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National Treatment Indicators Report

2010–2011 Data

March 26, 2013

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Executive Summary

Substance abuse is a significant health, economic and social issue in Canada, with annual costs estimated at $40 billion (Rehm et al., 2006). Investments in evidence-based services and supports are an effective way to reduce the burden of substance use. Although all provinces, territories and federal agencies collect data about their own treatment systems, the guidelines and definitions used vary considerably. This lack of comparable information means there is no reliable information base that can be used to identify and respond to system-level trends in the services being provided and the populations accessing them. The gap in national-level information also restricts Canada's ability to provide meaningful data to initiatives addressing the health and social impacts of substance use at the international level.

Better, more consistently collected data at all levels are needed to support the kinds of investments necessary to effectively and efficiently respond to Canadians' needs, as well as the latest trends and knowledge in substance use treatment and services. Better data will help to:

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

The purpose of the National Treatment Indicators (NTI) project is to provide a comprehensive picture of substance use treatment in Canada. The data presented in this report illustrate the potential wealth of information available as the project continues to improve data collection and increase participation.

The National Treatment Indicators are contributing to the system-level information required to plan, implement, monitor and evaluate an evidence-based approach to substance use in Canada by:

- Providing the first cross-Canada picture of treatment system use through data collected according to common categories;
- Providing a central, accessible source of information that allows those within and outside the substance use field to discover what national treatment system data exists;
- Building Canada's capacity to provide meaningful, reliable information on substance use services to support evidence-based decision making at regional, provincial, territorial and national levels; and

- Facilitating collaboration and knowledge sharing between Canada and other countries and international organizations by providing a central source for national-level data.

This second annual NTI report provides 2010–2011 fiscal-year data from eight provinces, one territory and one federal department. It also presents an expansion in scope with the addition of data from Yukon, Manitoba, and Newfoundland and Labrador; and a new indicator: data on use of driving-while-impaired (DWI) programs. Provincial-level treatment service data were provided for a second year by Prince Edward Island, Nova Scotia, New Brunswick, Ontario, Saskatchewan and Alberta. The Correctional Service of Canada (CSC) also provided data for both reports on the federal offender population.

This report provides data on both unique individuals (the number of people using services) and treatment episodes (the number of times services are accessed). One individual can have more than one treatment episode over the course of the year; therefore, individuals indicate the population impact whereas episodes indicate the treatment system impact.

The NTIs provide jurisdictional-level descriptive information on treatment services in Canada by presenting information such as the number of individuals accessing publicly funded, specialized services[1] and their basic demographic characteristics (e.g., age, gender). This report presents the data in detail for use by researchers and analysts; the executive summary and discussion provide information targeted to leaders, decision makers and advisors looking to support service planning, development and communications.

Key findings from this report include:

- The rate of treatment episodes varies considerably between jurisdictions in Canada, as does the number of unique individuals accessing such services.
- There were fewer problem gambling episodes during 2010–2011 than substance use-related episodes.
- Non-residential treatment services (e.g., day treatment) make up the majority of all substance use treatment episodes, accounting for approximately 60–70% in most jurisdictions.
- Between 4% and 13% of substance use treatment episodes are accounted for by persons seeking treatment for someone other than themselves, such as a family member. This rate is even higher for gambling, at approximately 20% in three provinces.
- Males are, on average, more likely than females to access specialized treatment services across all service categories.
- On average, individuals aged 25–34 make up the largest percentage of persons accessing substance use treatment services (20–30%), followed closely by 35–44 year olds (17–25%).
- The majority of individuals accessing specialized treatment services who had used drugs by injection in the past year are male (52–67%).
- More than 80% of individuals attending DWI programs are male, with men aged 18–34 making up the largest percentage of these clients.

These results have implications for system development and resourcing. This report indicates that in most provinces, between 0.5% and 1.5% of the population accessed specialized substance use treatment in the past year—a conservative estimate given that it does not include, for example, private facilities or primary care. This number illustrates the burden substance use places on

[1] This report does not include data from private services, rapid detoxification, primary care or non-specialized hospital or community-based services.

Canada's health and social services. The fact that up to 13% of treatment episodes represent people seeking help because of a family member or friend's substance use further illustrates the broad impact of substance use and the need to ensure appropriate treatment is available.

Data collection for the next report (2011–2012 fiscal year) is underway and has been expanded to include two additional indicators: substances used and employment status. These additions will increase linkages to other national reports providing data on alcohol and other drug use by Canadians (the Canadian Alcohol and Drug Use Monitoring Survey, for example). The Canadian Centre on Substance Abuse (CCSA) is also working more closely with the Canadian Institute for Health Information to identify methods for capturing access to non-specialized, community-based treatment. As the NTI project evolves, CCSA hopes to engage with a broader scope of service providers (for example, community- and hospital-based services) to better capture data that reflect the full continuum of services provided in Canada.

As participation in the NTI project increases and more consistent data is collected, future reports will move from being descriptive to being analytical in nature (for example, by being able to compare trends over time and across jurisdictions). Collectively, the expansion of information provided over time and through additional sources will lead to the achievement of the goal of the NTI project: a comprehensive picture of service use to inform effective policy, resourcing and development for substance use treatment in Canada.

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List of Acronyms

General

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

Canadian organizations and jurisdictions

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

Canadian data collection

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

Introduction

Substance use has a significant health, economic and social impact in Canada, with annual costs estimated at $40 billion (Rehm et. al., 2006). It is also a significant contributor to diseases such as cancer, HIV/AIDS, cardiovascular disease and diabetes—further burdening healthcare systems that are already overwhelmed.

According to the 2011 Canadian Alcohol and Other Drug Use Monitoring Survey, close to 10% of Canadians 15 years and older have used an illegal drug. Of these, 17.6% have experienced harm associated with their drug use (Health Canada, 2012). In addition, the majority of Canadians report consuming alcohol in the past year (78%). Of these, 18.7% exceeded Canada's Low-Risk Alcohol Drinking Guidelines[2] for chronic effects and 13.1% exceeded the Guidelines for acute effects (Health Canada, 2012).

One way to reduce the risks and harms associated with alcohol and other drugs is to ensure Canadians have access to a comprehensive system of effective, evidence-based services and supports. Yet, instead of taking a strategic approach to system development, investments in this area have often done little more than carry forward existing allocations or respond to political calls for action (National Treatment Strategy Working Group, 2008).

Better, more consistently collected data at all levels are needed to support investments in substance use services—and to ensure the treatment system is operating effectively and efficiently in response not only to Canadians' current needs, but also to the latest trends and evolving knowledge. Addressing the need for better data are the National Treatment Indicators (NTIs): a set of measures that are, for the very first time, collecting treatment system data according to common categories across the country.[3] By providing a central source of information accessible to those both within and outside the substance use field, the NTIs make it possible to identify and respond to the gaps that exist in Canada's national treatment system data.

