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National Treatment Indicators Report

2013–2014 Data

October 2016

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Executive Summary

Background

Problematic substance use is a significant health, economic and social issue in Canada. One way to reduce its burden is through evidence-informed treatment. Providing Canadians with appropriate and timely access to treatment requires reliable data to inform decisions so they contribute to effective system and service planning.

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

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

Project Purpose and Contribution

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

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

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

Limitations

The NTI report captures data from publicly funded, treatment services only,[1] and does not include information from sources such as privately funded treatment centres, self-help groups (e.g., Alcoholics Anonymous), primary care services or hospital admissions. Variation in data collection and reporting means that direct comparisons between jurisdictions should not be made. Not all

[1] Driving-while-impaired programs are included in this report, but may be accessed on a fee-for-service basis.

information collected from the jurisdictions could be presented in this report; rather, only a subset of indicators agreed upon by the NTI Working Group (NTIWG) is included. This decision was made to ensure the report remains as succinct yet informative as possible.

Results

This fifth NTI report provides 2013–2014 fiscal-year information from seven provinces, one territory, one provincial association and one federal association, an expansion (from six provinces, one territory and one provincial association) in the jurisdictional representation in the previous report.

As the fifth in the series, this report looks at trends in the data from 2009–2010 to 2013–2014. The results show a great deal of variability in service use trends across Canada. Many jurisdictions have seen a substantial increase in the number of individuals accessing substance use treatment services. However, the ratio of episodes to individuals has remained relatively consistent across most of Canada.

Key Findings

- Between April 1, 2013, and March 31, 2014, a total of 157,123 unique individuals from six Canadian provinces and one provincial association accessed publicly funded substance use treatment services, accounting for nearly 218,263 treatment episodes.
- Between 4.5% and 13.5% of unique individuals accessing treatment services, accessed treatment for a family member or friend with problematic substance use. This fact indicates the need for services and supports to extend beyond the individual seeking treatment.
- In all participating jurisdictions, males accounted for the majority of all individuals accessing treatment services in general and by each specific treatment type. These trends have remained stable since 2011–2012.
- Approximately half (49.0%) of all treatment episodes were accessed by individuals between the ages of 25 and 44, a finding that was consistent across the different treatment types.
- Non-residential treatment accounted for the majority (66.2%) of treatment episodes.
- Alcohol was the most common substance used in the past 12 months by clients of publicly funded treatment centres. In Alberta, Saskatchewan and Ontario, clients between the ages of 25 and 34 had the highest past-year prevalence of alcohol and cannabis use. In Nova Scotia, however, clients 45–54 years of age had the highest past-year prevalence of alcohol consumption, while clients between the ages of 15 and 17 had the highest past-year prevalence of cannabis use. In both Ontario and Nova Scotia, jurisdictions that submitted data on the primary substance for which treatment was sought, alcohol was implicated in the greatest proportion of treatment episodes. The second most commonly reported primary substances were cannabis followed by cocaine in Ontario, and opioids in Nova Scotia.
- Among jurisdictions that submitted data on employment status, the majority (between 34.6% and 53.7%) of all treatment episodes were accessed by individuals who noted their employment status as “unemployed” at the time of treatment.
- In many Canadian jurisdictions, the number of individuals accessing treatment services appears to have increased over the past five fiscal years. These differences might be attributable to improved data collection methods resulting in more accurate reporting of information or to expanded treatment availability, rather than true increases in treatment service access.

Conclusions and Next Steps

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

Building on the project's progress to date, the long-term goal of the NTIWG is to continue to expand and strengthen data collection and provide a truly comprehensive national picture that will better serve system planning needs. To this end, the NTIWG has been working with a number of partners to enhance the comprehensiveness of the report. For example, this year the NTIWG expanded its membership to include representation from British Columbia and enhanced the comprehensiveness of the report by capturing 2013–2014 information from Prince Edward Island and First Nations and Inuit Health Branch (FNIHB). Further, significant progress has been made to identify and secure representatives from private sector treatment facilities expressing interest in participating in the NTI project.

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

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List of Acronyms

General

DWI	Driving while impaired
IDU	Injection drug use
KMb	Knowledge mobilization
NRT	Non-residential treatment
NRWM	Non-residential withdrawal management
RT	Residential treatment
RWM	Residential withdrawal management
SBIR	Screening, Brief Intervention and Referral

Canadian organizations and programs

ADS	Alcohol and Drug Services
ADSI	Anti-Drug Strategy Initiative
AIDQ	Association des intervenants en dépendance du Québec
AFM	Addictions Foundation of Manitoba
AHS	Alberta Health Services
CAMH	Centre for Addiction and Mental Health
CAPA	Choice and Partnership Approach
CCSA	Canadian Centre on Substance Abuse
CIHI	Canadian Institute for Health Information
CSC	Correctional Service Canada
DTFP	Drug Treatment Funding Program
FNHA	First Nations Health Authority
FNIHB	First Nations and Inuit Health Branch
MHCC	Mental Health Commission of Canada
NNADAP	National Native Alcohol and Drug Abuse Program
NYSAP	National Youth Solvent Abuse Program
VAC	Veterans Affairs Canada

Canadian data collection systems

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

Introduction

The fifth National Treatment Indicators (NTI) report provides aggregate-level descriptive information from the 2013–2014 fiscal year on access to publicly funded substance use treatment services in Canada.[2] It is intended for a broad audience including researchers, analysts, leaders, decision makers and advisors looking for information to support service planning, development and communications.

Problematic substance use can result in a variety of health, social and economic harms that impact both the individual and society. According to the 2013 Canadian Tobacco, Alcohol and Drugs Survey (CTADS), 75.9% of Canadians 15 years of age and older consumed alcohol in the past 12 months and, of these individuals, 15% exceeded low-risk drinking guidelines within the past seven days (Statistics Canada, 2015). In addition, 11.3% of Canadians reported using at least one drug to get high in the past 12 months,[3] with approximately 20% of these people reporting that they experienced one or more types of harm from their drug use (Statistics Canada, 2015). One way to reduce the risks and harms associated with problematic substance use is to ensure Canadians have access to a comprehensive system of effective, evidence-based services and supports.

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

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

The NTI report remains the only national, accessible source of information on publicly funded substance use treatment centres in Canada. It illustrates the type of treatment information that is currently being collected, and helps to identify information gaps. Currently, the NTI report collects information on four treatment categories: residential treatment (RT), non-residential treatment (NRT), residential withdrawal management (RWM) and non-residential withdrawal management (NRWM). The NTI report also helps indicate whether the treatment system is responding to the latest trends and

[2] Driving-while-impaired programs are included in this report, but may be accessed on a fee-for-service basis.

[3] The drugs used to get high include illicit drugs such as cannabis, cocaine, speed/methamphetamine, ecstasy, hallucinogens, salvia, heroin and inhalants, as well as prescription pain relievers, stimulants and sedatives.

evolving knowledge in the substance use field. For a complete list of indicators collected for this report, see Appendix A.

National Treatment Indicators

The NTI project was established in 2009 and was built on previous work by the Canadian Institute for Health Information (2001), the Canadian Centre on Substance Abuse (CCSA) (Thomas, 2005) and the National Treatment Strategy Working Group (2008).

The project is led by the NTI Working Group (NTIWG), which was formed in 2009 and is chaired by CCSA. As of January 2016, the NTIWG includes representatives from nine provinces, one territory, federal and provincial departments with treatment delivery responsibility, and the Canadian Institute for Health Information (for a list of current NTIWG members, see Appendix B). The NTIWG intends to continue expanding its membership to obtain complete cross-Canada representation.

Funding for the NTI project is provided through Health Canada's Anti-Drug Strategy Initiative (ADSI).

Progress to Date

The NTI project has made significant progress since its inception. The 2014–2015 NTI report was downloaded some 1,700 times in the past year from CCSA's website, more than any previous report in this series. In recent years the project has also expanded the number of indicators it collects, as well as the number of jurisdictions and sources that contribute data to the annual report.

In 2013, a secure, online data collection tool was developed to improve the data collection process and minimize data entry errors and inconsistencies. In 2014, a new report format was introduced to provide jurisdiction-specific context, reduce reporting errors, mitigate cross-jurisdictional comparisons and improve the utility and relevance of information being presented.

This year, the NTIWG expanded its membership to include representation from British Columbia, and further enhanced the comprehensiveness of the report by capturing 2013–2014 data and information from Prince Edward Island and Health Canada's First Nations and Inuit Health Branch (FNIHB).

Although private treatment centre data is not presented in this year's report, CCSA has made significant progress identifying and securing representatives from the private sector who have expressed interest in participating in the NTI project and contributing to the annual report in future years.

The Road Ahead

The goal of the NTIWG is to continue to expand and strengthen data collection and to provide a truly comprehensive national picture. Improvements will include obtaining data from all provinces, territories and national agencies with responsibility to deliver substance use services on:

- Services provided in hospital settings;
- Non-specialized services offered by community and private sector partners; and
- An expanded set of indicators.

Administrative Context: Contributing to a National and International Picture

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

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

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

Methods

This report provides aggregate-level descriptive information on individuals who accessed publicly funded services for substance use treatment in Canada during 2013–2014.[4] Data for this report were submitted to CCSA by members of the NTIWG using a secure, online data collection tool. The NTIWG is comprised of representatives from Canadian jurisdictions that have treatment service delivery responsibilities. Working group members were asked to provide information on 35 indicators; however, not all jurisdictions were able to provide information on each indicator.

The data presented in this report are the outcome of a multi-stage process. First, service providers enter client level data, which are then submitted at the regional or provincial level according to reporting requirements. The data are then analyzed at the provincial level according to the definitions and data-collection protocols developed by CCSA in consultation with the NTIWG.[5] Next, data are entered into a secure, online platform specially designed for the NTI project. Finally, CCSA conducts data analysis and produces the report in close consultation with the NTIWG.

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

Data Collection

This fifth NTI report provides information from seven provinces, one territory, one federal association, and one provincial association on individuals who accessed publicly funded substance use treatment services during 2013–2014. Specifically, provincial-level treatment service data were provided by Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador; territorial information was provided by the Yukon; federal information was provided by FNIHB. The Association des intervenants en dépendance du Québec (AIDQ) also provided data on driving-while-impaired programs in Quebec.

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

Limitations

Developing a list of common core indicators presents many challenges. The general limitations to the current data are described below and noted in explanations throughout the report. Limitations specific to each jurisdiction's data are included in each jurisdiction's respective summary. Because of these limitations the data are not completely comparable across jurisdictions. Fortunately, the limitations are

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

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

expected to diminish with time as data-collection capacity develops and jurisdictions identify new methods to report information more directly in line with the NTI data-collection protocols. At this time, however, the following limitations must be considered when reviewing the data:

Services included: The data represent only publicly funded services. Private treatment[6] and rapid detoxification data are not included. Many people with problematic substance use also have a multitude of other health-related issues that can account for their contact with the healthcare system. The report however, does not capture most substance use treatment in primary care or hospital settings. As the NTI project evolves, CCSA hopes to better capture data reflecting the full continuum of substance use treatment services provided in Canada (e.g., community supports, primary care).

Jurisdictional participation: This report is based on data submitted by eight of a possible 16 administrative jurisdictions across Canada. Unfortunately, not all jurisdictions were able to participate in this year's annual report. CCSA and the NTIWG will continue to work with all jurisdictions to improve and enhance data collection as well as identify additional sources of information to include in future reports (e.g., privately funded treatment centre data).

Reliability: The accuracy of aggregate data depends on the accuracy and consistency of the individual case data being entered at the frontline level. In many provinces and territories, there are different data-collection systems in place across regions, creating inconsistencies in data definitions and data-entry practices. Service-level data-collection capacity is developing and will help improve consistency in future reports.

Service definitions: The collection of consistent information relies on the use of a standard, agreed-upon set of definitions. However, service delivery models vary widely across Canada. The core indicator definitions can be revisited as the project progresses to ensure that they best reflect work in the field.

Administrative variation: Small differences in how cases are recorded can result in tremendous variations at the aggregate level. For example, some jurisdictions consider a case to be "open" at first contact, whereas others wait until the formal treatment intake.

Comparability: The limitations listed above mean that although all jurisdictions are using the same data collection protocols, the data being provided across jurisdictions are not yet comparable.

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

Results

This report contains data from the 2013–2014 fiscal year on indicators related to substance use treatment services submitted by seven provinces (Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, Newfoundland and Labrador) as well as AIDQ. Further contextual information provided by the Yukon and FNIHB is also included.

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

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

Finally, the results include the ratio of service episodes to individuals, recognizing that an individual can have several episodes in a given year. The ratio, however, indicates an average that can be affected by variations in how an episode is measured between jurisdictions[7] or by a small number of individuals with a high number of episodes.

Definitions	
Episode	An episode refers to an admission to a specific treatment service. A person can access several different services or re-enter the same service more than once in a given year, and thus can have multiple episodes recorded. Jurisdictions vary in their documentation of whether transfers between services are recorded as discrete episodes.
Unique Individual	A unique individual refers to a single person. One unique individual might have several treatment episodes over the course of a year.

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

Yukon

Population: 30,348[8]
Gender: 51.0% Male; 49.0% Female

Overview and Summary

The Yukon joined the NTIWG in 2009 and has contributed substance use treatment data to three of the five annual reports that have been published to date. Data for 2013–2014 could not be submitted as during the collection process it was discovered that the two data collection tools in use contradicted each other, resulting in inaccurate numbers. Currently, there is a project team exploring options for incorporating a new database system that will collect not only data for the NTI project, but also for monthly data submissions to the health minister.

There are several key addiction treatment activities underway in the Yukon. Work on the Yukon Addictions Services Systems, Standards and Evaluation Project, funded by Health Canada's Drug Treatment Funding Program (DTFP), is ongoing. There are three components to this project: standards development and implementation, program evaluation and outcome measures, and project evaluation.

In addition, an expansion in service provision by Alcohol and Drug Services (ADS) in Whitehorse is anticipated with their imminent move to a new facility, planned for July 2016.

Currently ADS services include:

- A 24-day gender-specific residential service that runs nine times per year;
- An outpatient treatment service;
- Youth services, including a high school-based counselling program;
- A withdrawal management program; and
- A community addictions program providing treatment and prevention services to remote areas of the Yukon.

Through the development of a new facility, ADS has taken the opportunity to develop a continuum of services based on *A Systems Approach to Substance Use in Canada* (National Treatment Strategy Working Group, 2008). Programs to be included are:

- Medically supported withdrawal management services for adults (14 beds);
- Medically supported withdrawal management services for youth (four beds);
- Intensive treatment program: phased program of up to 80 days for concurrent disorders, 10 beds male and 10 beds female (gender-specific programs);
- Youth treatment program;
- Transition programs (eight beds);

[8] All demographic data for the Yukon and the provinces are for 2013 and are taken from Statistics Canada, Table 051–0001: www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&tabMode=dataTable&srchLan=-1&p1=-1&p2=9. Population figures are based on individuals 15 years of age and older.

- Community addiction program: full-time workers based in three communities and itinerant workers in all other communities throughout the Yukon providing prevention, pre-treatment, treatment and continual support after treatment services;
- Counselling program; and
- Prevention and education services.

