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Withdrawal Management Services in Canada: The National Treatment Indicators Report

2015-2016 Data

March 2019



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Conflict of Interest

None of the listed authors has any conflicts of interest to declare.



National Summary

Introduction

Withdrawal management (WM) is an important part of, and often one of the first steps in, the continuum of care to address substance use and addiction for individuals in need of assistance. The various needs of Canadians with substance use disorders require a diverse array of WM services. At the 2017 annual meeting of the National Treatment Indicators Working Group (NTIWG), members identified a need to explore the various WM programs offered throughout Canada, and decided to produce a special report highlighting the landscape of WM services in Canada. The NTIWG formulated the following objectives for this report:

NTIWG defines **withdrawal management** as the initial supervised period of withdrawing from substances, and includes a diverse array of services (described below).

- Present a robust and consistent national picture of WM;
- Serve as a resource to researchers and healthcare system planners to assist in planning for future needs;
- Help identify gaps in the data that should be filled to provide a more complete picture and improve efforts to address the issue; and
- Educate partners about the range, type and extent of WM services available across jurisdictions.

The report provides an overview of the use of WM services in Canada in 2015–2016, including episodes of care offered within specialized community-based services and in hospitals. Additionally, the report provides insights that could assist practitioners and policy makers in their approaches to, and decisions about, WM. The following section contains a brief description of WM services, including their objectives and role within the care continuum for substance use disorders, and describes some data on the national picture. While this report provides as complete a picture as possible, not all provinces and territories were able to provide data, and this report does not include every source of data on WM service events (e.g., private treatment). Please refer to the Methods section for all limitations.

Withdrawal Management Services

WM services (sometimes referred to as detoxification or detox) offer support and care for the safe management of withdrawal symptoms and medical complications when someone who has a substance use disorder is ceasing to use the substance (Diaper, Law, & Melichar, 2014; Mattick & Hall, 1996). WM services can be medically supervised, including with pharmacological support provided in hospital, in medically staffed residential settings, in doctors' offices or through mobile services (e.g., home visits), with varying levels of psychosocial supports. Non-pharmacological or psychosocial WM can also be offered in community-based clinics. WM services should include the promotion of transition to active treatment. For example, individuals accessing WM services for opioids should always be immediately transitioned to evidence-based opioid treatment to mitigate the increased risk of overdose associated with lower tolerance after a period of abstinence (Bruneau et al., 2018). Furthermore, not all substance use treatment can or should be preceded by WM.

The Needs-Based Planning project has identified four categories of WM, including acute intoxication services, community non-residential WM services, community residential WM services, and hospital



for enhanced residential WM services (Rush, 2018). While this model and others provide valuable approaches to delivering various types of WM services, jurisdictions across Canada have not yet established evidence-based models and continue to aspire to improving their systems towards them. Equally important, each jurisdiction varies in its issues and needs and so will always be required to tailor any model or system to meet their individual needs.

Community-Based Treatment for Substance Use

In 2015–2016, 146,885 unique individuals accessed publicly funded (community) specialized substance use treatment services in Alberta, Manitoba, Newfoundland and Labrador, Ontario, Prince Edward Island and Saskatchewan, which accounted for 199,509 service events. Of these individuals, 61.3% ($n = 90,089$) were new cases.¹ These numbers include individuals and service events for all treatment types.² The majority of these individuals (91.0%, $n = 133,714$) accessed treatment services for their own problematic substance use; however, 11,696 individuals (8.0%) accessed treatment for a friend or family member.

A **unique individual** refers to a single person. One unique individual might have several service events over the course of a year.

A **service event** refers to admission to a specific treatment service with an associated discharge or case closure. One person might access several services over the course of a year. For example, transferring from one program or service to another (e.g., WM to non-residential treatment) will comprise two service events. A non-residential service event can include multiple appointments.

WM includes residential and non-residential services. The provinces and territories that contributed community WM data to this report include Alberta, Manitoba, Newfoundland and Labrador, Ontario, Prince Edward Island, Saskatchewan and the Yukon. Data for individuals and for other treatment services was not available for the Yukon, so in some instances data is reported on the six provinces rather than the seven jurisdictions. Additionally, of these seven jurisdictions only Ontario and Prince Edward Island offer non-residential WM. With respect to WM, more than 27,915 unique individuals³ accessed these services, which accounted for 46,405 WM service events or approximately 25% of all community treatment service events (see Table 2).

Residential withdrawal management (RWM) includes programs where clients spend nights at a WM facility, treatment facility or hospital. **Non-residential withdrawal management (NRWM)** includes daytox and home or community detox.

The ratio of WM service events to individuals among the six provinces that provided data is presented in Table 1. On average, individuals had between one and two WM admissions during the year, with re-admissions slightly more common among those who received residential WM than those who received non-residential WM.

Table 1: Ratio of service events to individuals (own use) for the six provinces providing data

Residential withdrawal management	1.7
Non-residential withdrawal management	1.2

1 New cases refers to unique people that began treatment during the current reporting year. This number would therefore exclude individuals with a treatment service event that began in the previous fiscal year.

2 Treatment types include residential treatment, non-residential treatment, residential withdrawal management and non-residential withdrawal management. Residential and non-residential treatment are not the focus of this report.

3 Not all jurisdictions reported on the number of individuals accounting for these episodes, so the reported number of unique individuals is an underestimate.



Treatment Type

As shown in Table 2, total WM services for the six provinces accounted for 24.6% of all treatment services (26.9% of services for males, and 20.8% of services for females). While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (75.4%). Across the six provinces, individuals accessing WM services accounted for 19.4%.

Table 2: Treatment service events and unique individuals⁴ by gender

	Residential and Non-residential WM*	Residential and Non-residential Treatment*	Total Counts*
Service Events:			
Total (including unknown gender)	24.6%	75.4%	<i>n</i> = 185,620
Males	26.9%	73.1%	<i>n</i> = 116,473
Females	20.8%	79.2%	<i>n</i> = 68,484
Other**	13.0%	87.0%	<i>n</i> = 675
Unique Individuals:			
Total (including unknown gender)	19.4%	80.6%	<i>n</i> = 143,895
Males	20.1%	79.9%	<i>n</i> = 88,511
Females	18.1%	81.9%	<i>n</i> = 53,693
Other**	9.7%	90.3%	<i>n</i> = 576

*These values represent the six provinces that reported data. Data for the total number of treatment service events, as well as for individuals, was not available for the Yukon, so are not included in this table.

**Values for Other⁵ are not included in the individual jurisdictional sections as they were too small to report.

There are various limitations to these data, as reported in the individual jurisdiction chapters.

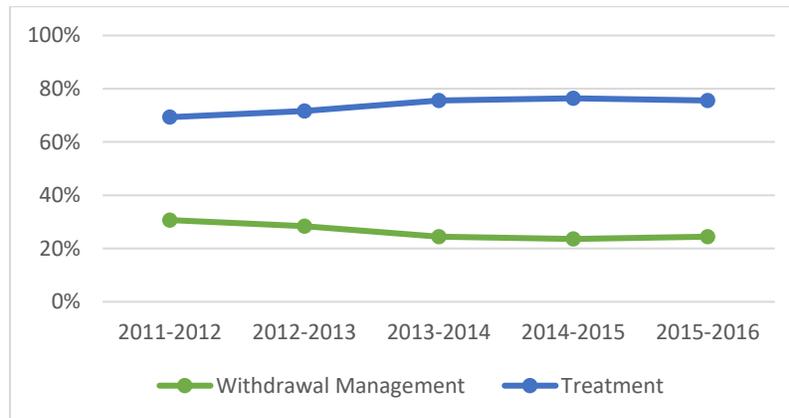
Community WM and treatment trends have been relatively consistent from 2011–2012 to 2015–2016, with WM services accounting for a slightly lower proportion of all substance use treatment service events in more recent years. However, despite these overall trends across jurisdictions, there are some variations in the patterns for treatment type within jurisdictions (please see individual jurisdictional sections for detailed breakdowns). Many factors determine the rates of service use, including demand, availability and awareness, so high rates of service use alone do not necessarily indicate level of need in the population or adequate service availability.

4 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

5 In many jurisdictions, individuals could have their gender recorded as male, female or other.



Figure 1: Trends in service events by treatment type from 2011–2012 to 2015–2016⁶



Gender

Across the seven jurisdictions,⁷ males accounted for the majority of WM service events, 68.5% ($n = 31,790$), while females accounted for 31.3% ($n = 14,498$) (Figure 2). Across all treatment services in the six provinces (data for the Yukon were not available), males still accounted for the majority of treatment service events, 62.7% ($n = 116,473$). However, the difference between male and female representation was less pronounced compared to WM only (Figure 3).

Figure 2: WM service events⁸ by gender⁹

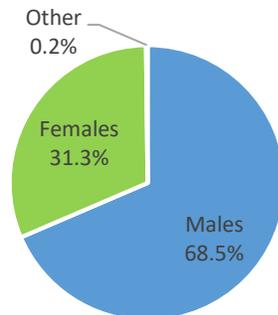
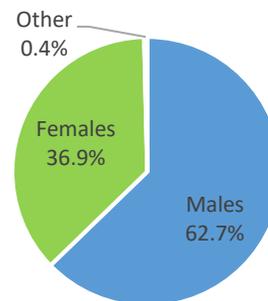


Figure 3: Total treatment service events¹⁰ by gender



Males have consistently represented a greater proportion of community WM service events than females, accounting for over two-thirds of WM service events (Figure 4).

⁶ Jurisdictions that contributed data to this trend analysis include Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island and Newfoundland and Labrador. Data is missing from Prince Edward Island from the 2012–2013 fiscal year.

⁷ The Yukon provided data on WM service events by age group and gender. Data for other treatment services or individuals was not available for the Yukon.

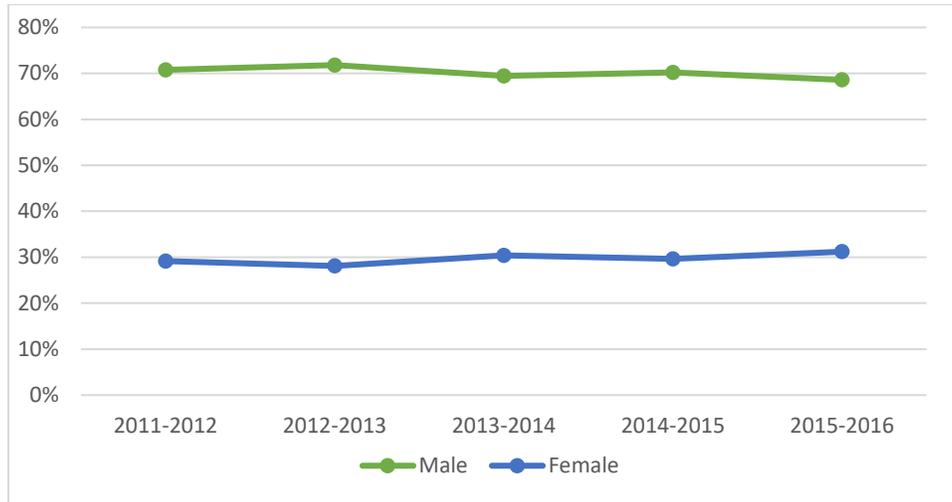
⁸ Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

⁹ Most jurisdictions that were able to contribute treatment data to this report collect data on Other types of gender. However, across most jurisdictions these numbers were low and therefore are not included in individual jurisdiction reports.

¹⁰ Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



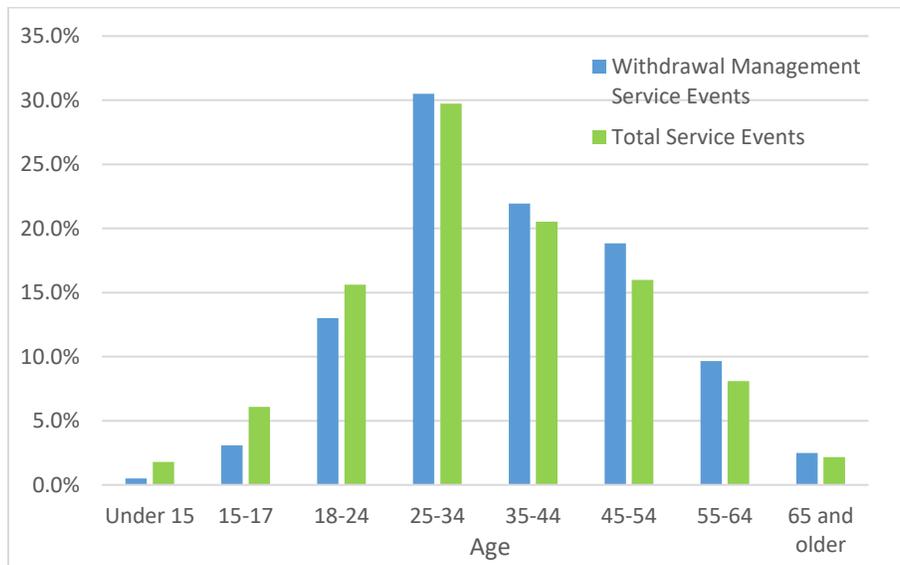
Figure 4: Trends in WM service events by gender from 2011–2012 to 2015–2016¹¹



Age

As shown in Figure 5, the highest percentage of WM service events in the seven jurisdictions and total overall service events across the six provinces¹² occurred among those aged 25–34 years, followed by those aged 35–44 years and those aged 45–54 years.

Figure 5: WM service events and total service events¹³ by age



11 Jurisdictions that contributed data to this trend analysis include Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island and Newfoundland and Labrador. Data is missing from Prince Edward Island from 2012–2013 fiscal year.

12 Data on the total number of treatment service events by age group were not available for the Yukon and is therefore not included in the distribution by total service events. However, there were data available from the Yukon on the distribution of WM service events by age group, which is included in the graph.

13 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members. Total service events includes WM service events as well as treatment service events.



Hospital-based Withdrawal Management

Hospitalizations by sex¹⁴

While specialized WM data were only available for some provinces, data on hospitalizations due to substance use withdrawal were available for all provinces and territories except Quebec. In 2015–2016 there were a total of 11,751 hospitalizations¹⁵ for WM for substance use, accounting for 30% of hospitalizations for substance-related disorders. The average length of stay for WM hospitalization was five days. Males represented 70.8% ($n = 8,316$) and females 29.2% ($n = 3,435$) of these hospitalizations (Figure 6). In comparison with community services, male and female WM hospitalizations by percentage (Figure 6) were similar to publicly funded service events (Figure 2). With respect to total days stayed, the total for all hospitalizations was 63,610 days.¹⁶ Days stayed in the hospital by males accounted for 70.6% (44,933 days) of total days and days stayed for females accounted for 29.4% (18,677 days) (Figure 7).

Figure 6: Hospitalizations for WM by sex (percentage) Canada excluding Quebec, FY 2015–2016.

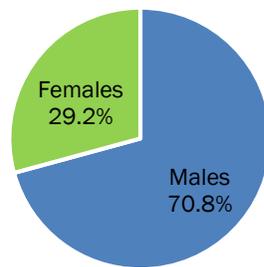
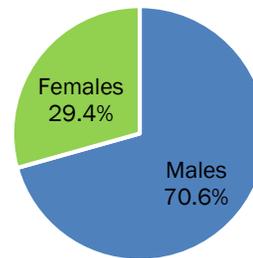


Figure 7: Days stayed in hospital for WM by sex (percentage), Canada excluding Quebec, FY 2015–2016



Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of WM hospitalizations¹⁷ occurred among those aged 45–54 years (26.1%), followed by those aged 55–64 years (21.4%) (Figure 8). This finding contrasts with community treatment services, where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 63,610 days, those aged 55–64 years accounted for the highest number at 15,890 days (25.0%) and, following this, those aged 45–54 years accounted for 14,661 days (23.0%).

¹⁴ Hospitalization data in this section are provided by the Canadian Institute for Health Information (CIHI). In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

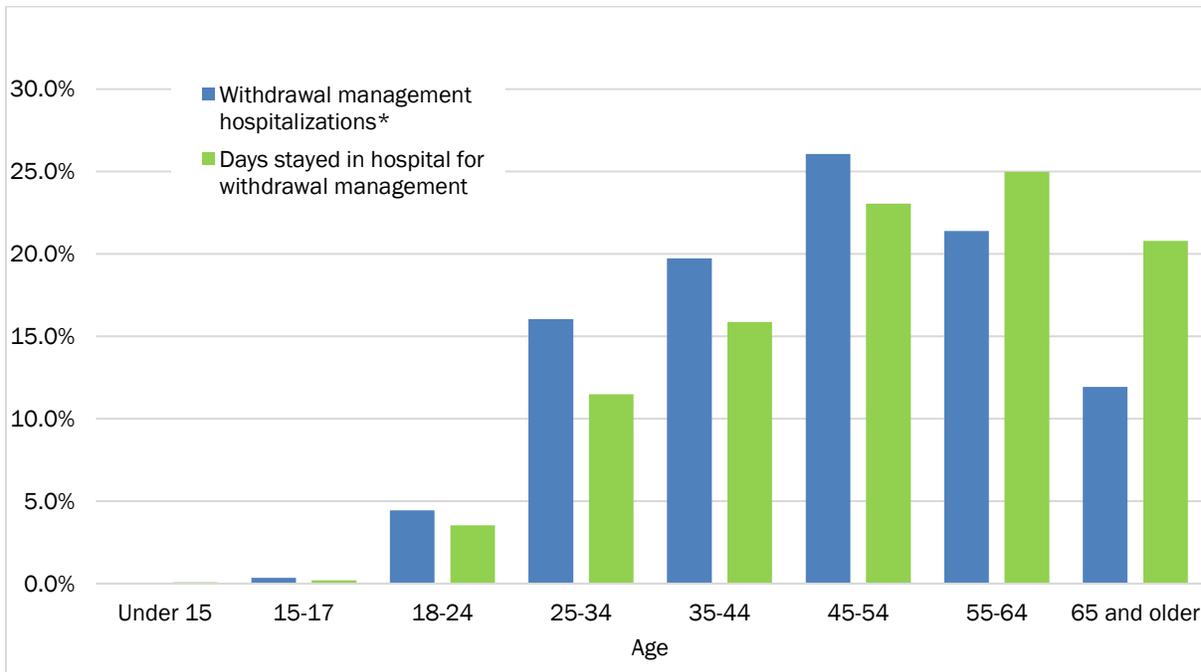
¹⁵ Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay or both. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal. General and psychiatric hospitals were included.

¹⁶ Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.

¹⁷ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Figure 8. Percent of hospitalizations* and days stayed for WM by age group, Canada excluding Quebec, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.

Conclusion

The NTI report provides information on publicly funded substance use treatment services across Canada. This year's report highlights the importance of WM services and serves as a reference for practitioners and policy makers. It was estimated that substance use cost the Canadian healthcare system approximately \$11.1 billion in 2014 (the most recent year for which data were available), of which \$600 million was for specialized community-based substance use treatment (Canadian Substance Use Costs and Harms Scientific Working Group, 2018). Not all jurisdictions submitted data on substance use treatment services, and therefore the values presented in this summary are an underestimate of the true number of substance use treatment service events in Canada. In addition, most individuals with a substance use disorder do not receive specialized treatment (National Treatment Strategy Working Group, 2008). Therefore, the 2014 cost estimates as well as 2015–2016 data in this report are an underestimate of the true volume of individuals in need of treatment. The legalization of cannabis and the opioid crisis highlight the importance of being able to track trends in service access over time to determine if we are being effective in increasing access to treatment in order to reduce opioid overdoses, and to monitor the impact of legalization on treatment for problematic cannabis use. Furthermore, shifting populations and evolving needs highlight the importance of services that can adapt to those needs. Accurate data can inform our response and target investments in service development as needed.



