. It is important to note that a “new case” is defined differently by each jurisdiction (jurisdiction-specific definitions can be found in each of the jurisdictional summaries).

Most-accessed treatment service

Non-residential treatment accounted for the majority (between 61% and 77%) of treatment episodes in every participating jurisdiction. This finding is not surprising, however, given that non-residential treatment is often the most accessible and least intrusive form of treatment. Despite this finding, it is important to understand that high rates of service use do not necessarily reflect or indicate adequate service availability, relative to the treatment need in the population.

On average, most individuals accessing residential treatment, non-residential treatment and non-residential withdrawal management only access these services once throughout the year. Most individuals attending residential withdrawal management programs, however, access the service twice or more throughout the year.

Complementary Projects

Hospital data

In 2014, CCSA obtained hospital data from the Canadian Institute for Health Information (CIHI). CCSA calculated the total number of hospital stays¹⁸ related to substance use disorders and their associated costs. The results of their study found that 1.2% of all hospital stays in 2011 involved a primary diagnosis of a substance use disorder representing 34,746 stays and costing an estimated \$267 million. Of these costs, alcohol consumed the greatest amount of hospital resources, accounting for more than half (54%) of these costs, followed by opioids, cannabinoids, cocaine and other stimulants, respectively.¹⁹ Findings from the report indicate that costs related to substance use disorder hospitalizations have increased by 22% since 2006 (Young, Jesseman, & Thomas, 2014).

¹⁸ A stay is defined as a departure from hospital through discharge or death.

¹⁹ This ranking excludes those diagnosed with “mental and behavioural disorders due to multiple drug use and use of other psychoactive substances,” as this category lacked specificity and was difficult to interpret.



The report also noted that the number of days spent in hospital due to opioid, cannabinoid and other stimulant-related disorders increased between 2006 and 2011, while hospitalizations related to cocaine decreased between 2006 and 2011. Compared to these substances, sedatives or hypnotics and hallucinogens or volatile solvents accounted for a negligible amount of hospital resources.

This analysis excludes hospital stays in which the patient's condition is indirectly attributable to a substance use disorder. Consequently, the numbers presented in this report underestimate the extent to which substance use disorders impact hospital resources and the magnitude of this underestimation is unknown.

Despite these limitations, these findings indicate that many Canadians use hospitals as a means to receive treatment for problems related to substance use.

Needs-Based Planning Project

One of the limitations that currently exist in the treatment sector is the inability to accurately measure and plan for service use. To obtain a better understanding of the gap between service need and service use, the NTIWG is linking to a needs-based planning research team led by Brian Rush at the Centre for Addiction and Mental Health and Joël Tremblay at the University of Quebec. This initiative is working to develop a model that estimates levels of treatment need based on population data derived from the Canadian Community Health Survey and other sources. It then translates these levels of need into service categories (Rush, 2013). The needs-based planning and NTI service categories align, allowing a comparison of population need versus service use. Together, the two projects contribute information required for evidence-based system planning.

For example, based on available survey data from 2002, and updated population data, the needs estimation model from needs-based planning would suggest that about 20% of Canadians 15 and over could benefit from some level of advice or formal treatment with respect to their substance use (about 5.7 million people) and, of these, a minimum of about 423,000 might be expected to seek help if services were available and accessible. This compares to the approximately 155,210 individuals who used the services reporting to the NTI project in 2012–2013.

At present, these data are subject to many limitations such as requiring updating with the new 2012 Canadian Community Health Survey population survey data; the exclusion of Aboriginal people living on-reserve from the survey-based in-need population; lack of needs-based projections for prescription opioid dependence; the lack of current NTI data from several Canadian jurisdictions, as well as several important services such as hospitals and primary care. In future iterations of the NTI and updated needs-based planning, it is anticipated that these and other limitations will be addressed.