As ADS prepares for the expansion of its capacity to work with a greater number of clients, the importance of a functional database to allow for the seamless movement of clients into programs that meet their needs has been emphasized. The implementation of a database that can house a client's file in one central location, thereby reducing the volume of duplicate information recorded in the separate databases, would enable staff to better provide services to clients. Further, a central system will allow ADS to gather data that can be used to understand the movement of clients throughout the system, as well as their use of services, so to inform programming and service provision decisions.

Alberta

Population: 3,276,609
Gender: 50.7% Male; 49.3% Female

Overview and Summary

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

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

Important Considerations and Limitations

- Although the vast majority of AHS services, both direct and contracted, are captured through STORS and ASIST, some parts of the province (i.e., health zones) have additional addiction programs that do not report to STORS or ASIST. These data are not included in this analysis.
- AHS does not offer non-residential withdrawal management.
- For the following results, a new case is defined as a unique individual admitted during the fiscal year. This excludes clients who received service in previous years and whose treatment carried over in 2013–2014.
- Data provided by AHS contracted services only includes information on the total number of treatment episodes. Information on unique individuals is not available.

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 32,729 unique individuals accessed publicly funded treatment services in Alberta for problematic substance use, of which 78.8% were new cases. In total, these 32,729 individuals accounted for 49,341 episodes.

The majority of individuals accessing treatment services (86.5%) were seeking treatment for their own problematic substance use. However, 4,420 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, accounting for 13.5% of the entire population of unique clients.

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

Total number of episodes and unique individuals by treatment category

Of the total number of episodes for individuals seeking treatment for themselves (43,946), 29,073 (66.2%) were episodes for non-residential treatment. Approximately 22.5% of the total episodes were for residential withdrawal management, and 11.3% for residential treatment.

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

Table 1. Ratio of episodes to individuals for direct services only, excluding funded services (Alberta)

Residential withdrawal management	1.4
Residential treatment	1.0
Non-residential treatment	1.1

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

Of the 43,946 episodes accessed by individuals seeking treatment for themselves, 28,778 (65.5%) were accounted for by males, while 15,043 (34.2%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 64.9%; females, 68.4%) in Alberta, followed by residential withdrawal management (males, 23.5%; females, 20.8%).

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

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

Figure 1. Treatment episodes (direct and contracted services) by age (Alberta)

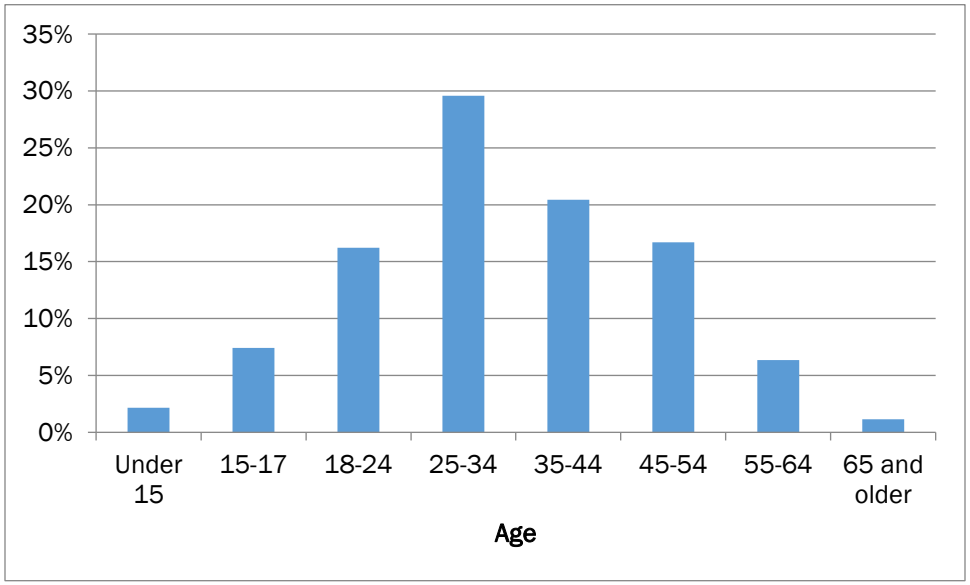


Figure 2. Unique individuals (direct service only) by age (Alberta)

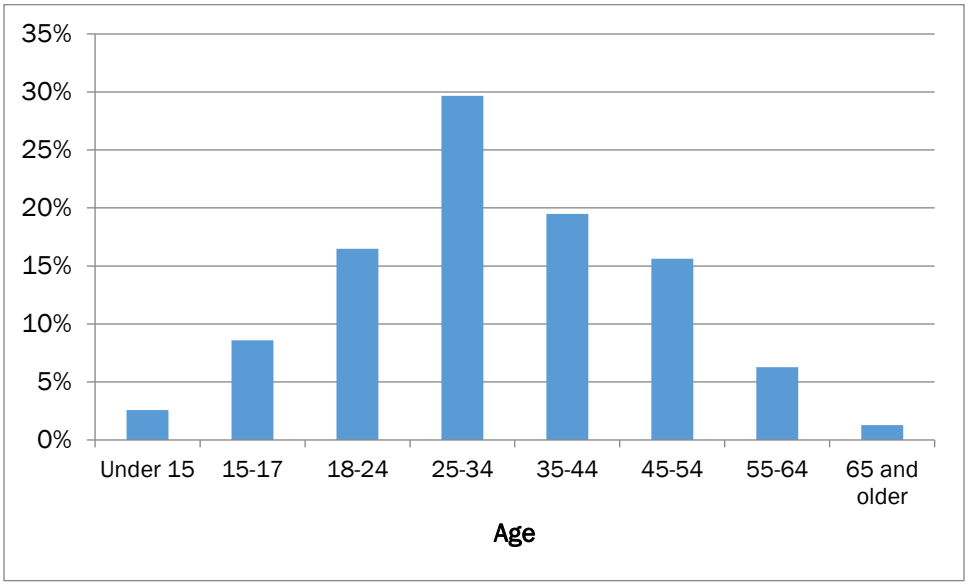
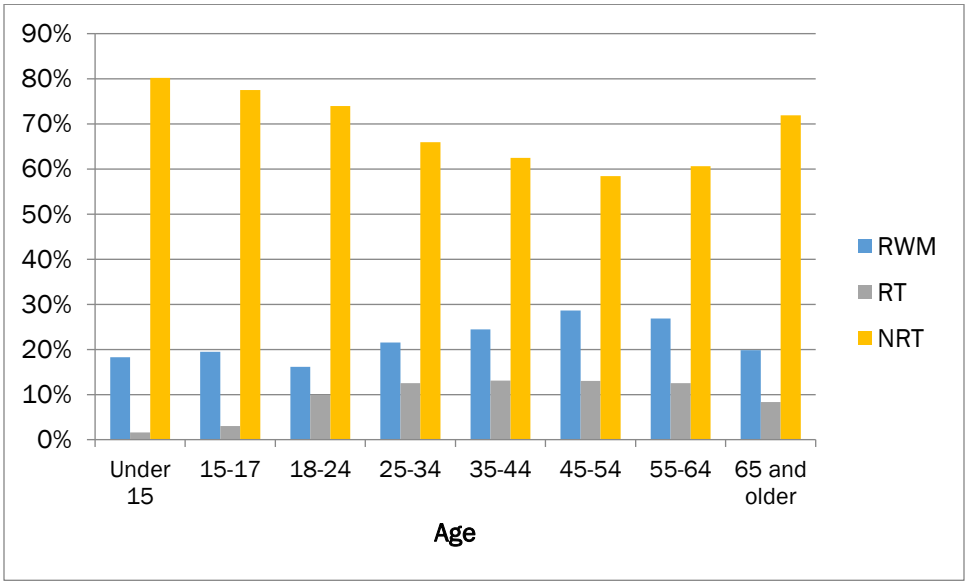


Figure 3. Episodes (direct and contracted services) by age and treatment type (Alberta)



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

In total, 1,741 unique individuals who accessed AHS direct treatment services in Alberta during 2013–2014 reported using drugs by injection in the 12 months preceding treatment. These 1,741 unique individuals accounted for 3,686 episodes. Males accounted for the majority (63.4%) of episodes of reported injection drug use. The ratio of episodes to individuals was the same for males and females at 2.1, indicating that on average individuals of either gender who used injection drugs in the past 12 months accessed treatment more than twice.

Total number of unique individuals accessing opioid substitution treatment

In total, 1,142 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 60.2% of all clients.

Past-year substance use among unique individuals seeking treatment

Among individuals accessing treatment services in Alberta during 2013–2014, alcohol was the most common substance used in the 12 months preceding treatment, followed by cannabis, cocaine and opioids.

Treatment episodes by employment status

Of 49,341 episodes, 53.7% were accessed by individuals who reported their employment status as "unemployed" at the time of treatment; 34.9% were accessed by individuals who reported "employed full-time"; 7.5% by individuals who reported "employed part-time"; and 3.9% who reported "other" as their employment status.

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded substance use treatment service usage in Alberta between April 1, 2013, and March 31, 2014.

Overall, the results revealed relatively consistent patterns and trends in service use when compared to data from previous years. Non-residential treatment remained the most commonly accessed treatment service in Alberta, accounting for 66.2% of all treatment episodes in 2013–2014. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment is typically the most accessible and cost-effective treatment service available.

The overall total number of treatment episodes and individuals decreased between 2012–2013 and 2013–2014. Specifically, there were 2,061 fewer residential withdrawal management episodes and 1,378 fewer residential treatment episodes in 2013–2014 as compared to 2012–2013. Changes in service volume could be due to a number of factors, including changes in service demand and capacity, service use and referral practices, population demographics, policy and legislation, and usage patterns of services not captured in this report.

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

In addition to monitoring service use, AHS tracks other indicators related to care, including client satisfaction, access times and outcomes. More information related to addiction and mental health services performance monitoring can be found in the annual *System Level Performance Report for Addiction and Mental Health Services in Alberta 2012/13* (Alberta Health Services, 2014).

Saskatchewan

Population: 897,971
Gender: 50.2% Male; 49.8% Female

Overview and Summary

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

The Saskatchewan Ministry of Health is responsible for publicly funded treatment services in Saskatchewan. These services are delivered directly through 12 regional health authorities, one unique health authority in northern Saskatchewan and community-based organizations. Saskatchewan has achieved some integration of mental health services and substance use services, at the administrative and clinical levels. The Province of Saskatchewan uses one system to capture alcohol and drug treatment services data from its regional health authorities and community-based organizations, the Alcohol, Drug and Gambling (ADG) system; however, the Saskatoon Health Region does not participate in this system and reports data to the Ministry of Health annually.

Important Considerations and Limitations

- All regional health authorities and community-based organizations funded by the Ministry of Health to provide alcohol and drug treatment services in the province submit data through the ADG system, except for Saskatoon Health Region, though all regional health authorities and community-based organizations are included in the data presented. Saskatchewan's ADG data system tracks service events rather than new admissions, so its data does not reflect the number of discrete (i.e., new) cases for the fiscal year of interest.
- Gender is identified for all service events entered into the ADG data system, but the system only captures male and female categories.
- Saskatchewan does not offer non-residential withdrawal management because all withdrawal management programs are residential.
- Information on individuals accessing methadone programs are captured under "non-residential treatment."
- External methadone clinics are not included in this data.
- Opiate substitution only captures sex, rather than gender.
- Not all treatment providers were able to submit data on each of the indicators. For this reason data discrepancies might be present in the data below.
- Saskatchewan does not collect information on the primary substance for which treatment is being sought. For this reason, information on substances used in the 12 months preceding treatment is provided.

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 15,451 unique individuals accessed publicly funded substance use treatment services in Saskatchewan. In total, these 15,451 individuals accounted for 21,673 episodes.

The majority of individuals accessing treatment services (89.2%) were seeking treatment for their own substance use problems. However, 1,192 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, accounting for 7.7% of the entire population of unique clients.[10]

Total number of episodes and unique individuals by treatment category

Of 19,843 episodes accessed by individuals seeking treatment for themselves, 70.3% were episodes for non-residential treatment. Approximately 20.4% of the total episodes were for residential withdrawal management, and 9.3% for residential treatment.

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

Table 2. Ratio of episodes to individuals by treatment category (Saskatchewan)

Residential withdrawal management	1.4
Residential treatment	1.1
Non-residential treatment	1.2

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

Of 19,843 episodes accessed by individuals seeking treatment for themselves, 12,737 (64.2%) were accounted for by males, while 7,097 (35.8%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 71.9%; females, 67.6%) in Saskatchewan, followed by residential withdrawal management (males, 19.4%; females, 22.0%).

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

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

[10] In 2013–2014, 510 cases did not report whether the primary reason for accessing treatment was their own substance use or a friend or family member's substance use.

Figure 4. Treatment episodes by age (Saskatchewan)

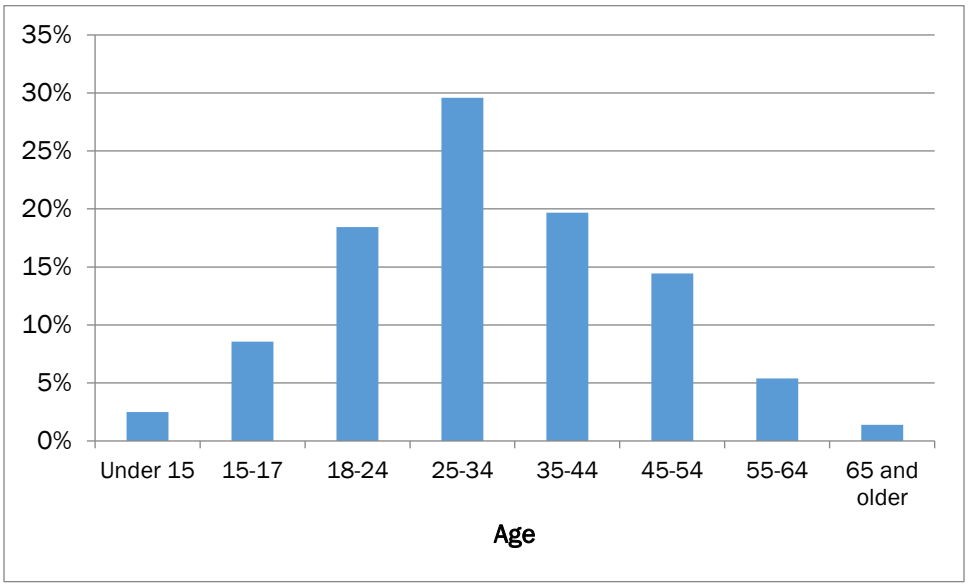


Figure 5. Unique individuals by age (Saskatchewan)