Introduction

Withdrawal management (WM) is an important part of, and often one of the first steps in, the continuum of care to address substance use and addiction for individuals in need of assistance. However, it is often not examined in detail or reported on, thus limiting the ability for practitioners and policy makers to address gaps and improve outcomes. At the 2017 annual meeting of the National Treatment Indicators Working Group (NTIWG), members identified a need to explore the various WM programs offered throughout Canada, and decided to produce a special report highlighting the importance of WM services. The NTIWG formulated the following objectives for this report:

- Present a robust and consistent national picture of WM;
- Serve as a resource to researchers and healthcare system planners to assist in planning for future needs;
- Help identify gaps in the data that should be filled to provide a more complete picture and improve efforts to address the issue; and
- Educate partners about the range, type and extent of WM services available across jurisdictions.

The report provides an overview of the use of WM services in Canada in 2015–2016, including episodes of care offered within specialized community-based services and in hospitals. Additionally, the report provides insights that might assist practitioners and policy makers in their approach to, and decisions about, WM. The following section contains a brief description of WM services, including their objectives and role within the care continuum for substance use disorders, and describes some data on the national picture. While this report provides as complete a picture as possible, not all provinces and territories were able to provide data, and this report does not include every source of data on WM service events (e.g., private treatment). Refer to the Methods section for all limitations.

Withdrawal Management Services

WM services (sometimes referred to as detoxification or detox) offer support and care for the safe management of withdrawal symptoms and medical complications of individuals with a substance use disorder who are ceasing to use the substance (Diaper et al., 2014; Mattick & Hall, 1996). The primary objectives of WM services are to support safe completion of the acute phase of withdrawal and to reduce the severity of withdrawal symptoms. Secondary objectives, which can differ among individuals, are to provide a period of rest from substance use and accompanying consequences and an opportunity for service providers to promote engagement in active treatment. These features describe the role of WM services in the broader care continuum for substance use. Importantly, WM services can precede an episode of treatment, but are not an effective standalone treatment (e.g., leading to sustained abstinence or reduced use and harms).

WM services may be medically supervised, including pharmacological support provided in hospital or medically staffed residential settings, doctors' offices or clinics, or via mobile services (e.g., home visits), with varying levels of psychosocial supports. Non-pharmacological or psychosocial WM can also be offered in community-based clinics. Programs are relatively short in duration, in the order of a few days to weeks. The symptoms of withdrawal and the pharmacological agents used in medically assisted WM services are all substance-specific. For more information see American Psychiatric Association (2013), Brigham and colleagues (2014) and Jesse and colleagues (2017) or the provincial and territorial guideline documents listed below.



The Transition from Withdrawal Management Services to Treatment

A key concern with WM services is promoting the transition to active treatment (pharmacological, residential or outpatient) (Redko, Rapp, & Carlson, 2006). In particular, in the context of Canada's current crisis of opioid overdoses, the delivery of WM services for opioids without immediate transition to evidence-based opioid treatment is explicitly recommended against, as there is an elevated risk of overdose associated with lower tolerance following a period of abstinence (Bruneau et al., 2018).

More generally, the timely transition (i.e., within a few days) between WM services and treatment is used as an indicator of care quality in performance measurement frameworks for substance use services (Garnick et al., 2011; Lee et al., 2014; Stein, Kogan, & Sorbero, 2009). These studies indicate that only a minority of people discharged from WM services enter a treatment program in a timely manner (within one month).

Research has shown that a lengthy transition time from WM to treatment can lead to the loss of engagement with a client. For instance, intervals ranging from several days to weeks can result in up to 30% of clients leaving and not progressing into treatment (Li, Sun, Marsh, & Anis, 2008). In comparison, other studies have found that individuals are significantly more likely to keep intake appointments scheduled within one day of contact in comparison to three and seven days later (Festinger, Lamb, Marlowe, & Kirby, 2002). Numerous interventions have been developed to facilitate this transition, including outreach visits by treatment staff, case management, incentives and escorts to treatment centres, as well as agency-level interventions like performance contracting (Carroll, Triplett, & Mondimore, 2009; Chutuape, Katz, & Stitzer, 2001; Haley, Dugosh, & Lynch, 2011; McLellan, Weinstein, Shen, Kendig, & Levine, 2005; Nielsen & Nielsen, 2018). Reducing delays at this point in the care continuum is an important opportunity to improve the quality of care.

Repeated Readmissions to Withdrawal Management Services

As with any service modality for substance use, readmission to WM services is not a uniformly negative outcome and requires contextualization. That said, studies have identified a cohort, accounting for approximately 10% to 15% of clients, with three or more detoxification episodes within a 12-month period, typically without additional treatment (Haley et al., 2011; McLellan et al., 2005). As noted, this pattern of service use is unlikely to assist people in establishing long-term recovery. Studies have shown that people with repeated admissions to WM services tend to be more socially marginalized, with high rates of unstable housing and unemployment (Callaghan, 2003; Callaghan & Cunningham, 2002b; McLellan et al., 2005), as well as poly-drug use and blood borne infections (Li et al., 2008). These findings speak to the need for tailored psychosocial supports to accompany pharmacological and medical care in WM service settings.

Sex and Gender Issues in Withdrawal Management Services

Substance use patterns and experiences, substance-related harms and impacts on health all differ between males and females, highlighting the importance of taking sex and gender¹⁸ into account in service and policy development (Greaves & Poole, 2007; Tuchman, 2010). Relative to males in treatment, females are more likely to have a history of trauma and co-occurring mental disorders, and experience a faster progression from use to disorder (Anderson, Hruska, Boros, Richardson, &

¹⁸ As defined by the World Health Organization, sex refers to the biological anatomy of an individual (i.e., their reproductive organs, chromosomes, etc.), sometimes referred to as sex assignment at birth. Gender refers to “the socially constructed characteristics of women and men — such as norms, roles and relationships of and between groups of women and men” (World Health Organization, 2011). The majority of jurisdictions collect data on Other individuals accessing withdrawal and treatment services. However, at this time the numbers are very low, which prevents reporting on them for individual jurisdictions.



Delahanty, 2018; Tuchman, 2010). There is also evidence of sex- and gender-specific barriers to entering treatment (e.g., stigma, fear of loss of child custody, lack of female-centred care)(Finnegan, 2013; Greaves & Poole, 2007; Stone, 2015).

As with other substance use services, sex and gender can shape experiences of WM services in a variety of ways that can have an impact on outcomes. Clinically, attention has been given to the pharmacological and medical management of withdrawal in pregnant women (Heberlein, Leggio, Stichtenoth, & Hillemacher, 2012; Klamon et al., 2017). Generally, findings are equivocal on gender differences in rates of leaving WM services, with some studies reporting no difference (Callaghan & Cunningham, 2002a; Hakansson & Hallen, 2014; Li, Sun, Purl, Marsh, & Anis, 2007a) and some studies reporting higher rates among women, particularly Indigenous women living in an urban context (Deacon, Hines, Curry, Tynan, & Day, 2014; Li, Sun, Marsh, & Anis, 2013). There is also evidence that females are more likely than males to transition to treatment from WM services (Mark, Dilonardo, Chalk, & Coffey, 2003), but are less likely to maintain abstinence after discharge, independent of whether they transition to treatment (Ivers et al., 2018). More attention is needed to the role of women-centred care and the role of factors such as trauma history, co-occurring mental disorders and parenting status, in shaping the experiences of females in WM services.

Other high-risk groups are those individuals who identify with minority sexual orientations and genders (e.g., lesbian, gay, bisexual, transgender, queer, etc. [LGBTQ+]) where research has shown higher prevalence rates of substance use in comparison to heterosexuals and individuals who are cisgender (Corliss et al., 2010; Marshal et al., 2008; Schrage et al., 2014). More research is needed to better understand the experiences of individuals in the LGBTQ+ community with WM and treatment (Corliss et al., 2010; Lyons et al., 2015; Schrage et al., 2014). Although there have been improvements in access to, and implementation of, treatment for these minority groups, a critical barrier for these individuals is the lack of services that address their specific needs. An important step is collecting and reporting on data pertinent to those in the LGBTQ+ community to develop targeted withdrawal and treatment services.

Other Factors Influencing the Effectiveness of Withdrawal Management

A variety of other factors can influence the effectiveness of WM services. These factors can be at the individual level or at a broader, more systemic level. For instance, the goal for individuals seeking detoxification might be abstinence, while for others it might be to reduce and better control their dependence (Diaper et al., 2014). In addition to sex and gender characteristics, age can also play a role. Some studies have shown that younger individuals (e.g., under 25) might be affected by less severe addiction and be less likely to use multiple substances, and might have greater psychosocial stability, which could improve their opportunities for successful detoxification (Sigmon et al., 2013).

The substance or substances from which an individual is withdrawing and the severity of addiction can also have an impact on the effectiveness of WM services. The variations in these areas are too broad to discuss here, but there are some general observations that can be gathered from the research. A severe addiction may be better addressed in highly controlled environments such as residential withdrawal management (RWM), whereas in other cases, outcomes may be more successful in non-residential withdrawal management (NRWM) settings (Diaper et al., 2014; European Monitoring Centre for Drugs and Drug Addiction, 2014; Muncie, Yasinian, & Oge, 2013). Regardless of treatment type, a variety of socio-economic factors such as social supports or potential mental health issues, employment and so on can influence treatment success. (Amato et al., 2013; Kassani, Niazi, Hassanzadeh, & Menati, 2015)



Another important factor that can affect the impact of WM is the management of the approach used. Generally speaking, there are three variations: 1) pharmacological strategies, which use medications to help manage withdrawal; 2) psychosocial strategies, which use cognitive or counselling methods; and 3) a combination of pharmacological and psychosocial strategies. Any approach used will be tailored to the needs of the individual and the type of substance or substances. Certain withdrawal approaches may be better addressed by an emphasis on a pharmacological approach, while other approaches may benefit from an emphasis on psychosocial approaches. However, research about effectiveness varies widely. A number of studies recommend combining pharmacological and psychosocial strategies that can jointly address the chemical dependence and psychological factors contributing to the addiction (Diaper et al., 2014; Merks et al., 2014). It is important to consider the various characteristics of the individual when combining pharmacological and psychosocial strategies.

There are other factors that can also have an impact on the effectiveness of WM, such as being a member of a specific population (e.g., race, cultural background, youth, low socioeconomic status)(Copeland & Swift, 2009; Li et al., 2007a; United Nations Office on Drugs and Crime, 2004). The overall implication is that WM is a complex component of the continuum of care that requires a variety of considerations when assisting individuals through their withdrawal process. Above all, success is highly dependent upon the involvement of the individual affected by substance use in their own withdrawal and treatment plan, as well as the inclusion of family or other relevant individuals where deemed appropriate (Diaper et al., 2014).

Jurisdictional Guidelines

There are no national standards for WM services. However, a number of jurisdictions have released their own standards, guidelines and best practices related to WM services. These include:

- British Columbia's Provincial Guidelines for Biopsychosocialspiritual Withdrawal Management Services (British Columbia Ministry of Health, 2017)
- Saskatchewan's Detox Programming Standards (Government of Saskatchewan, 2012)
- Ontario's Provincial Standards for Withdrawal Management Services (Addictions and Mental Health Ontario, 2014)
- Nova Scotia's Adolescent Withdrawal Management Guidelines (Government of Nova Scotia, 2013)
- The Northwest Territories' Assessment and Review of Withdrawal Management Services (Crowe MacKay, 2014)



Methods

This report provides aggregate-level, descriptive information on individuals who accessed publicly funded services for substance use WM services in Canada during fiscal year 2015–2016. It provides information on two treatment categories: RWM and NRWM. NTIWG members were asked to provide information on 47 indicators; however, only those pertaining to WM were analyzed for this report. For a complete list of indicators, see Appendix B, and for the indicator definitions see Appendix C. Not all jurisdictions were able to provide information on each indicator, as some jurisdictions are not able to consistently collect this information. (Appendix D describes availability of indicators for each jurisdiction.) The subset of indicators presented in this report have been agreed upon by the NTIWG.

The data submitted by the jurisdictions were the outcome of a multi-stage process. First, service providers enter client-level data, which were then collated at the regional or provincial level according to reporting requirements. The data were then analyzed at the provincial level according to the definitions and data-collection protocols developed by the Canadian Centre on Substance Use and Addiction (CCSA) in consultation with members of the NTIWG.¹⁹ Next, data were entered into a secure, online platform specially designed for the NTI project.

As an additional feature to this report, hospitalization data pertaining to WM are also presented for various jurisdictions. The Canadian Institute for Health Information (CIHI) provided CCSA with aggregated hospitalization data. The data were collected according to CIHI's data collection protocols,²⁰ securely transmitted to, and stored on, CCSA's internal secure servers.

Finally, CCSA analyzed the jurisdictional and hospitalization data sets. The results of the hospitalization data were checked by CIHI, and the entire report was reviewed by the NTIWG, which worked in close consultation with CCSA to produce the final report.

Data Collection

This seventh NTI report and first report focused on WM provides information on individuals who accessed publicly funded substance use WM services (jurisdictional data) or who accessed hospital services (CIHI data) during 2015–2016. Specifically, the Yukon, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador provided provincial and territorial-level WM data. Within Indigenous Services Canada's Mental Wellness Program, the Youth Solvent Addictions Committee and the Thunderbird Partnership Foundation also provided information about some treatment services pertaining to First Nations.

A variety of different systems, methods and processes were used to collect this information across Canada. Generally, a substantial amount of service and client information is collected at the point of screening and assessment or intake. However, requirements for the type and quality of data submitted also vary, depending on the use for the data. Across Canada, there are differences in the quality and quantity of the information collected, the format in which it is recorded and the availability.

Hospitalization data were provided by CIHI from the Hospital Mental Health Database (HMHDB). The HMHDB is a pan-Canadian database that contains data from administrative separation records of psychiatric and general hospitals. A separation refers to the departure of an inpatient from a hospital, due to discharge or death. For the purposes of this report, separations will be referred to as

¹⁹ Data collection protocols are available from CCSA on request. See Appendix B for more information on the data collection process.

²⁰ More information about CIHI's data collection standards and protocols can be found on their website at <https://www.cihi.ca/en/submit-data-and-view-standards>.



hospitalizations. The HMHDB contains data from four separate data sources: the Discharge Abstract Database (DAD), the Hospital Morbidity Database (HMDB), the Ontario Mental Health Reporting System (OMHRS) and the Hospital Mental Health Survey (HMHS).

Every hospitalization record includes a code indicating the main reason for the hospital stay. The DAD and HMDB use the International Statistical Classification of Disease and Related Health Problems, 10th revision (ICD-10-CA) (Canadian Institute for Health Information, 2015) (see Appendix E). The OMHRS and HMHS report diagnoses codes that are based on the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR). While most provinces and territories only use ICD-10-CA, the hospital data from Ontario contain records coded using both ICD-10-CA and DSM-IV-TR. Hospitalization data are presented for the Yukon, Nunavut, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador.

Limitations

General limitations to this data are described below and limitations specific to jurisdictions are included in each jurisdiction's respective summary. It is expected that limitations will be addressed with increased data-collection capacity and as jurisdictions identify new methods to report information aligned with the NTI data-collection protocols. At this time, however, the following limitations must be considered when reviewing and interpreting the data.

Jurisdictional Community-based Treatment Data

- **Services included:** Data represent publicly funded services; private treatment is not included. Those with a problematic substance use could have other health-related issues that can account for their contact with the healthcare system. As the NTI project evolves, CCSA intends to better capture data reflecting the full continuum of substance use treatment services provided in Canada (e.g., community supports, primary care).
- **Jurisdictional participation:** Through the inclusion of hospitalization data provided by CIHI, 10 of the 11 Canadian jurisdictions that are part of the NTIWG were able to participate in this year's report. Among the ten jurisdictions, seven were also able to provide community-based data. The reasons for not contributing to the current report included a jurisdiction not being able to collect or share jurisdictional data or, in other cases, the jurisdiction could only provide some background information. 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 data entry at the frontline level. In many provinces and territories there are different data-collection systems in place, creating inconsistencies in data definitions and data-entry practices. For example, some jurisdictions consider a case to be "open" at first contact, whereas others wait until the formal treatment intake. 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 standard, agreed-upon definitions. However, service delivery models vary widely across Canada and the core indicator definitions are continuously reviewed as the project progresses to ensure they best reflect work in the field.



- **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.
- **Sex and gender:** Hospital records include the individual's sex. Community-based treatment records include a mixture of an individual's sex or gender. For the purposes of this report, the term "gender" is used for analysis and reporting of all community-based treatment.

Hospital Data Limitations

- In the DSM-IV-TR, the codes 291.0 and 292.81 can include hospitalizations for intoxication delirium as well as hospitalizations for withdrawal delirium. Therefore, the number of hospitalizations for substance-related withdrawal in Ontario could be a slight overestimate.
- The diagnosis information does not differentiate between conditions that were due to substances used for medical purposes and conditions due to use for non-medical purposes.

Results

The following sections of the report display treatment data and context for the 2015–2016 fiscal year separately by jurisdiction. The results include the ratio of service events to individuals, recognizing that an individual can have several events in a given year. The ratio, however, indicates an average that can be affected by variations in how a service event is measured between jurisdictions²¹ or by a small number of individuals with a high number of service events.

²¹ Limitations for each jurisdiction are reported in their respective sections; however, examples of differences include some jurisdictions track service events for a single individual while others are not able to, or some jurisdictions offer NRWM while others do not.



Yukon

Population: 37,289²²

Gender: 18,953 males (50.8%); 18,336 females (49.2%)

Withdrawal Management Overview and Summary

Yukon has one dedicated RWM program located in Whitehorse. Withdrawal Management Services (WMS) provides a safe and supportive environment to assist youth and adults in safely withdrawing and recovering from the effects of substance use or dependence. The length of stay varies with each individual depending on withdrawal severity, health status and treatment plans.

The service provided is medically supported. There are two licensed practical nurses on each shift and they are supported by recovery unit attendants. Medical standards, protocols and general standing orders have been implemented. The licensed practical nurse can initiate standing or client-specific orders that have been approved by the nurse practitioner, therefore reducing client movement to Whitehorse General Hospital. WMS are informed and supported by a quality assurance supervisor who is a registered nurse.

In October 2016, WMS moved to an expanded facility with expanded programming and capacity. At the time of the data being reported, WMS consisted of 10 beds. Two beds were held for women and four beds were designated for acute withdrawal. Also, if available, four beds were used for transition in the week either before or after admission into the Intensive Treatment Program. Limited bed capacity at the time resulted in 20% to 25% of clients being unable to access services because a bed was not available.

The new facility provides 18 beds total. Four beds are available for acute withdrawal, two for males and two for females. Four beds are in a separate Youth Withdrawal Management program, which provides programming specifically designed for youth²³ requiring stabilization. Although the youth unit is co-located within WMS, it has restricted access to prevent the different client groups from mixing. Ten beds are available for adult RWM. Expanded services includes a nurse practitioner who provides direct services to WMS clients five days per week.