This report is intended for a broad audience that includes researchers, analysts, leaders, decision makers and advisors looking for information to support service planning, development and communications. The components of this report present varying levels of detail to meet the needs of these different audiences.

National Treatment Indicators

Building on previous work by the Canadian Institute for Health Information (2001), the Canadian Centre on Substance Abuse (CCSA, Thomas, 2005) and the National Treatment Strategy Working Group (2008), the purpose of the National Treatment Indicators project is to provide a comprehensive picture of the use of substance use treatment in Canada, filling the gap between the information required to monitor Canada's treatment system and the information currently available.

The project is led by the National Treatment Indicators Working Group (NTIWG), which was formed in 2009 and includes representatives from all 10 provinces, one territory (Yukon) and federal departments with treatment delivery responsibility. The NTIWG intends to continue to expand its membership to obtain complete cross-Canada representation. (For more information on the membership of the NTIWG, please see Appendix A.)

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[2] *Canada's Low-Risk Alcohol Drinking Guidelines* are available from www.ccsa.ca.

[3] Gambling information is also provided where it is readily available.

The NTI project has been funded to date through Health Canada's Drug Treatment Funding Program. It is anticipated that the NTI project will continue beyond the expiry of this funding stream, largely due to the data collection and monitoring capacity it has facilitated at the provincial, territorial and national levels.

Progress to Date

Published in March 2012, the first National Treatment Indicators report presented 2009–2010 data provided by six provinces (Prince Edward Island, Nova Scotia, New Brunswick, Ontario, Saskatchewan, Alberta) and one federal department (Correctional Service of Canada). This second report includes data from an additional two provinces (Newfoundland and Labrador, Manitoba) and one territory (Yukon), bringing it closer to full national representation. The number of jurisdictions providing data on participation in driving-while-impaired (DWI) programs has also increased from two in the 2009–2010 report to seven for 2010–2011. Although two reports do not provide enough information to indicate trends, the results to date generally point toward consistency.

For the purpose of this report, *jurisdictions* refers to provincial, territorial, federal, First Nations, Inuit and Métis authorities with stewardship over substance use service systems.

The NTI project is also featured on the Systems Approach website (www.ccsa.ca/Eng/topics/Monitoring-Trends/National-Treatment-Indicators/Pages/default.aspx). This website provides system-level information for all provinces and territories in Canada as well as information briefs, change management guides, and planning tools and templates for enhancing the accessibility, quality and range of services and supports for substance use.

The Road Ahead

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

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

Administrative Context: Contributing to a National and International Picture

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

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

Canada also has international reporting responsibilities. The United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), the Pan-American Health Organization (PAHO) and the Inter-American Drug Abuse Control Commission (CICAD) all have annual or semi-annual reporting requirements. The reports produced by these organizations all include national treatment data. As an international leader in health care, Canada should be able to meet these requirements in a timely and meaningful manner. However, much of the information Canada currently provides on substance use services is based on partial data from some provinces and territories, or estimates derived by taking data from a small number of jurisdictions and extrapolating to the national level. By building Canada's capacity to provide meaningful, reliable information on national substance use services to the international community, the NTI project is helping to facilitate collaboration and knowledge exchange between Canada and other countries and international organizations.

Methods

This report provides jurisdictional-level descriptive information on treatment services in Canada by presenting information such as the number of individuals accessing publicly funded specialized treatment services and their basic demographic characteristics (e.g., age, gender). The treatment indicators were identified by the National Treatment Indicators Working Group (NTIWG) based on information already being collected at the jurisdictional level. This initial set of indicators (referred to as "green light" indicators) provided the core starting point for the NTI reports. The NTIWG also identified "yellow light" and "red light" indicators with the intention of expanding data-collection capacity over time to continually enhance the information available on services and supports for substance use in Canada. (See Appendix B for more information on the indicators.) Gambling information is also provided where it is readily available.[4]

Green light indicators

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

The data in this report represent the outcome of a multi-stage process. First, service providers entered client-level data, which were submitted at the regional or provincial level according to reporting requirements. The data were then analyzed at the provincial level (according to the definitions stated in Appendix C) and data-collection protocols developed by CCSA in consultation

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

with the NTIWG.[5] Next, data were entered into collection templates and submitted to CCSA by NTIWG members. All information provided to CCSA and presented in this report is at the aggregate level rather than the individual case level. Finally, CCSA conducted data analysis and produced this report in close consultation with the NTIWG.

Data Submissions

This report provides 2010–2011 fiscal-year data from eight provinces, one territory and one federal department. Specifically, provincial-level treatment service data were provided by Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Ontario, Manitoba, Saskatchewan and Alberta; territorial-level data were provided by Yukon; and the Correctional Service of Canada (CSC) provided data on the federal offender population. The Association des centres de réadaptation en dépendance de Québec also provided data on DWI programs in Quebec.

Jurisdictional Data Collection

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

Limitations

Developing a list of common core indicators presents many challenges. As a result, there are several limitations to the current data, which are noted in the explanations and footnotes provided throughout this report. The impact of these limitations is that the data provided are not comparable across jurisdictions. Fortunately, these limitations are expected to diminish with time as data-collection capacity develops and jurisdictions identify new methods to report information in line with the NTI data-collection protocols. At this time, the following limitations should be considered when reviewing the data.

Services included: The data represent only publicly funded and specialized services. Private treatment[6] and rapid detoxification data are not included. Many clients with substance use problems also have a multitude of other health-related issues that may be the cause of their contact with the healthcare system; however, substance use treatment in primary care or hospital contexts is not captured here. As the NTI project evolves, CCSA hopes to engage with a broader scope of service providers to better capture data reflecting the full continuum of substance use treatment services provided in Canada.

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[5] Data-collection protocols are available from CCSA on request.

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

Jurisdictional participation: This report is based on data submitted by 10 of a possible 16 administrative jurisdictions across Canada. Some jurisdictions were unable to participate for capacity reasons, while others were still in the process of finalizing data-sharing agreements. CCSA and the NTIWG will continue to work with all jurisdictions to increase data submission in future years.

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

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

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

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

Results

This report contains information from the 2010–2011 fiscal year for nine indicators related to substance use and gambling treatment services. Because of the limitations noted above, data should not be compared across jurisdictions. Footnotes have been inserted on an as-needed basis to ensure data are interpreted appropriately.

Empty cells in the tables indicate that data could not be provided by the respective jurisdiction. Cells displaying "N/A" indicate that the data point is not applicable (for example, the category of treatment is not provided in the jurisdiction). Tables only include jurisdictions that were able to provide data for the indicator or breakdown presented. Asterisks indicate that numbers have been suppressed (i.e., for data representing less than five individuals for most jurisdictions or less than 10 individuals for New Brunswick). Suppression of data helps to ensure individuals are not identifiable owing to unique characteristics or service access within the aggregate-level data.