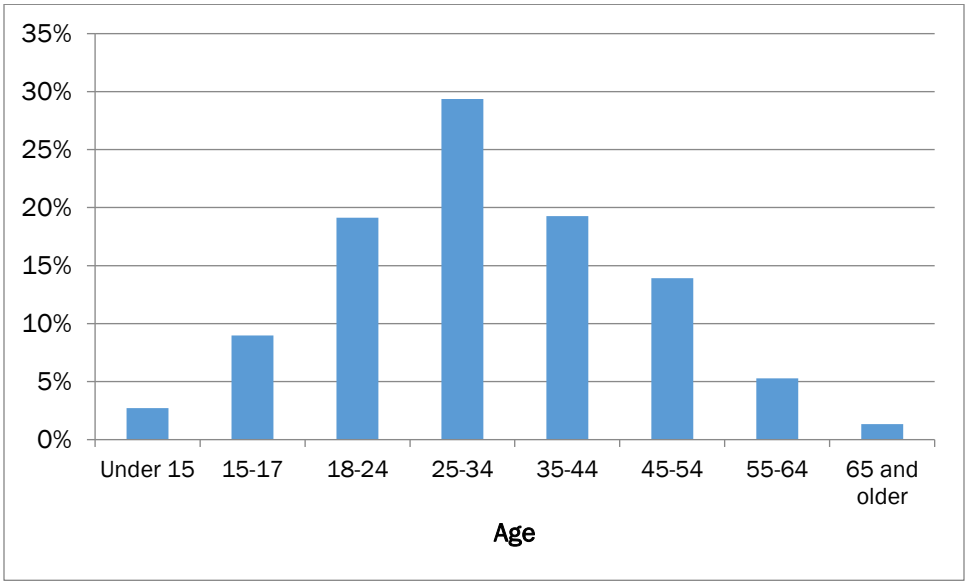
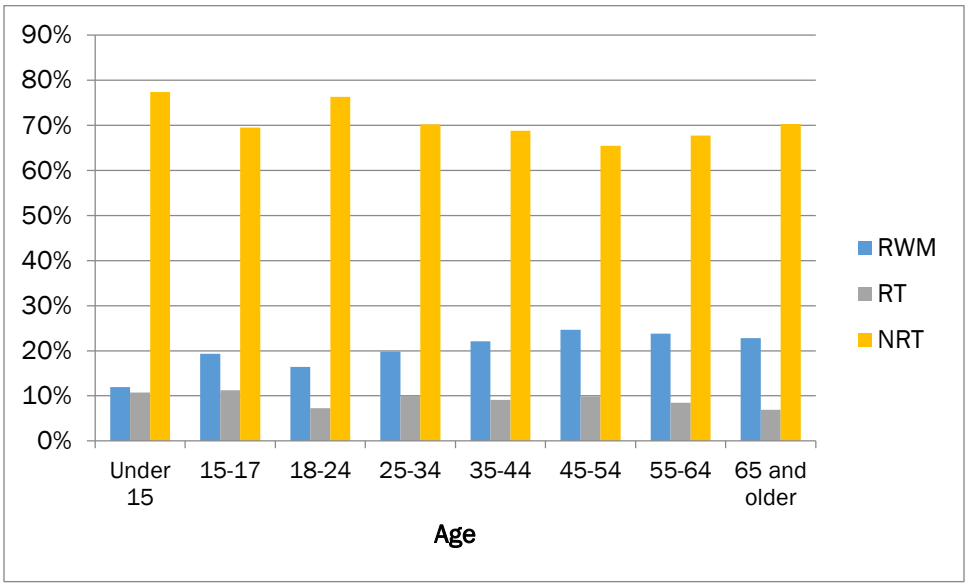


Figure 6. Episodes by age and treatment type (Saskatchewan)



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

In total, 1,972 unique individuals who accessed treatment services in Saskatchewan during 2013–2014 reported using drugs by injection in the 12 months preceding treatment. These 1,972 unique individuals accounted for 3,190 episodes. The ratio of episodes to individuals was approximately even for males and females (1.6 and 1.7 episodes per individual, respectively).

Total number of unique individuals accessing opioid substitution treatment

In total, 460 individuals accessed publicly funded opioid substitution treatment, of which males and females each accounted for approximately 50% of all clients. The majority (40.0%) of opioid substitution clients were ages 25–34 followed by individuals 35–44 (29.1%).

Past-year substance use among unique individuals seeking treatment

In fiscal year 2013–2014, the top three substances individuals reported having used in the past 12 months were alcohol (81.8%), cannabis (46.7%) and opioids (29.8%). Past-year use of hypnotics was also reported by 26.4% of the client population.

Treatment episodes by employment status

Of 20,831 episodes, 36.6% were accessed by individuals who reported “unemployed” as their employment status at the time of treatment; 32.5% reported being employed “full-time”; 11.0% identified as a student; 10.0% were employed “part-time”; and 9.9% fell into the “other” employment status category.[11]

Discussion

This jurisdictional summary has presented aggregate-level information on publicly funded treatment service use in Saskatchewan between April 1, 2013, and March 31, 2014.

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

Overall, treatment use has remained relatively constant since 2009–2010 with approximately 15,000 individuals accessing publicly funded services in Saskatchewan each year. Between 2009–2010 and 2013–2014, non-residential treatment remained the most commonly accessed treatment service in Saskatchewan, and in the data year presented in this report accounted for approximately 70% of all treatment episodes. This finding is also consistent across other jurisdictions and is unsurprising given that non-residential treatment is accessible in all regional health authorities and is typically the starting point for families and individuals concerned about their own or others use of alcohol or drugs. Furthermore, individuals returning home from a residential treatment program are encouraged to access non-residential treatment.

The overall total number of treatment episodes and individuals increased slightly between 2012–2013 and 2013–2014. Specifically, there were 442 additional residential withdrawal management episodes, 177 additional residential treatment episodes and 375 additional non-residential treatment episodes in 2013–2014 as compared to 2012–2013.

In light of the fact that most individuals accessing treatment services in Saskatchewan are doing so on a non-residential basis, it is important to highlight the work being done to monitor wait times of adult and youth accessing these services in Saskatchewan. The Ministry of Health, in collaboration with the regional health authorities, developed benchmarks for the maximum length of time a client should wait for outpatient services, according to their level of need represented by four triage categories: very severe, severe, moderate and mild. In 2013–2014, the benchmark was set at 70% for all triage categories. As of April 1, 2013, regional health authorities began to submit monthly data to the Ministry of Health to assess how often these targets were met. In 2014–2015, the target was increased to 85% for all four categories.

Manitoba

Population: 1,028,915
Gender: 49.3% Male; 50.7% Female

Overview and Summary

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

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

Important Considerations and Limitations

- Manitoba does not offer non-residential withdrawal management.
- There are inconsistencies in how treatment service providers collect and report employment status, past 12 month substance use and housing status. For this reason, these data are not presented.
- Some agencies were unable to provide data for certain indicators of interest. Manitoba submitted data only for indicators that most agencies including AFM were able to report.
- Manitoba is currently improving agency-level data collection processes.
- There are limited common data collection processes in Manitoba, making it difficult to fully validate the data provided by agencies.
- Because Manitoba's publicly funded agencies do not share data from agency to agency, new cases can only be tracked for a specific agency, not at a system level.
- Carry over data (i.e., cases that began in 2011–2012 and continued into 2012–2013) are not reported by all agencies in Manitoba and so were not submitted for 2013–2014.
- In Manitoba, a new case is defined as an individual with no treatment experience in the fiscal year and does not include the same individual being transferred to a new program within the same agency.

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 9,476 unique individuals accessed publicly funded substance use treatment services in Manitoba, of which 93.6% were new cases. In total, these 9,476 individuals accounted for 15,191 episodes.

The majority of individuals accessing treatment services (94.0%) were seeking treatment for their own problematic substance use. However, 629 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, which accounts for 6.6% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the treatment episodes in Manitoba, the majority (75.4%) were for non-residential treatment. Approximately 16.7% were for residential treatment and 7.8% for residential withdrawal management.

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

Table 3. Ratio of episodes to individuals (Manitoba)

Residential withdrawal management	1.6
Residential treatment	1.1
Non-residential treatment	1.5

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

Of the 14,042 episodes where gender was reported, 8,439 (60.1%) were accounted for by males, while 5,603 (39.9%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 75.4%; females, 72.9%) in Manitoba followed by residential treatment (males, 15.6%; females, 19.3%).

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

As shown in Figures 7 and 8, people aged 25–34 accounted for the highest percentage of treatment episodes, as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of treatment episodes while persons age 18-24 accounted for the second highest percentage of unique individuals accessing treatment. As shown in Figure 9, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 7. Treatment episodes by age (Manitoba)

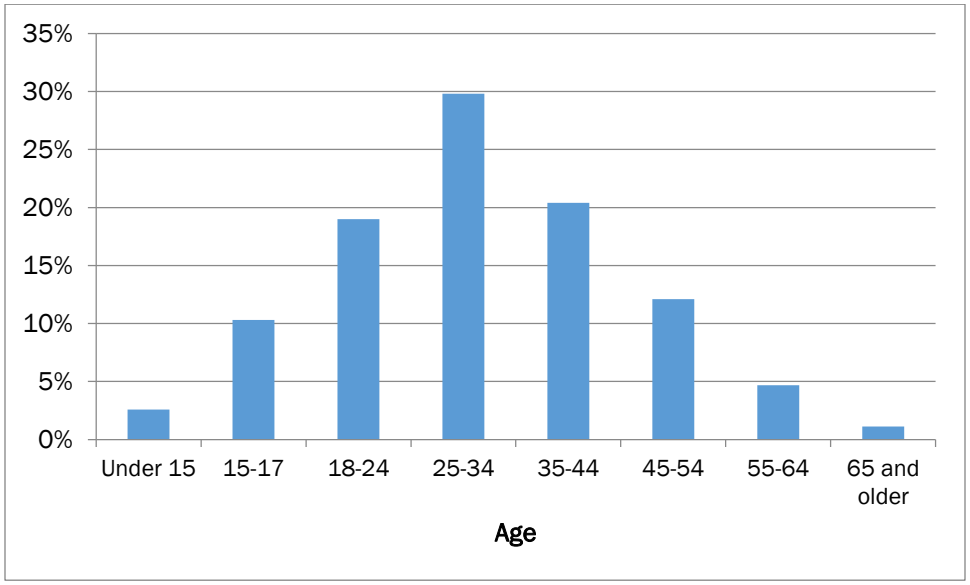


Figure 8. Unique individuals by age (Manitoba)

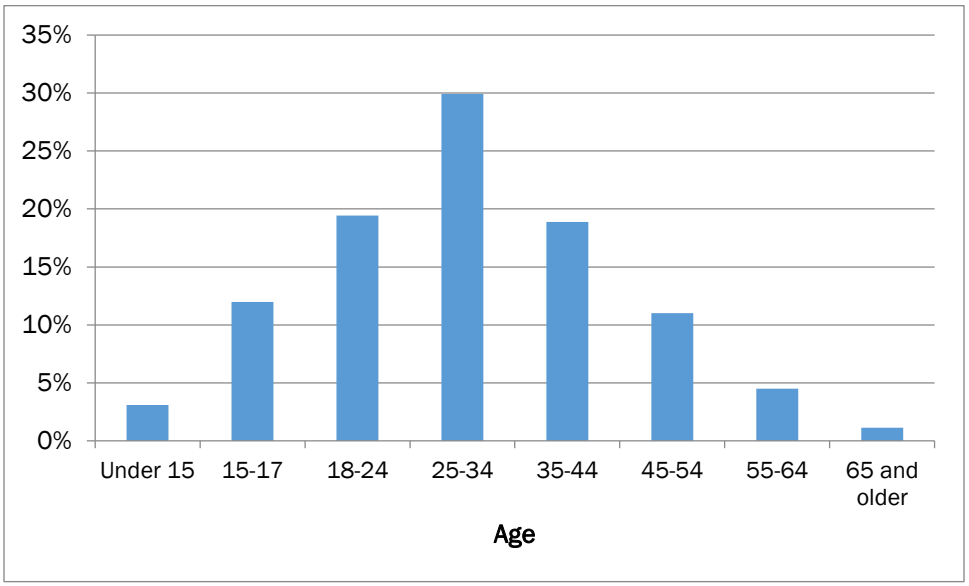
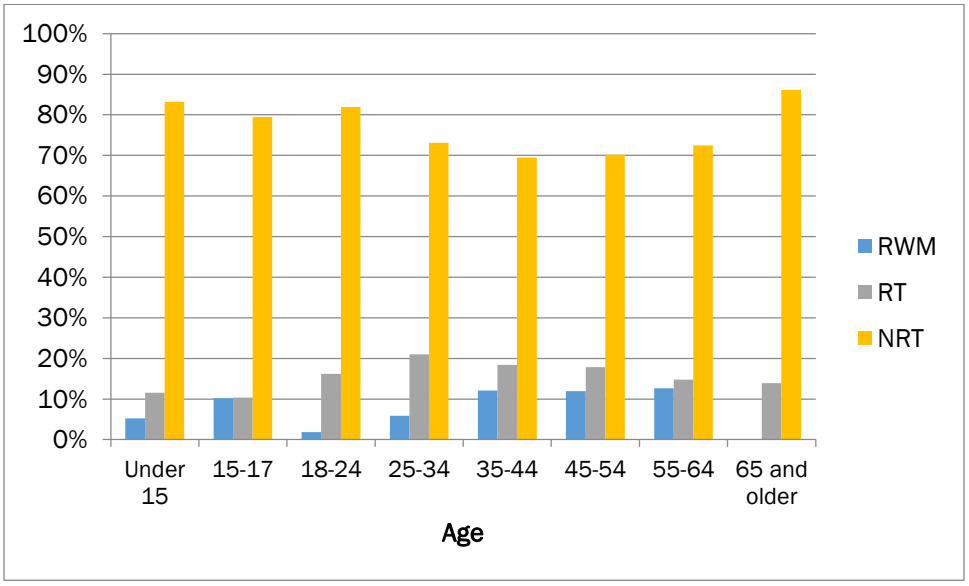


Figure 9. Episodes by age and treatment type (Manitoba)



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

Males accounted for the majority (52.9 %) of all episodes related to treatment for injection drug use. The ratio of episodes to individuals was approximately even for males and females (1.0 and 1.1 episodes per individual, respectively).

Total number of unique individuals accessing opioid substitution treatment

In total, 70 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 52.9% of all clients.

Total number of people participating in driving-while-impaired programs

In total, 1,731 individuals attended driving-while-impaired (DWI) programs in Manitoba during the 2013–2014 fiscal year. The vast majority of these individuals were male (83.0%). Nearly one-third (29.5) of all DWI clients were between the ages of 25 and 34. Individuals ages 18–24 made up the second highest percentage of DWI clients (22.0%), followed by 35–44 year olds (20.2%) and 45–54 year olds (17.7%).

Discussion

This jurisdictional summary has presented aggregate-level information on the use of publicly funded substance use treatment services in Manitoba between April 1, 2013, and March 31, 2014.

Overall, the total number of treatment episodes decreased slightly between 2012–2013 and 2013–2014. Specifically, there were 679 fewer residential withdrawal management episodes, 101 fewer residential treatment episodes and 13 fewer non-residential treatment episodes in 2013–2014, as compared to 2012–2013. The decrease in residential withdrawal management episodes is explained by the fact that the largest residential withdrawal management program was transitioning into a new building and from co-ed to gender-specific services. Also, its continued transition to a new information system changed its methods of tracking client admissions. The decrease in residential and non-residential treatment is relatively minor and likely represents normal fluctuations in treatment service access.

Between 2009–2010 and 2013–2014, non-residential treatment remained the most commonly accessed treatment service in Manitoba, and in the most recent year of data collection accounted for approximately 75% of all treatment episodes. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment services are accessible from many sites province wide, whereas the majority of residential services are located in Winnipeg. Furthermore, best practice suggests that the majority of individuals seeking treatment for problematic substance use do not require residential treatment services and therefore non-residential treatment is the most appropriate service type.