Additional programming in WMS includes:

- Daily group awareness and education sessions that provide clients with information about substance use, addiction, recovery and available services.
- Social work support that can refer clients to additional services and help clients with transitioning back into the community.
- Access to weekly drop-in counselling appointments with clinical counsellors.

Day contracts are available for clients who need some additional outpatient WMS supports, but who have sufficient stability in their family or home environment to not require continual onsite services. This provision ensures that WMS beds are available to those in the greatest need, and that the service and support options best match the client's care needs and stage of recovery. Day

²² Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>

²³ Youth is defined as all clients aged 13–18 and clients aged 19–24 assessed on a case-by-case basis for best client and program fit.



programming can include participation in awareness and education sessions and continued social work support.

Individuals can receive WM support in Whitehorse General Hospital or in community hospitals located in Watson Lake and Dawson City. Nurses in the Community Health Centres can also provide some WM support to individuals who are unable or unwilling to attend WMS in Whitehorse. These services are not formalized, but inpatient services in the three hospitals are reported to the CIHI.

Some First Nations provide on-the-land programming for their citizens when needed. WM support can be one aspect of this programming. Staff from addictions services have provided support to these programs; however, they are not formalized or conducted on an ongoing basis. Data from these programs are not available for inclusion in this report.

Important data considerations and limitations

Data collection is limited to services provided by WMS in Whitehorse and services provided in the three territorial hospitals. Any support provided by First Nations governments or through Community Health Centres are not included in this report.

Due to how data has been collected, WMS data is restricted to overall service events. One unique individual can have multiple service events within the year. At this time, it is not possible to determine how many service events each unique individual accessed.

Results

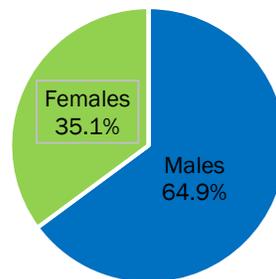
Community-based Withdrawal Management

Residential withdrawal management service events

Currently, data are only available for RWM services, and only these data are reported here. Data pertaining to total service events and unique individuals are not yet available.

In 2015–2016, a total of 760 RWM service events were recorded in the Yukon. Among these service events, males accounted for 64.9% ($n = 493$ events) and females accounted for 35.1% ($n = 267$ events) (Figure 9).

Figure 9. Residential WM service events²⁴ by gender



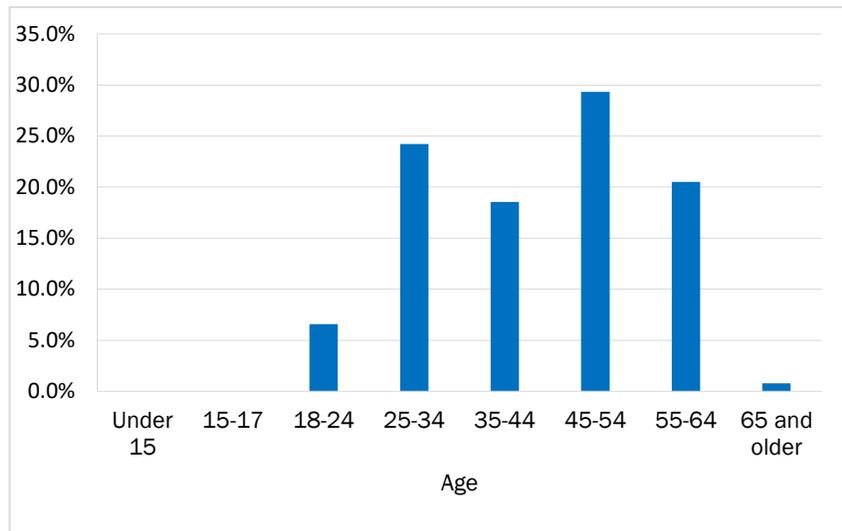
²⁴ Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Number of residential withdrawal management service events by age

As shown in Figure 10, the highest percentage of RWM service events occurred among those aged 45–54 years.

Figure 10. Residential WM service events²⁵ by age



Hospital-based Withdrawal Management

Hospitalizations by sex²⁶

In the Yukon, there were a total of 51 hospitalizations²⁷ for WM from substance use. The average length of stay for WM hospitalization was three days. Males represented 72.5% ($n = 37$) of the hospitalizations and females represented 27.5% ($n = 14$) of the hospitalizations (Figure 11). In comparison to community services, male hospitalizations by percentage (Figure 11) were higher than publicly funded male service events (Figure 9). With respect to length of stay, the total for all hospitalizations was 176 days.²⁸ Days stayed in the hospital by males accounted for 80.7% (142 days) of total days and days stayed for females accounted for 19.3% (34 days) (Figure 12).

25 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

26 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

27 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

28 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



Figure 11. Hospitalizations for WM by sex (percentage), FY 2015–2016

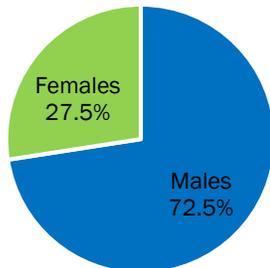
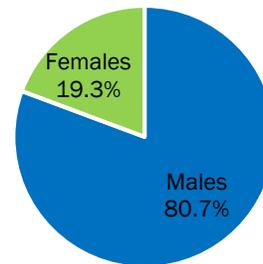


Figure 12. Days stayed in hospital for WM by sex (percentage), FY 2015–2016

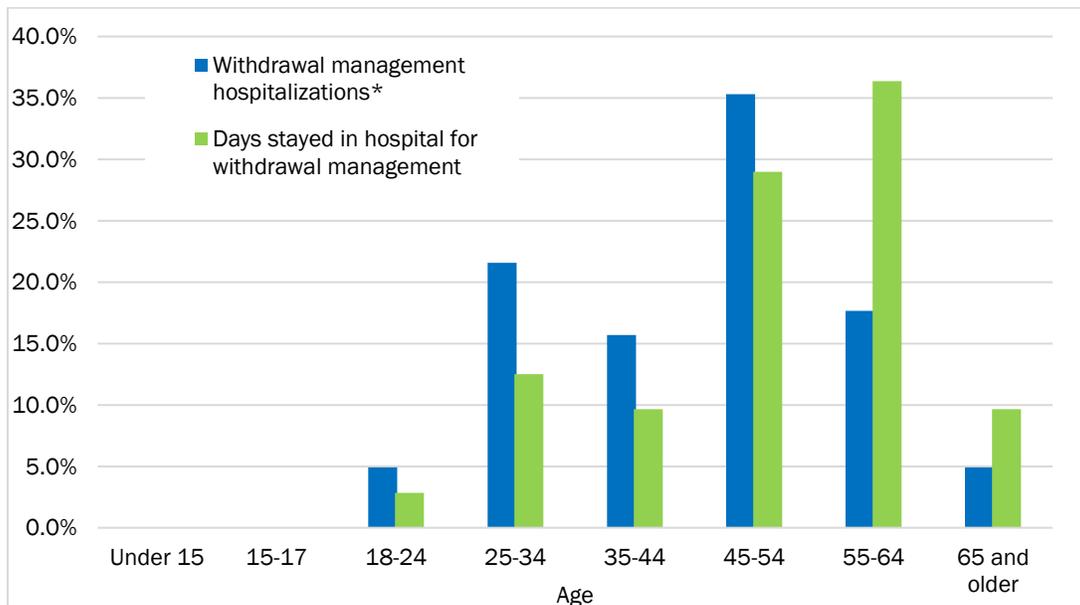


Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations²⁹ occurred among those aged 45–54 years (35.3%), followed by those aged 25–34 years (21.6%) (Figure 13). With respect to length of stay in the hospital, of the total 176 days those aged 55–64 years accounted for the highest number at 64 days (36.4%) and, following this, those aged 45–54 years accounted for 51 days (29.0%).

Figure 13. Percent of hospitalizations* and days stayed (days) for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.

²⁹ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Nunavut

Population: 36,608³⁰

Gender: 18,939 males (51.7%); 17,669 females (48.3%)

Overview and Summary

The Government of Nunavut is committed to the development of addiction treatment capacity across the territory, with a focus on community-based services and supports. Currently, there are no formalized WM services within Nunavut. WM is provided on a case-by-case basis. Hospital-based withdrawal services can be provided at the Qikiqtani General Hospital in Iqaluit, as required. All residential addiction services are provided out-of-territory and medical detox at a facility outside of Nunavut can also be arranged as part of a client's care plan. Community-based staff can also support clients in receiving medication to manage cravings in their recovery from problematic substance use or substance use disorders.

Results

Hospital-based Withdrawal Management

Hospitalizations by sex³¹

In Nunavut, there were a total of 14 hospitalizations³² for WM for substance use. The average length of stay for WM hospitalization was 1.6 days. With respect to length of stay, the total for all hospitalizations was 22 days.³³ Due to low data counts and suppression of data, hospitalizations by gender have not been specifically reported.

Hospitalizations by age

Due to very low data counts and suppression of data, hospitalizations by age have not been reported.

30 Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>

31 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term "sex" is used, referring to an individual's reproductive system and other physical characteristics.

32 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual's length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

33 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



British Columbia

Population: 4,694,699

Gender: 2,329,956 males (49.6%), 2,364,743 females (50.4%)

Withdrawal Management Overview and Summary

In British Columbia, specialized substance use services, including WM services, are delivered primarily through five regional health authorities, the First Nations Health Authority and the Provincial Health Services Authority. The publicly funded system is supplemented by private treatment centres located across the province.

Dedicated residential or inpatient units offering medically assisted WM services are available in most regions of the province, typically located in the major urban or populated centres within each health region. These offer short stays of up to about seven days, with medical support for the acute symptoms of withdrawal from substances. Some are linked to stabilization or transitional housing services where clients can stay for longer periods before discharge to the community or to other treatment facilities. Dedicated assistance with withdrawal symptoms is also available at selected public and private residential treatment facilities and in some hospitals.

WM support is also available on an outpatient basis in some regions. Designed for people who have a stable living situation, these include day programs and home-based and mobile services that are accessed in the community. As an example, the Substance use Treatment and Response Team in Vancouver, started in 2016, offers rapid access to a two-week home-based WM service that includes medical assessment, home visits and related supports (e.g., take-home naloxone). Community-based WM services typically include at least minimal medical supports, including medications, medical assessment and monitoring.

The province also has a small number of sobering and assessment centres, which aim to provide a safe setting for people to stay while the acute effects of substance use wear off and to connect with other local resources where possible. Stays are limited to under 24 hours. These are harm reduction services designed to support people who are acutely intoxicated, rather than assisting with symptoms of withdrawal.

While WM services are available throughout the province, this does not imply all who are in need are able to access services in a timely manner. Provincial guidelines for WM, updated in 2017, recommend the development and expansion of community-based services and supports for managing withdrawal symptoms in British Columbia (British Columbia Ministry of Health, 2017). The recommendations include home-based and mobile services, as well as assistance provided in primary care settings. The guidelines also note that medically assisted inpatient and RWM is required by only a minority of people with problematic substance use (e.g., those with complex co-occurring conditions and other complications) and advocate for greater use of community-based supports.

Substance-specific Practices

For opioid use disorders, the recently updated provincial guidelines for WM advise against standalone WM (i.e., in the absence of immediate transition to longer-term treatment) due to the elevated risks of overdose, relapse, and other harms (British Columbia Ministry of Health, 2017; British Columbia Centre on Substance Use, 2017). It is recommended that WM for opioid use disorder is provided in outpatient settings (unless residential or inpatient services are indicated, as above) with immediate transition to treatment, including opioid agonist therapy and psychosocial supports.



Results

Hospital-based Withdrawal Management

Hospitalizations by sex³⁴

In British Columbia, there were a total of 2,783 hospitalizations³⁵ for WM for substance use. The average length of stay for WM hospitalization was five days. Males represented 71.3% ($n = 1,984$) of hospitalizations and females represented 28.7% ($n = 799$) of hospitalizations (Figure 14). With respect to length of stay, the total for all hospitalizations was 12,681 days.³⁶ Days stayed in the hospital by males accounted for 70.5% (8,934 days) and days stayed for females accounted for 29.5% (3,747 days) (Figure 15).

Figure 14. Hospitalizations for WM by sex (percentage), FY 2015–2016

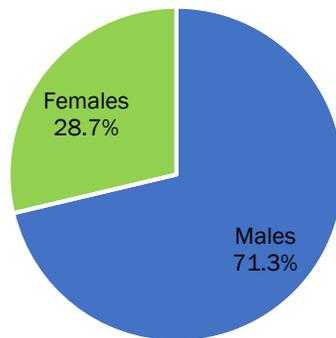
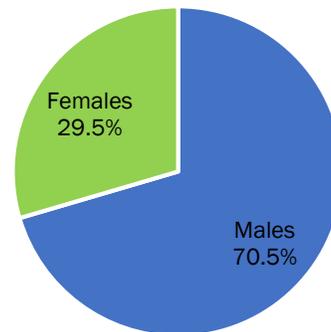


Figure 15. Days stayed in hospital for WM by sex (percentage), FY 2015–2016



Hospitalizations by age

In terms of age, the highest percentage of hospitalizations³⁷ occurred among those aged 45–54 years (26.2%), followed by those aged 55–64 years (21.1%) (Figure 16). With respect to length of stay in the hospital, of the total 12,681 days those aged 45–54 years accounted for the highest number at 3,246 days (25.6%) and, following this, those aged 55–64 years accounted for 3,031 days (23.9%).

³⁴ Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

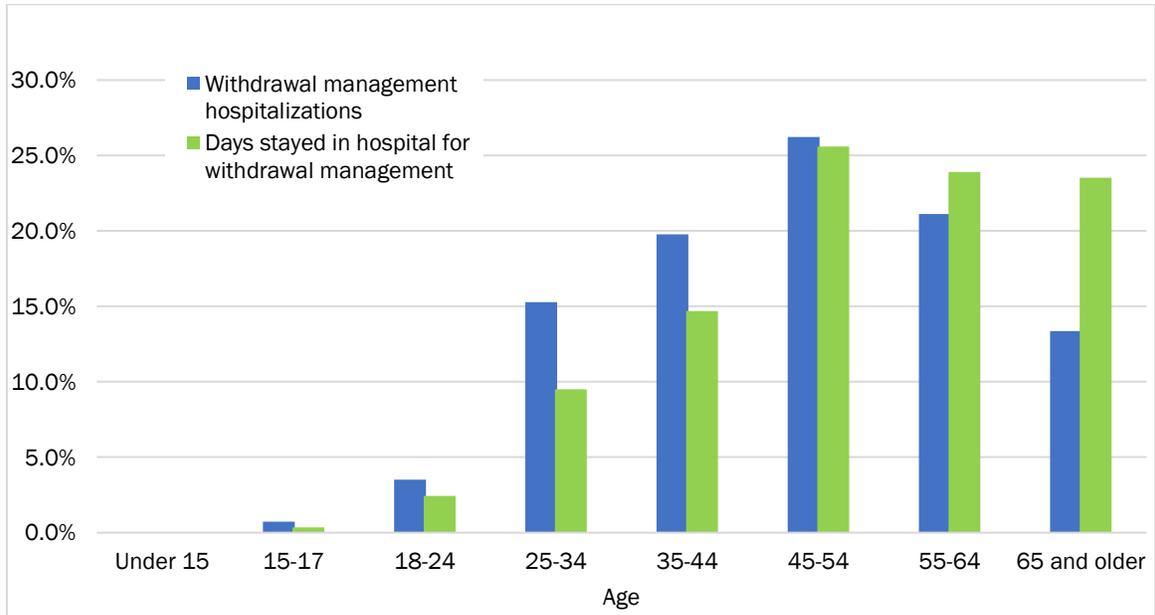
³⁵ Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

³⁶ Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.

³⁷ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Figure 16. Percent of hospitalizations and days stayed for WM by age group, FY 2015–2016





Alberta

Population: 4,177,527³⁸

Gender: 2,122,710 males (50.8%); 2,054,817 females (49.2%)

Withdrawal Management Overview and Summary

The primary WM services in Alberta are community-based RWM services. As the ministry responsible for addiction treatment services, Alberta Health is responsible for setting policy, legislation and standards for WM services in the province and the delivery of service is the responsibility of the regional health authority, Alberta Health Services (AHS). Some services operate independently from the healthcare system and are funded through different levels of government or ministries or through charitable foundations or donations. These services are not addressed in this summary.

The majority of WM services are directly operated by AHS, with in-house medical supports and designated beds, often followed by further residential or non-residential treatment. These services typically include health stabilization, assessment, referral, information sessions, introductions to self-help groups, and treatment planning facilitated by addiction counselors. Alberta Health Services also contracts with community agencies to provide WM services. Some contracted agencies provide medically supported detoxification services but the majority provide non-medical, social detoxification through designated beds and shelter mats.

AHS offers WM services for both adults and youth. Youth services include both voluntary and mandatory detoxification programs that help youth safely withdraw from substance use while exploring further treatment options. The Protection of Children Abusing Drugs (PChAD) program is a stabilization service where children under 18 years of age whose substance use has caused or is likely to cause themselves or others social, psychological or physical harm are mandated to attend the program through court orders requested by the children's legal guardians. Youth typically stay in voluntary and mandatory services for 10 days. Adult detoxification services tend to be shorter in duration, with adults typically remaining in the program five to seven days. Both youth and adult detoxification services can be extended when necessary.

As of the end of 2015–2016 fiscal year, there were six AHS operated detox facilities with 114 beds, nine contracted agencies with 115 detox beds and 83 shelter mats, and four mandatory detox facilities for youth (PChAD program) with 22 beds. Some contracted providers have additional beds or mats that are funded through sources other than AHS and are not included in these bed numbers.

Currently, AHS does not offer NRWM through any of its directly operated or contracted services.

Important data considerations and limitations

Alberta results include only AHS directly operated services and exclude AHS contracted services. For some service locations, results include both clients receiving WM services and clients who are not assigned beds, but only screened or referred to the nearest emergency department or treatment other than WM services.

³⁸ Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=>



Alberta results do not include services offered in hospitals and there was no overlap between the results and the hospital data submitted to CIHI. Hospitalization data from CIHI is provided below.

Substance-specific Practices

WM services within Alberta are not substance specific but there are some substance specific practices within these services. For example, AHS has a specific protocol for withdrawing clients from alcohol in its medical detoxification services. This protocol specifies the need to complete a comprehensive assessment, including a Clinical Institute of Withdrawal Assessment scale that guides what clinical intervention the clients receive and the frequency of monitoring client vital signs. The protocol also identifies when to use benzodiazepines to assist in the clients' withdrawal. Likewise, AHS directly operated WM services and some contracted service providers have recently begun initiating opioid dependent clients on opioid agonist treatment.

Results

Community-based Withdrawal Management

Total service events and unique individuals

In 2015–2016, 32,407 unique individuals accessed publicly funded (AHS direct operated) substance use treatment services in Alberta, which accounted for 42,895 service events. Of these individuals, 75.3% (n = 24,389) were new cases. These numbers include individuals and service events for all treatment types. The majority of individuals 87.9% (n = 28,480) accessed treatment services for their own problematic substance use; however, 3,927 individuals accessed treatment for a friend or family member.

With respect to WM, NRWM is not offered. However, 4,457 unique individuals accessed RWM services, which accounted for 6,199 RWM service events. Males accounted for the majority, 64.6% (n = 4,006), of these service events, while females accounted for 34.7% (n = 2,148) (Figure 17). Across all treatment services males still accounted for the majority of treatment service events, 63.1% (n = 24,012) (Figure 18).