Discussion

Substance abuse is a significant health, economic and social issue in Canada. Access to a comprehensive system of effective evidence-based services and supports will help reduce the risks and harms associated with alcohol and drug use. The data provided in this fourth NTI report provide multi-jurisdictional aggregate-level information on clients who accessed publicly funded, specialized treatment services in 2012–2013. This report provides a picture of substance use treatment service use across several jurisdictions in Canada, which will inform system planning, development, and monitoring.

Overall, the findings indicate that publicly funded treatment services are being accessed by a variety of individuals (e.g., males, females, youth, seniors, employed, unemployed) with varying substance use profiles. Responding effectively to such a variety of clients requires the availability of a comprehensive range of treatment services, including gender-based services, age-appropriate services, housing and employment supports, and family services.

Findings also indicate that alcohol is not only the most commonly used substance among the treatment-seeking population, but it is also the most commonly reported substance for which treatment is sought in both public and hospital-based services. This finding highlights the continued financial and health impact alcohol has on Canadian society and further highlights the importance of investing in targeted treatment services such as early intervention, and screening, brief intervention and referral (SBIR) (sbir-diba.ca), as well as prevention and education initiatives such as the low-risk alcohol drinking guidelines (www.ccsa.ca/Eng/topics/alcohol/drinking-guidelines/Pages/default.aspx).

While most individuals access treatment services for their own substance use problem, many access specialized services to deal with a family member or close friend's substance use. This means that services and supports need to extend beyond the individual with the problem. It also indicates the broad impact substance use has beyond the 1.2 million Canadians estimated to have a substance use disorder, further supporting the need for greater investments to reduce the associated health, social and economic harms of substance use.

This year's data show that rates of treatment use by youth are somewhat low despite higher rates of reported substance use (CADUMS, 2012). This suggests that a gap between service use and potential need might exist, which points to the importance of research to explore, for example, if young adults face greater barriers to service access, if they are more likely to access non-specialized services not captured in the NTI data, or if they are less likely to see the need to seek support for their substance use. The answers to these questions could be used to contribute new evidence for system planning purposes, and might assist the development of age-appropriate services or the design of screening and assessment approaches that better capture young adults.

While this report does not include information from sources such as privately funded specialized treatment centres, community supports (e.g., Alcoholics Anonymous) or primary care services (e.g., those offered by family physicians), it does present information on hospital stays related to substance use disorders. This new information contributes to our understanding of the impact substance use has on non-specialized services in Canada and also confirms what we know about substance use in Canada.

Unfortunately, the nature of the data currently prevents accurate comparisons among jurisdictions. However, consistent results indicate trends and patterns relevant to system and service planning, making this information helpful at both the national and jurisdictional levels.



Areas for Improvement

Although the NTI project has helped improve our understanding of substance use treatment use in Canada, there are still many areas that need improvement. For example, as a country, we are unable to estimate the number of Canadians who access other forms of treatment for substance use issues (e.g., privately funded treatment centres). To achieve this goal, we ask all treatment service providers in Canada to participate in the NTI project to the extent possible.

We also lack up-to-date information on how much substance use costs our society. The most recent cost estimate was published by in 2006 (Rehm et al. 2006). Their report states that in 2002 alcohol and drugs cost Canadians an estimated \$22.8 billion, of which 20% (\$4.2 billion) was attributed to direct healthcare costs. Furthermore, and of particular importance to this project, we are unable to estimate the amount spent treating substance use related issues.

Lastly, a major challenge for individuals seeking treatment for substance use issues is their ability to navigate different treatment services and supports (National Treatment Strategy Working Group, 2008). Therefore, it is important that all jurisdictions in Canada work toward offering a comprehensive treatment model that offers a continuum of services and supports irrespective of the severity of the individual's issue or point of access to the system.

Next Steps

The NTIWG is committed to improving the collection and reporting of substance use treatment service data in Canada. The NTIWG will continue to work towards identifying and addressing inconsistencies and errors in data collection to improve the accuracy and validity of their jurisdiction's treatment information.