In 2011–2012, publicly funded treatment services in Manitoba attempted implementing a common data collection and reporting process with the result that five agencies now use this common system. However, because the data collection tool was not adopted in larger agencies, data collection across the province remains inconsistent. Internal changes to data collection and data definitions likely impact overall numbers as compared to previous years. Manitoba anticipates addressing data collection issues until common collection methods and tools are in place.

Ontario

Population: 11,358,301
Gender: 48.7% Male; 51.3% Female

Overview and Summary

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

The Ministry of Health and Long-Term Care is responsible for treatment services in Ontario. Treatment services in Ontario are delivered through 14 Local Health Integration Networks (LHINs), as well as through community agencies. Mental health services are integrated with substance use services at the administrative level. Ontario uses the Drug and Alcohol Treatment Information System (DATIS), a browser-based system,[12] to collect its treatment data. DATIS figures are reported quarterly and annually.

Important Considerations and Limitations

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

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 83,232 unique individuals accessed publicly funded substance use treatment services in Ontario, of which 74.7% were new cases. In total, these 83,232 individuals accounted for 111,493 episodes.

The majority of individuals accessing treatment services (93.2%) were seeking treatment for their own problematic substance use. However, 5,689 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, which accounts for 6.8% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of 105,428 episodes accessed by individuals seeking treatment for themselves, the majority (63.3%) were episodes for non-residential treatment. Approximately 25.0% were for residential withdrawal management, 8.8% for residential treatment and 2.0% for non-residential withdrawal management.

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

Table 4. Ratio of episodes to individuals (Ontario)

Residential withdrawal management	1.9
Non-residential withdrawal management	1.1
Residential treatment	1.2
Non-residential treatment	1.2

[12] A browser-based system is able to connect to a central data-collection system that allows users to enter data directly from separate locations and for the generation of summary reports.

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

Of 105,428 episodes accessed by individuals seeking treatment for themselves, 68,758 (65.2%) were accounted for by males, while 36,619 (34.7%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 60.0%; females, 69.5%) in Ontario, followed by residential withdrawal management (males, 29.0%; females, 19.9%).

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

As shown in Figure 10 and Figure 11, people aged 25–34 accounted for the highest percentage of treatment episodes, as well as the highest percentage of unique individuals, while people aged 35-44 accounted for the second highest percentage of both episodes and unique individuals accessing treatment. As shown in Figure 12, non-residential treatment accounted for the majority of episodes for all age categories.

Figure 10. Treatment episodes by age (Ontario)

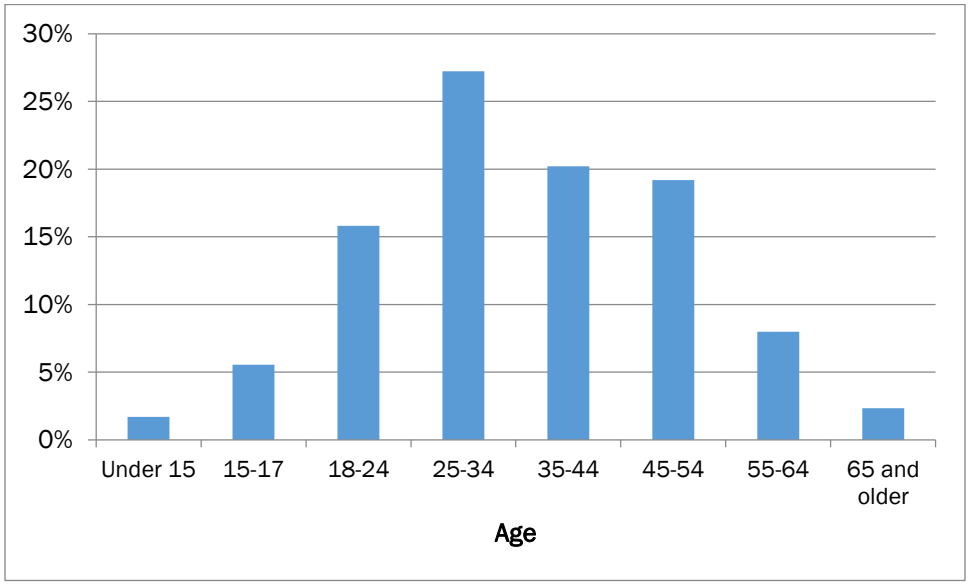


Figure 11. Unique individuals by age (Ontario)

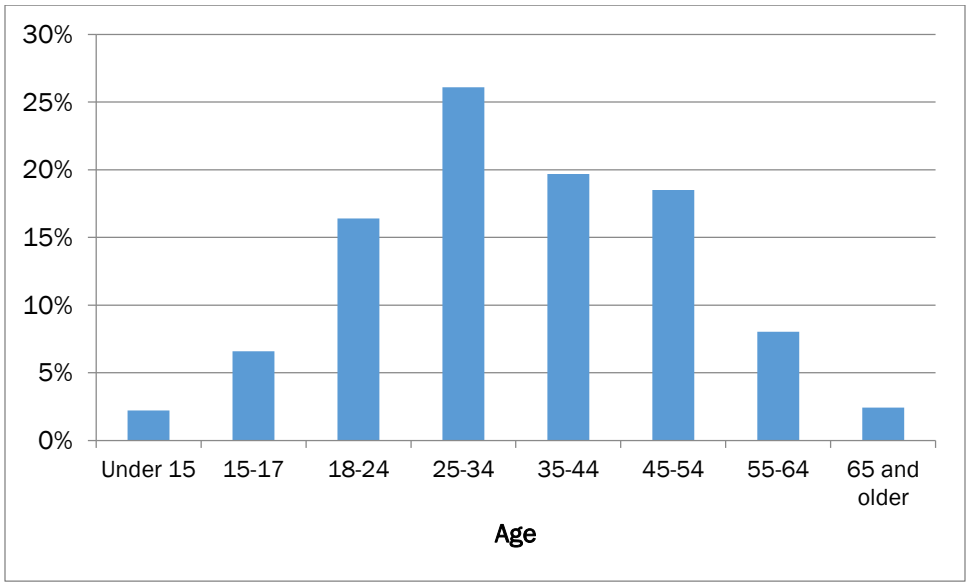
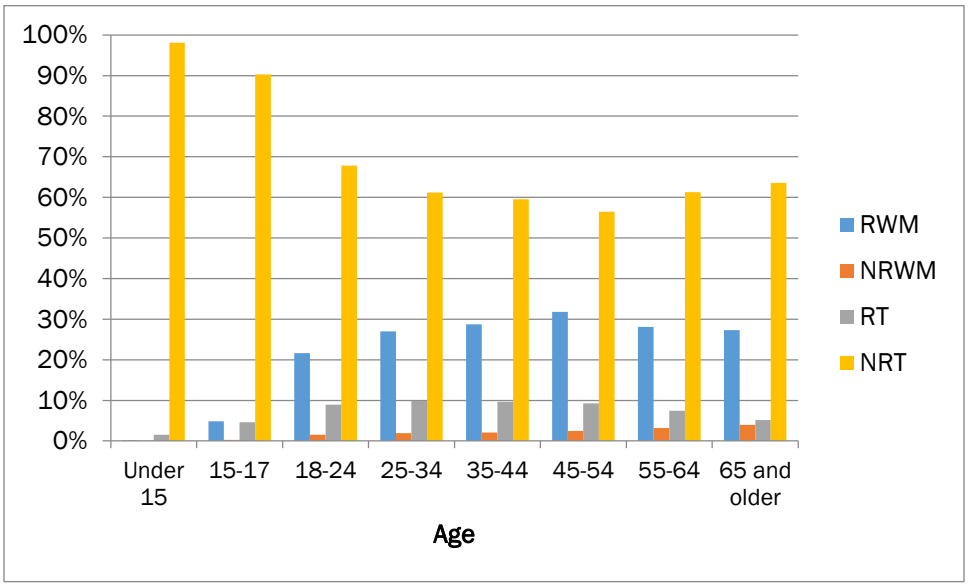


Figure 12. Episodes by age and treatment type (Ontario)



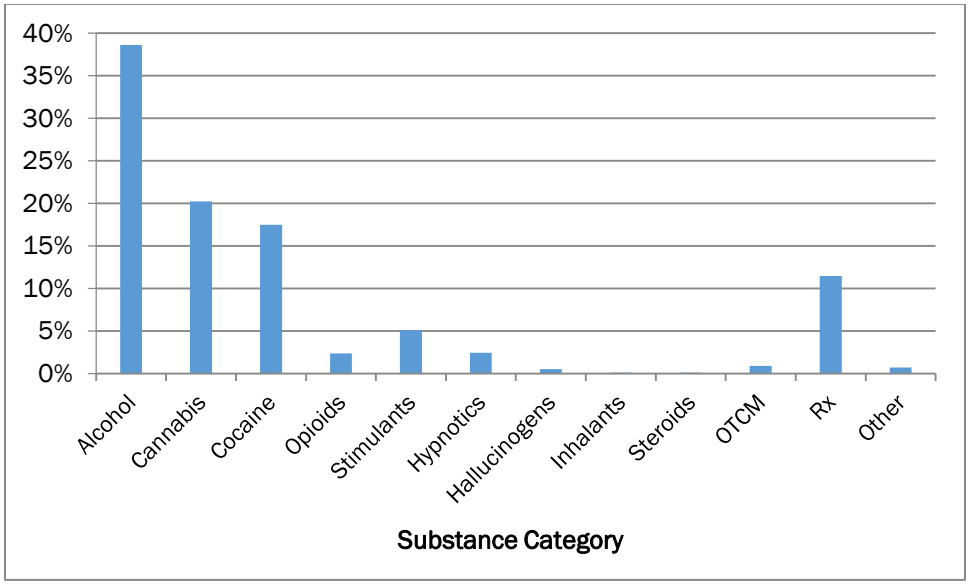
Total number of episodes and unique individuals who have used drugs by injection within the 12 months prior to treatment

Males accounted for the majority (64.3%) of the 13,146 episodes related to treatment for injection drug use. Based on the number of individuals accessing treatment for each respective gender, the ratio of episodes to individuals was slightly higher among males (1.7) than females (1.6).

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

As shown in Figure 13, alcohol was the substance most commonly reported as the reason for seeking treatment, accounting for 38.6% of all treatment episodes, followed by cannabis (20.2%) and cocaine (17.5%).

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



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

Treatment episodes by employment status

Of the 111,493 episodes, 34.6% were accessed by individuals who reported "unemployed" as their employment status at the time of treatment; 28.4% were identified as "other" and 22.7% were employed full-time.

Discussion

This jurisdictional summary has presented aggregate-level information on the use of publicly funded substance use treatment services in Ontario between April 1, 2013, and March 31, 2014.

Overall, Ontario experienced a 6.3% decrease in the total number of treatment episodes between 2012–2013 and 2013–2014. This difference might be explained by the increase in attention to data quality from DATIS and by the increase in data scope obtained by interfacing DATIS proprietary software with software commonly used in multi-sectoral agencies.

In 2013–2014, non-residential treatment remained the most commonly accessed treatment service in Ontario, accounting for approximately 63% of all treatment episodes. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment is typically the most accessible and cost-effective treatment service available.

Alcohol as the primary substance for which treatment was sought was responsible for the greatest proportion of treatment episodes in Ontario during 2013–2014. However, in the last six years, Ontario has seen a noticeable rise in the number of admissions listing prescription opioids as the client's primary reason for seeking treatment.

[13] Note that individuals can present up to two primary substances.

Quebec

Population: 6,900,390
Gender: 49.4% Male; 50.6% Female

Overview and Summary

Substance use treatment services in Quebec include residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management. Currently, data on Quebec treatment services is limited to DWI programs. These data are provided by the Association des intervenants en dépendence du Québec (AIDQ).

The Ministry of Health and Social Services is responsible for substance use treatment services in Quebec.

Important Considerations and Limitations

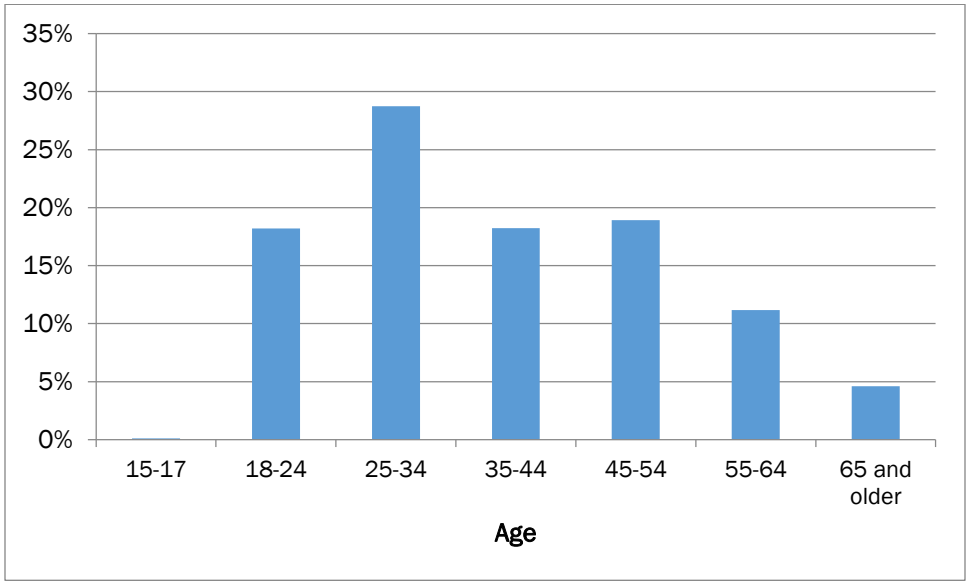
Only data on individuals accessing DWI programs is included in this report.

Results

Total number of people participating in driving-while-impaired programs

In total, 14,176 individuals accessed DWI programs in Quebec during the 2013–2014 fiscal year. The vast majority of these individuals were male (82.0%). As shown in Figure 14, nearly 30% of all DWI individuals were between the ages of 25 and 34. More than 80% of all DWI clients were between the ages of 18 and 54.

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



Discussion

For over 15 years the AIDQ has been managing and implementing the Programme d'évaluation des conducteurs automobiles based on the standards set out in an agreement between the Société d'assurance automobile du Québec, the AIDQ and the Centre de réadaptation en dépendance.

The protocols used by the AIDQ have not changed since 2002. The 2011–2012 fiscal year allowed for the development of protocols based on best practices following legislative changes to the Highway Safety Code in 2010; however, the 2013–2014 fiscal year presented significant challenges to the implementation of related measures. Throughout the years, AIDQ has noticed that the evolution of legislative and administrative measures has relied heavily on assessments, which have gone from 5,250 in 2003–2004 to 14,176 in 2013–2014, an increase of nearly 175%.

Nova Scotia

Population: 808,800
Gender: 48.6% Male; 51.4% Female

Overview and Summary

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

The Department of Health and Wellness is responsible for treatment services in Nova Scotia which are delivered through nine district health authorities and the IWK Health Centre. Nova Scotia is currently in the process of integrating mental health services and addiction services. The province uses the Addiction Services Statistical Information System Technology (ASsist) system to collect its treatment data. ASsist is a browser-based system and data are submitted in real-time.

