A Systems Approach

to Substance Use Services & Supports in Canada

> National Treatment Indicators Report, 2012

CCSA - CCLAT

Canadian Centre on Substance Abuse

This document was published by the Canadian Centre on Substance Abuse (CCSA).

Suggested citation: Beasley, E., Jesseman, R., Patton, D., & National Treatment Indicators Working Group. (2012). *National Treatment Indicators report, 2012*. Ottawa, ON: Canadian Centre on Substance Abuse.

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This document can also be downloaded as a PDF at www.ccsa.ca

Ce document est également disponible en français sous le titre :
Rapport sur les indicateurs nationaux de traitement 2012

ISBN - 978-1-926705-83-5

> Executive Summary

This inaugural National Treatment Indicators report—prepared by the Canadian Centre on Substance Abuse collaboratively with the National Treatment Indicators Working Group (NTIWG)—is intended as a first step toward addressing the current gap in substance use treatment data at the national level. The NTIWG consists of representatives from the provinces and territories, as well as from federal agencies responsible for service delivery.[1] This report presents data submitted by six provinces and one federal agency on not only specialized substance use services, but also on gambling services where such information could readily be distinguished.

Accurate and current information about how the system is being used is an important part of an effective planning process. Canada currently does not collect national-level data on substance use treatment. Although all provinces, territories and federal agencies collect data on their own treatment systems, the guidelines and definitions used vary considerably. This lack of comparable information means there is no reliable information base that can be used to identify and respond to system-level trends in the services being provided and the populations accessing them. The gap in national-level information also restricts Canada's ability to provide meaningful data to initiatives addressing the health and social impacts of substance use at the international level.

The purpose of the National Treatment Indicators project is to provide a comprehensive national picture of treatment in Canada with basic data such as the number of people who access treatment, their basic demographic characteristics (e.g., age, gender), and the kind of treatment accessed. The data presented illustrate the potential wealth of information that could be available as the project continues to improve data collection and gain broader participation. The benefits of collecting national-level data include, for example:

- Informing the business case for investing in services and supports for people with substance use problems;
- Indicating patterns and trends in service use and population characteristics;
- Measuring and monitoring the impact of system change;
- Facilitating the evaluation of specific strategies or programs at regional, provincial/territorial or national levels; and
- Supporting coordination and collaboration across provincial, territorial, federal and international systems.

The results of this report provide useful information about the system, such as the fact that males are more likely than females to access services, more people access non-residential services than residential services (with the exception of withdrawal management), and people receiving services are most likely to be between 25 and 54 years of age.

The results also have implications for system development and resourcing—in particular, the importance of collaboration between jurisdictions and sectors. For example, the results indicate that about 7–13% of individuals accessing services are doing so because of the impact of someone else's substance use—information that highlights the broad impact that substance use has not just on the individual, but also on those around him or her. The data also indicate that there is a small but consistent number of individuals accessing services outside their own jurisdiction, which has implications for both resourcing and system navigation. Finally, the data available on individuals with no fixed address indicate that they make up a disproportionate number of clients accessing residential withdrawal services, highlighting the need for a close relationship between these services and the housing sector.

[1] Appendix A lists the members of the National Treatment Indicators Working Group.

As this inaugural National Treatment Indicators report is the first step toward documenting consistent national information, there are limitations to the data presented and to the extent to which analysis and comparison can be conducted. For example, incomplete data submission and differences in definitions mean that the data cannot provide a total number of Canadians accessing services or an average rate of admissions across jurisdictions. The intentions of presenting this information collected at the beginning of the collaboration process, despite its limitations, are to share the information available and to indicate the project's potential.

The current report is also limited to information on the public specialized treatment sector. However, many Canadians access services and supports outside that sector (for example, through hospital, private, primary care, peer-led and community providers). One of the long-term goals of the NTIWG is to expand data collection beyond the specialized system and into the broader range of non-specialized and community-based services.

Because this report is the first in what will become an annual series, it provides a comprehensive introduction outlining the substance use service context in Canada and the development of the National Treatment Indicators before moving on to the results of the data collection. The intention of the National Treatment Indicators project is to continue working to improve the consistency and scope of data reported over time. Future reports will therefore present a more extensive analysis and interpretation of results.

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List of Acronyms

General:

n	Number
DWI	Driving while impaired
N/A	Not applicable
NFA	No fixed address

Canadian organizations and jurisdictions:

AB	Alberta
AFM	Addictions Foundation Manitoba
AHS	Alberta Health Services
AMU	Addictions Management Unit (Manitoba)
BC	British Columbia
CAMH	Centre for Addiction and Mental Health
CCSA	Canadian Centre on Substance Abuse
CIHI	Canadian Institute for Health Information
CRD	Addiction Rehabilitation Centres (Quebec)
CSC	Correctional Service Canada
CSSS	Community Health and Social Service Centres (Quebec)
DHA	District Health Authority
LHIN	Local Health Integration Network (Ontario)
MB	Manitoba
NB	New Brunswick
NL	Newfoundland and Labrador
NNADAP	National Native Alcohol and Drug Abuse Program
NS	Nova Scotia
NU	Nunavut
NWT	Northwest Territories
ON	Ontario
PEI	Prince Edward Island
PHSA	Provincial Health Services Authority (British Columbia)
QC	Quebec
RHA	Regional Health Authority
SK	Saskatchewan
VAC	Veterans Affairs Canada
YT	Yukon

List of Acronyms (cont'd)

Canadian data collection:

ADG	Alcohol, Drugs and Gambling System
AIMS	Addictions Information Management System
ASIST	Addiction System for Information and Service Tracking
ASsist	Addiction Services Statistical Information System Technology
CADUMS	Canadian Alcohol and Drug Use Monitoring Survey
CCENDU	Canadian Community Epidemiology Network on Drug Use
CRMS	Client Referral and Management System
DATIS	Drug and Alcohol Treatment Information System
DART	Drug Abuse Registry of Treatment
ISM	Integrated System Management
MHIS	Mental Health Information System
MMR	Minimum Reporting Requirements
NTI	National Treatment Indicators
NTIWG	National Treatment Indicators Working Group
OMS	Offender Management System
RASS	Regional Addiction Service System
SIC-SRD	Customer Information System for Rehabilitation Services in Addictions
SPSS	Statistical Package for the Social Sciences
STORS	Service Tracking and Outcome Reporting System

International:

AIHW	Australian Institute of Health and Welfare
AOTDS	Australian Alcohol and Other Drug Treatment Services
CICAD	Inter-American Drug Abuse Committee
DASIS	Drug and Alcohol Services Information System (United States)
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
EU	European Union
NDTMS	National Drug Treatment Monitoring System (United Kingdom)
NMDS	National Minimum Data Set (Australia)
NTA	National Treatment Agency (United Kingdom)
PAHO	Pan-American Health Organization
SAMHSA	Substance Abuse and Mental Health Service Administration
TEDS	Treatment Episode Data System (United States)
TDI	Treatment Demand Indicator (European Union)
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

> Introduction

Case study: A regional health authority (RHA) providing services for an urban centre is determining where to invest additional money to improve substance use treatment. Local program managers share data indicating that the number of older adults accessing opioid withdrawal management services has increased. The RHA is able to use this information to justify investing in a withdrawal management program targeting the needs of older adults. These data are also rolled up at the provincial level, where a similar trend is found and the issue is raised as a possible priority for a new mental health and addiction strategy that is being developed. The data is also shared at the national level, where comparisons with data in other jurisdictions illustrate that the trend appears to be moving from eastern to western provinces. Project leads in the west are then able to connect to colleagues in the east to share lessons learned and identify ways to address the trend.

Alcohol and other drug use is a significant health, economic and social issue in Canada, with more than 75% of the adult population considered current drinkers and more than 10% of Canadians age 15 and older reporting the use of cannabis (CADUMS, 2010). Furthermore, use of cannabis and other illegal drugs is higher among youth. For example, more than 25% of youth ages 15–24 reported the use of cannabis in the past year (CADUMS, 2010). Although many people are able to use alcohol and other substances without experiencing harm, there is a small percentage of people for whom the use of these substances creates a variety of legal, social and health problems—the consequences of which can be costly to the individual and society. The most recent estimates conservatively indicate that the annual social and economic costs related to substance use are $14.6 billion for alcohol and $8.2 billion for illicit drugs (Rehm et al., 2006).

One way to address these costs is by ensuring that Canadians with substance use problems are able to access effective, evidence-based services and supports. Public accountability requires that dollars be spent effectively. Reliable data on program and system operations, clients and population need is required to inform strategic planning.

Some key questions need to be answered to inform system planning: *How many Canadians access specialized services for substance use in a given year? What are current or emerging trends or patterns in service use?* Canada does not consistently collect the information needed to answer these questions.

Key informant interviews conducted in 2011 by the Centre for Addiction and Mental Health (CAMH) with representatives from provincial and territorial bodies responsible for funding and delivering services found that *"effective planning is greatly limited by the lack of a detailed understanding of which substance use service doors—including doors in other sectors—are open to clients, how many individuals are walking through them and with what types of issues."* (Health Systems and Health Equity Research Group, 2011)

Our best estimates indicate, though, that only a small minority of those who could potentially benefit from services do, in fact, access them (National Treatment Strategy Working Group, 2008).

We know that better, more consistently collected data at all levels are needed to support the business case for investing in substance use services, and to ensure that the system is operating effectively and efficiently in a way that is responsive to population needs and trends. With improvements in

information technology, there are new opportunities to collect and share system information in a relatively cost-efficient manner.

In addition, many jurisdictions at regional, provincial/territorial and national levels have recently launched, or are in the process of developing, new programs and strategies to address substance use. Data collection is a necessary part of monitoring the service impact of these programs and strategies to ensure continuous quality improvement. Reporting on the data collected is also an important means of ensuring transparency and increasing awareness of the services provided for substance use and gambling in Canada.

Jurisdiction refers to all federal, provincial/territorial, First Nations, Inuit and Métis authorities that have stewardship over systems that provide services and supports for substance use.

> Administrative Context[2]

In Canada, the administration and delivery of health care 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 in the form of fiscal transfers. Treatment for substance use and gambling is included in the umbrella of health care services. There are also federal agencies that provide treatment for specific populations, including Correctional Services 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 and Youth Solvent Addiction Program for First Nations and Inuit people and communities.

Jurisdictional autonomy means that jurisdictions can tailor their health care systems to best meet the unique needs of their populations. However, autonomy also results in a number of interjurisdictional differences in how services are funded and/or delivered, impacting the range of available

Data collection in other countries:

In an effort to improve the effectiveness and efficiency of substance abuse treatment programs and associated delivery systems, several regions and countries around the world, including the United Kingdom (NDTMS), Australia (AOTDS-NMDS) and the United States (TEDS/DASIS), already collect data from their networks of substance abuse treatment providers based on a number of common treatment indicators. These data are used to prepare short reports, advisories and news releases that provide valuable information on the cost savings achieved through treatment, on emerging trends, and on issues of interest. Through these targeted reports, data therefore support a more accurate understanding of substance use at public and political as well as system-planning levels. While each system is unique in its construction, definitions and output, one benefit of developing National Treatment Indicators for Canada is facilitated collaboration and knowledge sharing between Canada and other jurisdictions. Appendix B provides additional information about data-collection systems in other countries.