Figure 17. WM service events³⁹ by gender

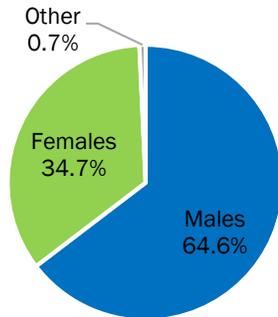
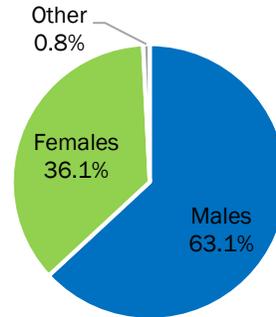


Figure 18. Total treatment service events⁴⁰ by gender



Withdrawal management service events and unique individuals by gender

As shown in Table 3, total WM service events accounted for 16.3% of all treatment services. While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (83.7%). Individuals accessing WM services accounted for 13.5% of all individuals accessing services.

Table 3: Total service events and unique individuals⁴¹ by gender

	RWM	Residential and Non-residential Treatment	Total Counts*
Service Events:			
Total (including unknown gender)	16.3%	83.7%	n = 38,057
Males	16.7%	83.3%	n = 24,012
Females	15.6%	84.4%	n = 13,750
Unique Individuals:**			
Total (including unknown gender)	13.5%	86.5%	n = 32,958
Males	13.6%	86.4%	n = 20,921
Females	13.4%	86.6%	n = 11,778

*Other was reported as a gender, but the numbers per cell were too small to display.

**The counts for individuals are higher than the actual number of individuals seeking treatment as individuals are counted uniquely within each service type and therefore can be counted more than once across all services.

The ratio of RWM service events to individuals was 1.4.

39 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

40 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

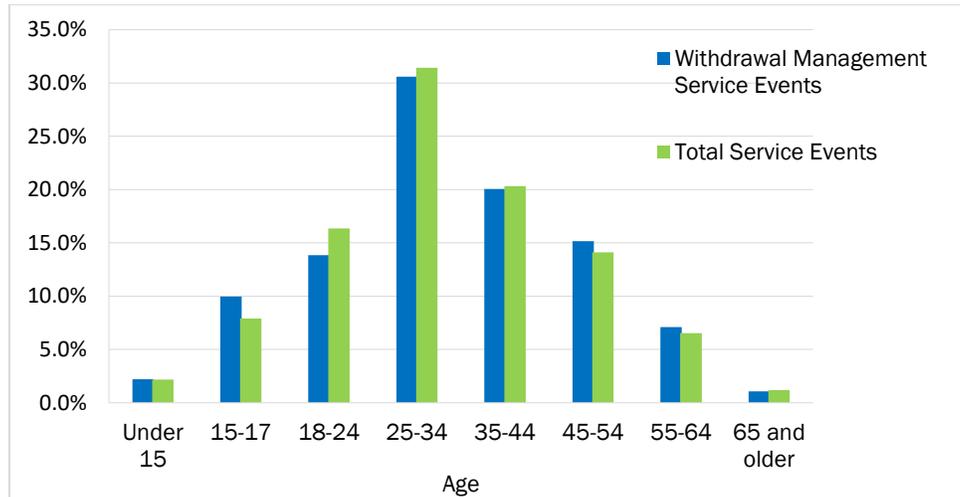
41 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Number of withdrawal management service events by age

As shown in Figure 19, the highest percentage of WM service events and total overall service events occurred among those aged 25–34 years.

Figure 19. WM service events and total service events⁴² by age



Hospital-based Withdrawal Management

Hospitalizations by sex⁴³

In Alberta, there were a total of 2,360 hospitalizations⁴⁴ for WM for substance use. The average length of stay for WM hospitalization was five days. Males represented 72.0% ($n = 1,699$) of hospitalizations and females 28.0% ($n = 661$) of hospitalizations (Figure 20). In comparison to community services, male and female hospitalizations by percentage (Figure 20) were somewhat similar to publicly funded male and female service events (Figure 17). With respect to length of stay, the total for all hospitalizations was 12,848 days.⁴⁵ Days stayed in the hospital by males accounted for 74.8% (9,616 days) of total days and days stayed for females accounted for 25.2% (3,232 days) (Figure 21).

42 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

43 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

44 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay, or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

45 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



Figure 20. Hospitalizations for WM by sex (percentage), FY 2015–2016

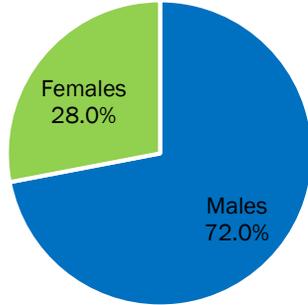
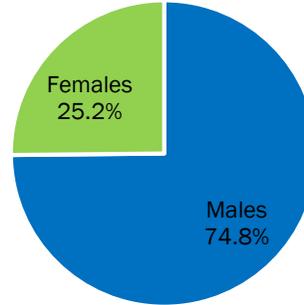


Figure 21. Days stayed in hospital for WM by sex (percentage), FY 2015–2016

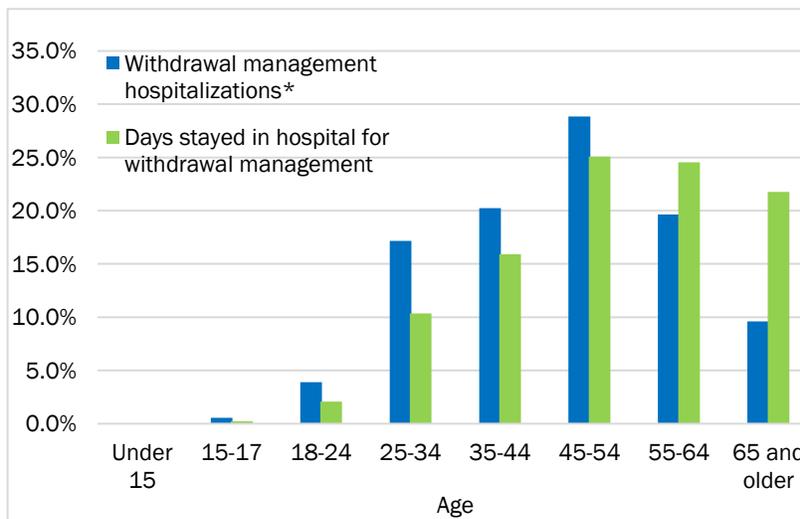


Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁴⁶ occurred among those aged 45–54 years (28.8%), followed by those aged 35–44 years (20.3%) (Figure 22). This contrasts somewhat with community treatment services, where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 12,848 days those aged 45–54 years accounted for the highest number at 3,224 days (25.1%) and, following this, those 55–64 years accounted for 3,153 days (24.5%).

Figure 22. Percent of hospitalizations* and days stayed for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.

⁴⁶ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Saskatchewan

Population: 1,131,150⁴⁷

Gender: 570,252 males (50.4%); 560,898 females (49.6%)

Overview and Summary

In 2015–2016, the Saskatchewan Ministry of Health funded, either directly or through the former regional health authorities,⁴⁸ a continuum of services to those affected by drug and alcohol misuse. These services include detoxification (detox) services, outpatient treatment, day programming, outreach, long-term residential, transitional and residential treatment options. While many individuals and families begin their treatment through outpatient services. For individuals with more severe substance use problems, treatment often begins in a detox facility.

In Saskatchewan, all publicly funded WM services for youth and adults are provided through the Saskatchewan Health Authority or community-based organizations. All WM programs in Saskatchewan are considered “residential” as individuals visit a facility to receive detox services. In some northern or rural communities, these programs may be located in a community health centre or hospital. Services are available for both youth and adult populations in the province.

Individuals requiring more significant medical support to withdraw from alcohol or drugs receive detox services in a hospital setting. While these services would be considered part of the continuum of alcohol and drug treatment, they are not captured in the community-based alcohol drug and gambling system and are not included in the NTI data. Data on hospital-delivered detox services can be found in the Discharge Abstract Database. With the exception of medical detox services provided in a hospital setting, detox programs are typically categorized into three types: brief detox, social detox and involuntary detox services for youth.

Brief detox

Brief detox programs provide a safe place for individuals to stay for a short period, typically 12–48 hours, to stabilize and recover from serious intoxication or problematic drug use and to stabilize physically, emotionally and socially. Supportive counselling and follow-up referrals are provided. Individuals can access these programs on a walk-in basis and would be admitted to a bed for the duration of their stay. Typically, individuals access brief detox to manage acute intoxication episodes or to stabilize before moving into a social detox program. Although brief detox services data is not included in the NTI data, as it does not fit the definition of RWM, a large number of individuals access this service every year.

Social detox

Social detox programs provide a safe and comfortable environment in which an individual is able to undergo the process of withdrawal from alcohol or drugs in a supervised, controlled period and stabilize physically, emotionally and socially. Individuals are admitted to a bed during their stay and if required will be given medications to manage the symptoms of withdrawal. Usually, a social detox program lasts seven to ten days, but may be adjusted based on individual need. During this time,

⁴⁷ Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>.

⁴⁸ On December 4, 2017, the structure of health services in Saskatchewan amalgamated from 12 regional health authorities to become one provincial health authority, known as the Saskatchewan Health Authority.



clients may attend self-help groups, participate in structured activities and receive referrals to other treatment programs and other services, as needed. Often, individuals attend a social detox program prior to accessing residential treatment.

For youth who require stabilization or detox services, the youth stabilization unit provides six beds for youth to voluntarily undergo the process of withdrawal and stabilization in a safe and supportive environment. Programming is provided by a multi-disciplinary team for up to 10 days aimed at providing the youth with insight and awareness into their substance use and related behaviours. Individuals may attend individual counselling, structured programming and educational workshops to assist with cravings and stress management. Mental health services, including psychology and psychiatry, are also provided to youth, if needed. Referrals to ongoing community supports, programs and residential treatment are provided, if required.

Involuntary youth detox

In Saskatchewan, involuntary detox was established under *The Youth Drugs Detoxification and Stabilization Act* (YDDSA) for youth, aged 12 to 17, who have severe alcohol or drug misuse issues to receive detox and stabilization services involuntarily. If a youth is assessed to meet criteria, involuntary detox and stabilization can be ordered to take place in a secure facility for up to five days, with the possibility of extension for a maximum of two additional five-day periods. Alternatively, the Act provides an opportunity for youth to detox and stabilize in the community for up to 30 days, through a community treatment order. The use of this legislation is viewed as a last resort option for youth with severe cases of drug or alcohol misuse and, as such, the issuance of the detox order or community treatment order is at the discretion of the physician.

Provincial picture of withdrawal management services

Detox services in Saskatchewan are guided by Provincial Standards for Brief and Social Detox Services. These standards were developed to reflect best available information from both clinical research and practice-based experience in relation to detox and WM, and focus on details for service delivery. The main goal of all types of detox programs in Saskatchewan is to provide a safe place to withdraw from alcohol and drugs, while promoting respect and dignity for this process, and assisting clients in accessing multiple health-related services (biological, social, psychological and spiritual) to promote ongoing recovery. Access to these programs also provides an opportunity for individuals to receive education on alcohol and drug misuse and health-related issues along with the process of recovery. The intensity of this content is appropriately matched to a client's physical and mental status.

In Saskatchewan, detox facilities are viewed as provincial resources for alcohol and drug treatment. In total, there are 15 facilities that can provide detox services, excluding hospitals. Individuals can access services regardless of where their home address is. The average wait time for services ranges from less than 24 hours up to 48 hours.

Table 4 illustrates the total number of detox beds, by type, for youth and adults across the province.



Table 4: Total number of detox beds according to area and type of bed

Location	Brief (Adult Only)	Social		Involuntary (Youth Only)
		Adult	Youth	
Moose Jaw		20		
Ile-a-la-Crosse		4		
La Loche		4		
La Ronge		8		
Meadow Lake		4		
Prince Albert	8	12		
Regina	20	25		6
Saskatoon	12	19	6	
Total	40	96	6	6

Important data considerations and limitations

- Admissions to hospitals for the purpose of WM for substance use are not included in Saskatchewan’s NTI data. This data is captured in the Discharge Abstract Database reported regularly to the CIHI.
- All WM programs in Saskatchewan are residential programs.
- Data on brief detox services is not included in the NTI data submissions.

Substance Specific Practices

Saskatchewan does not have withdrawal services specific to the type of substance being used. Individuals will be assessed upon admission into services and appropriate treatment, including withdrawal medication, will be provided based on their need.

Results

Community-based Withdrawal Management

Total service events and unique individuals

In 2015–2016, 13,734 unique individuals accessed publicly funded substance use treatment services in Saskatchewan, which accounted for 19,008 service events. The majority of individuals 89.3% ($n = 12,261$) accessed treatment services for their own problematic substance use; however, 1,411 individuals accessed treatment for a friend or family member.

With respect to WM, 3,345 unique individuals accessed these services which accounted for 4,376 WM service events. Males accounted for the majority, 61.5% ($n = 2,691$), of the withdrawal service events, while females accounted for about a third of withdrawal service events, 38.4% ($n = 1,678$) (Figure 23). A small minority (0.1%) of service events were for individuals who did not identify as male or female.⁴⁹ The distribution of withdrawal service events by gender (Figure 23) was similar to

⁴⁹ While the former Saskatoon Health Region records service events in which the individual seeking treatment did not identify as male or female, the rest of Saskatchewan did not record this, meaning this may be an underestimation.



the distribution of all treatment services by gender (Figure 24). Data for those individuals who do not identify as either male or female were also collected and are represented in the category Other; however, these numbers were too small to report.

Figure 23. WM service events⁵⁰ by gender

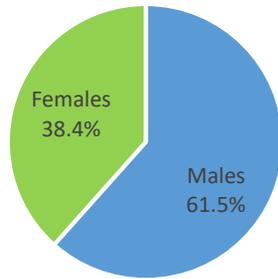
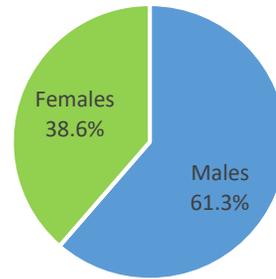


Figure 24. Total treatment service events⁵¹ by gender



Withdrawal management service events and unique individuals by gender

The province of Saskatchewan offers RWM, but does not offer NRWM. As shown in Table 5, total WM service events accounted for 25.0% of all treatment services. While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (75.0%). Individuals accessing WM services accounted for 22.4% of all individuals accessing services.

Table 5: Total service events and unique individuals⁵² by gender

	RWM	Residential and Non-residential Treatment	Total Counts*
Service Events:			
Total (including unknown gender)	25.0%	75.0%	n = 17,521
Males	25.1%	74.9%	n = 2,691
Females	24.8%	75.2%	n = 1,678
Unique Individuals:**			
Total (including unknown gender)	22.4%	77.6%	n = 13,694
Males	22.4%	77.6%	n = 8,378
Females	23.6%	76.4%	n = 5,309

*Other was reported as a gender, but the numbers per cell were too small to display.

**The counts for individuals are higher than the actual number of individuals seeking treatment as individuals are counted uniquely within each service type and therefore can be counted more than once across all services.

The ratio of RWM service events to individuals was 1.3.

50 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

51 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

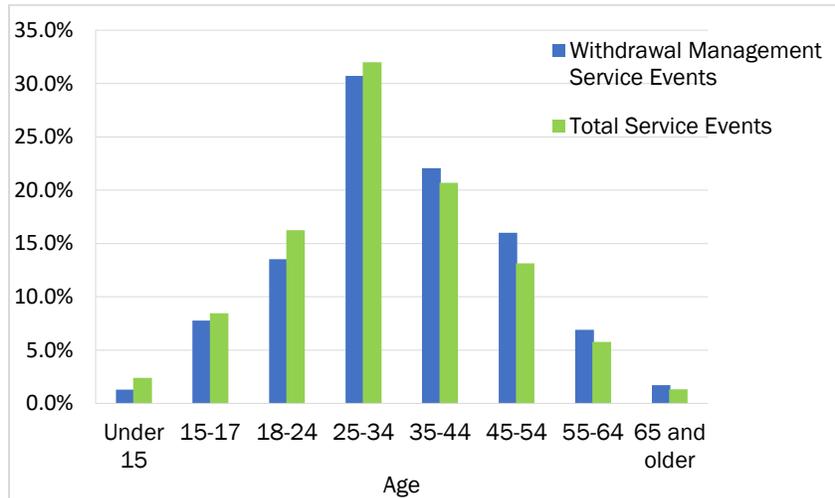
52 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Number of withdrawal management service events by age

As shown in Figure 25, the highest percentage of WM service events and total overall service events occurred among those aged 25–34 years.

Figure 25. Total service events and WM service events⁵³ by age



Hospital-based Withdrawal Management

Hospitalizations by sex⁵⁴

In Saskatchewan, there were a total of 692 hospitalizations⁵⁵ for WM for substance use. The average length of stay for WM hospitalization was four days. Males represented about 64.5% ($n = 446$) of the hospitalizations and females represented about 35.5% ($n = 246$) of the hospitalizations (Figure 26). In comparison with community services, male hospitalizations by percentage (Figure 26) were higher than publicly funded male service events (Figure 23). With respect to length of stay, the total for all hospitalizations was 3,080 days.⁵⁶ Days stayed in the hospital by males accounted for 62.5% (1,924 days) of total days and days stayed for females accounted for 37.5% (1,156 days) (Figure 27).

53 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

54 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

55 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

56 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



Figure 26. Hospitalizations for WM by sex (percentage), FY 2015–2016

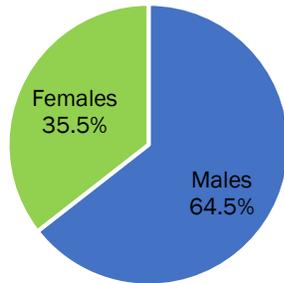
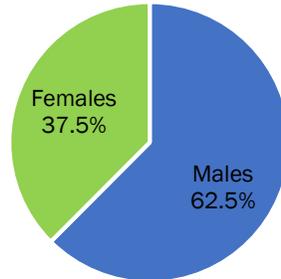


Figure 27. Days stayed in hospital for WM by sex (percentage), FY 2015–2016

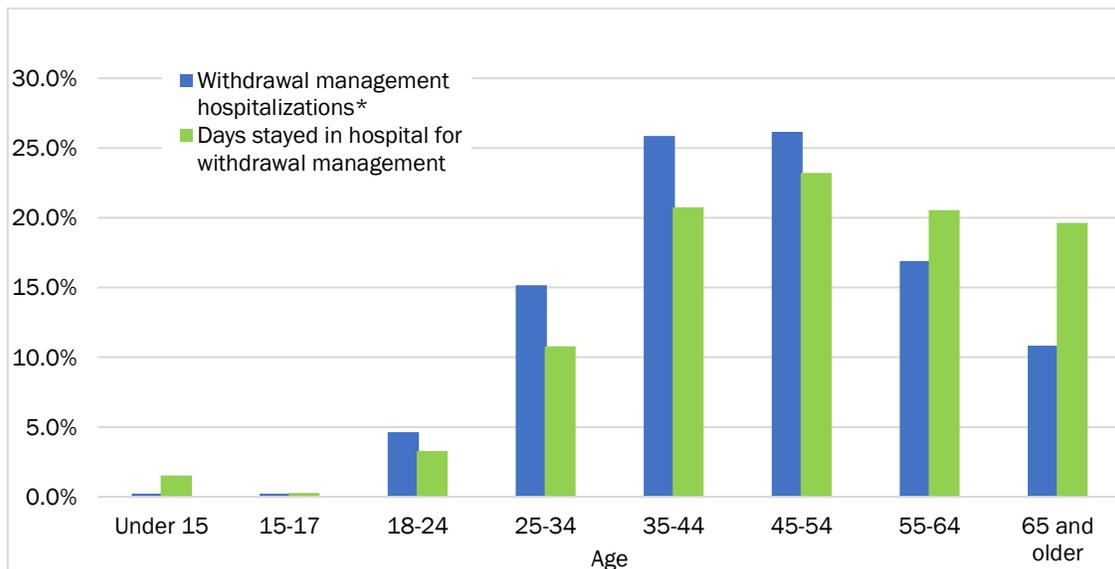


*Includes suppressed data

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁵⁷ occurred among those aged 45–54 years (26.2%), followed by those aged 35–44 years (25.9%) (Figure 28). This contrasts with community treatment services, where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 3,080 days those aged 45–54 years accounted for the highest number at 715 days (23.2%) and, following this, those aged 35–44 years accounted for 639 days (20.7%).