The interpretation of these results should also be guided by recognition that the number of people receiving substance use and gambling services is the result of many combined factors, and is not an accurate measure of need in the population (the text box below describes one initiative working toward this measure). Factors influencing service numbers include the rate of a given problem in the population; the structure, availability and accessibility of services within the system; and various other health and social factors. For example, a high-profile anti-stigma campaign for youth with substance use problems can result in an increase in referrals and rates of treatment in one jurisdiction, despite no change in the actual baseline rate of substance use and associated harms.

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

Brian Rush, Joël Tremblay and colleagues at the Centre for Addiction and Mental Health are developing a method to estimate levels of treatment need based on population data (Rush et al., 2012). This needs-based planning (NBP) project is currently in the pilot stage. There is cross-representation between the NBP and NTI projects to ensure that the two are complementary. For example, service functions in the NBP project roll up into the service categories in the NTI project. As a result, once both projects are expanded, the population-need estimates can be compared to service use data to produce a gap analysis and promote evidence-based system planning.

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

Indicator 1

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

Indicator 2

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

Indicators 1 and 2 are presented together in the interest of brevity. They provide information on the total number of specialized treatment service episodes related to substance use and problem gambling, respectively, in a given jurisdiction during the 2010–2011 fiscal year.

Table 1 provides information on the total number of treatment episodes related to substance use (i.e., residential withdrawal management, non-residential withdrawal management, residential treatment, non-residential treatment) and problem gambling in a given jurisdiction during the 2010–2011 fiscal year. The number of episodes per 100,000 persons is also presented in Table 1 and is based on Statistics Canada 2010 population estimates for each respective jurisdiction.

Table 1. Treatment episodes for substance use and problem gambling, 2010–2011[8]

Jurisdiction	Substance Use		Problem Gambling	
	n	n/100,000	n	n/100,000
Newfoundland and Labrador	2,938	574	207	40
PEI	2,933	2,050	24	17
Nova Scotia	12,535	1,326	459	49
New Brunswick	9,356	1,243	420	56
Ontario	109,777	830	6,455	49
Manitoba[9]	17,130	1,386	731	59
Saskatchewan	21,144	2,025	423	41
Alberta[10]	51,269	1,377	2,409	65
Yukon	2,951	8,529	N/A	N/A
CSC[11]	2,420	10,881	N/A	N/A

[8] Population estimates used to calculate rate per 100,000 are based on Statistics Canada 2010 estimates for the entire population of a jurisdiction (available at http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm). CSC population was drawn from the *2010 Corrections and Conditional Release Statistical Overview* (available at http://www.publicsafety.gc.ca/res/cor/rep/2010-ccrso-eng.aspx#c1).

[9] Several agencies were unable to provide carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). Therefore, the majority of data represent only the information collected from cases beginning April 1, 2010, to March 31, 2011.

[10] Includes Alberta Health Services (AHS) direct and AHS-funded/contracted services. Excludes clients who cited “tobacco only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

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

Table 2 compares the total number of substance use and problem gambling treatment episodes for individuals seeking treatment for themselves to those seeking treatment on behalf of a family member. The data indicate that over 90% of substance use treatment episodes during 2010–2011 were accounted for by individuals seeking treatment for themselves; between 3% and 10% of substance use treatment episodes were accounted for by persons seeking treatment for some else's substance use (e.g., family member, close friend).

Substance use has impacts beyond the individual user, particularly on family and close friends (Center for Substance Abuse Treatment, 2004).

Table 2. Treatment episodes for substance abuse and problem gambling where the person was seeking treatment for themselves or seeking treatment for a family member, 2010–2011[12]

Jurisdiction	Substance Use					Problem Gambling				
	Episodes where individuals were seeking treatment for themselves		Episodes where individuals were seeking treatment for a family member		Total number of treatment episodes	Episodes where individuals were seeking treatment for themselves		Episodes where individuals were seeking treatment for a family member		Total number of treatment episodes
	n	%	n	%		n	%	n	%	
Newfoundland and Labrador	2,848	96.9	107	3.6	2,938	206	99.5	*		207
PEI	2,850	97.2	83	2.8	2,933	24	100.0			
Nova Scotia	11,848	94.5	687	5.5	12,535	373	81.3	86	18.7	468
Ontario	104,413	95.1	5,364	4.9	109,777	5,221	80.9	1,234	19.1	6,455
Manitoba	15,580	91.0	1,550	9.0	17,130	606	82.9	125	17.1	731
Saskatchewan	19,743	93.4	1,379	6.5	21,144	389	92.0	34	8.0	423
Alberta	46,233	90.2	5,036	9.8	51,269	2,137	88.7	272	11.3	2,409
Yukon					2,997	N/A	N/A	N/A	N/A	N/A

[12] In some jurisdictions, a single episode can have more than one presenting issue (e.g., one for self and one for family). For this reason, the overall total may be less than the additive total of self and other.

Indicator 3

Total number of unique individuals treated in public, specialized treatment services for substance use (alcohol and other drugs) problems

Indicator 4

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

Analysis of the 2010 Canadian Community Health Survey indicates that close to 9% of the Canadian population reported substance use-related problems that indicate the potential need for specialized treatment (Rush et al, 2012).

Indicators 3 and 4 are also presented together in the interest of brevity. They provide information on the total number of unique individuals treated in public, specialized treatment services for substance use problems and problem gambling, respectively, during the 2010–2011 fiscal year.

Table 3 indicates that, on average, individuals access treatment services more than once in a given year. Interpretation of these ratios should take into consideration the fact that there are variations in how an episode is measured between jurisdictions, and that a small number of individuals with a high number of service episodes can inflate the overall average.

Table 3. Unique individuals accessing substance use and problem gambling services, 2010–2011

Jurisdiction	Substance Use			Problem Gambling		
	n	n / 100,000	Ratio of episodes to individuals	n	n / 100,000	Ratio of episodes to individuals
Newfoundland and Labrador	1,454	284	2.0	101	20	2.0
PEI	2,050	1,433	1.4	23	16	1.0
Nova Scotia	7,626	807	1.6	430	45	1.1
New Brunswick	6,107	811	1.5	311	41	1.4
Ontario	71,647	542	1.5	6,014	45	1.1
Manitoba[13]	10,159	822	1.7	440	36	1.7
Saskatchewan	14,778	1,415	1.4	338	32	1.3
Alberta[14]	33,685	905	1.5	1,790	48	1.2
Yukon	743	2,147	4.0	N/A	N/A	N/A
CSC	2,346	10,881	1.0	N/A	N/A	N/A

[13] Substance use does not include data from three agencies (n = 901). Minimal carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) are included for substance use, and none are included for gambling.

[14] AHS direct services only. Excludes clients who cited “tobacco only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment. Please note that ratios were calculated using AHS direct services data only (not presented in tables).

Table 4 illustrates that the majority (>87%) of all individuals accessing substance use services during the 2010–2011 fiscal year were seeking treatment for themselves, while between 4% and 13% of all individuals were seeking treatment due to someone else's substance use. The number of individuals seeking treatment for someone else's gambling is higher yet, at approximately 20% in three provinces.