[2] This report provides a brief summary; a more detailed explanation can be found in CAMH's *Development of Needs-Based Planning Models for Substance Use Services and Supports in Canada: Current Practices* (2011).

treatment options. For example, provinces and territories may contract services through regional health authorities or directly with service agencies. Substance use may be completely distinct from or integrated with mental health, or somewhere in between. Although all jurisdictions collect information to monitor system activities and performance, the nature and sophistication of these efforts varies substantially. Due to this variation and the variation in system structure and program delivery, the data collected are often not comparable across jurisdictions.

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 include national treatment data. As an international leader in health care, Canada should be able to meet these requirements in a timely and meaningful manner; however, much of the information Canada currently provides on substance use services is 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. The National Treatment Indicators (NTI) project is a necessary step in building Canada's capacity to provide meaningful, reliable information on national substance use services to the international level.

There are tremendous opportunities for collaboration and coordination between jurisdictions that can result in more effective use of resources and better client outcomes. A data source based on consistently collected information will provide the common information base needed as a foundation to support these opportunities.

Enhanced data-collection capacity and quality—at all levels across Canada—are needed to:

- Support the business case for investing in services and supports for people with substance use problems;
- Better assess the capacity of systems at all levels to respond to demand and determine the access barriers experienced by certain populations;
- Measure and monitor the impact of system change;
- Facilitate the evaluation of specific strategies or programs at regional, provincial/territorial or national levels;
- Assist in the identification of trends in the characteristics of people seeking services;
- Provide an indicator of emerging patterns of substance use and associated problems;
- Provide guidance and assistance in the ongoing development of broader health and social service information systems through increased collaboration and communication;
- Provide valid comparisons between national and jurisdictional levels to inform quality improvement and planning; and
- Contribute reliable, pan-Canadian information to international data-collection initiatives.

> Methods

Current Jurisdictional Data Systems

A variety of different systems and processes are currently used to collect information about treatment services in jurisdictions 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, RHAs 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 to be provided to funders also vary. Across the provinces, there are a number of differences in terms of the quality and quantity of information being collected, the format in which it is recorded, and its availability. A number of provinces are now reviewing their information systems with the intention of improving them, creating an opportune time to promote the use of a core group of comparable indicators across jurisdictions.

Table 1 provides an overview of data-collection systems currently in place across Canada, including the ministry responsible for overseeing service provision at the jurisdictional level, and whether or not the system is administratively integrated with mental health. The table also lists the data systems used for collection and whether or not they are browser-based—meaning that data entry or retrieval can be accessed remotely through the Internet or an internal network.

TABLE 1. Current Services and Data-collection Systems

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[3]	Data Systems	Browser-based System[4]	Reporting
AB	Alberta Health and Wellness	Alberta Health Services (single health authority) Also through a variety of private and community agency providers	Y	ASIST (Addiction System for Information and Service Tracking) for directly funded services STORS (Service Tracking and Outcome Reporting System) for contracted agencies	Y	Annually (provincial level)
BC	Ministry of Health Services	One provincial health authority and five regional health authorities	Y	AIMS (Addictions Information Management System) MMR (Minimum Reporting Requirements), which will integrate substance use and mental health, is in pilot stage	N	N/A at provincial level

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

[4] 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[3]	Data Systems	Browser-based System[4]	Reporting
MB	Department of Healthy Living, Youth and Seniors	Addictions Foundation Manitoba and other provincial grant-funded agencies (number varies)	N	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 provincially funded agencies
NB	Department of Health	Two regional health authorities	Y	RASS (Regional Addiction Service System)	N	Annually
NL	Department of Health and Community Services	Four regional health authorities	Y	CRMS (Client Referral Management System)	N	Annually
NWT	Department of Health and Social Services	Eight health authorities	Y	Excel-based system (manual data entry)	N	Monthly
NS	Department of Health and Wellness	Nine district health authorities and the IWK Health Centre	Y	ASsist (Addiction Services Statistical Information System Technology)	Y	Real-time updates at regional and provincial levels
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
ON	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) Connex Ontario[5] also captures a large amount of service and client data	Y	DATIS figures are reported quarterly and annually

[5] Previously known as DART (Drug Abuse Registry of Treatment).

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[3]	Data Systems	Browser-based System[4]	Reporting
PEI	Department of Health and Wellness	Health PEI (centralized provincial agency)	Y	ISM (Integrated System Management)	N	Annually
QC	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 (Customer Information System for Rehabilitation Services in Addictions)	N	Annually
SK	Saskatchewan Ministry of Health	12 regional health authorities	IP	ADG (Alcohol, Drugs and Gambling) system MHIS (Mental Health Information System) that track clients and services	N	
YT	Ministry of Health and Social Services	Ministry has service delivery responsibility	N	Access database (manual data entry into an Excel file)	N	Monthly
NNA DAP	Health Canada's First Nations & Inuit Health Branch	49 adult and nine youth residential treatment centres More than 500 community-based agencies across Canada	N	Currently developing a new data-collection system	N	
CSC	Public Safety Canada	Five regions, including institutions and Aboriginal healing lodges	N	OMS (Offender Management System)	Y	
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

The Development of Canadian National Treatment Indicators

The purpose of the National Treatment Indicators project is to provide a comprehensive national picture of treatment in Canada through annual reports with data such as the number of people who access treatment, their basic demographic characteristics (e.g., age, gender), and the kind of treatment accessed. As the project continues, this information will also be used to identify and monitor trends. Knowing how the current system is being used is a key component of effectively planning system development.

In 2001, the Canadian Institute for Health Information (CIHI) identified a significant gap between the information that was required to monitor the substance use treatment system and the information that was available (CIHI, 2001). Similarly, in 2005, a national scan on treatment indicators in Canada conducted by the Canadian Center on Substance Abuse (CCSA) indicated the need to enhance data collection and reporting across the country (Thomas, 2005).

The *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada* (2005) identified improving treatment systems as one of 13 priorities.[6] The report *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*, released in 2008, was developed to respond to the treatment priority. The report focuses on the need for a comprehensive continuum of services and supports, ranging from prevention and early intervention, to short- and long-term residential programs and other specialized services where clients are removed from their environment to focus on achieving treatment goals. The report emphasizes the need to move from the traditional focus on the specialized substance use system to the broader range of non-specialized and community-based services that are more likely to be accessed by Canadians. In order to support the development of the service continuum, the Systems Approach report also includes recommendations for measuring and monitoring system performance.

To move the system performance recommendations ahead, the National Treatment Indicators Working Group (NTIWG) was subsequently established in 2009 by CCSA, through funding provided by Health Canada's Drug Treatment Funding Program (DTFP). The NTIWG consists of representatives from the provinces and territories, federal departments with treatment delivery responsibility, and national organizations involved in data collection. (See Appendix A for the NTIWG membership list.) The current NTIWG also had the benefit of building on the work conducted by a previous group that contributed to the development of the Systems Approach report.[7]

The NTIWG developed a list of possible indicators on which to collect data, classifying them into 'green light', 'yellow light' and 'red light' indicators. The green light (or core) indicators were either currently available or could reasonably be captured through modified data collection or reporting mechanisms in the first two years of this project. The yellow light indicators were those that may be available over the next several years with revisions to current data collection or reporting mechanisms. The red light indicators were those that are not feasible in the foreseeable future due to the need for significant revisions to data collection or to considerable challenges in accessing the required data. (See Appendix C for the complete list of green, yellow and red light indicators.)

The green light indicators were piloted using historical data, revised, and then used to guide current-year data collection for fiscal year 2009–10. All indicators are at the aggregate level; no individual client data is provided to CCSA and any cell counts that are low enough to allow individual identification are suppressed. The collection of additional indicators currently classified as yellow and red will be explored as the project progresses. As the project is beginning with the data that is currently most accessible, the indicators focus on specialized services. Over time, the intention of the project is to better capture information about non-specialized services through capacity building within the NTIWG and through partnerships with other organizations such as CIHI. Gambling information is also provided in the report where it was readily available.[8]

[6] The report is also accompanied by the guidance document *Applying a Sex/Gender/Diversity-based Analysis*, authored by Colleen Dell and Nancy Poole and published by CCSA in 2009.

[7] Additional information on the National Treatment Indicators Working Group is available at www.ccsa.ca/Eng/Priorities/Treatment.

[8] In many jurisdictions, services for gambling and substance use are under the same administrative envelope. The NTIWG agreed to include gambling data separately where it was available for information purposes at this time, but to maintain an overall focus on substance use. There are many other initiatives with an exclusive gambling focus that contain information and interpretation beyond the scope of this report.

Green light indicators

1. Total number of treatment episodes in public, specialized treatment services for substance use problems.
2. Total number of treatment episodes in public, specialized treatment services for problem gambling.
3. Total number of unique individuals treated in public, specialized treatment services for substance use problems.
4. Total number of unique individuals treated in public, specialized treatment services for problem gambling.
5. 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.
6. 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.
7. Total number of episodes and unique individuals treated in public, specialized treatment services by injection drug status.
8. Total number of individuals in opioid substitution treatment in public, specialized treatment services and external opioid substitution clinics.
9. Total number of people served within driving-while-impaired education programs.

Limitations

Developing a list of common core indicators presents many challenges. As a result, there are several limitations to the current data, which are noted in the explanations and footnotes provided throughout the report. These 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, limitations to be considered when reviewing the data include:

Services included: The data represent only publicly funded and specialized services. Data from non-specialized services such as hospitals or rapid detoxification are not included. Further, many addiction clients also have a multitude of other health-related issues that may be the cause of their contact with the health care system; addictions treatment in primary health care contexts is not captured here. Privately funded treatment providers operate independently and are under no obligation to provide data to the jurisdictions or any federal authority. As the NTI project evolves, CCSA hopes to engage with a broader scope of service providers in order to better capture data that reflect the full continuum of services provided in Canada.

Jurisdictional participation: The inaugural report is based on data submitted by seven of a possible 16 administrative jurisdictions (provinces, territories and federal departments). Some jurisdictions were unable to participate for capacity reasons, while others were still in the process of finalizing data-sharing agreements. CCSA and the NTIWG will continue to work with all jurisdictions to increase data submission in future years.

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 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. As more jurisdictions move toward more clearly defined standards of care, the core indicator definitions can be revisited 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 'open' at first contact, whereas others wait until the formal intake

process is completed. Similarly, different jurisdictions 'close' cases at different times, and there are differences in recording and following up with clients who have not formally completed service. These 'opening' and 'closing' variations impact the number of active cases at any given time.

> Results

The following tables present the numbers reported for each indicator in fiscal year 2009–10 by the jurisdictions able to provide data. In this inaugural data-collection year, data were provided by Alberta, Correctional Services Canada, New Brunswick, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan. CCSA is working with the other jurisdictions to increase data submission in future years. Not all jurisdictions were able to provide data for each indicator consistent with the data-collection definitions (see Appendix D) and protocols.[9] Data was included in the report to the extent possible despite some variations from the protocols, with these variations noted accordingly as footnotes to each indicator.