To obtain a more complete understanding of treatment service use in Canada, CCSA is working to secure data on publicly funded treatment services from other jurisdictions not currently participating in the NTI project. CCSA is also working to obtain data from privately funded treatment centres in British Columbia. Additional efforts will be made to expand the collection of privately funded treatment data to other jurisdictions across Canada.

The expansion and improvement of information provided over time and through additional sources will lead to the realization of the goal of the NTI project: to produce a comprehensive picture of service use to inform effective policy, resourcing and development for substance use treatment in Canada. Achieving this goal further contributes to the overall goal of CCSA's treatment initiatives: to improve the range, quality and accessibility of services and supports for substance use problems.



Conclusions

The National Treatment Indicators project has made and continues to make a significant contribution to our understanding of the use of substance use treatment services in Canada. This fourth report has contributed new information on publicly funded substance use treatment services and has identified common patterns and trends in treatment service use. It is currently the only report to provide information on publicly funded substance use treatment services in Canada. Through the development and implementation of data collection protocols, the NTI project has improved the quality and consistency of treatment data being collected at the jurisdictional levels, which has helped paint a more accurate national picture of treatment service use in Canada.



References

- Canadian Institute for Health Information. (2001). *Mental health and addiction indicators: Prototype report*. Ottawa, ON: Author.
- Government of Nova Scotia. (2013). *Together We Can: The plan to improve mental health and addictions care for Nova Scotians*. Retrieved from <http://novascotia.ca/dhw/mental-health/reports/MHS-Together-We-Can-One-Year-Update.pdf>.
- Health Canada. (2013). *Canadian Alcohol and Drug Use Monitoring Survey, 2012* (dataset). Ottawa, ON: author.
- National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a national treatment strategy*. Ottawa, ON: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.
- Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., ... Taylor, B. (2006). *The Costs of Substance Abuse in Canada 2002*. Ottawa, ON: Canadian Centre on Substance Abuse.
- Statistics Canada. (2014a). *Canadian Community Health Survey (CCHS): Mental Health—Public Use Microdata File, Derived Variable (DV) Specifications*. Ottawa, ON: Statistics Canada.
- Statistics Canada. (2014b). *Population by year, by province and territory*. Retrieved from <http://www.statcan.gc.ca/tables-tableaux/sum-som/I01/cst01/demo02a-eng.htm>.
- Thomas, G. (2005). *Addiction treatment indicators in Canada: An environmental scan*. Ottawa, ON: Canadian Centre on Substance Abuse.
- Young, M. M., & Jesseman, R. (2014). *The impact of substance use disorders on hospital use*. Ottawa, ON: Canadian Centre on Substance Abuse.



Appendix A: Indicators Collected for 2012–2013 Data Collection

Indicator 1: Total number of treatment episodes in public, specialized treatment services for substance abuse problems.

Indicator 2: Total number of treatment episodes in public, specialized treatment services for problem gambling.

Indicator 3: Total number of unique individuals treated in public, specialized treatment services for substance abuse problems.

Indicator 4: Total number of unique individuals in public, specialized services for problem gambling.

Indicator 5: Total number of episodes and unique individuals treated in public, specialized treatment services for substance abuse by treatment categories (i.e., residential withdrawal management, non-residential withdrawal management, residential treatment, and non-residential treatment).

Indicator 6: Total number of episodes and unique individuals treated in public, specialized treatment services for substance abuse by gender, age, and housing status within treatment categories (i.e., residential withdrawal management, non-residential withdrawal management, residential treatment, and non-residential treatment).

Indicator 7: Total number of episodes and unique individuals treated in public, specialized treatment services for substance abuse that have injected drugs within 12 months of beginning treatment.

Indicator 8: Total number of individuals in opioid substitution treatment in public, specialized treatment services and external methadone clinics.

Indicator 9: Total number of people served within driving-while-impaired education programs.

Indicator 10–21: Total number of episodes for public, specialized treatment services by primary substance for which treatment was being sought.