Table 4. Unique individuals seeking treatment for substance use and problem gambling for themselves or others, 2010–2011[15]

Jurisdiction	Substance Use					Problem Gambling				
	Individuals seeking treatment for themselves		Individuals seeking treatment for a family member		Total number of individuals	Individuals seeking treatment for themselves		Individuals seeking treatment for a family member		Total number of individuals
	n	%	n	%		n	%	n	%	
Newfoundland and Labrador	1,391	95.7	74	5.1	1,454	100	99.0	*	*	101
PEI	1,972	96.2	78	3.8	2,050	23	100.0	0	0.0	23
Nova Scotia	7,148	93.7	478	6.3	7,626	332	81.2	77	18.8	409
New Brunswick					6,107					311
Ontario	66,556	92.9	5,091	7.1	71,647	4,816	80.1	1,198	19.9	6,014
Manitoba[16]	9,405	92.6	834	8.2	10,159	349	79.3	92	20.9	440
Saskatchewan	13,519	91.5	1,237	8.4	14,778	304	89.9	34	10.1	338
Alberta[17]	29,344	87.1	4,341	12.9	33,685	1,545	86.3	245	13.7	1,790
Yukon					743	N/A	N/A	N/A	N/A	N/A
CSC	2,346	100.0	N/A	N/A	2,346	N/A	N/A	N/A	N/A	N/A

[15] In some jurisdictions, a single episode can have more than one presenting issue (e.g., one for self and one for family). For this reason, the overall total may be less than the additive total of self and other.

[16] For substance use, three agencies were unable to provide data on individuals seeking treatment for themselves. Minimal carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) are included.

[17] AHS direct services only.

Table 5 provides data on the total number and percentage of individuals who were considered new cases in their respective jurisdiction for substance use and problem gambling during the 2010–2011 fiscal year.

Table 5. Unique individuals who are new cases, 2010–2011[18]

Jurisdiction	Substance Use		Problem Gambling	
	n	%	n	%
Newfoundland and Labrador	655	45.0	31	30.7
PEI	1,538	75.0	17	73.9
Nova Scotia	7,232	94.8	289	70.7
New Brunswick	2,000	32.7	129	41.5
Ontario	44,928	62.7	2,631	43.7
Manitoba[19]	9,709	95.6	440	100.0
Alberta	26,822	79.6	1,443	80.6
Yukon			N/A	N/A
CSC	2,024	86.3	N/A	N/A

Indicator 5

Total number of episodes and unique individuals treated in public, specialized treatment services by treatment category

Indicator 5 presents a breakdown of the number of episodes and unique individuals accessing specialized treatment services for substance use by treatment category (i.e., residential withdrawal management, non-residential withdrawal management, residential treatment, non-residential treatment).

> **Effectively addressing substance use requires a comprehensive continuum of services and supports. Treatment categories should respond to varying risks, harms, patterns of use and individual needs.**
> ***A Systems Approach to Substance Use in Canada, 2008***

Among the jurisdictions that provided data, non-residential treatment is the most common type of service accessed when measured by both number of episodes and number of individuals; however, percentages varied by jurisdiction. With the exception of Yukon, Newfoundland and Labrador, the ratio of episodes to unique individuals was higher for residential withdrawal management than non-residential treatment. Table 6 provides a detailed breakdown of service access by treatment service category.

[18] There is variation in terms of cases that are considered “new.” For example, some jurisdictions count a new episode when a new service component is being accessed, while others limit new episodes to new entries to the treatment system as a whole.

[19] For substance use, five agencies were unable to provide data.

Episodes

Table 6. Treatment episodes by service category, 2010–2011

Jurisdiction	Residential Withdrawal Management			Non-Residential Withdrawal Management			Residential Treatment			Non-Residential Treatment		
	n	%	Ratio (E:I)	n	%	Ratio (E:I)	n	%	Ratio (E:I)	n	%	Ratio (E:I)
Newfoundland and Labrador[20]	673	27.4	1.5	N/A	N/A	N/A	193	7.8	1.0	1,593	64.8	1.9
PEI	935	31.4	1.6	804	27.0	1.3	135	5.0	1.1	1,090	36.6	1.1
Nova Scotia	3,796	27.0	1.7	535	3.8	1.2	783	5.6	1.2	8,957	63.7	1.1
New Brunswick[21]	3,170	33.9	1.6	N/A	N/A	N/A	361	3.9	1.1	5,825	62.3	1.2
Ontario	41,257	33.4	2.4	1,790	1.5	1.1	9,786	7.9	1.1	70,588	57.2	1.2
Manitoba[22, 23]	1,782	11.5	1.9	5	0.0	1.0	2,632	16.6	1.2	11,168	71.9	1.5
Saskatchewan	4,095	22.3	1.4	N/A	N/A	N/A	1,678	9.2	1.0	12,565	68.5	1.1
Alberta[24]	11,328	24.5	1.4	N/A	N/A	N/A	5,172	11.2	1.1	29,733	64.3	1.1
Yukon[25]	827	28.0	2.7	N/A	N/A	N/A	104	3.5	1.1	2,020	68.5	2.0
CSC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2,420	100.0	1.0

[20] Newfoundland and Labrador does not offer non-residential withdrawal management.

[21] New Brunswick does not offer non-residential withdrawal management.

[22] Numbers do not include carry-overs (i.e., cases that began in 2009–2010 and continued into 2010–2011) for adult medical residential withdrawal management.

[23] For adult residential treatment, numbers are based on admissions only and do not include Addictions Foundation of Manitoba (AFM) intake and assessments or pre-/post-programming (such data are captured in non-residential treatment data). The numbers for residential treatment do not include carry-over data for AFM and four other agencies. The data for non-residential treatment do not include carry-overs from AFM.

[24] There are no non-residential withdrawal services in Alberta. Excludes clients who cited "tobacco only," "gambling only" or "other only" as their reason for treatment. Also excludes clients who did not provide a reason for treatment. Ratios were calculated using AHS direct services data only (not presented in tables).

[25] Yukon is unable to separate residential withdrawal management and non-residential withdrawal management because clients attending "detox" stay in their building until they are ready to leave.

Table 7 presents the number and percentage of unique individuals treated for substance use in 2010–2011 according to the type of category of service accessed. The majority of individuals access non-residential treatment.