Due to the extent of limitations in this inaugural report, data should not be considered comparable across jurisdictions (in particular, where footnotes are provided). For this reason, summary information such as totals and averages are not included in the data tables. Data that are suppressed due to small numbers (less than five, or less than 20 in New Brunswick) are indicated by an asterisk. Data suppression in these cases is intended to ensure that no individuals can be identified through the aggregate-level information reported. Blank cells indicate that data were not available.

Interpretation of these results should also be guided by recognition that the number of people receiving substance use and gambling 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. For example, a high-profile public campaign for gambling services may result in an increase in referrals and rates of treatment in one jurisdiction, despite no change in the actual baseline rate of gambling problems.

The data presented are not intended to be examined in isolation, but as significant contributions to the information available about substance use and its impacts in Canada, including, for example, CADUMS information on self-reported rates of substance use in the population and CIHI information about hospital-based discharges associated with substance use.

Commentary on the data provided in this report is limited. The intention of this report is to indicate the potential of the project through presenting the information collected at the beginning of the collaboration process. The goal of the NTIWG is to decrease data limitations and increase discussion of trends and implications in future reports.

[9] The complete data collection protocols are available from www.nts-snt.ca/Eng/NationalPicture/NationalTreatmentIndicators.

Indicator 1:

Total number of treatment episodes in public, specialized treatment services for substance use problems

Indicator 2:

Total number of treatment episodes in public, specialized services for problem gambling

Indicators 1 and 2 are presented together in the interest of brevity. The unit of analysis for both indicators is treatment episodes (i.e., the number of admissions to service). A single individual can have a number of service episodes over the course of the year.

TABLE 2. Treatment Episodes for Substance Use and Gambling Services, 2009–10

Jurisdiction	Indicator 1: Substance Use		Indicator 2: Gambling	
	n	Rate/100,000	n	Rate/100,000
AB[10]	52,637	1,434.0	2,592	70.6
NB	9,125	1,217.8	511	68.2
NS	14,727	1,568.2	607	64.6
ON	107,753	824.8	6,354	48.6
PEI	3,261	2,311.1	36	25.5
SK[11]	20,189	1,961.8	388	37.7
CSC[12]	2,719	11,952.2	N/A	N/A

Note: Population estimates used to calculate rate per 100,000 are based on Stats Canada 2009 estimates for the entire population of a jurisdiction (available at: www40.statcan.ca/l01/cst01/demo02a-eng.htm). CSC population was drawn from the 2009 *Corrections and Conditional Release Statistical Overview* (available at: www.publicsafety.gc.ca/res/cor/rep/2009-ccrso-eng.aspx).

[10] AHS direct and contracted/funded services. Clients may cite multiple reasons for treatment. The number for Indicator 1 excludes 'gambling only' episodes. The number for Indicator 2 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=662).

[11] 'Problem related to' is not completed by service providers in every instance.

[12] As of January 2010, the Pacific Region of CSC has implemented a pilot of the Integrated Correctional Program Model, which focuses on all aspects of the offender's criminal behaviour but is not a specialized substance abuse treatment program. As such, offenders enrolled in the Integrated Correctional Program Model will not be included in these data.

In some cases, usually when services are not available within a given jurisdiction, individuals may receive treatment in a jurisdiction in which they do not live. Four jurisdictions were able to provide the number and percentage of episodes where treatment was received by clients outside the jurisdiction. The figures for substance use services are consistently low, while there appears to be greater variation for gambling services.

TABLE 3. Substance Use and Gambling Episodes from Outside Jurisdiction, 2009–10

Jurisdiction	Indicator 1: Substance Use		Indicator 2: Gambling	
	n	%	n	%
AB[13]	840	1.6	255	9.8
NB	145	1.6	*	1.6
NS	37	0.3	*	
SK[14]	174	0.1	0	0

Several jurisdictions were also able to report the number of episodes in which services were sought for someone else (e.g., a family member) rather than the individual with a substance use or gambling problem. The rate of episodes where clients received services for someone else's substance use or gambling issues was generally between 5–10% with some variation.

TABLE 4. Non-self Episodes for Substance Use and Gambling, 2009–10

Jurisdiction	Indicator 1: Substance Use		Indicator 2: Gambling	
	n	%	n	%
AB[15]	5,250	10.0	249	9.6
NS	819	5.6	63	10.4
ON	5,226	4.9	1,380	21.7
PEI	192	5.9	33	8.3
SK[14]	1,376	6.8	36	9.3

[13] AHS direct and contracted/funded services. Clients may cite multiple reasons for treatment. The number for Indicator 1 excludes 'gambling only' episodes. The number for Indicator 2 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=662).

[14] 'Problem related to' is not completed by service providers in every instance.

[15] AHS direct and contracted/funded services. Clients may cite multiple reasons for treatment. The number for Indicator 1 excludes 'gambling only' episodes. The number for Indicator 2 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=339).

Indicator 3:

Total number of unique individuals in public, specialized treatment services for substance use problems

Indicator 4:

Total number of unique individuals in public, specialized services for problem gambling

Indicators 3 and 4 are also presented together in the interest of brevity. For each indicator, unique individual is the unit of analysis. Each individual who received services is counted only once, regardless of the number of admissions to service.

TABLE 5. Unique Individuals for Substance Use and Gambling Services, 2009–10

Jurisdiction	Indicator 3: Substance Use		Indicator 4: Gambling	
	n	Rate/100,000	n	Rate/100,000
AB[16]	34,853	949.5	1,965	53.5
NB	5,994	799.9	376	50.2
NS	9,514	1,013.1	543	57.8
ON	69,766	534.0	5,954	45.6
PEI	2,625	1,860.3	33	23.4
SK[17]	14,694	1,427.9	340	33.0
CSC	2,640	11,604.9	N/A	N/A

Note: Population estimates used to calculate rate per 100,000 are based on Stats Canada 2009 estimates for the entire population of a jurisdiction (available at: www40.statcan.ca/l01/cst01/demo02a-eng.htm). CSC population was drawn from the 2009 *Corrections and Conditional Release Statistical Overview* (available at: www.publicsafety.gc.ca/res/cor/rep/2009-ccrso-eng.aspx).

[16] AHS direct services only. Clients may cite multiple reasons for treatment. The number for Indicator 3 excludes 'gambling only' episodes. The number for Indicator 4 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=563).

[17] 'Problem related to' is not completed by service providers in every instance.

Consistent with the trend seen in the episode data, the percentage of individuals receiving substance use services that are from outside the province/territory is consistently low, with somewhat greater variation for gambling services.

TABLE 6. Individuals for Substance Use and Gambling Treatment from Outside Jurisdiction, 2009–10

Jurisdiction	Indicator 3: Substance Use		Indicator 4: Gambling	
	n	%	n	%
AB[18]	325	0.9	200	10.2
NB	130	2.2	*	1.2
NS	32	0.3	*	*
SK[19]	126	0.8	0	0

The percentage of individuals receiving services for someone else's substance use and/or gambling problems was fairly consistent in the range of 7–13%.

TABLE 7. Non-self Individuals for Substance Use and Gambling Services, 2009–10

Jurisdiction	Indicator 3: Substance Use		Indicator 4: Gambling	
	n	%	n	%
AB[20]	4,576	13.1	226	11.5
NS	793	8.3	63	11.6
ON	5,029	7.2	1,323	22.2
PEI	183	7	0	0
SK[19]	1,283	8.7	36	10.5

Several jurisdictions were able to identify the percentage of cases that were new in the 2009–10 fiscal year rather than cases continued from the previous year. New admissions represent the majority of cases reported.

TABLE 8. New Individuals for Substance Use and Gambling, 2009–10

Jurisdiction	Indicator 3: Substance Use		Indicator 4: Gambling	
	n	%	n	%
AB[21]	28,853	82.8	1,597	81.3
NB	1,959	32.7	177	47.1
NS	7,073	74.3	388	71.5
ON	45,637	65.4	3,334	56
PEI	2,058	79.6	0	0
CSC	2,152	81.5	N/A	N/A

[18] AHS direct services only. Clients may cite multiple reasons for treatment. The number for Indicator 3 excludes 'gambling only' episodes. The number for Indicator 4 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=563).

[19] 'Problem related to' is not completed by service providers in every instance.

[20] AHS direct services only. Clients may cite multiple reasons for treatment. The number for Indicator 3 excludes 'gambling only' episodes. The number for Indicator 4 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=303).

[21] AHS direct services only. Clients may cite multiple reasons for treatment. The number for Indicator 3 excludes 'gambling only' episodes. The number for Indicator 4 includes episodes for 'gambling only' as well as episodes where the client cited 'gambling combined with substance use'. For both indicators, numbers **exclude** admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=563).

Tables 9 and 10 present the ratio of service episodes (Indicator 1) to the number of individuals receiving services (Indicator 3) in 2009–10 as well as the percentage of individuals with more than one episode. The data indicate many individuals access services more than once over the course of the year. Service access could refer to the same service or different types of services within the system. Caution should be used in interpreting this data without additional information. For example, a small number of individuals accessing many services over the course of the year would increase the overall ratio.

TABLE 9. Ratio of Episodes (Substance Use) to Individuals, 2009–10

Jurisdiction	Number of Episodes: Individuals	Ratio
AB[22]	44,562 : 34,853	1.3
NB	9,125 : 5,994	1.52
NS	14,727 : 9,514	1.54
ON	107,753 : 69,766	1.54
PEI	3,261 : 2,625	1.24
SK[23]	20,189 : 14,694	1.37
CSC[24]	2,719 : 2,640	1.02

TABLE 10. Ratio of Episodes (Gambling) to Individuals, 2009–10

Jurisdiction	Number of Episodes: Individuals	Ratio
AB[25]	2,278 : 1,965	1.2
NB	511 : 376	1.35
NS	607 : 543	1.11
ON	6,354 : 5,954	1.07
PEI	36 : 33	1.09
SK[23]	388 : 340	1.14

[22] AHS direct services only. Clients may cite multiple reasons for treatment. The counts for episodes and individuals **exclude** 'gambling only' as the reason for treatment, as well as cases where the client cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=563).

[23] 'Problem related to' is not completed by service providers in every instance.

[24] As of January 2010, the Pacific Region of CSC has implemented a pilot of the Integrated Correctional Program Model, which focuses on all aspects of the offender's criminal behaviour but is not a specialized substance abuse treatment program. As such, offenders enrolled in the Integrated Correctional Program Model will not be included in these data.

[25] AHS direct services only. Clients may cite multiple reasons for treatment. The counts for episodes and individuals include 'gambling only' as the reason for treatment, as well as cases where the client cited 'gambling combined with substance use'. Numbers **exclude** cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=563).

Indicator 5:

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[26]

Looking at the distribution of clients and episodes across service categories provides a more complete picture of how the treatment systems are operating. The four broad categories of residential withdrawal management, non-residential withdrawal management, residential treatment and non-residential treatment (see Appendix D for definitions) are applied because they represent distinctions in service focus and operation, and are the categories used in most jurisdictions for data collection and monitoring.