Important Considerations and Limitations

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

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 11,447 unique individuals accessed publicly funded substance use treatment services in Nova Scotia, of which 76.2% were new cases. In total, these 11,447 individuals accounted for 12,593 episodes.

The majority of individuals accessing services (94.4%) were seeking treatment for their own problematic substance use. However, 636 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, which accounts for 5.6% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the total number of episodes for individuals seeking treatment for themselves (11,942), the majority (75.6%) were episodes for non-residential treatment. Approximately 20.1% of the total episodes were for residential withdrawal management, 1.2% for residential treatment and 3.1% for non-residential withdrawal management.

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

Table 5. Ratio of episodes to individuals (Nova Scotia)

Residential withdrawal management	1.4
Non-residential withdrawal management	1.0
Residential treatment	1.1
Non-residential treatment	1.0

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

Of 11,942 episodes, 8,171 (68.4%) were accounted for by males and 3,746 (31.4%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 77.0%; females, 72.8%) in Nova Scotia, followed by residential withdrawal management (males, 19.4%; females, 21.4%).

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

As shown in Figure 15 and Figure 16, people aged 25–34 accounted for the highest percentage of treatment episodes, as well as the highest percentage of unique individuals. Non-residential treatment accounted for the majority of episodes for all age categories, as shown in Figure 17.

Figure 15. Treatment episodes by age (Nova Scotia)

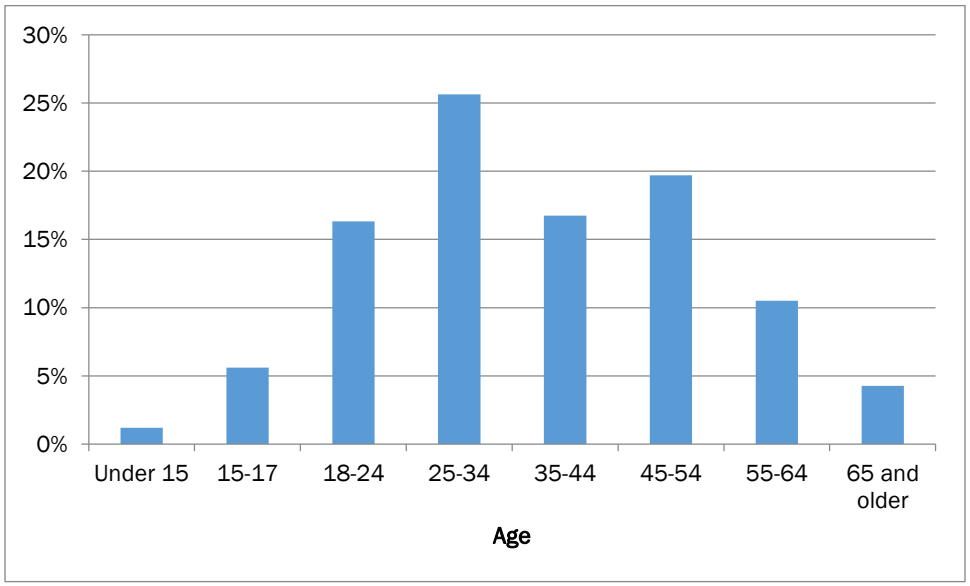


Figure 16. Unique individuals by age (Nova Scotia)

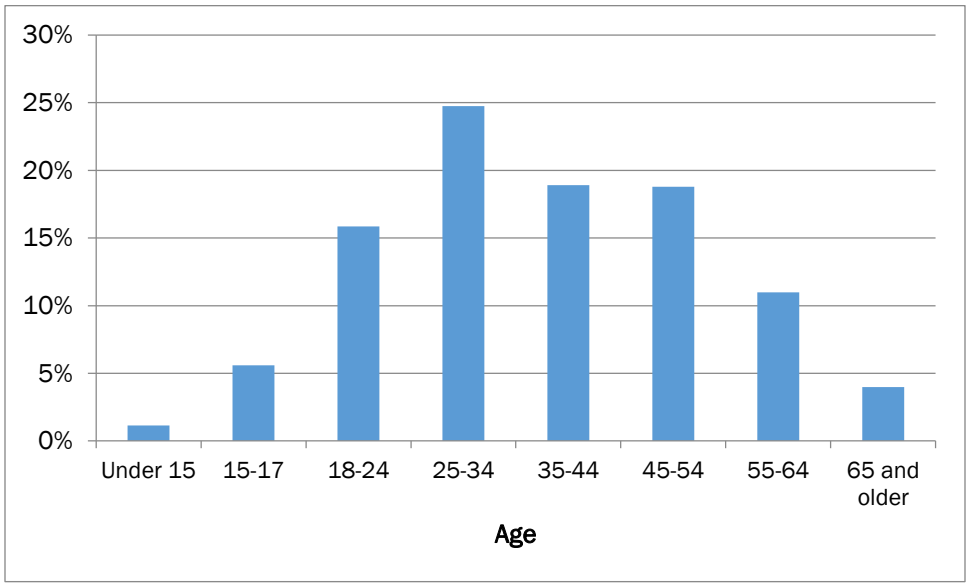
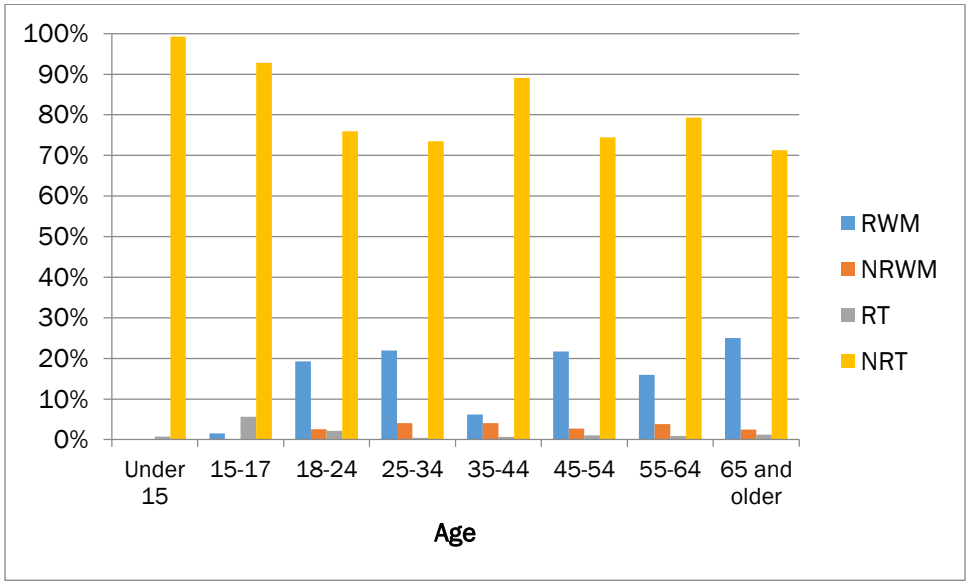


Figure 17. Episodes by age and treatment type (Nova Scotia)



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

Males accounted for the majority (62.1%) of all episodes related to treatment for injection drug use. However, based on the number of individuals accessing treatment for each respective gender, the ratio of episodes to individuals was identical for males and females at 1.5 episodes for every unique individual.

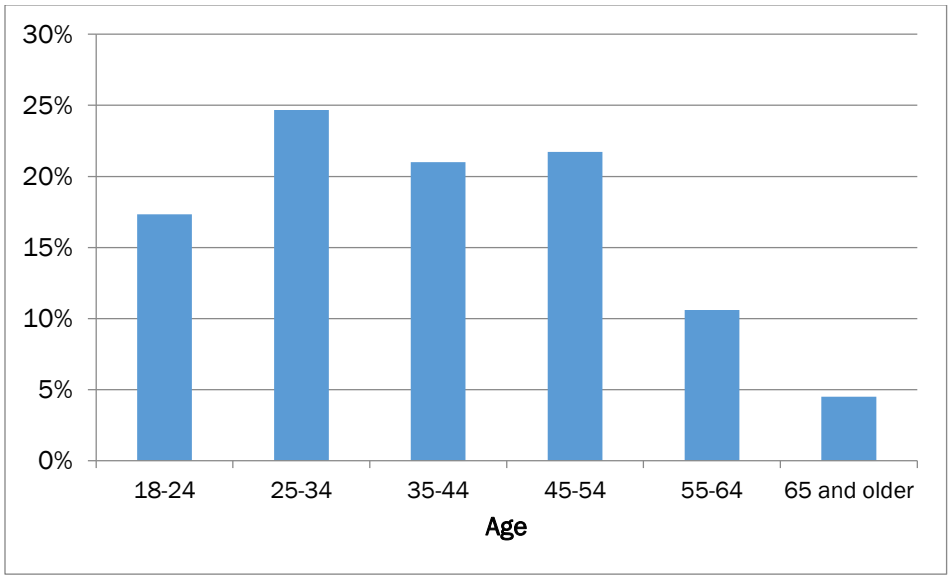
Total number of unique individuals accessing opioid substitution treatment

In total, 807 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 62.8% of all clients. The majority (43.1%) of opioid substitution clients were ages 25–34 followed by individuals 18–24 (26.8%).

Total number of people participating in driving-while-impaired programs

In total, 1,690 individuals accessed DWI programs in Nova Scotia during the 2013–2014 fiscal year. The vast majority of these individuals were male (82.8%). As shown in Figure 18, roughly one quarter of all individuals in DWI programs were between the ages of 25 and 34, while less than 20% were over the age of 54.

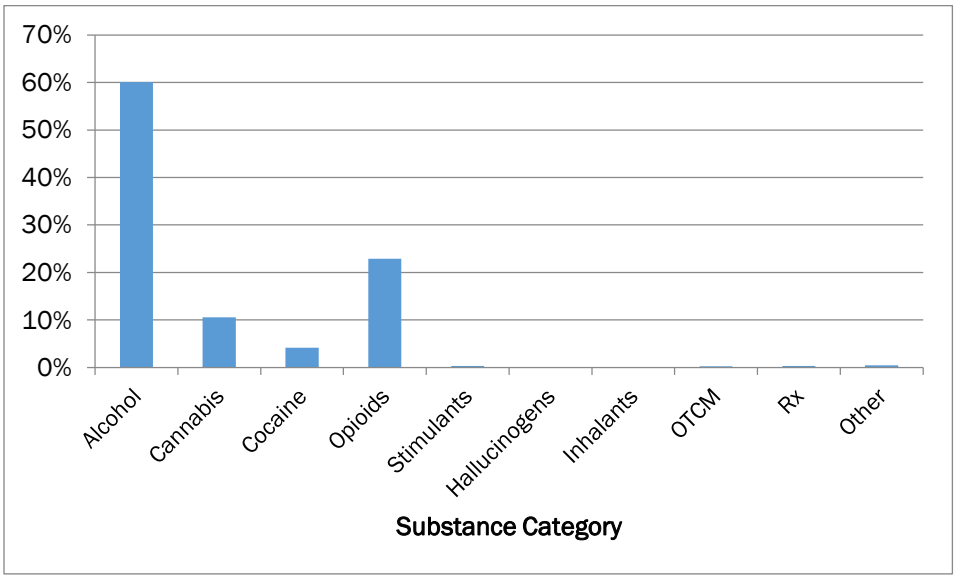
Figure 18. Percentage of individuals participating in driving-while-impaired programs by age (Nova Scotia)



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

As shown in Figure 19, alcohol was the substance most commonly reported as the reason for seeking treatment, accounting for 60.0% of all treatment episodes. Opioids were the second most commonly reported substances, accounting for over one-fifth of treatment episodes.

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



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

Treatment episodes by employment status

Of the 12,593 episodes, 44.3% were accessed by individuals who reported "unemployed" as their employment status at the time of treatment; 27.6% were employed full-time, 22.4% listed "other" as their employment status at the time of treatment and 5.7% were employed part-time.

Discussion

This jurisdictional summary has presented aggregate-level information on the use of publicly funded substance use treatment services in Nova Scotia between April 1, 2013, and March 31, 2014.

Overall, treatment use patterns and trends in Nova Scotia have been fluctuating over the past four years for which data was collected. For example, in 2009–2010 Nova Scotia experienced nearly 15,000 treatment episodes; however, these numbers fell to 12,535 and 12,935 in 2010–2011 and 2011–2012, respectively and increased to 13,743 in 2012–2013. In 2013–2014, the total number of treatment episodes stabilized at 12,593. This change represents a 14.5% decrease in treatment episodes since 2009–2010. Interestingly, there was a 20.3% increase in unique individuals in the same time period. Fluctuation in the total number of treatment episodes over the past four years is difficult to explain as there have been no major changes to staffing or programming throughout the province.

Since 2009–2010, non-residential treatment has remained the most commonly accessed treatment service in Nova Scotia, accounting for 75.6% of all treatment episodes in 2013–2014. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment offers the least intrusive form of intervention and is often more accessible (i.e., same community, town, etc.) than other service types.

Alcohol as the primary substance for which treatment was sought was responsible for the greatest proportion of treatment episodes in Nova Scotia during 2013–2014, followed by opioids. However, it is important to note that the total number of individuals seeking treatment for opioid-related issues has increased over the last few years. To address this trend, the Mental Health and Addiction Strategy has funded the expansion of opioid replacement treatment by funding 70 additional treatment spots; sponsoring training sessions that allow family physicians to receive their exemption to prescribe methadone for dependency purposes; providing supplies used in the assessment of opioid misuse; and offering training for 50 additional physicians to provide opiate dependency treatment (Government of Nova Scotia, 2013).

In 2013–2014, Nova Scotia developed a service delivery model for inpatient withdrawal management. The goal of this model is to provide access to timely and safe addictions care, linking clients to the least intrusive level of service that matches their individual needs, and to ensure that inpatient withdrawal management is integrated with other components of addiction and mental health services, so clients experience the best chance for coordinated, effective care that leads to improved health.

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

More information related to addiction services performance monitoring can be found in the Nova Scotia Addiction Services annual report (2015).

Prince Edward Island

Population: 145,441
Gender: 48.7% Male; 51.3% Female

Overview and Summary

Prince Edward Island (PEI) joined the NTIWG in 2009 and has contributed substance use treatment data to four of the five annual reports that have been published to date. Publicly funded substance use treatment services in PEI include residential treatment, non-residential treatment, non-residential withdrawal management and residential withdrawal management.

The Department of Health and Wellness is responsible for policy development and strategic planning of PEI's health system. Health PEI is a crown corporation responsible for the operation and delivery of publicly funded health programming in the province. In PEI, mental health services are integrated with substance use services at the administrative level. Integrated System Management (ISM) is a browser-based data system used to collect and report publicly funded treatment data; it is the primary record for client information in PEI's addiction treatment system. ISM is overseen by Health PEI. Provincial-level data are reported on annual and "as-needed" bases.

Important Considerations and Limitations

- In PEI, a client can be active in more than one of the treatment services throughout the year. They would be counted as a unique individual in each treatment service, which might result in counting them more than once.
- PEI does not currently collect information on clients' past-year use of substances. Rather, clients are asked to identify substances they have used in the past more generally.
- PEI does not currently collect information on clients' past-year use of injection drugs. Instead, clients who indicate they have used injection drugs in the past are asked to identify whether they are a "current" or "long-term" user of injection drugs.
- There were no external methadone clinics in PEI during the 2013–2014 fiscal year.
- Information on clients attending DWI education programs in PEI is available from PEI's Transportation and Public Works Highway Safety Division.
- PEI does not capture clients' use of steroids or over the counter medications.
- The category "Other Drugs" includes crystal meth, ecstasy, heroin, LSD and nicotine.