Table 7. Unique individuals by service category, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	n	%	n	%	n	%	n	%
Newfoundland and Labrador[26]	464	31.1	N/A	N/A	193	13.0	833	55.9
PEI	582	24.8	628	26.7	135	5.7	1,004	42.7
Nova Scotia	2,280	20.0	460	4.0	654	5.8	7,979	70.2
New Brunswick[27]	2,034	28.4	N/A	N/A	326	4.6	4,797	67.0
Ontario	17,208	20.2	1,637	1.9	8,675	10.2	57,513	67.6
Manitoba[28]	915	8.6	5	0.0	2,071	19.5	7,612	71.8
Saskatchewan	2,982	18.7	N/A	N/A	1,612	10.1	11,330	71.2
Alberta[29]	4,910	14.7	N/A	N/A	2,128	6.4	26,473	79.0
Yukon[30]	311	21.4	N/A	N/A	97	6.7	1,043	71.9
CSC	N/A	N/A	N/A	N/A	N/A	N/A	2,346	100.0

Indicator 6

Total number of episodes and unique individuals treated in public, specialized treatment services by gender, age and housing status, and within categories of treatment

Episode: Gender

Table 8 provides information on the number of episodes that took place during the 2010–2011 fiscal year stratified by gender. Males made up the highest proportion of those accessing substance use services in all treatment service categories with the exception of non-residential withdrawal management in Manitoba and residential treatment in Yukon.

Males are significantly more likely than females to use both illegal drugs and alcohol, and to report exceeding low-risk drinking guidelines (Health Canada, 2012).

[26] Newfoundland and Labrador does not offer non-residential withdrawal management.

[27] New Brunswick does not offer non-residential withdrawal management.

[28] Residential withdrawal management does not include adult medical residential withdrawal management or carry-over data for adult services (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). Non-residential withdrawal management does not include carry-over data. Residential treatment does not include data from two agencies, and includes minimal carry-overs. Non-residential treatment includes minimal carry-overs.

[29] Includes AHS direct services only. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[30] Yukon is unable to separate residential withdrawal management and non-residential withdrawal management because clients attending "detox" stay in their building until they are ready to leave.

Table 8. Treatment episodes by service category and gender, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	Male n (%)	Female n (%)	Male n (%)	Female n (%)	Male n (%)	Female n (%)	Male n (%)	Female n (%)
Newfoundland and Labrador[31]	493 (73.3)	180 (26.7)	N/A	N/A	130 (67.4)	63 (32.6)	1,020 (64.0)	558 (35.0)
Nova Scotia	2,632 (69.8)	1,130 (30.0)	333 (62.5)	199 (37.3)	522 (67.7)	248 (32.2)	7,569 (63.3)	4,383 (36.7)
New Brunswick	2,307 (72.8)	863 (27.2)	N/A	N/A	298 (82.5)	63 (17.5)	3,774 (64.8)	2,051 (35.2)
Ontario	31,326 (75.9)	9,924 (24.1)	930 (52.0)	860 (48.0)	6,328 (64.7)	3,455 (35.3)	45,003 (63.8)	25,550 (36.2)
Manitoba[32]	1,049 (59.4)	717 (40.6)	0	5 (100.0)	1,429 (56.4)	1,106 (43.6)	6,707 (60.7)	4,340 (39.3)
Saskatchewan	2,767 (61.7)	1,716 (38.3)	N/A	N/A	1,048 (62.4)	631 (37.6)	8,999 (67.3)	4,367 (32.7)
Alberta[33]	7,957 (70.2)	3,364 (29.7)	N/A	N/A	3,387 (65.5)	1,782 (34.5)	19,253 (64.8)	10,419 (35.0)
Yukon	647 (78.2)	180 (21.8)	N/A	N/A	39 (37.5)	65 (62.5)	1,105 (54.7)	915 (45.3)
CSC	N/A	N/A	N/A	N/A	N/A	N/A	2,261 (93.4)	159 (6.6)

All Service Categories[34]		
Jurisdiction	Male n (%)	Female n (%)
PEI	2,087 (63.7)	1,191 (36.3)

[31] Newfoundland and Labrador does not offer non-residential withdrawal management.

[32] Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). Adult intake and assessment and pre-/post-treatment are not included in AFM data (such data are captured in non-residential treatment data).

[33] Includes AHS direct and AHS-funded/contracted services. There are no non-residential withdrawal management services in Alberta. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[34] Prince Edward Island is not able to report gender by service category

Episode: Age

Tables 9–13 provide detailed breakdowns of the total number of unique individuals who accessed substance use treatment services by age. In many jurisdictions, clients accessing services are most heavily distributed across the 25–34, 35–44 and 45–54 age ranges.

Patterns of substance use vary with age. Youth (ages 15–24) report significantly higher rates of illicit drug use, lower rates of alcohol consumption and higher likelihood of exceeding low-risk drinking guidelines (Health Canada, 2012).

Table 9. Residential withdrawal management episodes by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	0 (0.0)	27 (4.0)	131 (19.5)	167 (24.8)	112 (16.6)	157 (23.3)	69 (10.3)	10 (1.5)
Nova Scotia	0 (0.0)	54 (1.4)	595 (15.6)	892 (23.4)	792 (20.7)	844 (22.1)	473 (12.4)	167 (4.4)
New Brunswick	11 (0.3)	60 (1.9)	474 (15.0)	775 (24.4)	631 (19.9)	732 (23.1)	375 (11.8)	112 (3.5)
Ontario	14 (0.0)	495 (1.2)	4,519 (11.0)	9,426 (22.8)	10,132 (24.6)	11,289 (27.4)	4,218 (10.2)	1,164 (2.8)
Manitoba, [35]	40 (19.4)	158 (76.7)						8 (3.9)
Saskatchewan	64 (1.4)	352 (7.8)	643 (14.3)	1,296 (28.9)	990 (22.1)	813 (18.1)	257 (5.7)	70 (1.6)
Alberta[36]	236 (2.1)	687 (6.1)	1,030 (9.1)	2,733 (24.1)	2,999 (26.5)	2,771 (24.5)	722 (6.4)	150 (1.5)

[35] Numbers do not include adult medical residential withdrawal management. Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). No data for adult medical residential withdrawal management. Regarding non-medical withdrawal, the agency was unable to provide data for the 18–24, 25–34, 35–44, 45–54 and 55–64 age groups because of the use of alternative age ranges.

[36] Includes AHS direct and AHS-funded/contracted services. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

Table 10. Non-residential withdrawal management episodes by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador[37]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nova Scotia	0 (0.0)	*	85 (15.9)	147 (27.4)	124 (23.1)	115 (21.5)	46 (8.6)	16 (3.0)
Ontario	*	36 (2.0)	185 (10.3)	446 (24.9)	445 (24.9)	481 (26.9)	148 (8.3)	47 (2.6)
Manitoba[38]	N/A	N/A	*	*	0 (0.0)	*	0 (0.0)	0 (0.0)
Saskatchewan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Alberta[39]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 11. Residential treatment episodes by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	0 (0.0)	0 (0.0)	17 (8.8)	71 (36.6)	44 (22.7)	40 (20.6)	20 (10.3)	*
Nova Scotia	*	46 (5.6)	128 (15.6)	138 (16.8)	143 (17.4)	199 (24.2)	124 (15.1)	43 (5.2)
New Brunswick		*	35 (10.0)	76 (21.7)	91 (25.9)	98 (27.9)	51 (14.5)	*
Ontario	17 (0.2)	230 (2.4)	1,439 (14.7)	2,818 (28.8)	2,469 (25.2)	2,152 (22.0)	579 (5.9)	82 (0.8)
Manitoba[40]	45 (2.4)	162 (8.5)	354 (18.6)	616 (32.4)	388 (20.4)	253 (13.3)	63 (3.3)	21 (1.1)
Saskatchewan	34 (2.0)	176 (10.5)	261 (15.5)	482 (28.7)	319 (19.0)	293 (17.4)	94 (5.6)	21 (1.3)
Alberta[41]	22 (0.4)	108 (2.1)	871 (16.8)	1,569 (30.3)	1,291 (25.0)	1,006 (19.5)	277 (5.4)	27 (0.5)

[37] Newfoundland and Labrador does not offer non-residential withdrawal management.