Indicator 22–33: Total number of unique individuals attending public, specialized treatment services by substances used in past 12 months.

Indicator 34: Total number of episodes for public, specialized treatment services by employment status.

Indicator 35: Total number of unique individuals attending public, specialized treatment services by employment status.



Appendix B: National Treatment Indicators Working Group Membership²⁰

Name	Organization
Camiré, Martin	Association des centres de réadaptation en dépendance du Québec
Chen, Debra	Canadian Institute for Health Information
Di'Giacchino, Lisha	Canadian Centre on Substance Abuse
Edwards, Mark	Health Canada
Evans, Todd	Health Canada
Hansen, Rebecca	Yukon Addiction Services, Alcohol and Drug Services
Hay, Laura	First Nations and Inuit Health Branch, Health Canada
Jahrig, Jesse	Alberta Health Services
Leggett, Sean	Manitoba Healthy Living and Seniors
Macknak, Kelsey	Saskatchewan Ministry of Health
Outhwaite, Harlie	Health Canada
Panait, Daniela	Health Canada
Pellerin, Annie	New Brunswick Department of Health
Pirie, Tyler	Canadian Centre on Substance Abuse
Rideout, Gina	Newfoundland and Labrador Department of Health and Community Services
Rocca, Claudio	Drug and Alcohol Treatment Information System (Ontario)
Ross, David	Veterans Affairs Canada, National Centre for Operational Stress Injuries
Ross, Pamela	Nova Scotia Department of Health and Wellness
Rush, Brian	Centre for Addiction and Mental Health
Weekes, John	Correctional Service Canada

²⁰ Membership is current as of February 12, 2015.



Appendix C: System Administration and Data Collection

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration ²¹	Data Systems	Browser-based System ²²	Reporting
N.L.	Department of Health and Community Services	Four regional health authorities	Y	CRMS (Client Referral Management System)	N	Annually (provincial level)
P.E.I.	Department of Health and Wellness	Health PEI (centralized provincial agency)	Y	ISM (Integrated System Management)	N	Annually
N.S.	Department of Health and Wellness	Nine district health authorities and the IWK Health Centre	IP	ASSist (Addiction Services Statistical Information System Technology)	Y	Real-time updates at regional and provincial levels
N.B.	Department of Health	Two regional health authorities	Y	RASS (Regional Addiction Service System)	N	Annually
Que.	Ministry of Health and Social Services	16 addiction rehabilitation centres 95 community health and social service centres Also through more than 100 inpatient private and community resources, either certified or in the process of certification or renewal	N	SIC-SRD (Système d'information clientèle pour les services de réadaptation en dépendance)	N	Annually
Ont.	Ministry of Health and Long-Term Care	14 LHINs (Local Health Integration Networks) Also through community agencies	Y	DATIS (Drug and Alcohol Treatment Information System)	Y	DATIS figures are reported quarterly and annually

²¹ Refers to the integration of mental health and substance use services at the administrative level: Y = yes; N = no; IP = in progress.

²² Refers to the ability to connect to a central data-collection system that allows all users to enter data directly from various locations and for the generation of summative reports.



Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration ²¹	Data Systems	Browser-based System ²²	Reporting
MB	Department of Healthy Living and Seniors (HLS) Department of Health	Addictions Foundation Manitoba and 11 provincial grant-funded agencies Adult residential withdrawal services and one residential treatment program are delivered through the two regional health authorities	N	HLYS statistical databases (SPSS-compatible) as well as an Excel-based system for provincial aggregate data	N	Data are provided monthly to the Addictions Management Unit by Addictions Foundation Manitoba and other provincially grant-funded addictions agencies Adult residential withdrawal management data are requested annually
SK	Saskatchewan Ministry of Health	12 regional health authorities	IP	ADG (Alcohol, Drugs and Gambling) System MHIS (Mental Health Information System) AMIS (Addiction and Mental Health Information System – Saskatoon Health Region)	N	
AB	Alberta Health and Wellness	Alberta Health Services Also through AHS community contracted services.	Y	ASIST (Addiction System for Information and Service Tracking) for AHS direct services	Y	Annually (provincial level)
				STORS (Service Tracking and Outcome Reporting System) for AHS contracted agencies	N	
BC	Ministry of Health Services	One provincial health authority and five regional health authorities	Y	AIMS (Addictions Information Management System) MRR (Minimum Reporting Requirements), which will integrate substance use and mental health, is in pilot stage	N	N/A at provincial level
YT	Ministry of Health and Social Services	Ministry has service delivery responsibility	N	Access database (manual data entry into an Excel file)	N	Monthly
NWT	Department of Health and Social Services	Eight health authorities	Y	Excel-based system (manual data entry)	N	Monthly



Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration ²¹	Data Systems	Browser-based System ²²	Reporting
NU	Department of Health and Social Services	Community health centres Also significant reliance on out-of-territory services	N	No client or system data (except financial) are currently collected systematically	N	N/A
CSC	Public Safety Canada	Five regions, including institutions and Aboriginal healing lodges	N	OMS (Offender Management System)	Y	
NNADAP / NYSAP	Health Canada's First Nations & Inuit Health Branch	Network of addiction treatment and prevention programming Includes 55 First Nations addiction treatment centres and more than 550 NNADAP community-based prevention programs	N	Currently developing a new data-collection system	N	
VAC	Veterans Affairs Canada	VAC district offices provide service referrals to 10 operational stress injury clinics across Canada as well as private service providers	Y	National Centre for Operational Stress Injuries conducts performance management for the 10 operational stress injury clinics	N	Quarterly and annually



Appendix D: Green, Yellow and Red Light Indicators

The following “green light” indicators were identified by National Treatment Indicators Working Group (NTIWG) as items that were either captured by existing jurisdictional data-collection mechanisms or could be reasonably be captured through modified mechanisms within the first or second year of the NTI project (i.e., 2009–2010 or 2010–2011).

- Total number of treatment episodes in public, specialized treatment services for substance use problems.
- Total number of treatment episodes in public, specialized treatment services for problem gambling.
- Total number of unique individuals treated in public, specialized treatment services for substance use problems.
- Total number of unique individuals treated in public, specialized treatment services for problem gambling.
- Total number of episodes and unique individuals treated in public, specialized treatment services by categories of residential withdrawal management, non-residential withdrawal management, residential treatment and non-residential treatment.
- Total number of episodes and unique individuals treated in public, specialized treatment services by gender, age and housing status, and within categories of residential withdrawal management, non-residential withdrawal management, residential treatment and non-residential treatment.
- Total number of episodes and unique individuals treated in public, specialized treatment services by injection drug status.
- Total number of individuals in opioid substitution treatment in public, specialized treatment services and external opioid substitution clinics.
- Total number of individuals served within driving-while-impaired programs.

The following “yellow light” indicators were identified by the NTIWG as items that may be available with some revisions to data collection or reporting mechanisms.

- Total number of episodes and unique individuals treated in public, specialized treatment services by drugs used.
- Total number of episodes and unique individuals treated in specialized treatment services by drug of principle concern (minimally alcohol/other drug and perhaps a small number of broader categories).
- Total number of episodes and unique individuals treated in public, specialized treatment services by employment status.



The following “red light” indicators are considered not feasible in the foreseeable future because of the need for significant revisions to data collection procedures or to considerable challenges in accessing the required data.

- Total number of episodes and unique individuals treated in public **and private** specialized treatment services by age and gender.
- Total number of episodes and unique individuals treated in public, specialized treatment services by frequency of drug use.
- Total number of episodes and unique individuals treated in public, specialized treatment services by age of first drug use.
- Total number of episodes and unique individuals treated in public, specialized treatment services by ethnic/cultural status.