Figure 28. Percentage of hospitalizations* and length of days stayed (days) for WM by age group, FY 2015–2016



*Includes suppressed data

57 Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Manitoba

Population: 1,295,422⁵⁸

Gender: 644,030 males (49.7%); 651,392 females (50.3%)

Withdrawal Management Overview and Summary

The Department of Health, Seniors and Active Living is the ministry responsible for treatment services in Manitoba. The continuum of services are delivered primarily through Addictions Foundation Manitoba and 11 provincial grant-funded agencies. One adult RWM service and one residential treatment service are delivered through two regional health authorities. Private organizations also exist. Mental health services are not currently integrated with substance use services at the administrative level.

WM services in Manitoba consist of one community residential service and one hospital-based medically assisted WM service, both based in Winnipeg, as well as a non-medical residential facility in Thompson, Manitoba. There are currently no NRWM services in Manitoba.

Important considerations and limitations

- Manitoba does not offer NRWM.
- Some agencies were unable to provide data for certain indicators of interest. Manitoba submitted data only for indicators that most agencies, including Addictions Foundation Manitoba, 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 validate the data provided by agencies.
- Because Manitoba's publicly funded agencies do not share data from agency to agency, new cases cannot be tracked at a system level.
- Carry over data (i.e., cases that began in 2014–2015 and continued into 2015–2016) are not reported by all agencies in Manitoba and so were not submitted for 2015–2016.

Results

Community-based Withdrawal Management

Total service events and unique individuals

In 2015–2016, 9,973 unique individuals accessed publicly funded substance use treatment services in Manitoba, which accounted for 16,956 service events. These numbers include individuals and service events for all treatment types. The majority of individuals 85.4% ($n = 8,516$) accessed treatment services for their own problematic substance use. Although data for individuals

⁵⁸ Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid=>



who accessed treatment for a friend or family member were not available for this report, the estimated percent of individuals who may have used this option is 14.6%.⁵⁹

With respect to WM, NRWM is not offered. However, 1,471 unique individuals accessed RWM services, which accounted for 1,868 RWM service events. Males accounted for a slight majority, 52.2% ($n = 960$), of these service events, while females accounted for 47.8% ($n = 879$) (Figure 29). Across all treatment services males also accounted for the majority of treatment service events, 55.2% ($n = 8,858$; Figure 30). Data for those individuals who do not identify as either male or female were also collected and are represented in the category Other; however, these numbers were too small to report.

Figure 29. Residential WM service events⁶⁰ by gender.

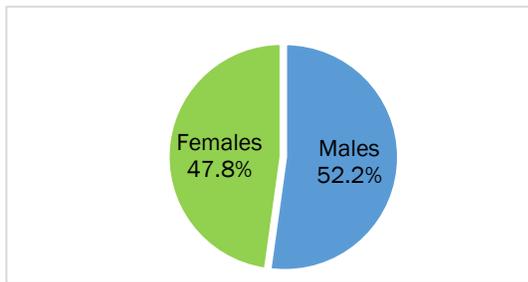
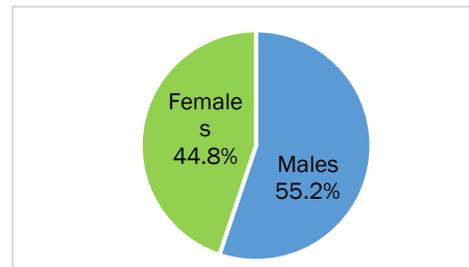


Figure 30. Total treatment service events⁶¹ by gender.



Withdrawal management service events and unique individuals by gender

As shown in Table 6, total WM services accounted for 11.6% of all treatment services. While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (88.4%). Individuals accessing WM services accounted for 13.6% of all individuals accessing services.

⁵⁹ It was assumed that any individual not categorized as seeking treatment for themselves was seeking treatment for family.

⁶⁰ Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

⁶¹ Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Table 6: Total⁶² service events and unique individuals⁶³ by gender

	RWM	Residential and Non-residential Treatment	Total Counts*
Service Events:			
Total (including unknown gender)	11.6%	88.4%	<i>n</i> = 16,087
Males	10.8%	89.2%	<i>n</i> = 8,858
Females	12.2%	87.8%	<i>n</i> = 7,201
Unique Individuals:**			
Total (including unknown gender)	13.6%	86.4%	<i>n</i> = 10,791
Males	n/a***	n/a***	n/a***
Females	n/a***	n/a***	n/a***

*Other was reported as a gender, but the numbers per cell were too small to display. Additionally, gender counts may not sum to the totals as not all individuals report their gender when they are recorded for services.
 **The counts for individuals are higher than the actual number of individuals seeking treatment as individuals are counted uniquely within each service type and therefore can be counted more than once across all services.
 ***Gender and age breakdown for unique individuals were not provided by one of the service providers contributing data and so are not shown for Manitoba.

The ratio of RWM service events to individuals was 1.3.

Number of withdrawal management service events by age

Data pertaining to RWM service events by age could not be reported due to a change in the way data was recorded for age groups by one service provider.

Hospital-based Withdrawal Management

Hospitalizations by sex⁶⁴

In Manitoba, there were a total of 557 hospitalizations⁶⁵ for WM for substance use. Some hospitalizations in one of the facilities may also have been counted above as RWM service events. The average length of stay for WM hospitalization was six days. Males represented 66.2% (*n* = 369) of hospitalizations and females 33.8% (*n* = 188) of hospitalizations (Figure 31). In comparison to community services, female hospitalizations by percentage (Figure 31) were lower than publicly funded female service events (Figure 29), and the percentage of male hospitalizations were higher than publicly funded service events. With respect to length of stay, the total for all hospitalizations was 3,478 days.⁶⁶ Days stayed in the hospital by males accounted for 61.4% (2,134 days) of total days and days stayed for females accounted for 38.6% (1,344 days) (Figure 32).

62 Non-medical withdrawal is reported separately in Manitoba and so not reported in these data.

63 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

64 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

65 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

66 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



Figure 31. Hospitalizations for WM by sex (percentage), FY 2015–2016

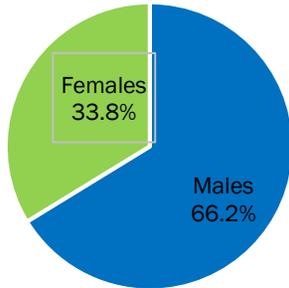
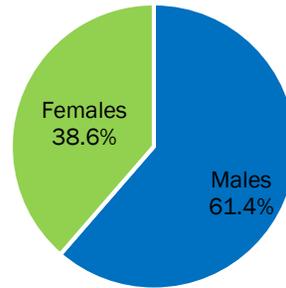


Figure 32. Days stayed in hospital for WM by sex (percentage), FY 2015–2016

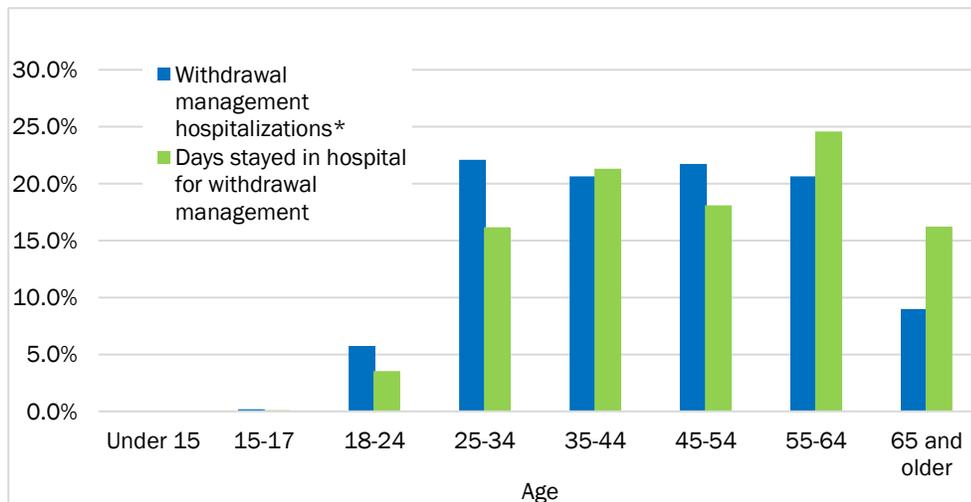


Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁶⁷ occurred among those aged 25–34 years (22.1%), followed by those aged 45–54 years (21.7%) (Figure 33). With respect to length of stay in the hospital, of the total 3,478 days those aged 55–64 years accounted for the highest number at 855 days (24.6%) and, following this, those aged 35–44 years and older accounted for 741 days (21.3%).

Figure 33. Percentage of hospitalizations* and days stayed for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.

⁶⁷ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Ontario

Population: 13,789,597⁶⁸

Gender: 6,773,184 males (49.1%); 7,016,413 females (50.9%)

Withdrawal Management Overview and Summary

Services provided by WM (detox) centres in Ontario provide support for voluntary withdrawal from alcohol or other drugs to individuals who are under the influence of these substances or in withdrawal or otherwise in crisis directly related to these substances. Services are provided with or without the aid of drug therapy or other medical interventions. Additional support such as discharge planning and early recovery education is provided.

WM services are provided by non-medical support staff, who are trained to safely monitor and manage client withdrawal symptoms. Depending on the intensity/severity of client symptoms there are medical consultation services available from physicians and from after hour's clinics, health centres or hospital emergency departments.

Residential withdrawal management services⁶⁹

All Ontario RWM services programs are associated with local hospitals for assistance with medical emergencies and to provide medical services. For instance, routine medical consultation and sufficient staff resources are available for management of the following medication situations:

- Medications for medical conditions;
- Medications for diagnosed psychiatric conditions;
- Pain medications for acute injuries or recent surgery;
- Clients using methadone; and
- Clients tapering off benzodiazepines or narcotics.

In Ontario, most of the locations are designed for males and females, but there are three distinct women's only RWM service locations. As of February 2018, there are 25 RWM service programs with 188 Ministry of Health and Long-Term Care-funded beds located around the province.

Community withdrawal management services

Community WM service programs, which are a component of the RWM system, provide support to clients who undertake voluntary withdrawal from alcohol or other drugs. Clients may be simultaneously accessing residential support services or they may be residing in their home, the home of a significant other or other supervised or unsupervised community settings. Care may be provided with or without the aid of drug therapy or other medical interventions. Additional supports such as discharge planning and early recovery education are provided. With the development of rapid access

⁶⁸ Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>

⁶⁹ Ontario uses the term Residential Withdrawal Management Services; however, for this report, in order to reflect the differences between jurisdictions in wording and treatment options offered, the slightly broader terms residential withdrawal management (RWM) and non-residential withdrawal management (NRWM) are used.



services in Ontario, there are more community-based agencies being funded for Community WM services. As of February 2018, there were 33 Community WM service locations in Ontario.

Agencies that provide WMS services can refer clients to other mental health and addiction programs or agencies following a treatment episode. Referrals to other services are not mandatory and generally happen when clients express a readiness for additional treatment and support.

Data provided by the Drug and Alcohol Treatment Information System (DATIS) in February of 2018 shows that in the 2016–2017 fiscal year, 20.2% of clients completing RWM service episodes had referrals to other addiction treatment programs. A similar referral rate of 20.6% was reported for clients following completion of CWMS programs.

Important data considerations and limitations

The data reported by Drug and Alcohol Treatment Information System describe clients and services provided by community-based, non-medical WMS programs only. Two hospitals in Ontario provide in-patient acute care WMS, offered in exclusively medical settings (hospitals) and are not included in the community results. Hospitalization data provided by CIHI is reported further below.

Results

Community-based Withdrawal Management

Total service events and unique individuals

In 2015–2016, 85,299 unique individuals accessed publicly funded substance use treatment services in Ontario, which accounted for 111,039 service events. Of these individuals, 72.3% ($n = 61,676$) were new cases. These numbers include individuals and service events for all treatment types. The majority of individuals 93.1% ($n = 79,417$) accessed treatment services for their own problematic substance use; however, 5,882 individuals accessed treatment for a friend or family member.

With respect to WM, 16,951 unique individuals accessed these services, which accounted for 30,260 WM service events. Males accounted for the majority, 71.5% ($n = 21,632$), of the withdrawal service events, while females accounted for 28.4% ($n = 8,599$) (Figure 34). Across all treatment services males still accounted for the majority of treatment service events, 63.8% ($n = 66,897$); however, this was less pronounced compared to WM only (Figure 35).



Figure 34. WM service events⁷⁰ by gender

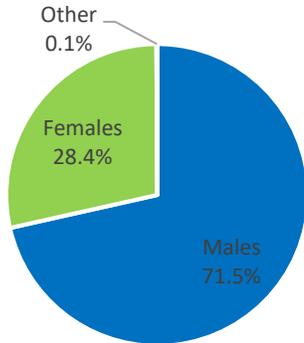
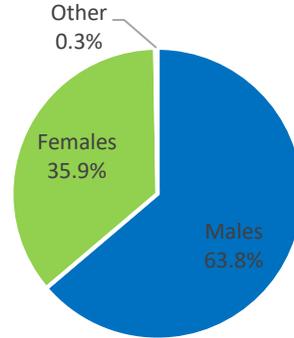


Figure 35. Total treatment service events⁷¹ by gender



Withdrawal management service events and unique individuals by gender

In Ontario, WM services include RWM as well as NRWM. As shown in Table 7, total WM services accounted for 28.9% of all treatment services. While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (71.1%). Individuals accessing WM services accounted for 21.4% of all individuals accessing services.

Table 7: Total service events and unique individuals⁷² by gender

	RWM	NRWM	Residential and Non-residential Treatment	Total Counts*
Service Events:				
Total (including unknown gender)	25.5%	3.4%	71.1%	n = 104,864
Males	29.2%	3.2%	67.7%	n = 66,897
Females	19.0%	3.8%	77.2%	n = 37,696
Unique Individuals:				
Total (including unknown gender)	17.5%	3.9%	78.7%	n = 79,416
Males	19.1%	3.7%	77.2%	n = 49,488
Females	14.9%	4.1%	81.0%	n = 29,684

*Other was reported as a gender, but the numbers per cell were too small to display.

The ratio of WM service events to individuals is presented in Table 8.

Table 8: Ratio of service events to individuals (own use)

Residential withdrawal management	1.9
Non-residential withdrawal management	1.2

70 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

71 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

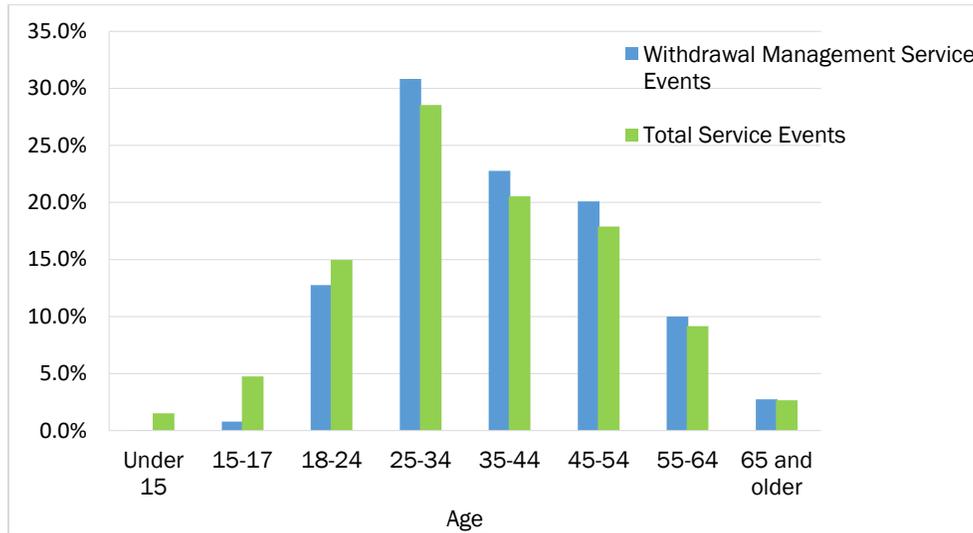
72 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Number of withdrawal management service events by age

As shown in Figure 36, the highest percentage of WM service events and total overall service events occurred among those aged 25–34 years.

Figure 36. WM service events and total service events⁷³ by age



Hospital-based Withdrawal Management⁷⁴

Hospitalizations by sex⁷⁵

In Ontario, there were a total of 3,578 hospitalizations⁷⁶ for WM for substance use. The average length of stay for WM hospitalization was five days. Males represented 71.8% ($n = 2,568$) of hospitalizations and females 28.2% ($n = 1,010$) of hospitalizations (Figure 37). In comparison to community services, male and female hospitalizations by percentage (Figure 37) were similar to publicly funded male and female service events (Figure 34). With respect to length of stay, the total for all hospitalizations was 18,504 days.⁷⁷ Days stayed in the hospital by males accounted for 71.9% (13,307 days) of total days and days stayed for females accounted for 28.1% (5,197 days) (Figure 38).

73 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

74 Hospitalization data for Ontario are coded through two systems: ICD-10 and DSM-V. See methods for description of dataset.

75 Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

76 Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

77 Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.