[38] Does not include carry-over data (data from cases that began in 2009–2010 and continued into 2010–2011).

[39] Alberta does not offer non-residential withdrawal management services.

[40] Does not include carry-over data (data from cases that began in 2009–2010 and continued into 2010–2011). No data from four adult agencies.

[41] Includes AHS direct and AHS-funded/contracted services. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

Table 12. Non-residential treatment episodes by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15-17 n (%)	18-24 n (%)	25-34 n (%)	35-44 n (%)	45-54 n (%)	55-64 n (%)	65+ n (%)
Newfoundland and Labrador	*	44 (2.8)	254 (16.0)	478 (30.2)	329 (20.8)	271 (17.1)	165 (10.4)	39 (2.5)
Nova Scotia	59 (0.7)	398 (4.6)	1,464 (17.0)	1,948 (22.7)	1,791 (20.8)	1,815 (21.1)	838 (9.7)	285 (3.3)
New Brunswick	200 (3.4)	1,509 (25.9)	1,118 (19.2)	982 (16.9)	875 (15.0)	713 (12.2)	336 (5.8)	92 (1.6)
Ontario	1,911 (2.7)	6,567 (9.3)	12,080 (17.1)	17,208 (24.4)	14,741 (20.9)	12,584 (17.8)	4,340 (6.1)	1,157 (1.6)
Manitoba[42]	394 (3.6)	1,463 (13.2)	2,212 (20.0)	2,956 (26.7)	2,032 (18.4)	1,339 (12.1)	481 (4.3)	109 (1.0)
Saskatchewan	389 (2.9)	1,347 (10.1)	2,897 (21.7)	3,639 (27.3)	2,510 (18.8)	1,811 (13.6)	609 (4.6)	150 (1.1)
Alberta[43]	988 (3.3)	2,880 (9.7)	5,343 (18.0)	8,230 (27.7)	6,026 (20.3)	4,587 (15.4)	1,389 (4.7)	290 (1.0)
CSC	N/A	N/A	406 (16.8)	866 (35.8)	671 (27.7)	382 (15.8)	81 (3.4)	14 (0.6)

Table 13. Treatment episodes in all service categories by age in PEI, 2010–2011[44]

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
PEI[45]	53 (1.6)	212 (6.5)	340 (10.5)	722 (22.2)	726 (22.4)	604 (18.6)	487 (15.0)	104 (3.2)

[42] Numbers do not include adult medical residential withdrawal management. Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). No data from four adult agencies. For one non-residential agency, the majority of clients seek treatment for substance abuse, but non-substance use related admissions are included.

[43] Includes AHS direct and AHS-funded/contracted services. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[44] Prince Edward Island is not able to report age by service category.

[45] Data represent all treatment categories for a given age.

Episode: Housing status, fixed address

Homelessness is correlated with increased rates of alcohol and illegal drug use and dependence, and higher-risk methods of use (Grinman et al., 2010; Palepu, Marshall, Lai, Wood & Kerr, 2010).

Tables 14 and 15 present the total number of episodes that took place in four jurisdictions based on an individual's housing status (i.e., fixed address versus no fixed address). In all reporting jurisdictions, the majority of episodes were accounted for by individuals with a fixed address. Based on the minimal data available, the highest proportion of episodes among individuals with no fixed address is found in the residential withdrawal management category.

Table 14. Treatment episodes by service category for individuals with a fixed address, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	n	%	n	%	n	%	n	%
Newfoundland and Labrador[46]	636	94.5	N/A	N/A	191	99.0	1,378	86.7
Ontario	31,668	76.8	1,624	90.7	8,468	86.5	65,689	93.1
Manitoba[47]	179	90.4	N/A	N/A	445	67.1	257	95.2
Alberta[48]	9,908	87.5	N/A	N/A	4,912	95.0	26,619	89.5
CSC	N/A	N/A	N/A	N/A	N/A	N/A	Incarcerated	N/A

[46] Newfoundland and Labrador does not offer non-residential withdrawal management.

[47] AFM and six agencies were unable to provide data. No carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) were provided.

[48] Includes AHS direct and AHS-funded/contracted services. There are no non-residential withdrawal services in Alberta. Excludes clients who cited "tobacco only," "gambling only" or "other only" as their reason for treatment. Also excludes clients who did not provide a reason for treatment. "Living status unknown" includes clients with no fixed address as well as cases where this element is missing.

Episode: Housing status, no fixed address

Table 15. Treatment episodes by service category for individuals with no fixed address, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	n	%	n	%	n	%	n	%
Newfoundland and Labrador[49]	37	5.5	N/A	N/A	*	*	212	13.3
Ontario	9,589	23.2	166	9.3	1,318	13.5	4,899	6.9
Manitoba[50]	19	9.6	N/A	N/A	218	32.9	13	4.8
Alberta[51]	1,420	12.5	N/A	N/A	260	5.0	3,114	10.5
CSC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[49] This number reflects individuals reporting "temporary address" only. The option "no fixed address" was not available. This number may over-represent homelessness if a legitimate temporary address was provided.

[50] AFM and six agencies were unable to provide data. No carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) were provided.

[51] Includes AHS direct and AHS-funded/contracted services. There are no non-residential withdrawal services in Alberta. Excludes clients who cited "tobacco only," "gambling only" or "other only" as their reason for treatment. Also excludes clients who did not provide a reason for treatment. "Living status unknown" includes clients with no fixed address as well as cases where this element is missing.

Unique individuals: Gender

Table 16 provides a detailed breakdown on the number of individuals that accessed substance use treatment services in 2010–2011 by gender and service category. As discussed previously, in nearly all jurisdictions, males are more likely to access substance use treatment services.

Males and females have different treatment needs. Gender-specific treatment considerations for women may include, for example, primary childcare responsibilities and substance use problems associated with trauma (Niccols, Dell & Clarke, 2010).