Episodes

Table 11 presents the number of episodes, or admissions, to service in each service category, as well as the percentage of overall admissions to service. Residential withdrawal services are more commonly accessed than non-residential withdrawal services. The reverse is true for non-withdrawal treatment, where the majority of episodes are non-residential.

TABLE 11. Withdrawal Management and Treatment Episodes, 2009–10

Jurisdiction	Residential Withdrawal Management		Non-residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	n	%	n	%	n	%	n	%
AB[27]	11,402	24.1	N/A	N/A	5,273	11.1	30,712	64.8
NB	3,194	35.0	0	0	351	3.8	5,580	61.2
NS[28]	4,063	28.8	407	2.9	1,107	7.9	8,516	60.4
ON[29]	41,462	31.2	1,881	1.42	10,535	7.9	79,005	59.5
PEI	920	28.4	772	23.9	84	2.6	1467	45.2
SK	3,733	20.2	0	0	1,918	10.4	12,822	69.4
CSC	0	0	0	0	0	0	2,719	100

Unique individuals

Table 12 provides the number and percentage of unique individuals in each service category during 2009–10. Recall that an individual may access services in more than one service category. The majority of individuals in all reporting jurisdictions are receiving non-residential treatment services. The pie charts in Figure 1 provide a visual illustration of these data.

[26] Includes only those seeking treatment for their own substance abuse issue, not that of a family member. Also excludes gambling due to low numbers, the majority of which are concentrated in non-residential services.

[27] AHS direct and contracted/funded services. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 5 **excludes** 'gambling only' episodes, as well as admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=323).

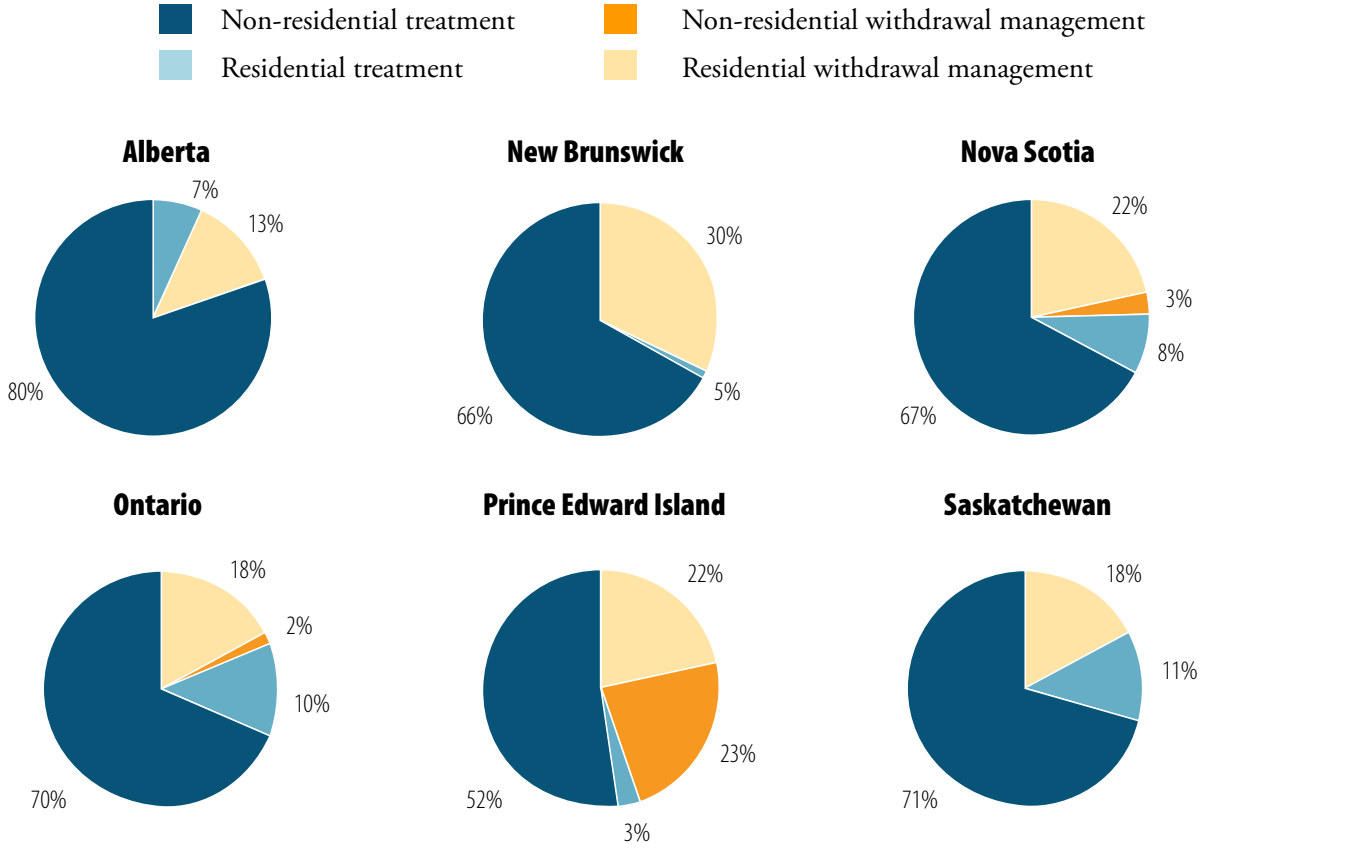
[28] Residential withdrawal and non-residential withdrawal (both episodes and individuals) counts are for substance use only (i.e., excludes gambling). Clients registered in residential treatment programs in NS may change housing options throughout the program (e.g., a client may start as a residential client but finish the program as a day patient). Counts displayed for residential treatment assume the client's housing remained residential throughout the entire program.

[29] An individual can receive treatment in any type of service within the same admission therefore totals will be higher than Indicator 1 (total episodes).

TABLE 12. Unique Individuals by Service Category, 2009–10[30]

Jurisdiction	Residential Withdrawal Management		Non-residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	n	%	n	%	n	%	n	%
AB[31]	3,939	13.0	N/A	N/A	2,036	6.7	24,302	80.3
NB	2,084	29.6			322	4.6	4,630	65.8
NS[32]	2,425	21.5	341	3	922	8.2	7,599	67.0
ON	16,942	18.2	1,672	1.8	9,270	9.9	65,365	70.1
PEI	566	21.6	615	23.4	80	3.1	1,364	52.0
SK	2,813	17.8	0	0	1,800	11.4	11,189	70.8
CSC	0	0	0	0	0	0	2,640	100

FIGURE 1. Distribution of Unique Individuals in Withdrawal Management and Treatment Services, 2009–10



[30] In NS, ON and SK, individuals were counted in each category of services; therefore, if an individual accessed more than one category of services, he/she would be counted more than once, resulting in a total exceeding that reported in Table 5. In AB, NB and PEI, individuals were counted only according to the first category of service accessed. We hope to resolve this methodological difference in future reports.

[31] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 5 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

[32] Residential withdrawal and non-residential withdrawal (both episodes and individuals) counts are for substance use only (i.e., excludes gambling) Clients registered in residential treatment programs in NS may change housing options throughout the program (e.g., a client may start as a residential client but finish the program as a day patient). Counts displayed assume the client was residential throughout the program.

Indicator 6:

Total number of episodes and unique individuals treated in public, specialized treatment services by gender, age and housing status, within categories of residential withdrawal management, non-residential withdrawal management, residential treatment and non-residential treatment[33]

Tables 13–17 further break down the types of service according to demographics for episodes and then individuals. Best practice indicates the importance of targeting service models to different demographic groups according to, for example, age and gender. Evidence also indicates that individuals with no fixed address are more likely to encounter problems with substance use and at higher levels of intensity. Improved understanding of the different rates of service use within these groups is helpful in indicating where there may be gaps in service access or programming.

Episode: Gender

The following tables present the number of service episodes, or admissions, according to gender. The data indicate that there is a higher rate of males accessing services than females across all service categories.

TABLE 13. Withdrawal Management and Treatment Episodes by Gender, 2009–10

Jurisdiction	Male	Female	Other[34]	% Male
Residential Withdrawal Management				
AB[35]	8,135	3,256	11	71.3
NB	2,308	886	0	72.3
NS	2,850	1,211	*	70.2
ON	31,608	9,843	6	76.4
PEI	639	281	0	69.5
SK	2,338	1,391	N/A	62.7
Non-residential Withdrawal Management				
NS	247	160	0	60.7
ON	994	886	*	52.8
PEI	559	213	0	72.4

[33] This data is only for clients who present for treatment for themselves, not a family member.

[34] 'Other' as a gender category includes transsexuals, those in transition, and those who refuse to be categorized or cannot be categorized by the classic gender nomenclature. Not all jurisdictions have this available as an option in their data system.

[35] AHS direct and contracted/funded services. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** 'gambling only' episodes, as well as admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=323).

TABLE 13. (cont'd) Withdrawal Management and Treatment Episodes by Gender, 2009–10

Jurisdiction	Male	Female	Other	% Male
Residential Treatment				
AB	3,552	1,717	*	67.4
NB	274	77	0	78.1
NS	745	362	0	67.3
ON	6,526	4,004	5	61.9
PEI	65	19		77.4
SK	1,109	651	N/A	66.0
Non-residential Treatment				
AB	20,238	10,352	122	65.8
NB	3,596	1,984	0	64.4
NS	5,987	2,526	*	70.3
ON	47,375	31,599	31	60.0
PEI	919	548		62.6
SK	8,625	4,184	N/A	66.9
CSC	2,490	229	0	91.6

Episode: Housing status, no fixed address

Two jurisdictions were able to report the rate of episodes by housing status where the individuals identified having no fixed address. The highest rate of episodes with no fixed address is found in the residential withdrawal category.

TABLE 14. Withdrawal Management and Treatment Episodes with No Fixed Address, 2009–10

Jurisdiction	Residential Withdrawal Management n (%)	Non-residential Withdrawal Management n (%)	Residential Treatment n (%)	Non-Residential Treatment n (%)
AB[36]	1,871 (16.4)	N/A	327 (6.2)	3,207 (10.4)
ON	11,141 (26.8)	216 (11.5)	1,571 (14.9)	5, 604 (7.1)

[36] AHS direct and contracted/funded services. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** 'gambling only' episodes, as well as admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=323).

When the address in missing on the client record, it is not possible to determine if this represents a client with no fixed address or an error (missing element) in the data set.

Episode: Age

Tables 15–18 present the number and percentage of service episodes, or admissions, according to age. Only two jurisdictions, Ontario and Nova Scotia, were able to provide an age breakdown for clients in non-residential withdrawal management. The data indicate that clients accessing services are most likely to be in the 25–54 age range.