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 2,176 unique individuals accessed publicly funded substance use treatment services in PEI; of which 65.3% were new cases. In total, these 2,176 individuals accounted for 3,873 episodes.

The majority of individuals accessing treatment services (92.2%) were seeking treatment for their own problematic substance use. However, 173 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, which accounts for 8.0% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of the total number of episodes for individuals seeking treatment for themselves (3,869), the majority (49.9%) were episodes for non-residential treatment followed by 27.6% for residential withdrawal management, 19.3% for non-residential withdrawal management and 3.2% for residential treatment.

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

Table 6. Ratio of episodes to individuals (PEI)

Residential withdrawal management	1.9
Non-residential withdrawal management	1.2
Residential treatment	1.2
Non-residential treatment	1.4

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

Of the 3,869 episodes accessed by individuals seeking treatment for themselves, 2,375 (61.4%) were accounted for by males, while 1,314 (34.0%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 46.3%; females, 49.8%) in PEI followed by residential withdrawal management (males, 29.6%; females, 27.5%).

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

As shown in Figure 20, people aged 18–24 accounted for the highest percentage of treatment episodes, followed by people aged 25–34. However, as indicated in Figure 21, 25–34 year olds accounted for the highest percentage of unique individuals accessing treatment services (22.4%), followed closely by 18–24 year olds (22.0%). Non-residential treatment accounted for the majority of episodes for all age categories, as shown in Figure 22.

Figure 20. Treatment episodes by age (PEI)

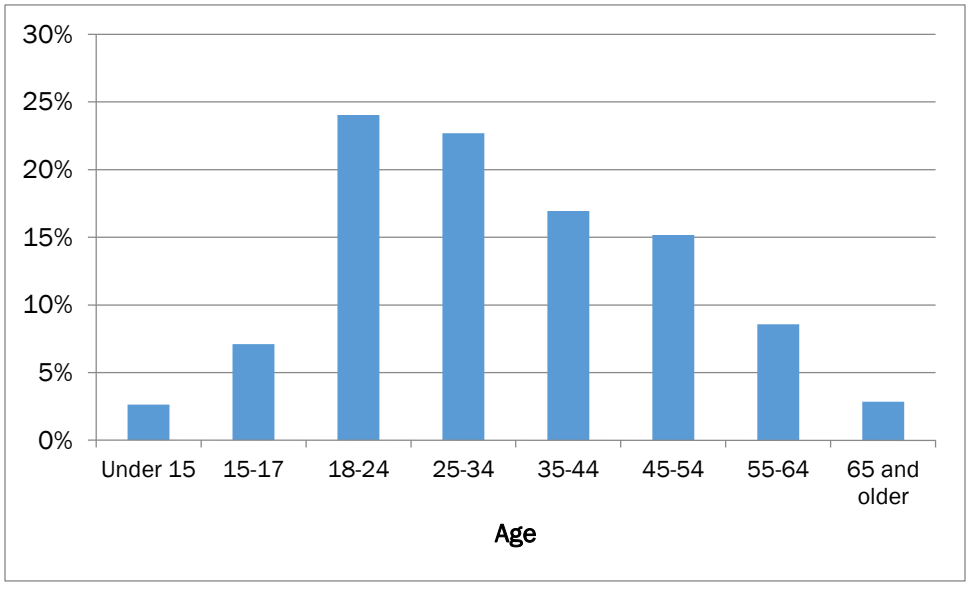


Figure 21. Unique individuals by age (PEI)

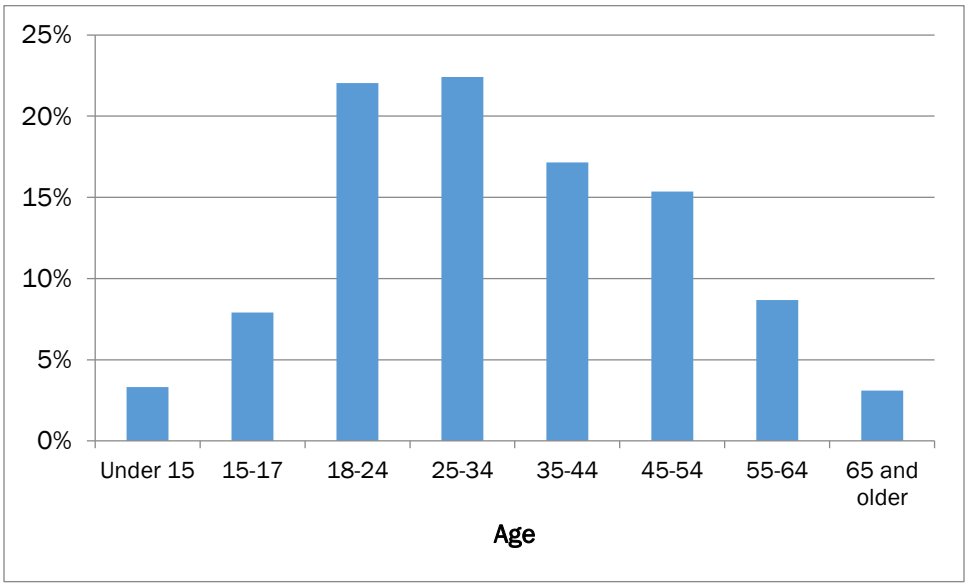
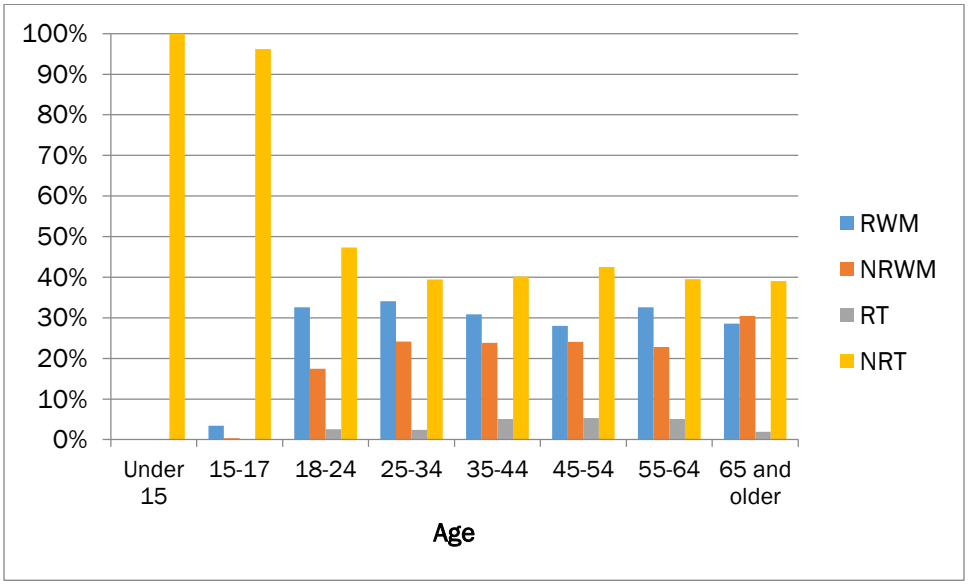


Figure 22. Episodes by age and treatment type (PEI)



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

In total, 391 unique individuals who accessed treatment services in PEI during 2013–2014 reported having used drugs by injection in the past. These 391 unique individuals accounted for 948 episodes. Males accounted for the majority (61.1%) of all episodes related to treatment for injection drug use. The ratio of episodes to individuals was equal for males and females at approximately 2.4 episodes per individual.

Total number of unique individuals accessing opioid substitution treatment

In total, PEI's electronic data system reported that 63 individuals accessed publicly funded opioid substitution treatment, of which males accounted for 55.6% of all clients. However, during this

reporting period, this program had not fully implemented the use of the electronic data system. Manual reports from the program team indicate a caseload of 215.

Substance use history of unique individuals seeking treatment

Among individuals accessing treatment services in PEI during 2013–2014, alcohol was the most common substance used in the 12 months preceding treatment, followed by "other drugs,"[14] cannabis and opioids.

Treatment episodes by employment status

Of 3,884 episodes,[15] 39.0% were accessed by individuals who reported their employment status as "unemployed" at the time of treatment; 26.5% were accessed by individuals who reported "other" as their employment status; 19.1% reported "full-time" employment; 10.3% were categorized as "student"; and 5.1% of episodes were accessed by individuals who reported "employed part-time" as their employment status.

Discussion

This jurisdictional summary has presented aggregate-level information on the use of publicly funded substance use treatment services in PEI between April 1, 2013, and March 31, 2014.

Overall, the results revealed that since 2009–2010, the total number of treatment episodes has increased nearly 20% while the total number of unique individuals has decreased 17% in the same time period. These changes might be a result of significant investments into the redesign of admission processes for residential withdrawal management facilitated by funding received under Health Canada's DTFP systems stream, which resulted in increased client flow and allowed for higher numbers of treatment episodes overall within that service.

Non-residential treatment remained the most commonly accessed treatment service in PEI, accounting for 49.9% of all treatment episodes in 2013–2014. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment is typically the most accessible and cost-effective treatment service available. In PEI, non-residential treatment is available in five communities, whereas residential withdrawal management is only available in Charlottetown, and recovery homes are present in the two largest communities of Charlottetown and Summerside.

Like many other participating jurisdictions, the majority of episodes were accounted for by individuals who were unemployed at the time of treatment.

[14] "Other drugs" includes crystal meth, ecstasy, heroin, LSD and nicotine.

[15] This number is a combination of treatment episodes for substance abuse (i1a= 3873) and treatment episodes for problem gambling (i2a=32). However, employment status was not entered into ISM for 21 of these episodes, resulting in the presented total of 3,884.

Newfoundland and Labrador

Population: 451,632
Gender: 49.0% Male; 51.0% Female

Overview and Summary

Newfoundland and Labrador joined the NTIWG in 2009 and has contributed substance use treatment data to four of the five annual reports that have been published to date. Publicly funded substance use treatment services in Newfoundland and Labrador include residential treatment, non-residential treatment and residential withdrawal management.

The Department of Health and Community Services is responsible for treatment services in Newfoundland and Labrador delivered through four regional health authorities. Mental health services are integrated with substance use services at the administrative level. Newfoundland and Labrador uses the Client and Referral Management System (CRMS) to collect treatment data. Newfoundland and Labrador does not offer non-residential withdrawal management.

Important Considerations and Limitations

- All data was extracted from the CRMS. Any services provided but not documented in this system are excluded from this analysis.
- A client can be active in more than one of the treatment services throughout the year. Therefore an individual would be counted as a unique individual in each applicable treatment service.
- Clients accessing treatment services for themselves or for a family member are included in the calculations of indicators 1–4 (total number of treatment episodes and of unique individuals in public, treatment services for problematic substance use or gambling). Data used for indicators 5–9 include clients seeking treatment services for themselves only.
- Missing dates of birth are uncommon, but do contribute to minor inaccuracies in the age related indicators.

Results

Total number of treatment episodes and unique individuals

In 2013–2014, 2,612 unique individuals accessed publicly funded substance use treatment services in Newfoundland and Labrador, of which 79.2% were new cases (2,069). In total, these 2,612 individuals accounted for 4,099 episodes.

The majority of individuals accessing treatment services (96.4%) were seeking treatment for their own problematic substance use. However, 118 individuals accessed treatment services for a friend or family member during the 2013–2014 fiscal year, which accounts for 4.5% of the entire population of unique clients.

Total number of episodes and unique individuals by treatment category

Of 3,955 treatment episodes, the majority (78.3%) were for non-residential treatment followed by 15.8% for residential withdrawal management, and 5.9% for residential treatment. Newfoundland and Labrador does not offer non-residential withdrawal management services.

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

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

Residential withdrawal management	1.8
Residential treatment	1.0
Non-residential treatment	1.3

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

Of the 3,997 episodes where gender was reported, 2,439 (61.0%) were accounted for by males, while 1,396 (34.9%) were accounted for by females. Non-residential treatment accounted for the majority of both male and female treatment episodes (males, 77.0%; females 80.1%) in Newfoundland and Labrador followed by residential withdrawal management (males, 17.2%; females, 13.8%).

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

As shown in Figure 23 and Figure 24, people aged 25–34 accounted for the highest percentage of treatment episodes, as well as the highest percentage of unique individuals. People aged 35–44 accounted for the second highest percentage of both individuals accessing treatment and total treatment episodes, followed closely by people aged 45–54. Non-residential treatment accounted for the majority of episodes for all age categories, as shown in Figure 25.

Figure 23. Treatment episodes by age (Newfoundland and Labrador)

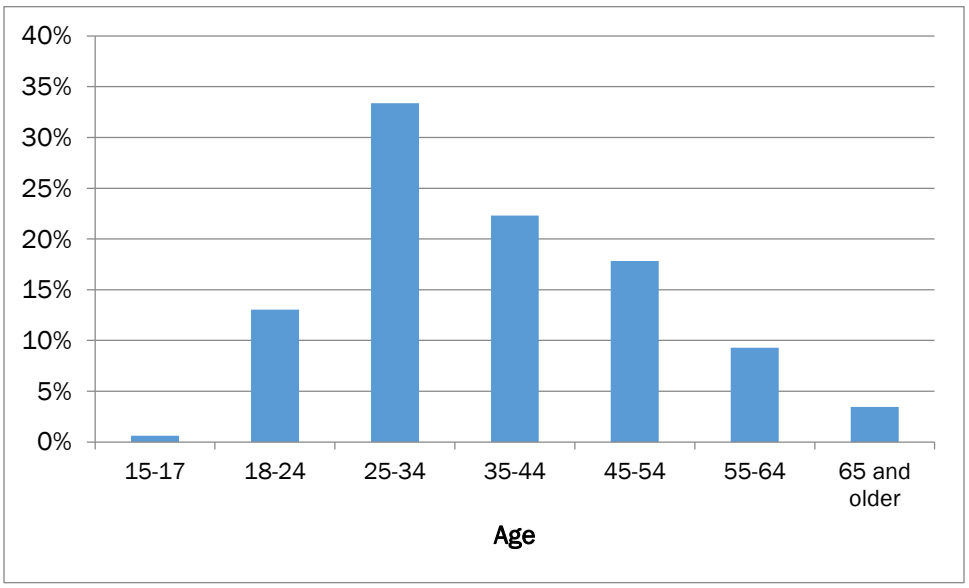


Figure 24. Unique individuals by age (Newfoundland and Labrador)