Table 16. Unique individuals by treatment category and gender, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	Male n (%)	Female n (%)	Male n (%)	Female n (%)	Male n (%)	Female n (%)	Male n (%)	Female n (%)
Newfoundland and Labrador[52]	346 (74.6)	118 (25.4)	N/A	N/A	130 (67.4)	63 (32.6)	992 (64.1)	541 (34.9)
Nova Scotia	1,629 (71.2)	657 (28.7)	293 (63.6)	167 (36.2)	426 (67.7)	202 (32.1)	5,448 (67.7)	2,605 (32.3)
New Brunswick	1,444 (71.0)	590 (29.0)	N/A	N/A	267 (81.9)	59 (18.1)	3,114 (64.9)	1,683 (35.1)
Ontario	12,168 (70.7)	5,034 (29.3)	881 (53.8)	756 (46.2)	5,497 (63.4)	3,175 (36.6)	36,798 (64.0)	20,681 (36.0)
Manitoba[53]	549 (74.7)	186 (25.3)	0 (0.0)	5 (100.0)	1,124 (58.5)	798 (41.5)	4,524 (60.4)	2,966 (39.6)
Saskatchewan	1,976 (60.3)	1,301 (39.7)	N/A	N/A	999 (62.2)	607 (37.8)	7,219 (67.4)	3,493 (32.6)
Alberta[54]	3,249 (66.2)	1,654 (33.7)	N/A	N/A	1,481 (69.6)	644 (30.3)	17,327 (65.5)	9,089 (34.3)
CSC	N/A	N/A	N/A	N/A	N/A	N/A	2,197 (93.6)	149 (6.4)

All Service Categories[55]		
Jurisdiction	Male n (%)	Female n (%)
PEI	1,644 (67.7)	784 (32.3)

[52] Newfoundland and Labrador does not offer non-residential withdrawal management.

[53] Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) or data from adult medical residential withdrawal management. For one non-residential agency, the majority of clients seek treatment for substance abuse, but non-substance use related admissions are included. Three agencies were unable to provide data for residential treatment.

[54] Includes AHS direct services only. There are no non-residential withdrawal services in Alberta. Excludes clients who cited "tobacco only," "gambling only" or "other only" as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[55] Prince Edward Island is not able to report gender by service category

Unique individuals: Age

Tables 17–21 present the number of individuals who accessed substance use treatment services in 2010–2011 by age and service category. Individuals in the 25–34 age group are most highly represented.

Table 17. Unique individuals in residential withdrawal management by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	0 (0.0)	19 (4.1)	98 (21.1)	129 (27.8)	78 (16.8)	87 (18.8)	45 (9.7)	8 (1.7)
Nova Scotia	0 (0.0)	42 (1.8)	367 (15.9)	543 (23.5)	492 (21.3)	479 (20.7)	275 (11.9)	112 (4.8)
New Brunswick	*	50 (2.5)	328 (16.2)	518 (25.6)	439 (21.7)	424 (20.9)	205 (10.1)	63 (3.1)
Ontario	13 (0.1)	338 (2.0)	2,678 (15.6)	4,610 (26.8)	4,171 (24.2)	3,881 (22.6)	1,232 (7.2)	285 (1.7)
Manitoba[56]	38 (21.2)	141 (8.5)		0 (0.0)				
Saskatchewan	57 (1.7)	280 (8.5)	502 (15.2)	914 (27.7)	775 (23.5)	546 (16.6)	172 (5.2)	52 (1.6)
Alberta[57]	170 (3.5)	502 (10.2)	511 (10.4)	1,215 (24.7)	1,099 (22.4)	1,039 (21.2)	304 (6.2)	70 (1.4)

Table 18. Unique individuals in non-residential withdrawal management by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Nova Scotia	0 (0.0)	*	75 (16.2)	123 (26.6)	109 (23.5)	97 (21.0)	42 (9.1)	14 (3.0)
Ontario	*	35 (2.1)	176 (10.8)	409 (25.0)	408 (24.9)	428 (26.1)	139 (8.5)	40 (2.4)
Manitoba[58]			*	*		*		
Saskatchewan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Alberta[59]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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[56] Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011) or data on adult residential withdrawal management.

[57] Includes AHS direct services only. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[58] Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011).

[59] Alberta does not offer non-residential withdrawal management services.

Table 19. Unique individuals in residential treatment by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	0 (0.0)	0 (0.0)	17 (8.8)	71 (36.6)	44 (22.7)	40 (20.6)	20 (10.3)	*
Nova Scotia	0 (0.0)	26 (4.0)	109 16.7)	120 (18.4)	124 (19.0)	149 (22.9)	90 (13.8)	33 (5.1)
New Brunswick	.	*	28 (8.9)	71 (22.5)	83 (26.3)	88 (27.8)	46 (14.6)	*
Ontario	17 (0.2)	216 (2.5)	1,254 (14.5)	2,473 (28.5)	2,183 (25.2)	1,919 (22.1)	536 (6.2)	77 (0.9)
Manitoba[60]	40 (2.3)	134 (7.6)	331 (18.8)	565 (32.1)	368 (20.9)	239 (13.6)	63 (3.6)	19 (1.1)
Saskatchewan	34 (2.1)	169 (10.5)	248 (15.4)	460 (28.6)	309 (19.2)	276 (17.2)	90 (5.6)	20 (1.2)
Alberta[61]	20 (0.9)	99 (4.7)	217 (10.2)	633 (29.7)	507 (23.8)	479 (22.5)	157 (7.4)	16 (0.8)

[60] Does not include data from four agencies. Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011).

[61] Includes AHS direct services only. Excludes clients who cited “tobacco only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

Table 20. Unique individuals in non-residential treatment by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	*	44 (2.9)	244 (15.9)	451 (29.3)	323 (21.3)	270 (17.5)	164 (10.7)	39 (2.5)
Nova Scotia	55 (0.7)	350 (4.5)	1,304 (16.8)	1,654 (21.3)	1,676 (21.6)	1,631 (21.0)	826 (10.6)	265 (3.4)
New Brunswick	181 (3.8)	1,280 (26.7)	886 (18.5)	801 (16.7)	700 (14.6)	601 (12.5)	271 (5.6)	77 (1.6)
Ontario	1,798 (3.1)	5,825 (10.1)	9,986 (17.4)	13,558 (23.6)	11,636 (20.2)	10,033 (17.4)	3,667 (6.4)	1,010 (1.1)
Manitoba[62]	334 (4.5)	1,179 (15.9)	1,459 (19.7)	1,874 (25.3)	1,314 (17.7)	872 (11.8)	308 (4.2)	80 (1.1)
Saskatchewan	338 (3.2)	1,154 (10.8)	2,418 (22.6)	2,904 (27.1)	1,935 (18.1)	1,378 (12.9)	469 (4.4)	119 (1.1)
Alberta[63]	881 (3.3)	2,500 (9.4)	4,742 (17.9)	7,327 (27.7)	5,370 (20.3)	4,132 (15.6)	1,244 (4.7)	277 (1.0)
CSC	0 (0.0)	0 (0.0)	393 (16.8)	833 (35.5)	651 (27.8)	376 (16.0)	79 (3.4)	14 (0.6)

Table 21. Unique individuals in all service categories by age in PEI, 2010–2011[64]

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
PEI[65]	47 (1.9)	194 (8.0)	320 (13.2)	575 (23.7)	464 (19.1)	376 (15.5)	374 (15.4)	78 (3.2)

[62] Does not include data from four agencies. Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). For one non-residential agency, the majority of clients seek treatment for substance abuse, but non-substance use related admissions are included.