TABLE 15. Residential Withdrawal Management Episodes by Age, 2009–10

Age	AB[37] n (%)	NB n (%)	NS n (%)	ON n (%)	PEI n (%)	SK n (%)
<15	180 (1.6)	*	0	10 (0.02)		74 (2.0)
15–17	605 (5.3)	46 (1.4)	61 (1.5)	499 (1.2)	15 (1.6)	317 (8.5)
18–24	955 (8.4)	420 (13.1)	679 (16.7)	4,296 (10.4)	133 (14.5)	633 (17.0)
25–34	9,517 (83.5)	801 (25.1)	931 (22.9)	9,619 (23.2)	243 (26.4)	930 (24.9)
35–44		648 (20.3)	885 (21.8)	11,381 (27.4)	182 (19.8)	879 (23.5)
45–54		794 (24.9)	903 (22.2)	10,930 (26.4)	195 (21.2)	619 (16.6)
55–64		400 (12.5)	453 (11.1)	3,784 (9.1)	107 (11.6)	229 (6.1)
65+	145 (1.3	77 (2.4)	151 (3.7)	938 (2.3)	45 (4.9)	52 (1.4)
Total[38]	**11,402**	**3,194**	**4,063**	**41,462**	**920**	**3,733**

TABLE 16. Non-residential Withdrawal Management Episodes by Age, 2009–10

Age	Jurisdiction	
	NS n (%)	ON n (%)
<15	0	*
15–17	*	25 (1.3)
18–24	46 (11.3)	248 (13.2)
25–34	97 (23.8)	434 (23.1)
35–44	107 (26.3)	504 (26.8)
45–54	115 (28.3)	480 (25.5)
55–64	33 (8.1)	149 (7.9)
65+	6 (1.5)	40 (2.1)
Total	**407**	**1,881**

[37] AHS direct and contracted/funded services. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** 'gambling only' episodes, as well as admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=323).

Unable to provide data in more refined age groupings.

[38] Totals are calculated to include all episodes, including those with missing or suppressed data.

TABLE 17. Residential Treatment Episodes by Age, 2009–10

Age	AB[39] n (%)	NB n (%)	NS n (%)	ON n (%)	PEI n (%)	SK n (%)
<15	19 (0.4)	*	*	46 (0.4)	*	25 (1.3)
15–17	98 (1.9)	*	79 (7.1)	250 (2.4)	*	142 (7.4)
18–24	760 (14.4)	27 (7.7)	164 (14.8)	1,419 (13.5)	*	350 (18.2)
25–34	4,368 (82.8)	74 (21.1)	217 (19.6)	2,981 (28.3)	25 (29.8)	603 (31.4)
35–44		93 (26.5)	216 (19.5)	2,806 (26.6)	19 (22.6)	402 (21)
45–54		103 (29.3)	256 (23.1)	2,324 (22.1)	22 (26.2)	280 (14.6)
55–64		49 (14.0)	131 (11.8)	633 (6.0)	9 (10.7)	93 (4.8)
65+	28 (0.5)	*	41 (3.7)	76 (.7)	*	23 (1.2)
Total	**5,273**	**351**	**1,107**	**10,535**	**84**	**1,918**

TABLE 18. Non-residential Treatment Episodes by Age, 2009–10

Age	AB[39] n (%)	NB n (%)	NS n (%)	ON n (%)	PEI n (%)	SK n (%)	CSC n (%)
<15	755 (2.5)	220 (3.9)	167 (2.0)	2,404 (3.0)	57 (4.7)	335 (2.6)	0
15–17	2,989 (9.7)	1,394 (25.0)	599 (7.0)	6,823 (8.6)	168 (11.5)	1,384 (10.8)	0
18–24	5,380 (17.5)	1,005 (18)	1,368 (16.1)	12,045 (15.2)	218 (14.9)	2,945 (23.0)	448 (16.5)
25–34	21,268 (69.2)	1,039 (18.6)	1,813 (21.3)	17,690 (22.4)	343 (23.4)	3,488 (27.2)	1,035 (38.1)
35–44		792 (14.2)	1,740 (20.4)	17,591 (22.3)	285 (19.4)	2,404 (18.7)	735 (27.0)
45–54		690 (12.4)	1,740 (20.4)	15,087 (19.1)	250 (17.0)	1,575 (12.3)	414 (15.2)
55–64		353 (6.3)	810 (9.5)	5,676 (7.2)	114 (7.8)	530 (4.1)	68 (2.5)
65+	319 (1.0)	87 (1.6)	279 (3.3)	1,689 (2.1)	32 (2.2)	160 (1.2)	19 (0.7)
Total	**30,712**	**5,580**	**8,516**	**79,005**	**1,467**	**12,821**	**2,719**

[39] AHS direct and contracted/funded services. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** 'gambling only' episodes, as well as admissions where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=323).

Unable to provide data in more refined age groupings.

Unique individuals: Gender

Table 19 presents the number of unique individuals according to gender. The data indicate that a larger percentage of males than females access services across all service categories.

TABLE 19. Individuals in Withdrawal Management and Treatment Services, 2009–10

Jurisdiction	Male	Female	Other[40]	% Male
Residential Withdrawal Management				
AB[41]	2,664	1,268	7	67.6
NB	1,484	600		71.2
NS	1,709	715	*	70.5
ON	11,892	5,043	6	70.2
PEI	395	171	0	69.8
SK	1,747	1,063	N/A	62.2
Non-residential Withdrawal Management				
NS	207	134	0	60.7
ON	892	779	*	53.3
PEI	442	173		71.9
Residential Treatment				
AB	1,428	606	*	70.1
NB	250	72	0	77.6
NS	615	307	0	66.7
ON	5,620	3,645	5	60.6
PEI	61	19		76.3
SK	1,191	597	N/A	66.7
Non-residential Treatment				
AB	16,212	7,979	111	66.7
NB	3,002	1,628	0	64.8
NS	5,343	2,254	*	70.3
ON	39,104	26,232	29	59.8
PEI	845	499		62.9
SK	7,277	3,502	N/A	65.0
CSC	2,424	216	0	91.8

[40] 'Other' as a gender category includes transsexuals, those in transition, and those who refuse to be categorized or cannot be categorized by the classic gender nomenclature. Not all jurisdictions have this available as an option in their data system.

[41] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

Unique individuals: Housing status, no fixed address

The distribution of individuals with no fixed address is parallel to the distribution of episodes, with the highest representation found in residential withdrawal.

TABLE 20. Individuals in Withdrawal Management and Treatment Services with No Fixed Address, 2009–10

Jurisdiction	Residential Withdrawal Management n (%)	Non-residential Withdrawal Management n (%)	Residential Treatment n (%)	Non-Residential Treatment n (%)
AB[42]	864 (21.9)	N/A	187 (9.2)	2 ,436 (10.0)
ON	3,733 (22.0)	171 (10.2)	1,370 (14.8)	4,354 (6.7)

Unique individuals: Age

Tables 21–24 and Figures 2–5 present the number of unique individuals according to age, type of service and jurisdiction. While all age groups do access treatment, the concentration of individuals in the 25–54 age group is consistent with the data for service episodes. The figures illustrate the overall consistency of age groups accessing services across reporting jurisdictions.

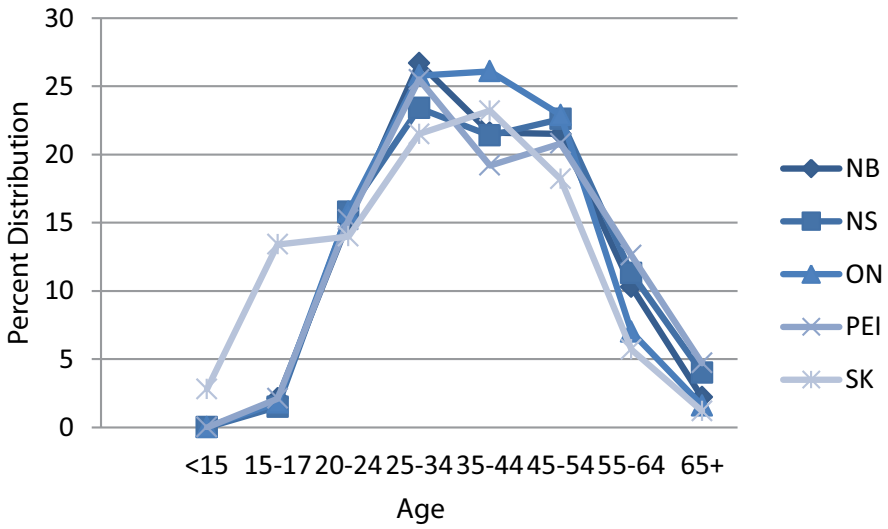
[42] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

When the address in missing on the client record, it is not possible to determine if this represents a client with no fixed address or an error (missing element) in the data set.

TABLE 21. Age Distribution of Individuals in Residential Withdrawal Management, 2009–10

Age	AB[43] n (%)	NB n (%)	NS n (%)	ON[44] n (%)	PEI n (%)	SK[44] n (%)
<15	86 (2.2)	*	0	9 (0.01)	*	59 (2.8)
15–17	320 (8.1)	44 (2.1)	37 (1.5)	314 (1.8)	12 (2.1)	257 (13.4)
18–24	381 (9.7)	315 (15.1)	383 (15.8)	2,550 (14.9)	87 (15.2)	474 (14)
25–34	3,096 (78.6)	557 (26.7)	567 (23.4)	4,422 (25.8)	146 (25.5)	708 (21.5)
35–44		451 (21.6)	519 (21.4)	4,476 (26.1)	110 (19.2)	657 (23.2)
45–54		449 (21.5)	547 (22.6)	3,925 (22.9)	119 (20.8)	472 (18.2)
55–64		214 (10.3)	275 (11.3)	1,203 (7.0)	72 (12.6)	151 (5.7)
65+	56 (1.4)	46 (2.2)	97 (4.0)	273 (1.6)	27 (4.7)	43 (1.2)
Total	**3,939**	**2,084**	**2,425**	**17,172**	**573**	**2,821**

FIGURE 2. Age Distribution of Individuals in Residential Withdrawal Management, 2009–2010



[43] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

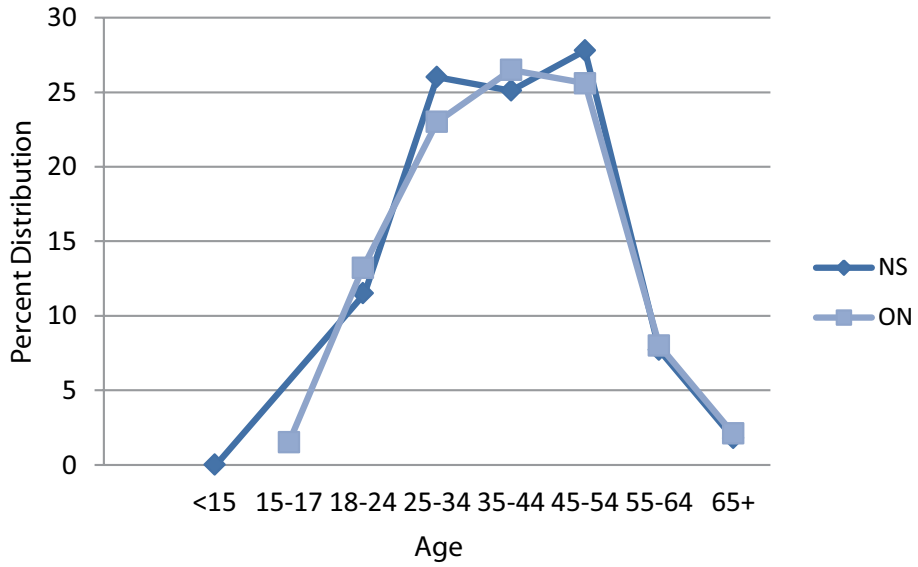
Unable to provide data in more refined age groupings.