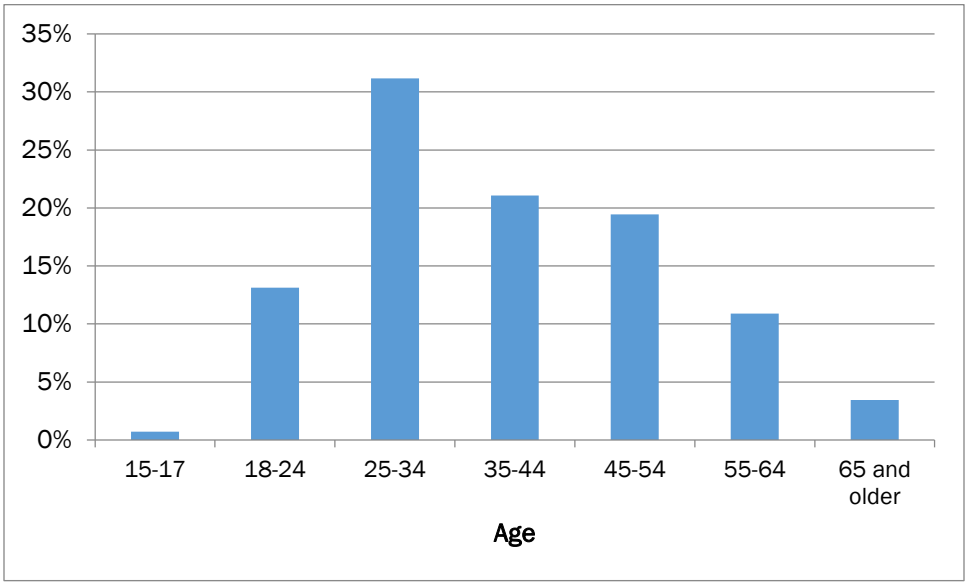
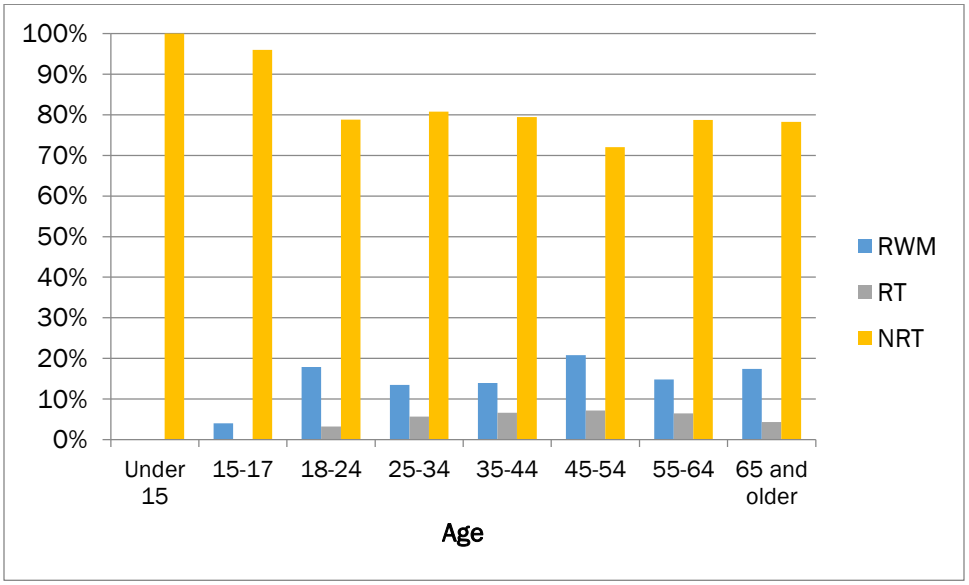


Figure 25. Episodes by age and treatment type (Newfoundland and Labrador)



Total number of episodes for opioid substitution

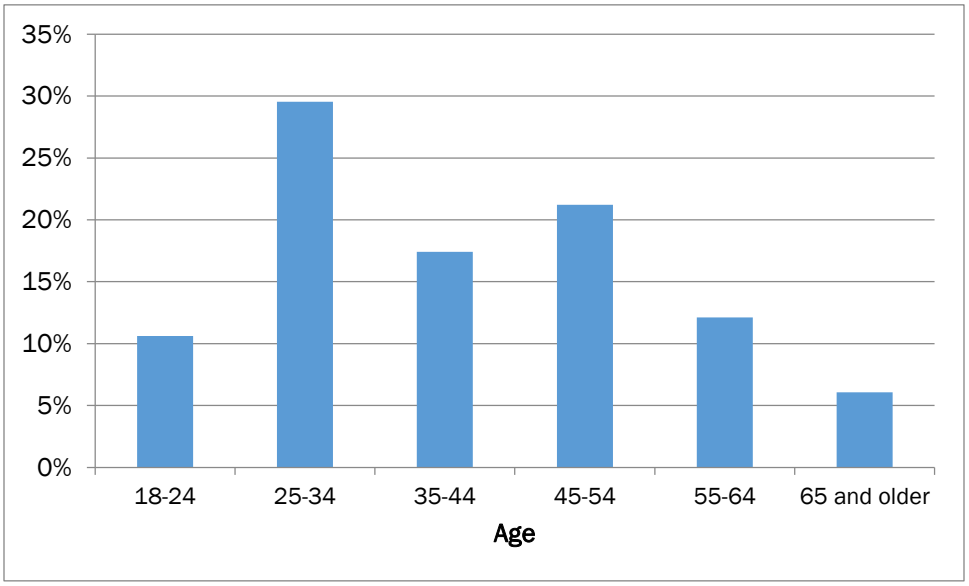
In total, 115 individuals accessed publicly funded opioid substitution treatment (i.e., methadone maintenance treatment), of which males accounted for 55.7% of all clients. The majority (53.5%) of these opioid substitution clients were ages 25–34 followed by individuals 35–44 (20.2%).

Newfoundland and Labrador currently serves a total of approximately 1,300 methadone maintenance clients with 87% accessing methadone through physicians in private practice. Clients accessing methadone privately are not captured in CRMS and are excluded from the analysis above.

Total number of people participating in driving-while-impaired programs

In total, 132 individuals attended DWI programs in Newfoundland and Labrador during the 2013–2014 fiscal year. The majority of these individuals were male (78.8%). As shown in Figure 26, nearly one-third of all DWI clients were between the ages of 25 and 34. Individuals ages 45–54 and 35–44 represented the next two highest age categories, respectively. Approximately 80% of all DWI clients were between the ages of 25 and 54.

Figure 26. Percentage of individuals participating in driving-while-impaired programs by age (Newfoundland and Labrador)



Discussion

This jurisdictional summary has presented aggregate-level information on the use of publicly funded substance use treatment services in Newfoundland and Labrador between April 1, 2013, and March 31, 2014.

Overall, treatment service use in Newfoundland and Labrador has increased approximately 40% since 2010–2011, from 2,938 episodes in 2010–2011 to 4,099 episodes in 2013–2014. The number of unique individuals has also increased substantially in the same time period from 1,454 individuals in 2010–2011, to 2,612 individuals in 2013–2014; this represents an increase of nearly 80%. It is important to note that these changes might be attributed to variation in how data is entered in each region, as well as to refinement of the data scripts used to pull data from CRMS to better reflect the NTI data protocols, rather than true increases in clients of substance use treatment centres in Newfoundland and Labrador.

Non-residential treatment remains the most commonly accessed treatment service in Newfoundland and Labrador, accounting for 78.3% of all treatment episodes in 2013–2014. This finding is consistent across other jurisdictions and is likely explained by the fact that non-residential treatment meets the needs of the broadest population base and is often the most accessible form of treatment. Moreover, access rates are also directly influenced by the treatment process in Newfoundland and Labrador whereby a client cannot access residential treatment without having first participated in non-residential treatment or residential withdrawal management.

Beyond the NTI project, the government of Newfoundland and Labrador will be developing a comprehensive mental health strategy to meet the needs of the population. The strategy will support

comprehensive, coordinated and integrated mental health and addictions services through the regional health authorities, supported by enabling legislation, policies and collaboration with other departments and agencies.

CRMS is a provincial health information system. The accuracy and completeness of the demographic and clinical data is dependent on the information recorded by service providers in the client health record. Variations in clinical documentation practices among the mental health and addictions programs of the regional health authorities contribute to data quality issues. Provincial initiatives are ongoing to strengthen data and documentation standards, and compliance to those standards, which are positively impacting the quality of the data. As a result, readers should exercise caution when interpreting the findings reported for Newfoundland and Labrador.

First Nations and Inuit Health Branch, National Native Alcohol and Drug Abuse Program and National Youth Solvent Abuse Program Network of Treatment Centres

This year, the NTI project has benefited from the participation of the FNIHB as part of the NTIWG. Although not able to contribute data for this iteration, FNIHB is aiming to submit data for future reports. To provide contextual information on substance use treatment services for First Nations and Inuit people on reserve, FNIHB provided the summary below.

Overview and Summary

Substance use continues to be a priority issue for First Nations and Inuit people in Canada. The primary network of addiction treatment programming in place to respond to these issues is supported through two national programs: the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP). Through these programs, Health Canada provides direct funding to First Nations addiction treatment centres.

NNADAP and NYSAP treatment centres include a range of mainstream and culturally relevant approaches. Through these national programs, First Nations and Inuit individuals on reserve have access to inpatient, outpatient and day treatment services, as well as services for people with unique needs (e.g., programming for families, youth, solvent abusers, women and people with concurrent disorders).

NNADAP and NYSAP treatment centres are located in Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, and Newfoundland and Labrador. In British Columbia, on October 1, 2013, the First Nations Health Authority (FNHA) took on the responsibility for the design, management and delivery of all federally funded health programs and services for First Nations in British Columbia, including NNADAP and NYSAP treatment centres. Health Canada no longer has any day-to-day operational responsibilities in British Columbia for First Nations health. All aspects of program delivery are now the responsibility of the FNHA.

National Picture

Overview of Treatment Services in Canada

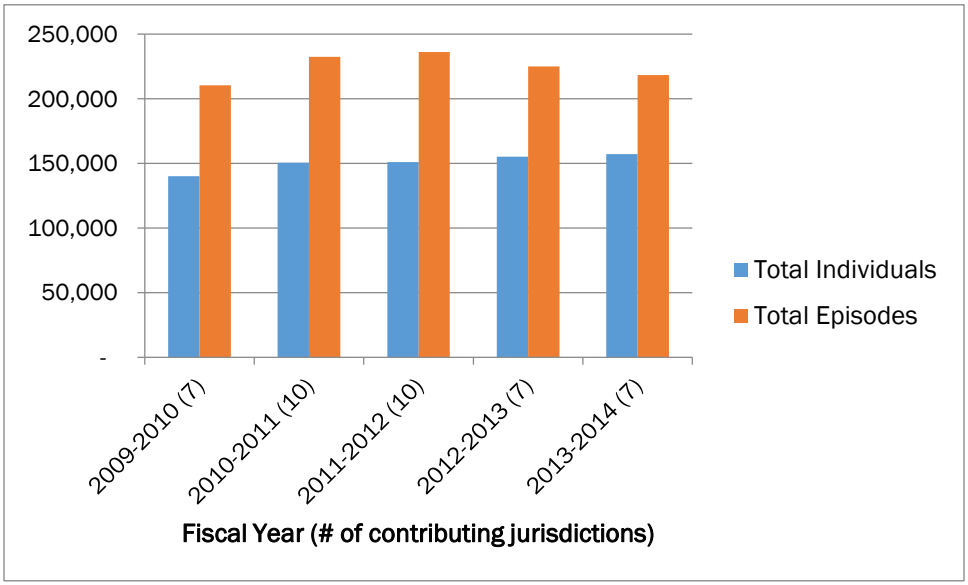
This section is intended to provide a national picture of treatment service use and related trends using findings from each of the participating jurisdictions referenced in this year's report. This section also includes additional information from projects that complement the findings from the NTI project.

Total number of unique individuals and treatment episodes

The NTI data indicate that between April 1, 2013, and March 31, 2014, a total of 157,123 individuals from seven Canadian provinces accessed publicly funded substance use treatment services. In total, these unique individuals accounted for nearly 218,263 treatment episodes.

In many Canadian jurisdictions, the number of individuals accessing substance use treatment services appears to have increased over the past five fiscal years, as shown in Figure 27. However, it is important to note that these differences might be attributable to improved data collection methods resulting in more accurate reporting of information, rather than true increases in treatment service access.

Figure 27. Total number of unique individuals and episodes by fiscal year



Treatment for friends and family

Problematic substance use affects not only the individual, but also his or her family members and friends. In 2013–2014, between 4.5% and 13.5% of unique individuals accessing substance use treatment accessed treatment because of someone else's substance use; that is, they accompanied a family member or friend to treatment or they accessed treatment services themselves to help them cope with a friend or family member's problem.

Gender

In all participating jurisdictions, males accounted for the majority of all individuals accessing treatment services during 2013–2014. Males also accounted for the majority of individuals accessing each specific treatment type. For example, in 2013–2014, males accounted for 70.3% of residential

withdrawal management episodes, 58.1% of non-residential withdrawal management episodes, 65.4% of residential treatment episodes and 63.2% of non-residential treatment episodes. These percentages have remained stable since 2011–2012.

Age

Approximately half (49%) of all treatment episodes in 2013–2014 were accessed by individuals between the ages of 25 and 44. Across the different treatment types this group accounted for 51.4% of all residential withdrawal management episodes, 61.8% of non-residential withdrawal management episodes, 54.1% of residential treatment episodes and 47.2% of non-residential treatment episodes in 2013–2014.

Substance use in the past 12 months

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

Reason for treatment

Understanding the primary substance for which individuals are seeking treatment in Canada is important for a number of reasons, including system enhancement, effectiveness and improvement, as well as to better understand and triangulate harmful substance use patterns and trends. While many jurisdictions do not collect this information, progress is being made to work towards a more comprehensive national picture. For example Manitoba expects to have this data collected in time for the 2016–2017 NTI report.

Ontario and Nova Scotia are currently the only participating jurisdictions that are able to provide this information. Their data indicate that alcohol was the most commonly reported reason for seeking treatment. In Ontario, the second most commonly reported reasons for attending treatment were cannabis, followed by cocaine, while in Nova Scotia opioids were second-most common.

Employment status

Not all jurisdictions have the capacity to collect and report information on employment status. However, in each of the jurisdictions that submitted this data, the greatest proportion (between 34.6% and 53.7%) of all treatment episodes were accessed by individuals who noted their employment status as “unemployed” at the time of treatment.

New clients

In most jurisdictions, new clients represent the majority of individuals accessing substance use treatment. A “new case” is defined differently by each jurisdiction (jurisdiction-specific definitions can be found in each of the jurisdictional summaries). Overall, new clients accounted for between 65.3% and 93.6% of unique individuals accessing publicly funded substance use treatment services in 2013–2014.

Most-accessed treatment service

Non-residential treatment accounted for the majority (66.2%) of treatment episodes in 2013–2014 This finding is not surprising, however, given that non-residential treatment is often the most accessible

and least intrusive form of treatment. Despite this finding, high rates of service use do not necessarily reflect or indicate adequate service availability, relative to the treatment need in the population.

On average, most individuals accessing residential treatment, non-residential treatment and non-residential withdrawal management only accessed these services once throughout the year while those attending residential withdrawal management programs accessed services more frequently.

Complementary Projects

There are a number of ongoing projects led by CCSA as well as its partners in the field that complement the NTI project. Some examples of these and their potential implications for the NTI project (and vice versa) are given below.

Canadian Community Epidemiology Network on Drug Use

Led by CCSA, the Canadian Community Epidemiology Network on Drug Use (CCENDU) is a nation-wide network of community-level partners who share information about local trends and emerging issues in substance use, and exchange knowledge and tools to support more effective data collection. In August 2015, CCENDU released a bulletin on deaths involving fentanyl in Canada (Canadian Centre on Substance Abuse, 2015), and is currently preparing a bulletin on community-based naloxone programs in Canada. Topical bulletins such as these help to shed light on the magnitude of problematic substance use across Canada, as well as on the potential impact of substance-related trends on the development and employment of new treatments and services. In this way, CCENDU material can provide support for the NTI project by demonstrating the need for improved data and national-level surveillance of service use to respond to emerging issues.