Figure 37. Hospitalizations for WM by sex (percentage), FY 2015–2016

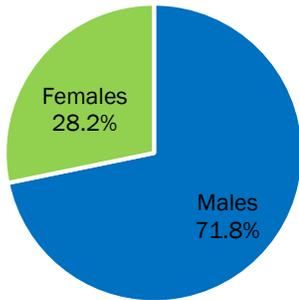
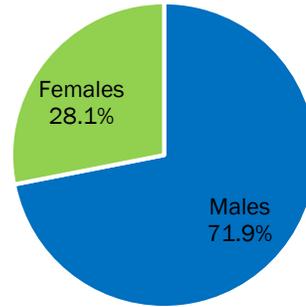


Figure 38. Days stayed in hospital for WM by sex (percentage), FY 2015–2016

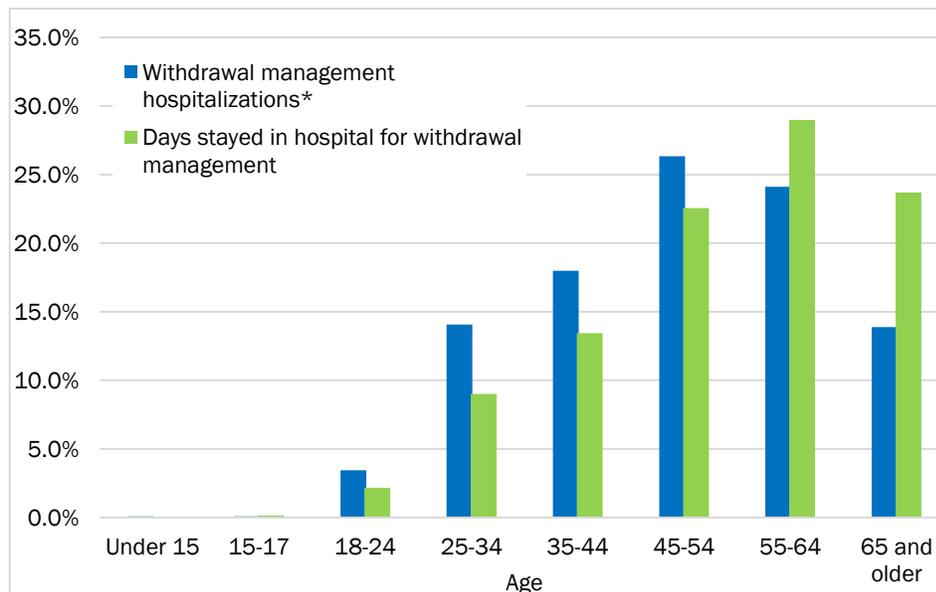


Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁷⁸ occurred among those aged 45–54 years (26.3%), followed by those aged 55–64 years (24.1%) (Figure 39). This contrasts with community treatment services, where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 18,504 days those aged 55–64 years accounted for the highest number at 5,361 days (29.0%) and, following this, those aged 65 years and older accounted for 4,383 days (23.7%).

Figure 39. Percentage of hospitalizations* and days stayed for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.

78 Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Nova Scotia

Population: 941,545⁷⁹

Gender: 461,401 males (49.0%); 480,144 females (51.0%)

Withdrawal Management Overview and Summary

WM in Nova Scotia is divided into four zones. Zone 1 offers Withdrawal Management Day, which is called Outpatient Withdrawal Management. They also have programs called the Wellness Clinic, Medical/Surgical Withdrawal Management, Opiate Replacement Therapy (ORT) Satellite Services, Urinary Drug Screen (UDS) testing site, Standardized Random UDS process, Bottle Assessment Service and Outpatient Nicotine Withdrawal Management. In Zone 2, WM Inpatient program has been entered into ASsist (provincial data tracking program, prior to April 1, 2018) and also sent for coding into Meditech. Currently, WM services are conducted on an outpatient basis. Zone 3 has a hospital-based inpatient WM. Zone 4 offers a hospital-based 16-bed Withdrawal Management Inpatient Program. This program offers medical withdrawal, recovery and relapse prevention content, one-on-one counselling, recreational therapy, discharge planning, in-house referrals, spiritual care and psychiatry.

The following are examples of the different withdrawal programs that are used throughout Nova Scotia:

- WM inpatient (residential) aims to optimize the health of clients who are harmfully involved with alcohol or drugs through a comprehensive range of treatment services. These services include assessment, medically managed detoxification, treatment planning, therapeutic and vocational counselling, support, education and referrals.
- WM day (non-residential) is a day detox program designed to meet the needs of clients who require intensive treatment but not a full inpatient admission. The program also allows clients to function in their own environment while medically managing their withdrawal.
- Of the clients who attended WM services, 10% continued on with another program in addiction services.
- The Izaak Walton Killam (IWK) Health Centre has the Garron Centre for Child and Adolescent Mental Health (acute inpatient care) and supports children and youth up to 19 years of age whose mental health and addiction needs are best met in an acute care setting. Children and youth served by the Garron Centre require either intense, short-term support to address or resolve a mental health or addiction crisis; or longer-term support so that the child or youth, family or caregivers, and the inpatient care team can learn more about the mental health or addictions difficulty and determine the best treatment options.

The following indicators are currently used to monitor addiction services:

- Basic volume of number of active clients, referrals, admissions, discharges, admitted or discharged, and wait lists;
- Average and median number of clients waiting for services, as well as changes to that number over time;

⁷⁹ Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>.



- Median and 90th percentile wait-time from referral to program admission (or intake closure);
- Triage levels: priority: target 7 days, regular: 28 calendar days;
- Type of primary dependencies seen;
- Length of stay (LOS); for example, looking at the expected LOS vs average LOS;
- Reason for discharge: The goal is to increase the relative percent of cases closed with mutual consent (not captured post April 1, 2018);
- Readmission rate to the WM Inpatient unit; and
- Fourteen-day continuity of care after inpatient discharge (number of discharged cases with attended outpatient appointment within 14 days from discharge divided by the number of cases discharged).

Important data considerations and limitations

In 2015–2016 some sites in Nova Scotia stopped tracking the WM program and client data in the ASsist system. This change has resulted in compromise to the data quality and the reason for not reporting numerical data in this report.

Substance Specific Practices

Zone 1 (Western: South Shore, South West, Annapolis Valley)

In Zone 1 the inpatient treatment program provides hospital-based medical, supervised WM and support to individuals who require treatment and support to manage their withdrawal symptoms from substances such as alcohol or drugs. Inpatient WM is currently offered at Soldier's Memorial Hospital and Yarmouth Memorial Hospital. (This offering occurred in 2015–2016, however and is not being done currently.). It will continue to be an option, even though both facilities are transitioning to an Outpatient Withdrawal Management/Wellness Clinic Model.

Historically, Soldier's Memorial Hospital, Middleton, Nova Scotia, offered the Intensive Treatment Program, which combined functions of an inpatient WM program and a Structured Treatment Program (STP), and provided the support of a team-based approach. Clients could enter the program needing WM (inpatient stay, usually three to five days) or structured treatment programming (residential stay, usually 21 days) and could receive both programming during their stay based on individual care plans. Service was offered 24 hours a day, seven days a week.

In outpatient WM (Withdrawal Management Day), the patient receives assessment by a physician or nurse or triage in the clinic. The client is sent home with any required medication and returns back the next day. If the patient requires an overnight stay, they can be admitted to the ER or the inpatient psychiatry unit, or arrangements can be made to bring on night staff, depending on the services that are available at that location. The patient would return to the outpatient WM program the following morning.

The Medical/Surgical Withdrawal Management with Addictions Services registered nurse consultation is for patients with acute health conditions. Nursing staff across the district are trained in ethyl alcohol withdrawal assessment and protocol implementation, which have effectively turned three hospitals into one large detox program, with inherent acute care support.



Outpatient Nicotine Withdrawal Management is the second such program in Canada, which treats nicotine as a drug with tangible withdrawal effects. The client is treated on an outpatient basis similar to any other outpatient WM procedure.

Zone 2 (Northern: Colchester East Hants, Cumberland, Pictou County)

Zone 2 offers assessment, medical withdrawal, treatment planning, counselling and referrals, which include long-term programs and follow-up treatment with outpatient services or ORT. These programs have scheduled Alcoholics Anonymous and Narcotics Anonymous meetings on the unit that clients attend as well as, Recovery Matters, every Thursday afternoon. Currently, medical withdrawal from all substances is offered. If clients are withdrawing from opiates, they are encouraged to connect with ORT clinics or providers and, at times, information is given to the family doctors about suboxone and recovery is supported through the family physician.

Zone 3 (Eastern: Cape Breton, Guysborough Antigonish Strait)

Zone 3 inpatient WM unit aims to optimize the health of clients who are harmfully involved in substances, primarily ethyl alcohol withdrawal assessment. Other admissions are determined on an interdisciplinary case management basis.

The inpatient WM unit offers short-term medically supervised inpatient treatment for acute WM. This includes assessment, medically managed detoxification, treatment planning, therapeutic support, education and referrals. Inpatients are immediately linked with a comprehensive outpatient Mental Health and Addiction Services and other follow up supports in the community. Patients would also be referred to outpatient withdrawal services and could attend wellness/programming education.

Zone 4 (Central: Halifax, Dartmouth, Musquodoboit, Hants)

Zone 4 offers a hospital-based 16-bed inpatient WM unit . All clients are registered in ASsist (not after April 1, 2018) and STAR (name of software). As of April 1, 2018, ASsist is no longer used to collect client and program information.

The Nova Scotia Hospital inpatient WM unit offers medical withdrawal (other than opioid withdrawal), recovery and relapse prevention group content, one-on-one counselling, Recreation therapy, discharge planning (which may include assistance in identifying resources for housing, assistance in connecting to income assistance, Pharmacare, assistance in applications to recovery homes, etc.). In-house referrals to spiritual care and psychiatry are also offered. Referrals can be made to mental health, community-based addiction counsellors, IWK maternity, medical, dental, infectious disease, opioid treatment program and other programs.

Table 9 depicts the number of residential and non-residential beds available in the various zones and the IWK Health Centre.

Table 9: Number of beds offering WM

	Number of non-residential beds	Number of residential beds
Zone 1	0	0
Zone 2	22	0
Zone 3	17	0
Zone 4	16	0
IWK (under 19 years old)	0	14



Results

Hospital-based Withdrawal Management

Hospitalizations by sex⁸⁰

In Nova Scotia, there were a total of 1,213 hospitalizations⁸¹ for WM for substance use. The average length of stay for WM hospitalization was eight days. Males represented 67.8% ($n = 823$) of hospitalizations and females 32.2% ($n=390$) of hospitalizations (Figure 40). With respect to length of stay, the total for all hospitalizations was 9,978 days.⁸² Days stayed in the hospital by males accounted for 66.3% (6,620 days) of total days and days stayed for females accounted for 33.7% (3,358 days) (Figure 41).

Figure 40. Hospitalizations for WM by sex (percentage), FY 2015–2016

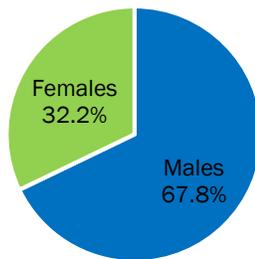
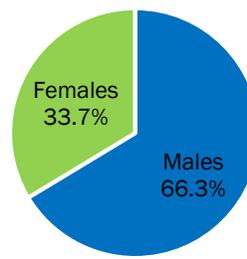


Figure 41. Days stayed in hospital for WM by sex (percentage), FY 2015–2016



Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁸³ occurred among those aged 45–54 years (21.7%), followed by those aged 25–34 years (21.5%) (Figure 42). With respect to length of stay in the hospital, of the total 9,978 days, those 45–54 years accounted for the highest number at 2,152 days (21.6%). Following this, those aged 55–64 years accounted for 2,009 days (20.1%) and those aged 25–34 years at 2,001 days (20.1%).

⁸⁰ Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

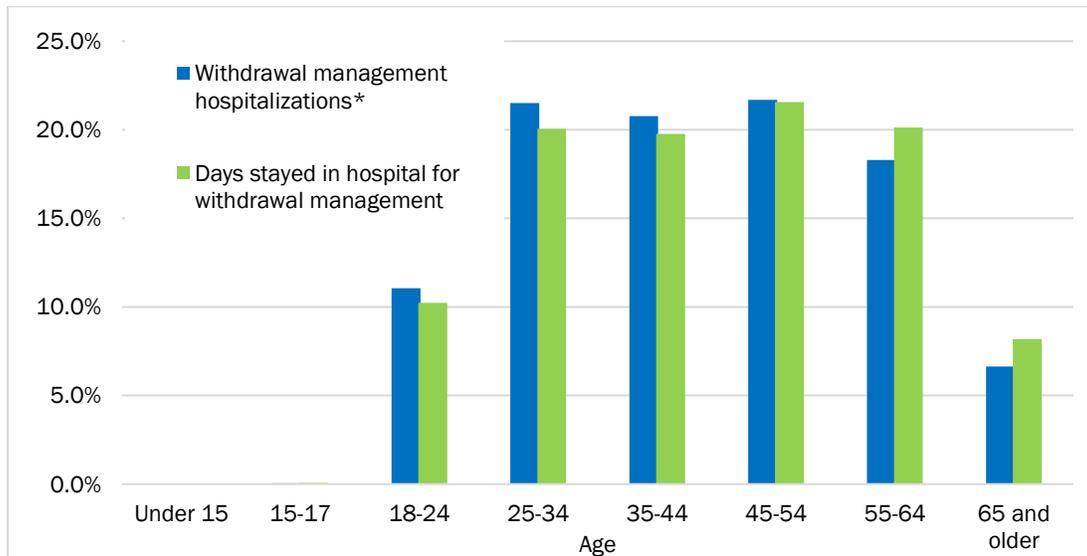
⁸¹ Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

⁸² Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.

⁸³ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Figure 42. Percentage of hospitalizations* and days stayed for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.



Prince Edward Island

Population: 146,791

Gender: 71,503 males (48.7%); 75,288 females (51.3%)

Withdrawal Management Overview and Summary

Prince Edward Island offers both inpatient and outpatient WM programs as part of addiction services and individuals can receive WM in hospitals and inpatient psychiatric units as well (although this data is not accounted for in this dataset).

One 16-bed inpatient WM program operates at the provincial addictions treatment facility, offering medical management of withdrawal symptoms under the care of nurses (registered nurses and licensed practical nurses) and under the supervision of a physician (general practitioner). Patients are offered the opportunity to participate in a psychoeducational group program that covers symptom management and recovery strategies. Lengths of stay range from 5 to 10 days depending on the drug of choice and its associated withdrawal effects.

In recognition of the vulnerability of clients who have completed WM and in response to high rates of unplanned readmissions following discharge, Health PEI created an 18-bed transition unit in 2015. Registered social workers, counsellors and social service workers offer clients case management, counselling and life skills training for clients in early recovery. Medical support is provided by the inpatient WM staff for the purpose of administering medication and offering consultation as needed. The program is three weeks long and offers one-week “booster sessions” for former clients as a means of preventing relapse. Many but not all clients discharged from inpatient withdrawal go directly to the transition unit before returning to the community. Clients may also be admitted to the transition unit from hospital or community.

Outpatient WM programs are operated in each county at five community mental health and addictions offices. Clients in these programs receive nursing assessment and counselling support, and participate in psychoeducational group programming similar to the inpatient program. Although standing orders for medications and physician coverage are available for these programs, medication is rarely used; clients requiring medication are most often referred to inpatient WM services or hospital.

Prince Edward Island has a provincial opioid replacement program and also supports a community methadone clinic (methadone and suboxone). During the 2015–2016 fiscal period, 405 clients were admitted to this clinic, of which 178 were new. During this time, the number of client visits including physician and counselling appointments were 4,898.

Important data considerations and limitations

In Prince Edward Island, a client can be active in more than one of the treatment services throughout the year. Such a client would be counted as a unique individual in each treatment service, which might result in counting them more than once. Hospital data are not included in the WM data, but reported separately with the hospitalization data below.



Results

Community-based Withdrawal Management

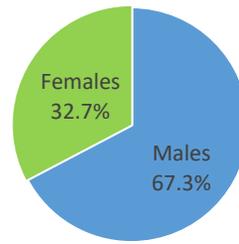
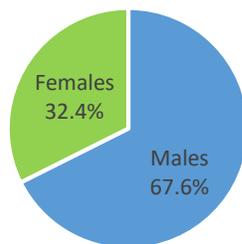
Total service events and unique individuals

In 2015–2016, 2,661 unique individuals accessed publicly funded substance use treatment services in PEI, which accounted for 5,028 service events. Of these individuals, 63.9% ($n = 1,701$) were new cases. These numbers include individuals and service events for all treatment types. The majority of individuals – 87.0% ($n = 2,315$) – accessed treatment services for their own problematic substance use; however, 354 individuals accessed treatment for a friend or family member.

With respect to WM, 1,517 unique individuals accessed these services, which accounted for 2,269 WM service events. Males accounted for the majority, 67.6% ($n = 1,534$), of the withdrawal service events, while females accounted for 32.4% ($n = 735$) (Figure 43). Across all treatment services males still accounted for the majority of treatment service events, 67.3% ($n = 3,314$), which was similar to WM only (Figure 44). Data for those individuals who do not identify as either male or female were also collected and are represented in the category Other; however, these numbers were too small to report.

Figure 43. WM service events⁸⁴ by gender

Figure 44. Total treatment service events⁸⁵ by gender



Withdrawal management service events and unique individuals by gender

In Prince Edward Island, WM services include RWM and NRWM. As shown in Table 10, total WM services accounted for 48.7% of all treatment services. While not the focus of this report, the remaining service events included residential treatment and non-residential treatment (57.8%). Individuals accessing WM services accounted for 45.7% of all individuals accessing services.

84 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

85 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Table 10: Total service events and unique individuals⁸⁶ by gender

	RWM	NRWM	Residential and Non-residential Treatment	Total Counts*
Service Events:				
Total (including unknown gender)	23.4%	25.3%	57.8%	n = 4,658
Males	25.8%	23.1%	51.1%	n = 3,134
Females	18.5%	29.7%	51.7%	n = 1,523
Unique Individuals:				
Total (including unknown gender)	17.6%	28.1%	54.4%	n = 3,324
Males	18.4%	25.8%	55.7%	n = 2,182
Females	16.0%	32.3%	51.7%	n = 1,141

*Other was reported as a gender, but the numbers per cell were too small to display.

The ratio of WM service events to individuals is presented in Table 11.

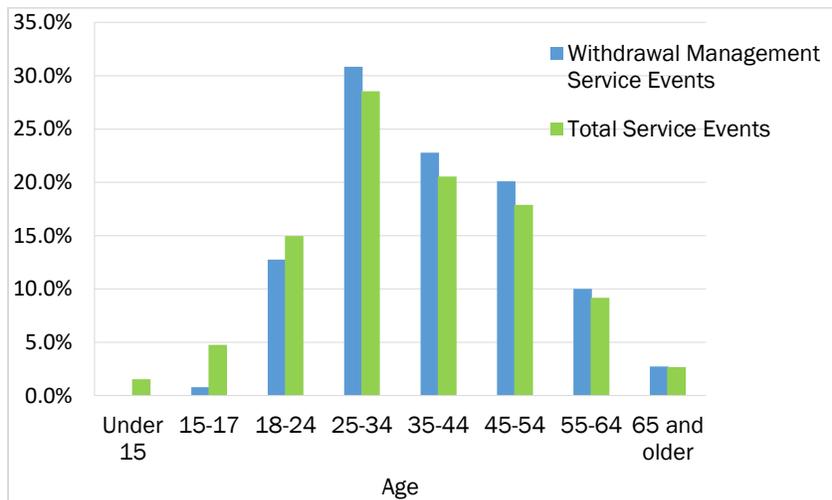
Table 11: Ratio of service events to individuals (own use)

Residential withdrawal management	1.9
Non-residential withdrawal management	1.3

Number of withdrawal management service events by age

As shown in Figure 45, the highest percentage of WM service events and total overall service events occurred among those aged 25–34 years.

Figure 45. WM service events and total service events⁸⁷ by age



86 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

87 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Hospital-based Withdrawal Management

Hospitalizations by sex⁸⁸

In Prince Edward Island, there were a total of 53 hospitalizations⁸⁹ for WM for substance use. The average length of stay for WM hospitalization was six days. The numbers and percentages of hospitalizations by sex were suppressed, but based on available data and assumptions made to impute the value of suppressed data, it was estimated that males represented about 73.6% of hospitalizations and females represented about 26.4% of hospitalizations (Figure 46). In comparison with community services, male and female hospitalizations by percentage (Figure 46) were similar to publicly funded male and female service events (Figure 43). With respect to length of stay, the total for all hospitalizations was 295 days.⁹⁰ Days stayed in the hospital by males accounted for 71.2% (210 days) of total days and days stayed for females accounted for 28.8% (85 days) (Figure 47).