[44] Clients who moved across age categories over subsequent admissions were counted in both categories. For example, a client with multiple admissions who was admitted once while 34 and once while 35 would be counted twice: once in the 25–34 age group and once in the 35–44 age group.

TABLE 22. Age Distribution of Individuals in Non-residential Withdrawal Management, 2009–10

Age	Jurisdiction	
	NS (%)	ON[45] (%)
<15	0	*
15–17	*	25 (1.5)
18–24	39 (11.5)	222 (13.2)
25–34	88 (26)	385 (23.0)
35–44	85 (25.1)	444 (26.5)
45–54	94 (27.8)	430 (25.6)
55–64	26 (7.7)	135 (8.0)
65+	6 (1.8)	36 (2.1)
Total	**341**	**1,672**

FIGURE 3. Age Distribution ofIndividuals in Non-residential Withdrawal Management, 2009–10

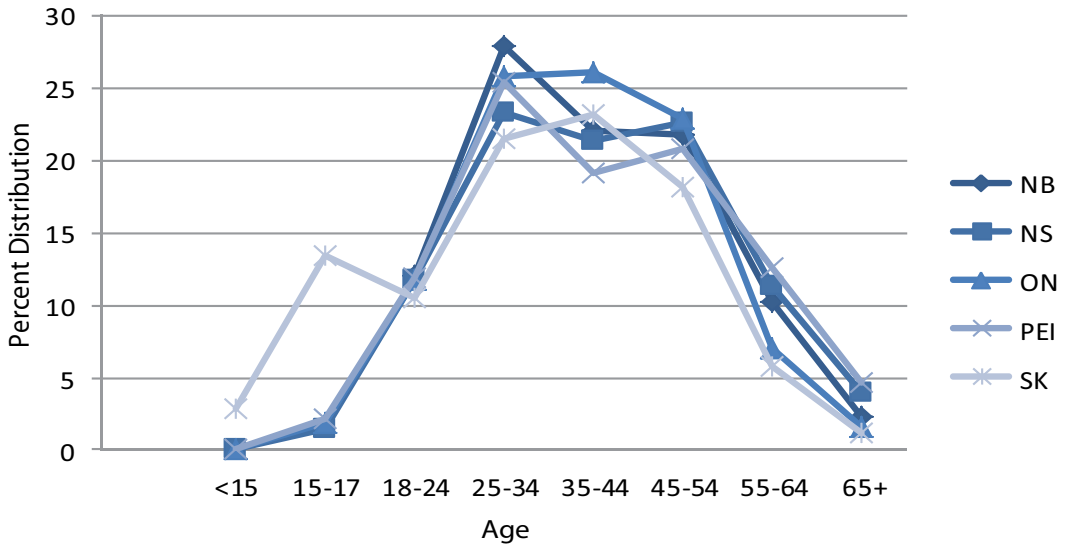


[45] Clients who moved across age categories over subsequent admissions were counted in both categories. For example, a client with multiple admissions who was admitted once while 34 and once while 35 would be counted twice: once in the 25–34 age group and once in the 35–44 age group.

TABLE 23. Age Distribution of Individuals in Residential Treatment, 2009–10

Age	AB[46] n (%)	NB n (%)	NS n (%)	ON[47] n (%)	PEI n (%)	SK n (%)
<15	11 (0.5)	*	*	42 (0.5)	*	21 (1.2)
15–17	69 (3.4)	0	57 (6.2)	231 (2.5)	*	130 (7.2)
18–24	208 (10.2)	26 (8.1)	141 (15.3)	1,243 (13.3)	*	322 (17.9)
25–34	1,729 (84.9)	72 (22.4)	192 (20.8)	2,580 (27.6)	23 (28.8)	558 (31.0)
35–44		83 (25.8)	178 (19.3)	2,498 (26.8)	19 (23.8)	380 (21.1)
45–54		92 (28.6)	218 (23.6)	2,081 (22.3)	22 (27.5)	264 (14.7)
55–64		44 (13.7)	98 (10.6)	589 (6.3)	7 (8.8)	90 (5.0)
65+	19 (0.9)	*	35 (3.8)	74 (0.8)	*	23 (1.3)
Total	**2,036**	**322**	**922**	**9,338**	**80**	**1,800**

FIGURE 4. Age Distribution of Individuals in Residential Treatment, 2009–10



[46] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

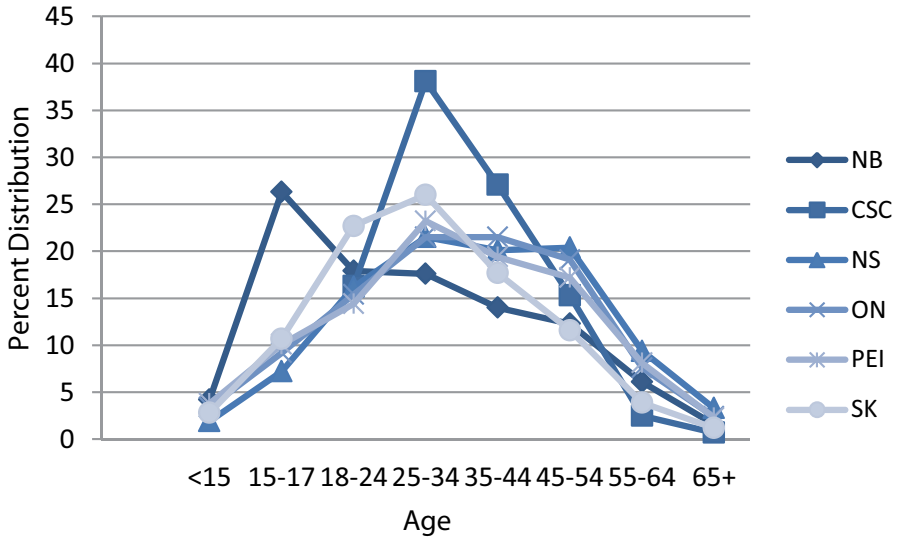
Unable to provide data in more refined age groupings.

[47] Clients who moved across age categories over subsequent admissions were counted in both categories. For example, a client with multiple admissions who was admitted once while 34 and once while 35 would be counted twice: once in the 25–34 age group and once in the 35–44 age group.

TABLE 24. Age Distribution of Individuals in Non-residential Treatment, 2009–10

Age	AB[48] n (%)	NB n (%)	NS n (%)	ON[49] n (%)	PEI n (%)	SK n (%)	CSC n (%)
<15	626 (2.6)	195 (4.2)	145 (1.9)	2,264 (3.4)	52 (3.8)	311 (2.8)	0
15–17	2,319 (9.5)	1,219 (26.3)	546 (7.2)	6,086 (9.2)	138 (10.1)	1,196 (10.7)	0
18–24	4,496 (18.5)	828 (17.9)	1,232 (16.2)	10,236 (15.4)	197 (14.4)	2,535 (22.7)	431 (16.3)
25–34	16,584 (68.2)	813 (17.6)	1,631 (21.5)	14,235 (21.5)	317 (23.2)	2,906 (26.0)	1,006 (38.1)
35–44		648 (14.0)	1,531 (20.1)	14,265 (21.5)	264 (19.4)	1,986 (17.7)	714 (27.0)
45–54		568 (12.3)	1,550 (20.4)	12,649 (19.1)	235 (17.2)	1,293 (11.6)	403 (15.3)
55–64		284 (6.1)	717 (9.4)	5,015 (7.6)	110 (8.1)	432 (3.9)	67 (2.5)
65+	277 (1.1)	75 (1.6)	247 (3.3)	1,561 (2.4)	31 (2.3)	133 (1.2)	19 (0.7)
Total	24,302	4,630	7,599	66,311	1,364	11,189	2,640

FIGURE 5. Distribution of Individuals in Non-residential Treatment, 2009–10



Indicators 5 and 6 illustrated the variation in service use according to age and gender. The information presented in Indicators 7, 8, and 9 complete the report by focusing specifically on distinct use and treatment components: injection drug use, opioid substitution, and driving-while-impaired education programs.

[48] AHS direct services only. Withdrawal services in Alberta are residential only. Clients may cite multiple reasons for treatment. The number for Indicator 6 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

Unable to provide data in more refined age groupings.

[49] Clients who moved across age categories over subsequent admissions were counted in both categories. For example, a client with multiple admissions who was admitted once while 34 and once while 35 would be counted twice: once in the 25–34 age group and once in the 35–44 age group.

Indicator 7:

Total number of episodes and unique individuals treated in public, specialized treatment services by injection drug status[50]

Table 25 presents the number of episodes and unique individuals reporting use of drugs by injection in the 12 months preceding treatment. The table also shows the percentage of clients using drugs by injection in relation to total episodes and unique individuals receiving service.[51] The data indicate that across all jurisdictions, those who report drug use by injection (IDU) are more likely to have more than one treatment episode in the 2009–10 fiscal year. (For a comparison to the overall client population, see Table 10).

TABLE 25. Injection Drug Use: Episodes and Unique Individuals, 2009–10

Jurisdiction	Episodes	% of All Treatment Episodes	Unique Individual	% of All Individuals	Ratio Episodes: Individuals
AB[52]	2,281	5.7	1,722	5.7	1.3
NB	780[53]	8.5	427	7.1	1.8
NS[54]	1,984	14.3	891	10.2	2.2
ON	21,333	20.8	10,642	16.4	2.0
PEI	277	9.0	137	5.6	2.0
SK[55]	3,172	16.9	1,812	13.5	1.8

[50] Only includes those seeking treatment for their own substance abuse issue, not that of a family member.

[51] This number is drawn from Indicator 1 (total episodes) and Indicator 3 (total individuals), but with non-self (family members) removed from the totals.

[52] AHS direct services only (n=39,412 episodes, n=30,277 individuals). Clients may cite multiple reasons for treatment. The number for Indicator 7 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes records with missing information for this database field (n=6,637 episodes, n=4,591 individuals).

[53] Cannot distinguish between family member receiving treatment from self; therefore, results are based on total episodes (Indicator 1).

[54] Injection status is based on 30 days prior to beginning treatment. The limitation of this report is that injection drug use is only collected if injection is the preferred route of administration for a self-identified treatment issue; therefore, the instance of injection drug use is likely underreported.

[55] 'Problem related to' is not completed by service providers in every instance.

Figures 6 and 7 illustrate the breakdown by gender according to episodes and individuals where injection drug use was reported in the past 12 months. The gender distribution, with males more likely than females to report using drugs by injection, is consistent across both episodes and unique individuals receiving services.