Appendix E: Availability of Treatment Indicators by Jurisdiction

	YT	AB	SK	MB	ON	NS	N.L.	ACRDQ
Total number of treatment episodes	♦	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed by non residents	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed for self	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed for a friend or family member	--	♦	♦	♦	♦	♦	♦	--
Total number of treatment episodes (gambling)	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed by non residents (gambling)	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed for self (gambling)	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes accessed for a friend or family member (gambling)	--	♦	♦	♦	♦	♦	♦	--
Total number of individuals accessing treatment	♦	♦	♦	♦	♦	♦	♦	--
Non resident individuals accessing treatment	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment for their own substance use problem	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment for the substance use issue of a friend or family member	--	♦	♦	♦	♦	♦	♦	--
Number of new individuals accessing treatment	--	♦	--	♦	♦	♦	♦	--
Total number of individuals accessing treatment (gambling)	--	♦	♦	♦	♦	♦	♦	--
Non resident individuals accessing treatment (gambling)	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment for their own (gambling) problem	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment for a (gambling) problem of a friend or family member	--	♦	♦	♦	♦	♦	♦	--
Number of new individuals accessing treatment (gambling)	--	♦	--	♦	♦	♦	♦	--
Episodes by treatment type (i.e. RWM, NRWM, RT, NRT)	♦	♦	♦	♦	♦	♦	♦	--
Individuals by treatment type (i.e. RWM, NRWM, RT, NRT)	♦	♦	♦	♦	♦	♦	♦	--
Treatment episodes by gender	♦	♦	♦	♦	♦	♦	♦	--
Treatment episodes by housing status	--	♦	--	♦	♦	--	♦	--
Treatment episodes by age	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment by gender	♦	♦	♦	♦	♦	♦	♦	--
Individuals accessing treatment by housing stats	--	♦	--	♦	♦	--	♦	--
Individuals accessing treatment by age	--	♦	♦	♦	♦	♦	♦	--
Treatment episodes for injection drug use by gender	--	♦	♦	♦	♦	♦	--	--
Individuals accessing treatment for injection drug use by gender	--	♦	♦	♦	♦	♦	--	--
Individuals accessing opioid substitution treatment by gender	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing opioid substitution treatment by age	--	♦	♦	♦	♦	♦	♦	--
Individuals accessing methadone treatment by gender	--	♦	--	--	--	♦	--	--
Individuals accessing methadone treatment by age	--	--	--	--	--	♦	--	--
Individuals attending driving while impaired programs	--	--	--	♦	--	♦	♦	♦
Individuals attending driving while impaired programs by gender	--	--	--	♦	--	♦	♦	♦
Individuals attending driving while impaired programs by age	--	--	--	♦	--	♦	♦	♦



	YT	AB	SK	MB	ON	NS	N.L.	ACRDQ
Primary substance for which treatment is sought	--	◆	--	--	◆	◆	--	--
Primary substance for which treatment is sought by gender	--	◆	--	--	◆	◆	--	--
Primary substance for which treatment is sought by age	--	◆	--	--	◆	◆	--	--
Substances used in the past 12 months	--	◆	◆	◆	◆	◆	--	--
Substances used in the past 12 months by gender	--	◆	◆	◆	◆	◆	--	--
Substances used in the past 12 months by age	--	◆	◆	◆	◆	◆	--	--
Treatment episodes by employment status	--	◆	◆	◆	◆	◆	--	--
Individuals accessing treatment by employment status	--	◆	◆	◆	◆	◆	--	--
Legend: ◆ Available -- Unavailable								



Appendix F: Definitions

Closed case

Closure criteria vary from province to province.

Driving-while-impaired (DWI) programs

Including education programs as well as treatment and rehabilitation programs, DWI programs are typically mandated by the court for those who plead guilty or are found guilty of an impaired-driving offence. Participation in such programs is typically a condition of license reinstatement. The content and administration of such programs vary among jurisdictions.