Figure 46. Hospitalizations for WM by sex (percentage), FY 2015–2016

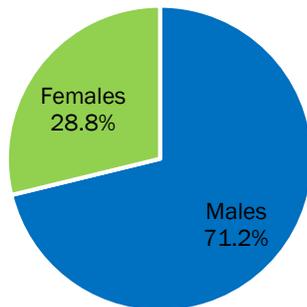
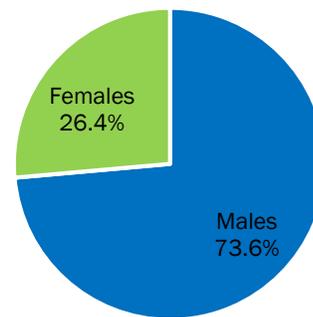


Figure 47. Days stayed in hospital for WM by sex (percentage), FY 2015–2016



Source: Hospital Mental Health Database, FY 2015–2016, CIHI.

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations⁹¹ occurred among those aged 65 years and over (35.8%), followed by those aged 45–54 years (22.0%) and 55–64 years (22.0%) (Figure 48). This contrasts with community treatment services (Figure 45), where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 295 days those aged 65 years and over accounted for the highest number at 98 days (33.2%) and, following this, those aged 55–64 years accounted for 78 days (26.4%), with those aged 44–54 years following closely after.

⁸⁸ Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

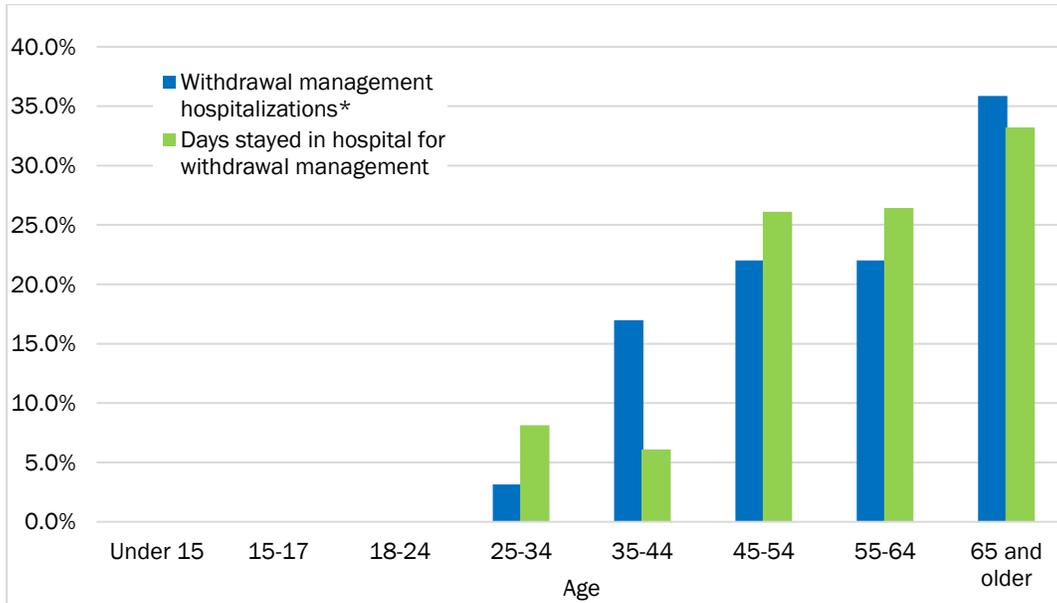
⁸⁹ Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

⁹⁰ Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.

⁹¹ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Figure 48. Percentage of hospitalizations* and days stayed for WM by age group, FY 2015–2016



* Hospitalizations for some age groups were too small to be released publicly and were suppressed by CIHI. Values for suppressed data were imputed and are included in the figure.



Newfoundland and Labrador

Population: 528,815⁹²

Gender: 260,749 males (49.3%); 268,066 females (50.7%)

Withdrawal Management Overview and Summary

Within Newfoundland and Labrador (N.L.), WM services are delivered by four regional health authorities (RHAs). A full continuum of service does not exist within each RHA; rather, the specialized residential services provided in three of the four RHAs are intended to be provincial in scope. Community-based WM services are not available in the province and information about the provision by individual primary care physicians of WM services is also not available. The four RHAs have acute healthcare facilities for substance use, including withdrawal. This hospital-based care plays a significant role in the continuum of WM services in N.L.

Clinical documentation related to these specialized residential services is recorded in the Client and Referral Management System (CRMS), the provincial health information system. The availability of this information enables aggregate statistics to be included in the current report.

Recovery Centre

The Recovery Centre is a 19-bed, provincial WM facility operated by Eastern Health, the largest of the four RHAs. The centre is located in St. John's. Residents from all regions of the province can access service at the Recovery Centre.

Until 2015–2016, the Centre operated as a non-medical, social setting detoxification program where those undergoing detox did so without any medication or medical support. This approach often resulted in individuals being transferred to the emergency department or discharging themselves early, which prompted reassessment and a change in approach.

In an effort to respond more effectively to the needs of individuals with complex addiction issues, the Recovery Centre has recently transitioned to a medically supported service. Under this new model, individuals admitted to the centre can now receive medication to help with their withdrawal symptoms and health complications, and be monitored around the clock by nursing staff.

The current clinical team includes a nurse practitioner, registered nurses, licensed practical nurses and an addictions counsellor. The team offers a more comprehensive approach to care by addressing the individual's physical and mental health needs during their stay. Admissions are planned during regular business hours to enable a comprehensive assessment of client needs. Urgent after-hours admissions are accommodated, as necessary.

The Mental Health and Addictions staff recognize that detox is often the first step in an individual's recovery from addiction. For that reason, staff strive to provide a service that best supports the withdrawal process, and improve access for those who need it most.

According to facility-reported statistics, 50–60% of clients admitted to the Recovery Centre for WM services are repeat admissions. Approximately 20% of individuals admitted to the Recovery Centre

92 Demographic data were retrieved from Statistics Canada, Table 051-0001, for the year 2015:

<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>



transition to residential treatment upon discharge, while 40% transition to outpatient services, which may include drop-in groups, counselling and self-help options.

Hope Valley Centre

The Hope Valley Centre is a 12-bed, provincial service located in the central area of the province, operated by Central Health. It offers WM and stabilization services, as well as residential addictions treatment specifically for youth between the ages of 12 to 18 years. Four of the beds are designated as WM beds. Due to the fact that it is primarily a residential treatment facility, it is categorized as such for the purpose of NTI statistics rather than a RWM facility.

The average length of stay is three months; however, youth may stay for longer periods of time depending on their individual needs. According to statistics reported by the facility, there were 37 admissions to the Hope Valley Centre in 2015–2016. All of the clients spent a portion of their stay receiving WM services; 24% of them completed WM only during their stay; 76% continued on to complete longer-term residential treatment at the centre. Cannabis (46%), opioids (27%) and inhalants (14%) were the top ranking substances being used by those admitted.

Humberwood Centre and the Grace Centre

The Humberwood Treatment Centre is a voluntary, provincial residential addictions treatment program located in the western portion of the province, operated by Western Health. It serves adults aged 19 years and over who require a more structured and intensive program than can be provided on an outpatient basis. The Humberwood Centre has four WM beds. Clients can be assigned to WM prior to admission or after admission if it is determined they require detox before starting treatment.

According to statistics reported by the facility, there were 22 admissions for WM in 2015–2016. Of the 22 admitted, 16 clients completed both the WM and treatment program (28 days). Two clients discharged themselves from the WM program and four others completed the WM program, but discharged early from the treatment program.

The Grace Centre offers a complementary program to the Humberwood Centre. It is a voluntary, provincial residential addictions treatment centre located in the eastern area of the province, operated by Eastern Health. It opened in February 2016 and services adults aged 18 years and older. As with the Humberwood Centre, it also provides a more intensive, structured program than can be provided on an outpatient basis. However, the Grace Centre provides more intensive medical monitoring than the Humberwood Centre and candidates for programs offered by the two centres are matched through a common intake process to the most suitable facility for their presenting needs.

Both the Humberwood and Grace centres have capacity to provide RWM to clients who require it upon entering the treatment program. The centres do not provide standalone WM services in the same manner that the Hope Valley Centre provides such services to youth.

Hospital-based withdrawal management services

Although hospital-based WM is not promoted as part of the continuum of WM services in the province, individuals are routinely admitted to acute care facilities in the regional health authorities if a responsible authority diagnoses them with a substance use issue, including withdrawal. For this reason, such acute care is an integral part of the available continuum of services.

Hospital-based WM is particularly relevant for the Labrador-Grenfell Health region, the majority of which is physically separated from the island portion of the province, where no other RWM facilities exist. Individuals from this region would otherwise have to leave the region to access services at the Recovery Centre or as part of treatment at one of the three residential addiction treatment centres.



Important data considerations and limitations

The data reported for hospital admissions does not overlap with the statistical data reported in the NTI indicators. NTI data are drawn from the CRMS. The data reported for 2015–2016 from the CRMS is considered more accurate than the data reported in previous years due to refinements made in the report queries. Residual data quality issues are minor, but the completeness and accuracy of CRMS data is dependent on the registration and clinical documentation entered in the course of service delivery.

Results

Community-based Withdrawal Management

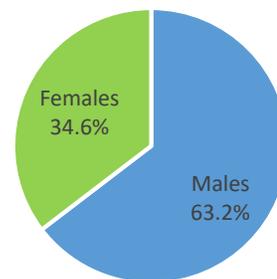
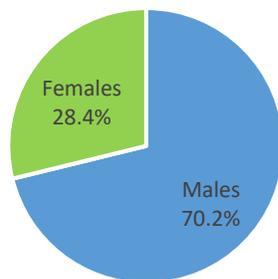
Total service events and unique individuals

In 2015–2016, 2,811 unique individuals accessed publicly funded substance use treatment services in N.L., which accounted for 4,583 service events. Of these individuals, 82.6% ($n = 2,323$) were new cases. These numbers include individuals and service events for all treatment types. The majority of individuals 96.9% ($n = 2,725$) accessed treatment services for their own problematic substance use. However, 122 individuals accessed treatment for a friend or family member.

With respect to community-based WM services, only RWM services are provided; NRWM services are not offered in N.L. A total of 174 unique individuals accessed these services, which accounted for 675 WM service events. Males accounted for the majority, 70.2% ($n = 474$), of the withdrawal service events, while females accounted for 28.4% ($n = 192$) (Figure 49). Across all treatment services males still accounted for the majority of treatment service events, 63.2% ($n = 2,832$) (Figure 50).

Figure 49. WM service events⁹³ by gender

Figure 50. Total treatment service events⁹⁴ by gender



Withdrawal management service events and unique individuals by gender

As shown in Table 12, total WM services accounted for 15.2% of all treatment services. While not the focus of this report, the remaining service events included non-residential treatment (75.5%) and residential treatment (9.0%).

93 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

94 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Table 12: Total service events and unique individuals⁹⁵ by gender

	RWM	Residential and Non-residential Treatment	Total Counts*
Service Events:			
Total (including unknown gender)	15.2%	84.8%	<i>n</i> = 4,481
Males	16.7%	83.3%	<i>n</i> = 2,832**
Females	12.4%	87.6%	<i>n</i> = 1,551**
Unique Individuals:			
Total (including unknown gender)	6.4%	93.6%	<i>n</i> = 2,725
Males	7.1%	92.9%	<i>n</i> = 1,715
Females	5.3%	94.7%	<i>n</i> = 946

*Other was reported as a gender, but the numbers per cell were too small to display.

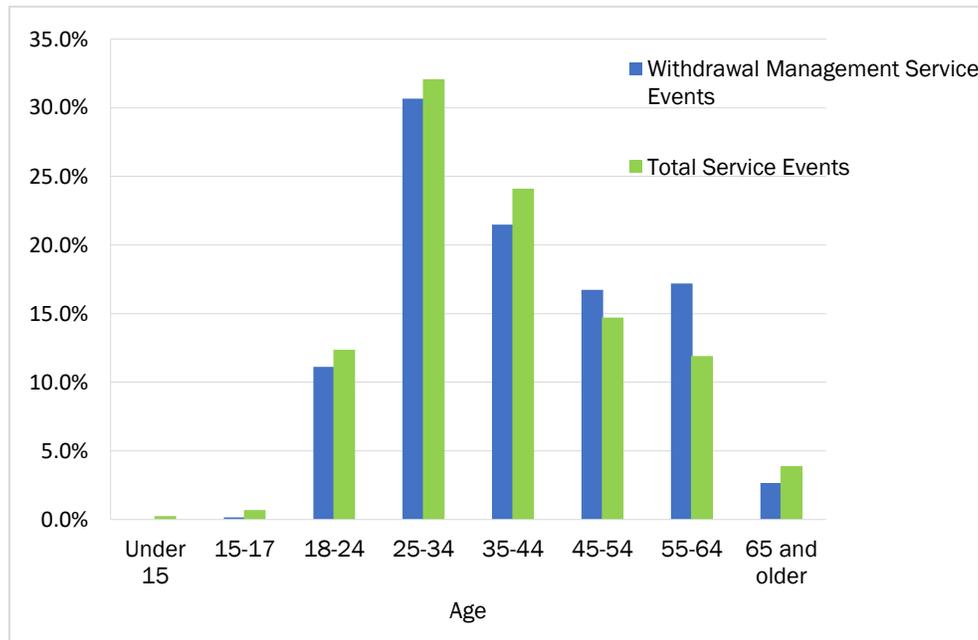
**The counts for service events by gender may be slightly lower than the total service events as a record may have more than one presenting issue or the presenting issue may not have been recorded for non-referral based activities.

The ratio of RWM service events to individuals was 3.9 to 1.

Number of withdrawal management service events by age

As shown in Figure 51, the highest percentage of WM service events and total overall service events occurred among those aged 25–34 years.

Figure 51. WM service events and total service events⁹⁶ by age



95 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.

96 Numbers represent service events and unique individuals who accessed treatment for themselves and not for friends or family members.



Hospital-based Withdrawal Management

Hospitalizations by sex⁹⁷

In Newfoundland and Labrador, there were a total of 186 hospitalizations⁹⁸ for WM for substance use. The average length of stay for WM hospitalization was five days. Males represented about 82.3% of the hospitalizations and females represented about 17.7% (Figure 52). The percentage of hospitalizations accounted for by males (Figure 52) was higher than the percentage of community service events accounted for by males (Figure 49). With respect to length of stay, the total number of days stayed for all hospitalizations was 992 days.⁹⁹ Days stayed in the hospital by males accounted for 83.4% (827 days) of total days and days stayed for females accounted for 16.6% (165 days) (Figure 53).

Figure 52. Hospitalizations for WM by sex (percentage), FY 2015–2016

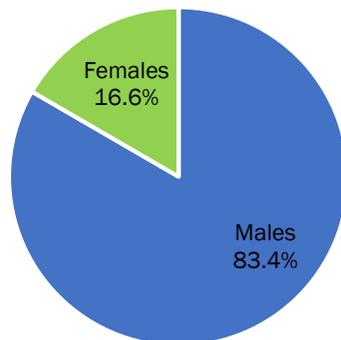
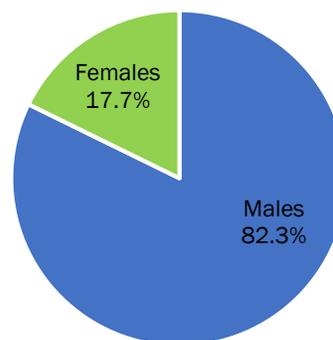


Figure 53. Days stayed in hospital for WM by sex (percentage), FY 2015–2016



*Includes suppressed data

Hospitalizations by age

In terms of age, the highest percentage of hospitalizations¹⁰⁰ occurred among those aged 55–64 years (31.7%), followed by those aged 45–54 years (23.1%) (Figure 54). This contrasts with community treatment services, where the highest percentage of events occurred among those aged 25–34 years. With respect to length of stay in the hospital, of the total 992 days, those aged 55–64 years accounted for the highest number at 326 days (32.9%) and, following this, those aged 65 years and older accounted for 275 days (27.7%).

⁹⁷ Hospitalization data in this section are provided by CIHI. In accordance with the data standards used for CIHI data collection, the term “sex” is used, referring to an individual’s reproductive system and other physical characteristics.

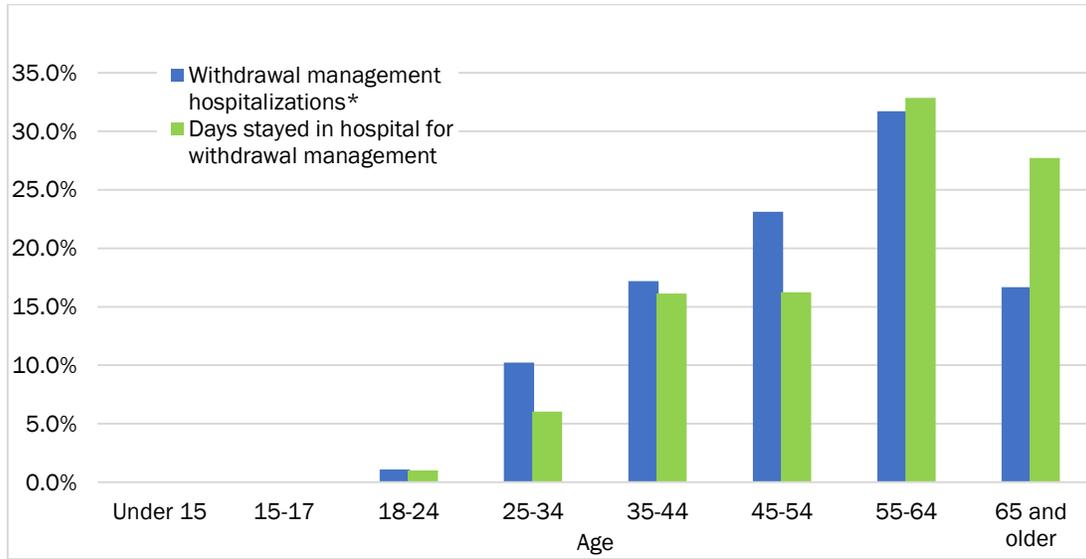
⁹⁸ Hospitalization data represent primary diagnosis of withdrawal from a substance (e.g., alcohol, opioids, stimulants). Hospitalizations for which withdrawal was recorded as an additional diagnosis were not included. A primary diagnosis reflects the main reason for the stay or the diagnosis that contributed most to the individual’s length of stay. Individuals may or may not have been registered to a hospital unit that was specialized for treatment of substance use and withdrawal.

⁹⁹ Days stayed refers to total days stayed for individuals who were discharged during the reporting period (April 1, 2015, through March 31, 2016). These data include days stayed that occurred prior to the reporting period, for clients who were admitted but not discharged in a prior reporting period. Where the individual was admitted and discharged on the same day, a one-day length of stay was assigned.

¹⁰⁰ Data reflects age at admission and not discharge. Hospitalizations are based on date at discharge where data is collected by fiscal year, April 1, 2015, through March 31, 2016.