Care Pathways

A key challenge for individuals seeking treatment for substance use issues is navigating the healthcare system to obtain the appropriate services and supports. In response, CCSA has undertaken a project to develop care pathways for treatment of those experiencing harms related to psychoactive prescription drug use, particularly youth and older adults given their prevalent use of these substances and susceptibility to experiencing harms from them.

To date, the objectives of this project have been to review the evidence and to identify knowledge gaps related to treatment for psychoactive prescription drug harms in each population. In addition to consultations with treatment experts, these reviews have informed the drafting of care pathways to help healthcare providers more easily and efficiently access and apply tools relevant to their role in treatment and to help patients navigate the treatment system. As this project continues to progress, these pathways will be expanded to include evidence and resources pertaining to treatment for harms from cannabis and other substances.

By bringing clarity and accessibility to the current evidence and knowledge gaps around approaches and resources for treating problematic substance use, the care pathways project can help inform the revision of existing indicators and the development of new ones to help support the improvement of data consistency and accuracy, and to better identify gaps in service provision (e,g,, limited availability of non-residential withdrawal management).

Needs-based Planning Project

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

allowing a comparison of population need versus service use. Together, the two projects contribute information required for evidence-based system planning.

For example, based on available survey data from 2002 and updated population data, the needs estimation model from needs-based planning would suggest that about 20% of Canadians ages 15 and over could benefit from some level of advice or formal treatment with respect to their substance use (about 5.7 million people), and, of these, a minimum of about 423,000 might be expected to seek help if services were available and accessible. This number compares to the approximately 157,123 individuals who used the services reporting to the NTI project in 2013–2014.

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

Discussion

Problematic substance use can result in a variety of health, social and economic harms that impact both the individual and society. Ensuring Canadians have access to a comprehensive system of effective evidence-based services and supports will help reduce the risks and harms associated with alcohol and drug use in Canada.

The data provided in this fifth NTI report provide multi-jurisdictional aggregate-level information on individuals who accessed publicly funded treatment services in 2013–2014. This report provides a picture of substance use treatment service use across several jurisdictions in Canada, which will inform system planning, development and monitoring.

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

Findings from this year's data, as well as from a 2014 report on the impact of substance use disorders on hospital use in Canada, indicate that not only is alcohol the most commonly used substance among the treatment-seeking population, but it is also the most commonly reported substance for which treatment is sought in both public and hospital-based services (Young & Jesseman, 2014). This finding highlights the continued financial and health impact alcohol has on Canadian society, and further highlights the importance of investing in targeted treatment services such as early intervention, and screening brief intervention and referral (SBIR) (College of Family Physicians & Canadian Centre on Substance Abuse, 2012), as well as prevention and education initiatives such as the low-risk alcohol drinking guidelines (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011).

While most individuals access treatment services for their own problematic substance use, many access services to deal with a family member or close friend's substance use. This means that services and supports need to extend beyond the individual directly experiencing the problem. It also indicates the broad impact substance use has beyond the 1.3 million Canadians estimated to have a substance use disorder (Statistics Canada, 2014), further supporting the need for greater investments to reduce the associated health, social and economic harms of substance use.

Youth are more likely than adults to experience harms from alcohol and other drug use, since their brains are undergoing rapid and extensive development. Such harms, including dependence, injury, infection, driving impairment and overdose, can place a burden on healthcare, social services and public safety systems (National Advisory Committee on Prescription Drug Misuse, 2013). Despite this increased susceptibility, data presented in this report indicate that rates of treatment use by youth are, comparatively, quite low. These findings might indicate a gap between service use and potential need or reflect the propensity of youth to seek services from a variety of sectors, including specialized addiction and mental health, education, justice, housing, outreach and primary care (Chaim & Henderson, 2014).

Awareness of the challenges — homelessness, offending, poor educational achievement, increased suicide risk and so on — faced by youth with problematic substance use or concurrent mental health issues is increasing. However, approaches to recognize and address these are inconsistent across sectors (Chaim, Henderson, & Brownlie, 2013). Thus, the full range of needs experienced by a young person might not be identified and addressed. The development of age-appropriate services across the continuum of care are essential to improved treatment approaches that better serve this group.

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

Areas for Improvement

Although the NTI project has helped improve our understanding of the usage of substance use treatment in Canada, there are still many knowledge and information gaps that need to be addressed. For example, as a country, we are unable to estimate the total number of Canadians accessing any form of treatment for problematic substance use. This gap is due, in part, to the fact that the number of public and private treatment service providers in Canada remains unclear, as do the capacity and wait times for different treatment programs.

We also lack up-to-date information on the costs associated with problematic substance use. The most recent Canadian estimate, published in 2006 (Rehm et al., 2006), estimates that in 2002 alcohol and drugs cost Canadians an estimated $22.8 billion, of which 20% ($4.2 billion) was attributed to direct healthcare costs. Furthermore, we are unable to estimate the amount of money spent treating problematic substance use and related issues in Canada. Understanding the cost implications of the integration of mental health and addiction services in many jurisdictions would also be helpful for resource and system planning.

Individuals seeking treatment for substance use face a major challenge in navigating different treatment services and supports (National Treatment Strategy Working Group, 2008). All jurisdictions in Canada need to work toward offering a comprehensive treatment model that offers a continuum of services and supports regardless of the nature, severity and complexity of the individual's issue or point of access to the system.

Next Steps

The NTIWG is committed to improving the collection and reporting of substance use treatment service data in Canada. The NTIWG will continue to work towards identifying and addressing inconsistencies and errors in data collection to improve the accuracy and validity of treatment information supplied by the various jurisdictions.

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

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

Conclusions

The NTI report is currently the only report to provide information on publicly funded substance use treatment services across Canada. The project continues to make a significant contribution to our understanding of the use of substance use treatment services in Canada. This fifth report has contributed new information on publicly funded substance use treatment services and has identified common patterns and trends in treatment service use. Through the development and implementation of data collection protocols, the NTI project has improved and continues to strive to improve the quality and consistency of treatment data being collected at the jurisdictional level in order to paint a more accurate national picture of treatment service use in Canada.

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Appendix A: Indicators Collected for 2013–2014 Data Collection

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B: National Treatment Indicators Working Group Membership[16]

Name	Organization
Camiré, Martin	Institut national d'excellence en santé et services sociaux
Chen, Debra	Canadian Institute for Health Information
Di'Gioacchino, Lisha	Canadian Centre on Substance Abuse
Edwards, Mark	Healthy Environments and Consumer Safety Branch, Health Canada
Evans, Todd	Strategic Policy Branch, Health Canada
Gallant, Stephen	Health PEI
Hansen, Rebecca	Yukon Health and Social Services, Alcohol and Drug Services
Hay, Laura	First Nations and Inuit Health Branch, Health Canada
Jahrig, Jesse	Alberta Health Services
Leggett, Sean	Manitoba Healthy Living and Seniors
Macknak, Kelsey	Saskatchewan Ministry of Health
Outhwaite, Harlie	Strategic Policy Branch, Health Canada
Panait, Daniela	Healthy Environments and Consumer Safety Branch, Health Canada
Pellerin, Annie	New Brunswick Department of Health
Pirie, Tyler	Canadian Centre on Substance Abuse
Rocca, Claudio	Drug and Alcohol Treatment Information System (Ontario)
Ross, David	Veterans Affairs Canada, National Centre for Operational Stress Injuries
Ross, Pamela	Nova Scotia Department of Health and Wellness
Rush, Brian	Centre for Addiction and Mental Health
Urbanoski, Karen	University of Victoria
Vivian-Beresford, Ann	Newfoundland and Labrador Centre for Health Information
Wallingford, Sarah	Canadian Centre on Substance Abuse
Weekes, John	Correctional Service Canada

[16] Membership is current as of January 14, 2016.

Appendix C: System Administration and Data Collection for 2013–2014

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[17]	Data Systems	Browser-based System[18]	Reporting[19]
N.L.	Department of Health and Community Services	Four regional health authorities	Y	CRMS (Client Referral Management System)	N	Annually (at provincial level)
P.E.I.	Department of Health and Wellness	Health PEI (centralized provincial agency)	Y	ISM (Integrated System Management)	Y	Annually
N.S.	Department of Health and Wellness	Nine district health authorities and the IWK Health Centre[20]	Y	ASsist (Addiction Services Statistical Information System Technology)	Y	Real-time updates and regional and provincial level
N.B.	Department of Health	Two regional health authorities	Y	RASS (Regional Addiction Service System)	N	Annually
Que.	Ministry of Health and Social Services	16 addiction rehabilitation centres 95 community health and social service centres Also through more than 100 inpatient private and community resources, either certified or in the process of certification or renewal	N	SIC-SRD (Système d'information clientèle pour les services de réadaptation en dépendence)	N	Annually
Ont.	Ministry of Health and Long-term Care	14 LHINs (Local Health Integration Networks) Also through community agencies	Y	DATIS (Drug and Alcohol Treatment Information System)	Y	Real-time reporting

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

[18] 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.

[19] Reporting is done as needed in each jurisdiction.

[20] As of April 1, 2015, nine health authorities became one (i.e., Nova Scotia Health Authority) and the IWK Health Centre.

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[17]	Data Systems	Browser-based System[18]	Reporting[19]
Man.	Department of Healthy Living and Seniors (HLS) Department of Health	Addictions Foundation Manitoba and 11 provincial grant-funded agencies Adult residential withdrawal services and one residential treatment program are delivered through the two regional health authorities	N	HLYS statistical databases (SPSS-compatible) as well as an Excel-based system for provincial aggregate data	N	Data are provided monthly to the Addictions Management Unit by AFM and other provincially grant-funded addictions agencies. Adult residential withdrawal management data are requested annually.
Sask.	Saskatchewan Ministry of Health	12 regional health authorities and community-based organizations	IP	ADG (Alcohol, Drug and Gambling) System AMIS (Addiction and Mental Health Information System — Saskatoon Health Region)	N	Annually
Alta.	Alberta Health	Alberta Health Services (AHS) (primarily) Also through AHS community contracted services	Y	ASIST (Addiction System for Information and Service Tracking) for AHS direct services STORS (Service Tracking and Outcome Reporting System) for AHS contracted agencies	Y N	Annually (at provincial level)
B.C.	Ministry of Health Services	One provincial health authority and five regional health authorities	Y	AIMS (Addictions Information Management System) MRR (Minimum Reporting Requirements), which will integrate substance use and mental health, is in pilot stage	N	N/A (at provincial level)
Yuk.	Ministry of Health and Social Services	Ministry has service delivery responsibility	N	Access database (manual data entry into an Excel file)	N	Monthly
N.W.T.	Department of Health and Social Services	Eight health authorities	Y	Excel-based system (manual data entry)	N	Monthly

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[17]	Data Systems	Browser-based System[18]	Reporting[19]
Nun.	Department of Health and Social Services	Community health centres Also significant reliance on out-of-territory services	N	No client or system data (except financial) are currently collected systematically	N	N/A
CSC	Public Safety Canada	Five regions, including institutions and Aboriginal healing lodges	N	OMS (Offender Management System)	Y	
NNADAP / NYSAP	Health Canada's First Nations and Inuit Health Branch	Network of addiction treatment and prevention programming Includes 55[21] First Nation addiction treatment centres and NNADAP community-based prevention programs in the majority of communities[22]	N	Currently developing a new data collection system[23]	N	
VAC	Veterans Affairs Canada	VAC district office 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

[21] Since 2013–2014, the First Nations Health Authority (FNHA) has taken on the responsibility for the design, management and delivery of all federally funded health programs and services for the First Nations in BC, including NNADAP/NYSAP. In 2015–2016, Health Canada supports a network of 43 treatment centres, as well as drug and alcohol prevention services in the majority of First Nation and Inuit communities across Canada through NNADAP and the NYSAP.

[22] Since 2013–2014, the First Nations Mental Wellness Continuum (FNMWC) framework has been published; outlining opportunities to build on community strengths and control resources to improve existing mental wellness programming for First Nation communities. The framework builds on a comprehensive community-driven review of substance use-related services and supports for First Nations.

[23] Since 2013–2014, the AMIS has been developed and successfully piloted in a sample of treatment centres and fully deployed to most of the NNADAP and NYSAP treatment centres.

Appendix D: Green, Yellow and Red Light Indicators

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

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

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

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

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

- Total number of episodes and unique individuals treated in public and private specialized treatment services by age and gender.

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

Appendix E: Availability of Treatment Indicators by Jurisdiction for 2013–2014 Data

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

Indicator	YT	AB	SK	MB	ON	NS	PE	N.L.	AIDQ
Individuals accessing methadone treatment by age	--	--	--	--	--	♦	--	--	--
Individuals attending driving while impaired programs	--	--	--	♦	--	♦	--	♦	♦
Individuals attending driving while impaired programs by gender	--	--	--	♦	--	♦	--	♦	♦
Individuals attending driving while impaired programs by age	--	--	--	♦	--	♦	--	♦	♦
Primary substance for which treatment is sought	--	♦	--	--	♦	♦	--	--	--
Primary substance for which treatment is sought by gender	--	--	--	--	♦	♦	--	--	--
Primary substance for which treatment is sought by age	--	--	--	--	♦	♦	--	--	--
Substances used in the past 12 months	--	♦	♦	♦	♦	♦	--	--	--
Substances used in the past 12 months by gender	--	♦	♦	♦	♦	♦	--	--	--
Substances used in the past 12 months by age	--	♦	♦	♦	♦	♦	--	--	--
Treatment episodes by employment status	--	♦	♦	♦	♦	♦	♦	--	--
Individuals accessing treatment by employment status	--	♦	♦	♦	♦	♦	♦	--	--

Legend:
♦ Available
-- Unavailable

Appendix F: Definitions

Closed case

Closure criteria vary from province to province.

Driving-while-impaired (DWI) programs

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

Employment status

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

Episode[24]

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.

New individuals

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

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

Non-residential treatment

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

Open case

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

Problem gambling

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

Residential treatment

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

Specialized services

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

Unique individual

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

Withdrawal management

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

Appendix G: Substance Categories

Category	Examples
Alcohol	beer, wine, liquor, cider, coolers
Cannabis	marijuana, hashish, hash oil
Cocaine	cocaine powder, crack
Opioids[25]	morphine, codeine, heroin, fentanyl, methadone, opium, Oxycontin™
Stimulants (excluding cocaine)	amphetamines, methamphetamines, ecstasy, methylphenidate
Hypnotics and sedatives	tranquillizers, anti-depressants, barbiturates, benzodiazepines, GHB, methaqualone
Hallucinogens	LSD, mushrooms, PCP, mescaline, salvia, ketamine
Inhalants and solvents	gasoline, glue, hairspray, aerosols, household cleaners, paint thinner
Steroids/performance enhancing drugs	human growth hormone, testosterone, winstrol, dianabol
Over the counter medication	antihistamine, ASA, ephedrine
Prescription drugs[26]	Concerta™, Ritalin™, Adderall™, Dexedrine™,
Other drugs	non-beverage alcohol

[25] Includes prescription opioids.
[26] Excludes prescription opioids.