Employment status

Employment statuses include employed full-time, employed part-time, student, unemployed and other (e.g., retired, unpaid labour, employment assistance/insurance, disability, leave of absence).

Episode²³

An episode refers to admission to a specific treatment service. One person might access several services over the course of a year (for example, by transferring from withdrawal management to non-residential treatment or leaving and re-entering services) and therefore have multiple episodes.

Family member

Family member is broadly described to include a child, parent, spouse, significant other and other close relations.

Gambling

Gambling is the act of risking money, property or something else of value on an activity with an uncertain outcome. There are a variety of venues where gambling takes place and includes:

- Games at a casino such as blackjack or slot machines;
- Betting on horses at a racetrack;
- Lotteries;
- Video lottery terminals (typically found in bars and restaurants);
- Betting on sports games, including private betting among acquaintances, betting with a bookie or through an organization such as Pro Line;
- A poker game or other such card game played in private residences with acquaintances or in a gaming venue; and
- Online games where a player pays a fee to join and can either win or lose money.

Housing status

Housing status refers to whether an individual reports a fixed address or not.

²³ Variation in jurisdictional data collection remains for this indicator. For example, some systems count a new episode when a new system component or category of service is accessed while others limit new episodes to individuals entering the system as a whole.



New individuals

Unique people that began treatment during the current reporting year. This number would therefore exclude individuals with a treatment episode that began in the previous fiscal year.

Non-residential treatment

Non-residential treatment refers to all remaining services that are not included in either detoxification or residential categories. This category includes outpatient services as well as services offered by facilities such as halfway houses, youth shelters, mental health facilities or correctional facilities where the primary purpose of residence is not substance use service provision. Non-residential treatment excludes withdrawal management or detoxification services.

Open case

A case opens when a client is officially registered. This is most often done face to face, but can also be done remotely (e.g., over the phone), especially in rural areas.

Problem gambling

Problem gambling is gambling behaviour that leads to negative consequences for the gambler, others in his or her social network, or the community.

Residential treatment

Residential treatment refers to programs in which overnight accommodation is provided for the purpose of substance use or gambling treatment. This does not include programs delivered in settings such as youth shelters, homeless shelters, prison facilities or mental health facilities where the primary purpose of residence is to address needs such as mental health, housing or public safety.

Specialized services

Specialized services have a mandate to provide alcohol, other drug and/or gambling treatment programs and services. Tobacco is not included.

Unique individual

A unique individual refers to a single person. One unique individual might have several treatment episodes over the course of a year.

Withdrawal management

Withdrawal management refers to the initial supervised, controlled period of withdrawing substances of abuse. Only withdrawal services that are part of a continuum (i.e., including counselling or aftercare) should be recorded; this does not include ambulatory services or brief detox. **Residential withdrawal management** includes programs where clients spend nights at the treatment service facility. **Non-residential withdrawal management** includes social detox, daytox and home detox.



Appendix G: Substance Categories

Category	Examples
Alcohol	beer, wine, liquor, cider, coolers
Cannabis	marijuana, hashish, hash oil
Cocaine	cocaine powder, crack
Opioids²⁴	morphine, codeine, heroin, fentanyl, methadone, opium, Oxycontin
Stimulants (excluding cocaine)	amphetamines, methamphetamines, ecstasy, methylphenidate
Hypnotics and sedatives	tranquillizers, anti-depressants, barbituates, benzodiazepines, GHB, methaqualone
Hallucinogens	LSD, mushrooms, PCP, mescaline, salvia, ketamine
Inhalants and solvents	gasoline, glue, hairspray, aerosols, household cleaners, paint thinner
Steroids/Performance Enhancing Drugs	human growth hormone, testosterone, winstrol, dianabol
Over the Counter Medication	antihistamine, ASA (Aspirin), ephedrine
Prescription Drugs²⁵	Concerta, Ritalin, Adderall, Dexidrine,
Other drugs	non-beverage alcohol

²⁴ Includes prescription opioids.

²⁵ Excludes prescription opioids.