Figure 54. Percentage of hospitalizations* and length of days stayed (days) for WM by age group, FY 2015–2016



*Includes suppressed data



First Nations and Inuit Health Branch, Mental Wellness Program

Problematic substance use continues to be a priority issue for First Nations and Inuit in Canada. The primary federal network of substance use treatment programming in place to respond to this issue is supported through the Mental Wellness Program, which provides direct funding for a national network of substance use treatment centres.

The network of federally funded treatment centres provides important treatment options and resources that include a range of mainstream and culturally relevant approaches. Through this national program, First Nations and Inuit individuals have access to inpatient, outpatient and day treatment services, as well as services for people with unique needs (e.g., programming for families, youth, those who use solvents, women and people with concurrent disorders).

WM and stabilization are processes that help people withdraw from the use of alcohol or other drugs. With respect to the Mental Wellness Program, the focus has been on treatment once withdrawal and stabilization has occurred. Individuals needing withdrawal services are generally referred to those managed by provincial or territorial healthcare systems, and are not reported here.

Although the Mental Wellness Program does not provide medical WM services, other types of WM services are provided. Non-medical or minimally medical WM approaches include cultural, social, mobile or home detoxification that can be offered within communities, on the land or within a home. Depending on symptoms, these may involve check-ins with primary care staff and medication. For this report, the Youth Solvent Addictions Committee (YSAC), which administers the 10 youth and family treatment centres of the program, and the Thunderbird Partnership Foundation, a national organization that develops and supports holistic healing and wellness approaches of First Nations, collaborated to provide additional context on the relationship between WM services and the YSAC, as well as general information about the treatment program.

The Youth Solvent Addictions Committee

The majority of centres in the YSAC are located on First Nations land, in most cases a fair distance away from provincially managed WM centres. Clientele are mostly youth with the exception of those centres that accept entire family units into treatment. There are no medically-supervised WM programs, though a medical admission form is required before treatment admission. It is expected that if medically supervised WM is indicated, the physician will specify it and refer a client to a provincial WM facility prior to residential treatment admission. The youth and family treatment centre programs are long enough that effective culturally based withdrawal symptom management and monitoring can occur in the early residential stages. Cultural interventions such as welcoming ceremonies, traditional medicines, Elder stabilization, cleansing sweat lodge, land-based interventions and foot soaks are a regular part of early stage stabilization treatment. There is a strong focus on programming that can be done concurrently and so YSAC recognizes that many symptoms of withdrawal are effectively managed through greater attention to relational practice, sleep hygiene, nutritional recovery and physical exercise.

In the next year, KaNaChiHih Treatment Centre will be partnering with a tribal council in the city of Thunder Bay to open a youth WM facility. Other youth and family centres have working partnerships with provincial facilities when, on the rare occasion, medically supervised WM is needed.



Discussion

This special report focusing on WM has provided a number of useful insights into the array of available treatment services for individuals affected by substance use issues. The inclusion of hospitalization data in this report has augmented these insights and, in some cases, provided data for some jurisdictions where it has not been possible to obtain community data. This report also describes the various providers of WM treatment (e.g., community services, hospitals, Indigenous health services) and the multiple ways in which WM can be addressed, including pharmacological and psychosocial, and combinations of these approaches. The findings also reveal important gaps and areas where greater investments in WM are needed to help improve treatment success.

The majority of WM service events in this study, whether community-based or hospital-based, were accessed by males at 68.5%, followed by females at 31.3%. This finding is consistent with other studies (Green, 2006; Satre, Mertens, Areán, & Weisner, 2004) and is important, as studies have shown that males are generally less likely to complete treatment programs. The high percentage of males in WM and the higher chances of relapse can increase the burden to those providing WM services to this population. There is a clear need to ensure that services across Canada meet the demands of the male population using them and to improve methods to encourage their continued commitment to treatment programs. Given the disproportionate number of males accessing treatment, the results also highlight the need to invest in more preventative measures with this population.

At the same time, the lower percentage of females accessing WM services could mean that females are not being adequately serviced by treatment programs. This possibility is concerning, as there have been increases in substance use by females in recent years and they often experience substance use issues differently than men (Callaghan & Cunningham, 2002a; Green, 2006). For instance, it was observed in the data of this report that for those jurisdictions (Ontario and Prince Edward Island) that offered NRWM services, females represented more of the NRWM service events than males. Although the data pool of two jurisdictions from one year is not enough to make broader conclusions, these data may suggest that there could be a difference in accessibility and preferences for types of WM services between males and females. Past NTI reports have also revealed that among NRWM services, females either access these services more often than males or relatively the same as males (McQuaid, Di Gioacchino, & National Treatment Indicators Working Group, 2017; Pirie, Wallingford, Di Gioacchino, McQuaid, & National Treatment Indicators Working Group, 2016).

The lack of NRWM options in some jurisdictions may be a barrier for females who may prefer or need these services over RWM. For instance, studies have shown that females face a number of barriers to treatment, including lack of services for pregnant women, women who have children or women who fear losing custody of their children (LaMarre, 2014; Tuchman, 2010). It is possible that many RWM services, which provide overnight accommodation, may not be set up to support the caregiver responsibilities of some women and may act as a deterrent to them seeking treatment. Other reasons may explain this difference (e.g., domestic violence, stigma, availability of services) and more research and data on this issue is required.

Nonetheless, the data demonstrate the need for improving practices in gender-based treatment. This possibility is not only important for those who identify as male and female based on their sex assignment at birth, but also for growing populations of individuals who identify in a variety of other ways where traditional sex-based treatments may not apply. Additional research and surveillance of WM services for all genders is required.

Some jurisdictions also reported low completion levels for referrals from WM to other treatment programs. The transition from WM to other components in the continuum of care is a common



challenge (Lee et al., 2014). For instance, long wait times, higher resources (financial or time) required from clients, transportation challenges and unstable housing all produce barriers to individuals attempting to continue their treatment process (Callaghan, 2003; Mark et al., 2003). These barriers do not reflect best practices, which suggest WM should not occur in isolation, but rather be a part of the continuum of care. While there has already been work done in this area (Carroll, Triplett, & Mondimore, 2009; Chutuape, Katz, & Stitzer, 2001; Timko, Schultz, Britt, & Cucciare, 2016), there remains an important gap for policy makers and healthcare providers to work to address.

With the exception of one jurisdiction, all jurisdictions that were able to provide age-related data recorded individuals aged 25 to 34 years were the most frequent users of WM services, followed by those aged 35 to 44 years. In contrast, hospitalization data for most jurisdictions revealed that those aged 45 to 54 years were the most common users of these types of services. In terms of number of days stayed in the hospital, the highest numbers were recorded relatively evenly between those aged 45 and 54 years and those aged 55 to 64 years. This finding is consistent with some studies (Li, Sun, Puri, Marsh, & Anis, 2007b; Satre et al., 2004), yet other studies have found that older adults drop out of treatment earlier than younger adults (Mark, Vandivort-Warren, & Montejano, 2006). These differences speak to the wide variety of factors that can influence engagement with, and the effectiveness of, withdrawal treatment (see Introduction).

The differences between community and hospital WM data found in this report suggest that age is an important factor in terms of which services are sought. Yet, there is insufficient information to explain these differences. For instance, is the difference due to varying levels of awareness and availability of services, financial or work-related reasons, a preferential choice or other factors? Best practices in WM require age-appropriate treatment, so it is necessary for future research to determine what is influencing these differences in the data to identify where to focus resources to ensure no population is being underserved.

Limitations

Although there were a number of important findings from this study, it is important to be mindful of the limitations discussed in the Methods section. For instance, not all services (e.g., private treatment) or all jurisdictions (e.g., British Columbia) are represented in the data. Due to varying types of service models and varying service providers collecting the data across Canada, there may be some variability in the way in which data are collected and reported. These gaps and variations in data emphasize several important needs. To improve the breadth, methods and consistency of data collected, more investment and resources are needed to improve the capacity to collect data from all service providers and jurisdictions, and to develop national data standards to support the process. Despite these limitations, the data reported in this study provide important insights and understandings of the current treatment population, which helps to identify needs for individuals and jurisdictions alike.

Conclusion

The importance of WM in the continuum of care for addressing substance use cannot be overstated. This special report reveals areas where jurisdictions are meeting needs of those affected by problematic substance use and, equally important, highlights several gaps and areas in need of improvement. It identifies specific areas for researchers, practitioners, policy makers and health system planners to focus on that require improvements, such as gender- and age-specific treatment, meeting the needs of specific populations, and the importance of ensuring WM services transition to other treatment services and not operate in isolation.



These needs are made more clear by a recent study that estimated that the 2014 cost of specialized substance use treatment in Canada was over \$600 million, and that substance use more generally costs the healthcare system approximately \$11.1 billion (Canadian Substance Use Costs and Harms Scientific Working Group, 2018). Most individuals with a substance use disorder do not receive the needed specialized treatment. Therefore, the 2014 cost estimates as well as 2015–2016 data in this report underestimate the true volume of individuals in need of treatment (National Treatment Strategy Working Group, 2008).

If improvements are to be made in the treatment system, researchers will need to expand studies to examine broader and emerging issues, practitioners will need greater resources, support and opportunities to implement best practices, and policy makers and health planners will need to ensure decisions are made that reflect and respond to shifting populations and evolving needs. The results in this special report on WM provide an important starting point and outline for decision makers to improve the accessibility and effectiveness of programs to better serve Canadians.



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Appendices

Appendix A: National Treatment Indicators Working Group Membership

As of August 2018

Name	Organization
Bowlby, Sandy	Yukon Department of Health and Social Services
Dell, Debra	Youth Solvent Addictions Committee
Elliot, Daniel	Data Evaluation Leadership Transformative Analyses (Ontario)
Evans, Todd	Strategic Policy Branch, Health Canada
Frescura, Anna-Maria	Healthy Environments and Consumer Safety Branch, Health Canada
Leggett, Sean	Manitoba Healthy Living and Seniors
MacCon, Karen	Data Evaluation Leadership Transformative Analyses (Ontario)
Macknak, Kelsey	Saskatchewan Ministry of Health
Maloney-Hall, Bridget (co-chair)	Canadian Centre on Substance Use and Addiction
Meister, Shawna (co-chair)	Canadian Centre on Substance Use and Addiction
Pellerin, Annie	New Brunswick Department of Health
Reddin, Shauna	Health PEI
Ridgeway, Diana	Canadian Institute for Health Information
Ross, Pamela	Nova Scotia Health Authority
Rush, Brian	Centre for Addiction and Mental Health
Shen, Zhijie	Alberta Health Services
(temporarily unassigned)	First Nations and Inuit Health Branch, Health Canada
Urbanoski, Karen (co-chair)	University of Victoria
Vadneau, Alana	Manager, Health Programs and Governance, Indigenous Services Canada
Vivian-Beresford, Ann	Newfoundland and Labrador Centre for Health Information
Waites, Sean	Health Information Specialist, Government of Nunavut



Appendix B: Metrics and Indicators Collected for 2015–2016 Data Collection

Data for analysis in this report on WM were obtained from indicator groups 1, 3, 5 and 6. Specific indicators included in this report can be found in Appendix D.

Indicator 1: Total number of treatment service events in public, specialized treatment services for substance use problems.

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

Indicator 3: Total number of unique individuals treated in public, specialized treatment services for substance use problems including data for international reporting by Health Canada.

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

Indicator 5: Total number of service events and unique individuals treated in public, specialized treatment services by treatment categories (i.e., residential WM, non-residential WM, residential treatment and non-residential treatment).

Indicator 6: Total number of service events and unique individuals treated in public, specialized treatment services by gender, age and housing status within treatment categories (i.e., residential WM, non-residential WM, residential treatment and non-residential treatment).

Indicator 7: Total number of service events and unique individuals treated in public, specialized treatment services by injection drug status.

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

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

Indicators 10–21: Total number of service events for public specialized treatment services (by primary substance for which treatment was being sought).

Indicators 22–33: Total number of unique individuals treated in public specialized treatment services (by substances used in past 12 months) (stratified by age and gender).

Indicator 34: Total number of service events for public specialized treatment services (by employment status) (stratified by age and gender).

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

Indicators 36–47: Total number of individuals attending public specialized treatment services by substance for which treatment is being sought.



Appendix C: Definitions

Gender

Gender refers to “the socially constructed characteristics of women and men — such as norms, roles and relationships of and between groups of women and men” (World Health Organization, 2011).

Family member

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

New individuals

New individuals refers to unique people who began treatment during the current reporting year. This number would therefore exclude individuals with a treatment service event that began in the previous fiscal year.

Non-residential treatment

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

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.

Service event

A service event refers to admission to a specific treatment service and with an associated discharge or case closure. One person might access several services over the course of a year. For example transferring from one program or service to another (e.g., WM to non-residential treatment) will comprise two service events. A non-residential service event can include multiple appointments.

Sex

Sex refers to the biological anatomy of an individual (i.e., their reproductive organs, chromosomes, etc.), sometimes referred to as sex assignment at birth (World Health Organization, 2011).

Specialized services

Specialized services have a mandate to provide alcohol, other drug 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 service events over the course of a year.



Withdrawal management

WM refers to the initial supervised, controlled period of withdrawing from substances. Residential WM includes programs where clients spend nights at WM, treatment facility or hospital. Non-residential WM includes daytox and home or community detox.



Appendix D: Availability of Treatment Indicators by Jurisdiction for 2015–2016 Data

As this report focused on WM services, italicized rows indicate data not reported on in this study.

Indicator	YT	AB	SK	MB	ON	PE	NL
Total number of treatment service events	–	✓	✓	✓	✓	✓	✓
Treatment service events accessed by non-residents	--	✓	✓	✓	--	✓	✓
Treatment service events accessed for self	--	✓	✓	✓	✓	✓	✓
Treatment service events accessed for a friend or family member	--	✓	✓	--	✓	✓	✓
<i>Total number of treatment service events (gambling)</i>	--	✓	✓	✓	✓	✓	✓
<i>Treatment service events accessed by non-residents (gambling)</i>	--	✓	✓	✓	--	--	✓
<i>Treatment service events accessed for self (gambling)</i>	--	✓	✓	✓	✓	✓	✓
<i>Treatment service events accessed for a friend or family member (gambling)</i>	--	✓	✓	✓	✓	✓	✓
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 individuals accessing treatment, excluding treatment for alcohol use	--	✓	✓	--	✓	✓	✓
<i>Total number of individuals accessing treatment (gambling)</i>	--	✓	✓	✓	✓	✓	✓
<i>Non-resident individuals accessing treatment (gambling)</i>	--	✓	✓	✓	--	--	✓
<i>Individuals accessing treatment for their own (gambling) problem</i>	--	✓	✓	✓	✓	✓	✓
<i>Individuals accessing treatment for a (gambling) problem of a friend or family member</i>	--	✓	✓	✓	✓	--	✓
<i>Number of new individuals accessing treatment (gambling)</i>	--	✓	--	✓	✓	--	✓
Service events by treatment type (i.e., RWM, NRWM, RT, NRT)	✓	✓	✓	✓	✓	✓	✓
Individuals by treatment type (i.e., RWM, NRWM, RT, NRT)	--	✓	✓	✓	✓	✓	✓
Treatment service events by gender	✓	✓	✓	✓	✓	✓	✓
<i>Treatment service events by housing status</i>	--	✓	--	--	✓	--	✓
Treatment service events by age	✓	✓	✓	✓	✓	✓	✓
Individuals accessing treatment by gender	--	✓	✓	✓	✓	✓	✓
<i>Individuals accessing treatment by housing status</i>	--	✓	--	--	✓	--	✓
Individuals accessing treatment by age	--	✓	✓	--	✓	✓	✓
<i>Treatment service events for injection drug use by gender</i>	--	✓	--	✓	✓	--	--



Indicator	YT	AB	SK	MB	ON	PE	NL
<i>Individuals accessing treatment for injection drug use by gender</i>	--	✓	--	✓	✓	--	--
<i>Individuals accessing opioid substitution treatment by gender</i>	--	✓	--	✓	✓	✓	✓
<i>Individuals accessing opioid substitution treatment by age</i>	--	✓	--	✓	✓	✓	✓
<i>Individuals accessing methadone treatment by gender</i>	--	--	--	--	--	--	--
<i>Individuals accessing methadone treatment by age</i>	--	--	--	--	--	--	--
<i>Individuals attending driving while impaired programs</i>	--	--	--	✓	--	--	✓
<i>Individuals attending driving while impaired programs by gender</i>	--	--	--	✓	--	--	✓
<i>Individuals attending driving while impaired programs by age</i>	--	--	--	✓	--	--	✓
<i>Primary substance for which treatment is sought</i>	--	--	--	--	✓	✓	--
<i>Primary substance for which treatment is sought by gender</i>	--	--	--	--	✓	✓	--
<i>Primary substance for which treatment is sought by age</i>	--	--	--	--	✓	✓	--
<i>Substances used in the past 12 months</i>	--	✓	✓	--	✓	✓	--
<i>Substances used in the past 12 months by gender</i>	--	✓	✓	--	✓	✓	--
<i>Substances used in the past 12 months by age</i>	--	✓	✓	--	✓	✓	--
<i>Treatment service events by employment status</i>	--	✓	✓	--	✓	✓	--
<i>Individuals accessing treatment by employment status</i>	--	✓	--	--	✓	✓	--



Appendix E: ICD-10-CA and DSM-IV-TR Diagnostic Codes

List of diagnostic codes used to select hospitalizations for WM.

Classification System	Code	Description	
ICD-10-CA	F10.3	Mental and behavioural disorders due to use of alcohol, withdrawal state	
	F10.4	Mental and behavioural disorders due to use of alcohol, withdrawal state with delirium	
	F11.3	Mental and behavioural disorders due to use of opioids, withdrawal state	
	F11.4	Mental and behavioural disorders due to use of opioids, withdrawal state with delirium	
	F12.3	Mental and behavioural disorders due to use of cannabinoids, withdrawal state	
	F12.4	Mental and behavioural disorders due to use of cannabinoids, withdrawal state with delirium	
	F13.3	Mental and behavioural disorders due to use of sedatives or hypnotics, withdrawal state	
	F13.4	Mental and behavioural disorders due to use of sedatives or hypnotics, withdrawal state with delirium	
	F14.3	Mental and behavioural disorders due to use of cocaine, withdrawal state	
	F14.4	Mental and behavioural disorders due to use of cocaine, withdrawal state with delirium	
	F15.3	Mental and behavioural disorders due to use of stimulants, withdrawal state	
	F15.4	Mental and behavioural disorders due to use of stimulants, withdrawal state with delirium	
	F16.3	Mental and behavioural disorders due to use of hallucinogens, withdrawal state	
	F16.4	Mental and behavioural disorders due to use of hallucinogens, withdrawal state with delirium	
	F18.3	Mental and behavioural disorders due to use of volatile solvents, withdrawal state	
	F18.4	Mental and behavioural disorders due to use of volatile solvents, withdrawal state with delirium	
	F19.3	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances, withdrawal state	
	F19.4	Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances, withdrawal state with delirium	
	DSM-IV-TR	291.0	Alcohol withdrawal delirium, Alcohol intoxication delirium
		291.81	Alcohol withdrawal
292.0		Amphetamine, cocaine, opioid, sedative, hypnotic, anxiolytic, or other (or unknown) substance withdrawal	
292.81		Amphetamine, cannabis, cocaine, hallucinogen, inhalant, opioid, or phencyclidine intoxication delirium, hypnotic, or anxiolytic withdrawal delirium, or other (or unknown) substance-induced delirium	