FIGURE 6. Injection Drug Status: Episodes by Gender, 2009–10[56]

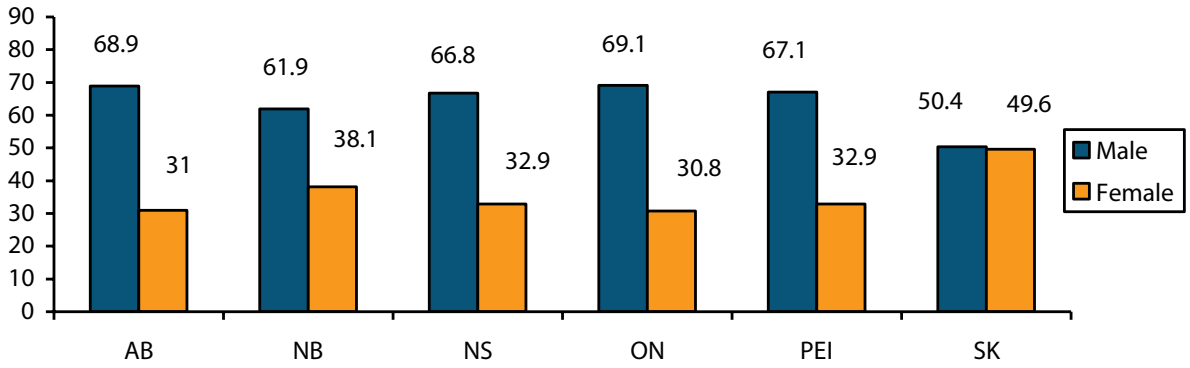
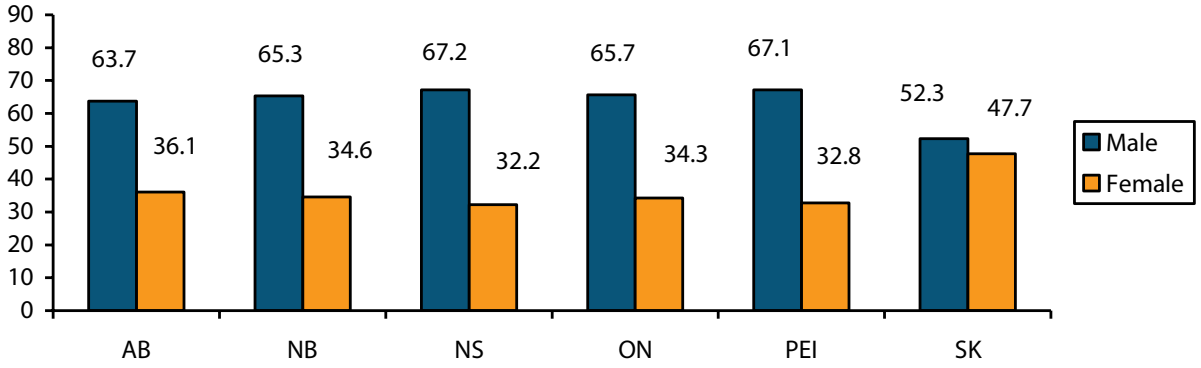


FIGURE 7. Injection Drug Status: Individuals by Gender, 2009–10[57]



[56] The gender category 'other' has been suppressed.

Indicator 8:

Total number of individuals in opioid substitution treatment in public, specialized treatment services and external opioid substitution treatment clinics[57,58]

Tables 26 and 27 present the number of individuals by gender and age in public, specialized opioid substitution treatment services. The data indicate that the representation of females compared to males is generally higher in these services compared to substance use services in general. As shown by Table 27 and Figure 8, the largest proportion of individuals in public opioid substitution services is between 25 and 34 years of age.

TABLE 26. Individuals in Public Opioid Substitution by Gender, 2009–10

Jurisdiction	Male	Female	Other	Total	% Male
AB[59]	731	451	8	1,190	61.4
NB				1,339	
NS[60]	306	142	0	448	68.3
PEI	83	63	0	146	56.8
SK[61]	174	193	N/A	367	47.4

[57] The term 'opiate substitution treatment' includes methadone treatment as well as buprenorphine treatment.

[58] Only includes those seeking treatment for their own substance abuse issue, not that of a family member.

[59] AHS direct services only. Private clinics in Alberta report on clients through the College of Physicians and Surgeons. Clients may cite multiple reasons for treatment. The number for Indicator 8 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

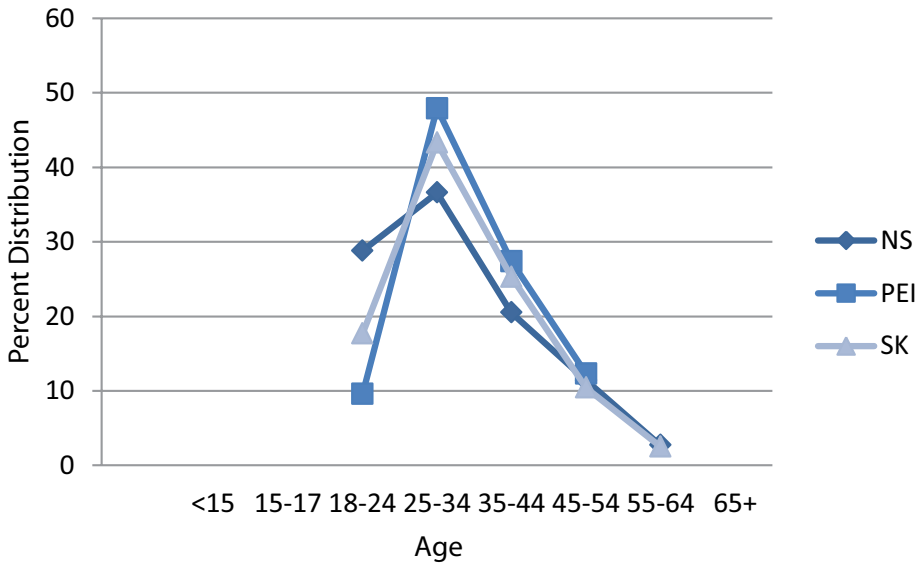
[60] The numbers provided primarily include methadone treatment; buprenorphine, although not part of the program protocol, may be offered on a case-by-case basis.

[61] Used age at first admission where birthday occurred during multiple admissions.

TABLE 27. Individuals in Public Opioid Substitution by Age, 2009–10

Age	Jurisdiction			
	AB (%)[62]	NS (%)[63]	PEI (%)	SK(%)[64]
<15	*	0	0	*
15–17	0	0	0	*
18–24	54 (4.5)	129 (28.8)	14 (9.6)	65 (17.7)
25–34	1,125 (94.5)	164 (36.6)	70 (47.9)	159 (43.3)
35–44		92 (20.5)	40 (27.4)	93 (25.3)
45–54		51 (11.4)	18 (12.3)	38 (10.4)
55–64		12 (2.7)	*	9 (2.5)
65+	8 (0.7)	0	0	*
Total	**1,190**	**448**	**146**	**367**

FIGURE 8. Individuals in Public Opioid Substitution by Age, 2009–2010



[62] AHS direct services only. Private clinics in Alberta report on clients through the College of Physicians and Surgeons. Clients may cite multiple reasons for treatment. The number for Indicator 8 **excludes** cases where clients cited 'gambling only' as their reason for treatment, as well as cases where clients cited 'tobacco only' or 'other only' as their reason for treatment. The number also excludes client records with missing information (n=260).

Unable to provide data in more refined age groupings.

[63] The numbers provided primarily include methadone treatment; buprenorphine, although not part of the program protocol, may be offered on a case-by-case basis.

[64] Used age at first admission where birthday occurred during multiple admissions.

External methadone clinics

Ontario was the only jurisdiction able to report on external (private) opioid treatment centres. Tables 28 and 29 present the number of individuals by gender and age in these services.

TABLE 28. Individuals in Private Opioid Treatment Centres in Ontario by Gender, 2009–10

Jurisdiction	Male	Female	Other	Total	% Male
ON	2,341	1,764	*	4,170	56.1

TABLE 29. Individuals in Private Opioid Treatment Centres in Ontario by Age, 2009–10

Age	n(%)
<15	11 (0.3)
15–17	62 (1.5)
18–24	715 (17.1)
25–34	1,642 (39.4)
35–44	1,078 (25.9)
45–54	566 (13.5)
55–64	84 (2.0)
65+	12 (0.3)
Total	**4,170**

Indicator 9:

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

Most jurisdictions provide driving-while-impaired (DWI) education programs. However, responsibility for these programs is often external to the department or ministry responsible for substance use treatment. Data collection on these programs varies, as indicated by the different age breakdowns provided below. CCSA and the National Treatment Indicators Working Group will work with the respective agencies responsible to increase data availability in future years.

Although limited to data from two provinces, the results indicate that the demographic groups most likely to be in DWI education programs are males in their mid-20s to early-50s.

TABLE 30. Individuals in DWI Education Programs by Gender, 2009–10

Jurisdiction	Total	Male	Female	Other	% Male
NB[65]	1,465				
NS	1,962	1,705	256	*	86.9

TABLE 31. Individuals in DWI Education Programs in Nova Scotia by Age, 2009–10

Age	Individual (%)
<15	0
15–17	*
18–24	340 (17.3)
25–34	474 (24.2)
35–44	416 (21.2)
45–54	417 (21.3)
55–64	220 (11.2)
65+	92 (4.7)
Total	**1,962**

TABLE 32. Individuals in DWI Education Programs in New Brunswick by Age, 2009–10

Age	Individual (%)
11–20	33 (2.3)
21–30	430 (29.4)
31–40	331 (22.6)
41–50	316 (21.6)
51–60	219 (14.9)
61–70	109 (7.4)
71–90	27 (1.8)
Total	**1,465**

[65] New Brunswick does not currently record gender in its data on DWI participants. Program staff consulted indicate that, historically, the majority of participants have been male.

> Discussion

The data indicate that despite variations in context, there is more consistency than disparity in substance use services across the provinces and territories that submitted data. The data reflect a number of recognized trends in the system, including:

- On average, people access services more than once in a year;[66]
- Males are more likely than females to access services;
- More people access non-residential services than residential services; and
- People receiving services are most likely to be between the ages of 24 and 54.

The data also highlight additional considerations relevant to system planning. As a whole, the number of individuals accessing services during the year in any province is not trivial—approximately 0.5–2.0% of the overall population. The data also indicate that 7–13% of individuals accessing services do so due to the impact of someone else's substance use. This rate highlights the impact of substance use beyond the individual experiencing problematic use, and aligns with the evidence base indicating the value of investing in services and supports for family, friends and others (e.g., Center for Substance Abuse Treatment, 2004; Comité permanent de lutte à la toxicomanie, 2005).

Two jurisdictions were able to provide data on the percentage of people accessing services that had no fixed address.[67] These individuals were disproportionately represented in residential withdrawal services. Meeting the service needs of people with unstable housing and substance use problems requires collaboration between housing and substance use sectors, and these data indicate where in the service system those collaborations might effectively be targeted (e.g., withdrawal management).

The data also indicate that individuals reporting injection drug use in the previous 12 months have a higher number of service episodes per person. There are a number of possible explanations for this observation, including, for example, the need to access a broader range of services (e.g., withdrawal management followed by treatment and continuing care) and an increased likelihood of accessing services a number of times. Both explanations highlight the importance of case management, referral and continuing care to ensure that 'every door is the right door' to access services and to promote efficient pathways between services.

The data collected through the National Treatment Indicators project should not be considered in isolation. There are a number of other national data-collection initiatives underway to improve our understanding of substance use rates and prevalence patterns in Canada that further contribute to a comprehensive understanding of substance use and gambling trends, patterns and services. These include the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS), the Canadian Community Epidemiology Network on Drug Use (CCENDU), and the *Cross-Canada Report on Student Alcohol and Drug Use*.

Collectively, the information provided through these initiatives will provide the comprehensive picture required to inform policy, resourcing and service development. For example, the student drug use surveys indicate that rates of use tend to be higher among youth. However, the National Treatment Indicators report suggests that those accessing treatment are more likely to be slightly older. Taken together, this information indicates the need to look more closely at patterns of use, harms and service access. For example, are youth less likely to experience harms associated with their substance use, or are improvements to the accessibility, quality and availability of services for youth required?

There are also a number of current initiatives demonstrating momentum to support enhancement of substance use data collection at the jurisdictional level. Health Canada's Drug Treatment Funding Program identified performance measurement and evaluation as one of three system-level investment areas. A number of provinces and territories are using these funds to enhance data collection and analysis capacities in the areas of service provision and outcome monitoring. Initiatives such as these create opportunities to promote the use of a core group of comparable indicators

[66] Accessing services more than once in a year can refer to accessing the same service more than once or different distinct services within the system.

[67] This could indicate missing data fields as well as actual housing status.

across jurisdictions. In addition, the Centre for Addiction and Mental Health in Ontario is leading a national project to develop a methodology for needs-based system planning. Knowledge of both system-level needs and system-level service delivery using consistent definitions will allow system planners to clearly identify trends and gaps in service in order to more strategically allocate resources.

> Conclusions and Next Steps

Investments in evidence-based services and supports are an effective way to reduce the health, social and economic burden of substance use and gambling in Canada. In order to ensure efficacy, efficiency and transparency, programs and services need to be supported by evidence-based system planning. The National Treatment Indicators project is intended to contribute to the system-level information required to plan, implement, monitor and evaluate an evidence-based systems approach to substance use in Canada.

The data presented in this inaugural report represent a step forward in developing a comprehensive national picture of the provision of services and supports for substance use and gambling in Canada. The National Treatment Indicators Working Group will build on this first step in subsequent annual reports by continuing to improve the scope and quality of the data collected. In the short term, the project will focus on including submissions of data from additional jurisdictions, and on refinements to data collection and reporting that will increase comparability. The long-term goal of the project is to move from the traditional focus on the specialized substance use system to the broader range of non-specialized and community-based services that are more likely to be accessed by Canadians—therefore capturing information on the full continuum of services and supports for substance use and gambling, and on the population accessing them.

As these data-collection improvements are achieved, the annual National Treatment Indicators reports will provide more thorough data analysis and interpretation of results. Sharing comparable information across jurisdictions will help to identify gaps and trends in service use that can be used to inform system-level planning, particularly when considered in combination with data on substance use (e.g. CADUMS) and the need for services (e.g., the CAMH needs-based planning project). National-level data will also position Canada alongside international partners such as the United States, the United Kingdom and Australia in providing meaningful data that will enhance the capacity to monitor and take action on international trends in substance use services.

The National Treatment Indicators project is working toward the collection, analysis and sharing of information that would allow, for example:[68]

- A region in Northern Ontario to establish a partnership with colleagues in Newfoundland and Labrador based on similar trends illustrated in the NTI annual report;
- The launch of a national research initiative to address the gap seen across jurisdictions between the need for community-based services for females with substance use problems illustrated by the CAMH needs-based planning model and the actual level of service illustrated by the National Treatment Indicators;
- Open discussion of system-level resource needs at federal, provincial and regional funding tables informed by transparent and consistent information on current system function and emerging trends;
- Greater consistency and increased quality of data-collection mechanisms through knowledge exchange between NTIWG members; and
- International partners to look to Canada as an example of overcoming internal jurisdictional barriers to data collection in order to provide meaningful, reliable national data to the UNODC, WHO and other global partners.

[68] Note that all examples are hypothetical. Although the situations are feasible goals identified by the NTIWG, the jurisdictions and populations provided are for illustration purposes only.

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> Appendix A: National Treatment Indicators Membership List

Current to June 21, 2011[69]

Name	Organization
Beasley, Erin	Canadian Centre on Substance Abuse
Behrooz, Renée	Centre for Addiction and Mental Health
Brar, Dave	BC Ministry of Health Services
Desrosiers, Pierre	Association des centres de réadaptation en dépendance du Québec
Dupuis, Robin	First Nations and Inuit Health Branch, Health Canada
Estey, John	New Brunswick Department of Health
Farrell MacDonald, Shanna[70]	Correctional Service Canada
Hansen, Rebecca	Yukon Alcohol and Drug Services
Hayward, Terrilyn	Nova Scotia Department of Health and Wellness
James, Darlene	Alberta Health Services
Jesseman, Rebecca	Canadian Centre on Substance Abuse
Joiner, Ian	Canadian Institute for Health Information
LeClair, Tina	Manitoba Healthy Living, Youth and Seniors
McCallum, John	Saskatchewan Health
O'Handley, Darren	Health PEI
Rideout, Gina	Newfoundland and Labrador Department of Health and Community Services
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[69] CCSA would also like to acknowledge the contributions of former Working Group members: Jennifer Van Koeveringe, Renee Ryan, Valerie Stevens, April Furlong, Sylvie Martin, Danyea Sulyma, Sara Johnson, Larry Corea, Sandy Goatcher, Andrea MacTavish and David Patton.

[70] On leave from June 2011 to June 2012; being replaced by Madelon Cheverie, Pamela Forrester and Meg Ternes.

> Appendix B: Treatment Data Systems in Other Countries

The United States, Australia and the United Kingdom have developed fairly comprehensive substance use treatment data systems. Although they are different from each other, there are some common aspects that can be used to help develop a unique system for Canada that enables comparisons with other countries and regions, in addition to enabling comparisons within the country.

The Treatment Episode Data System (TEDS) in the U.S. is an administrative dataset that provides descriptive information about admissions to substance use treatment programs that are publicly funded.

The TEDS is composed of two datasets, Admissions Data System and Discharge Data System, which are linked to provide information on a complete treatment episode. Records are submitted within six months of admission, and data are transferred to a Substance Abuse and Mental Health Service Administration (SAMHSA) contractor monthly or quarterly for processing. The files are available for public use via online analysis and are used to produce routine reports, such as the Drug and Alcohol Services Information System (DASIS) reports. Annual TEDS reports are also available on specific topics, such as describing changes in admissions over 10 years for pain specific concerns. This type of information can be used for sharing information across jurisdictions, and for identifying client trends in treatment as well as changes in the types of substances clients are using (which is potentially useful for improving staff training in order to more effectively work with these clients).

The advantages of such a system as TEDS are clear. Comparisons across jurisdictions, where common indicators are used in a consistent manner, can facilitate an examination of differences and similarities. The impacts of administrative changes can be observed by comparing jurisdictions. Perhaps more significantly, changes over time can be tracked, allowing for more informed strategic planning and anticipation of subsequent population need.

The National Treatment Agency for Substance Misuse (NTA) in the United Kingdom publishes a wide range of information about treatment using the National Drug Treatment Monitoring System (NDTMS). National statistics are produced monthly by the National Drug Evidence Centre at the University of Manchester from approximately 2,000 drug treatment centers in England. Reports are produced annually, usually about six months after the fiscal year-end data is available. The initial NDTMS was developed to collect data on adult drug misusers in treatment, but is now being expanded to include information on alcohol-specific treatment. As with TEDS, specific reports can be produced to provide information about trends in admissions (e.g., youth admissions for heroin use have decreased over the past five years) that can assist with program planning and the resource allocation required to fund services appropriately. The information collected is used to not only support the National Drug Strategy, but also as a needs assessment at the regional and local levels. The information collected is used to assist with making decisions ('performance management') about the effectiveness of services and to ensure that the best outcomes possible are achieved. The information is made publicly available through the website (www.ndtms.net), and reports are provided to the public demonstrating transparency and accountability.

Australia has also developed a fairly comprehensive data-collection system. The Australian Alcohol and Other Drug Treatment Services produces an annual report based on the National Minimum Data Set (NMDS). The NMDS is populated by information provided to the Australian Institute of Health and Welfare (AIHW) from publicly funded alcohol and other drug treatment services and their clients. The data are a nationally agreed-upon set of items collected by service providers, collated by health authorities and compiled by the AIHW. The data include information about services, clients, drugs of concern and the types of treatment provided. Specific reports can be produced; for example, the most recent report shows that there were 10,000 fewer treatment episodes in 2008–09, compared with the previous year. Regional changes and differences can also be highlighted, again offering the opportunity to target local resources more accurately during strategic planning.

These systems offer some guidelines for the development and implementation of a national process to collect comparable data for substance use and gambling treatment. Consultation with local authorities, identification of clear indicators, and

timely reports provide planners and system administrators with useful information. The systems also provide a means to inform the public about the effectiveness of investments in the treatment system.

The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has achieved within the European Union (EU) what Canada's National Treatment Indicators are trying to achieve at a national level. The EMCDDA collects information at the EU level through five key epidemiological indicators with standardized data collection parameters applied across all member states. The information collected is used to report on trends and developments in the EU drug situation, and to analyze the impact of policies and actions on drug use. The Treatment Demand Indicator (TDI) is one of these five key indicators; it consists of a core dataset of 20 items, with information collected anonymously for each presenting client in the EU regarding social characteristics, treatment contact details and drug profile.

The EMCDDA's TDI has found that relevance of the information at the local level, as well as support and cooperation at both service provider and administrative levels, are vital to ensuring data quality. The data collected through the TDI is used to inform the EMCDDA's annual report as well as a range of periodicals, series, policy papers and special investigations.

> Appendix C: Green, Yellow and Red Light Indicators

Green Light Indicators:

1. Total number of treatment episodes in public, specialized treatment services for substance use problems.
2. Total number of treatment episodes in public, specialized treatment services for problem gambling.
3. Total number of unique individuals treated in public, specialized treatment services for substance use problems.
4. Total number of unique individuals treated in public, specialized treatment services for problem gambling.
5. 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.
6. 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.
7. Total number of episodes and unique individuals treated in public, specialized treatment services by injection drug status.
8. Total number of individuals in opioid substitution treatment in public, specialized treatment services and external opioid substitution clinics.
9. Total number of people served within driving-while-impaired education programs.

Yellow Light Indicators

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

Red Light Indicators

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

> Appendix D: Data Definitions

Closed case
Closure criteria vary from province to province.

Driving-while-impaired 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 licence reinstatement. The content and administration of such programs vary among jurisdictions.

Episode
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.

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.

New individual
A new individual refers to a unique individual 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.

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.

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