[63] Includes AHS direct services only. Excludes clients who cited "tobacco only," "gambling only" or "other only" as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

[64] Prince Edward Island is not able to report age by service category

[65] Data represent all treatment categories for a given age.

Unique individuals: Housing status

As illustrated by Table 22, the majority (>66%) of individuals accessing substance use treatment services have a fixed address.

Table 22. Unique individuals by service category and housing status, 2010–2011

Jurisdiction	Residential Withdrawal Management		Non-Residential Withdrawal Management		Residential Treatment		Non-Residential Treatment	
	Fixed Address	No Fixed Address	Fixed Address	No Fixed Address	Fixed Address	No Fixed Address	Fixed Address	No Fixed Address
Newfoundland and Labrador[66]	444 (95.7)	20 (4.4)	N/A	N/A	191 (99.0)	*	1,338 (86.6)	207 (13.4)
Ontario	14,355 (83.4)	2,853 (16.6)	1,493 (91.2)	144 (8.8)	7,607 (87.7)	1,068 (12.3)	54,232 (94.3)	3,281 (5.7)
Manitoba[67]	604 (66.2)	309 (33.8)	N/A	N/A	285 (60.5)	186 (39.5)	257 (95.2)	13 (4.8)
Alberta[68]	4,031 (82.1)	879 (17.9)	N/A	N/A	1,961 (92.2)	167 (7.8)	23,684 (89.5)	2,789 (10.5)
CSC	N/A	N/A	N/A	N/A	N/A	N/A	Incarcerated	N/A

Indicator 7

Total number of episodes and unique individuals treated in public, specialized treatment services that have used drugs by injection within the 12 months prior to treatment

Indicator 7 provides information on the total number of episodes and unique individuals treated in specialized treatment services that injected drugs within 12 months before beginning treatment.

Injection drug use is associated with increased health risks, including overdose as well as blood-borne viruses such as HIV and hepatitis C (Public Health Agency of Canada, 2006).

Table 23 provides a breakdown of the number of treatment episodes during 2010–2011 in which the client reported using drugs by injection in the 12 months before beginning treatment. This table also provides a breakdown according to gender and the ratio of episodes to individuals. Males are more likely to report using drugs by injection; however, the ratio of episodes to individuals generally varies more according to province than gender. This variation may reflect differences in service use as well as service structure and recording.

66 Newfoundland and Labrador does not offer non-residential withdrawal management. The residential and non-residential treatment numbers reflect individuals reporting “temporary address” only. The option “no fixed address” is not available. This number may over-represent homelessness if a legitimate temporary address was provided.

67 Does not include carry-over data (i.e., data from cases that began in 2009–2010 and continued into 2010–2011). No data from adult medical residential withdrawal management. Addictions Foundation of Manitoba (AFM) and four agencies were unable to report on residential and non-residential treatment. For one non-residential agency, the majority of clients seek treatment for substance abuse, but non-substance use related admissions are included.

68 Includes AHS direct services only. There are no non-residential withdrawal services in Alberta. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment. “Living status unknown” includes clients with no fixed address as well as cases where this element is missing.

Table 23. Treatment episodes for clients using drugs by injection by gender, 2010–2011

Jurisdiction	Male		Female		Overall Ratio (E:I)
	n (%)	Ratio (E:I)	n (%)	Ratio (E:I)	
New Brunswick	477 (67.5)	1.9	230 (32.5)	1.7	1.9
Ontario	7,230 (66.7)	2.0	3,658 (33.6)	1.7	1.9
Saskatchewan	1,499 (51.8)	1.6	1,393 (48.2)	1.8	1.7
Alberta[69]	2,006 (61.6)	1.5	1,250 (38.4)	1.6	1.5

Table 24 provides a breakdown by gender of the total number of unique individuals who reported using drugs by injection within 12 months of beginning treatment. In each jurisdiction that provided data, males were more likely than females to report using drugs by injection within 12 months of beginning treatment.

Table 24. Unique individuals using drugs by injection by gender, 2010–2011

Jurisdiction	Male n (%)	Female n (%)
New Brunswick	245 (65.0)	132 (35.0)
Ontario	3,659 (63.6)	2,091 (36.3)
Saskatchewan	910 (53.5)	790 (46.5)
Alberta[70]	984 (62.4)	592 (37.5)

Indicator 8

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

Eight jurisdictions were able to provide information on the number of individuals in opioid substitution treatment, seven of which were able to provide a breakdown by gender, as shown in Table 25. Opioid substitution treatment rates are influenced by many factors, including trends in use, access to physicians licensed to prescribe methadone and/or buprenorphine, and access to licensed dispensaries. There is growing recognition of the impact of prescription drugs such as oxycodone on rates of opioid abuse and the resulting demand on substitution programs. Although the majority of substitutions consist of methadone, buprenorphine has been available for prescription as an opioid substitute in Canada since 2008.

There are no reliable national data on rates of prescription opioid abuse; however, there are indications of increasing rates of morbidity and mortality (Fischer & Argento, 2012). CCSA is working with national partners toward a Canadian strategy to address prescription drug misuse, anticipated for release in 2013.

[69] Includes AHS direct and AHS-funded/contracted services. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment. Ratios were calculated using AHS direct services data only (not presented in tables).

[70] Includes AHS direct services only. Excludes clients who cited “tobacco only,” “gambling only” or “other only” as their reason for treatment. Also excludes clients who did not provide a reason for treatment.

Table 25. Unique individuals in public opioid substitution by gender, 2010–2011

Jurisdiction	Male n (%)	Female n (%)
Newfoundland and Labrador	75 (61.5)	44 (36.1)
PEI	24 (54.5)	20 (45.5)
Nova Scotia	305 (67.2)	149 (32.8)
New Brunswick	1,716 (100.0)	
Ontario	2,677 (58.2)	1,922 (41.8)
Manitoba[71]	56 (60.9)	36 (39.1)
Saskatchewan	171 (46.3)	198 (53.7)
Alberta[72]	705 (60.1)	463 (39.5)
Yukon	N/A	N/A

Table 26 reports the number and percentage of individuals in public opioid substitution treatment by age. Most clients accessing these services are males between the ages of 25 and 34.

Table 26. Unique individuals in public opioid substitution by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Newfoundland and Labrador	0 (0.0)	*	24 (20.0)	63 (52.5)	20 (16.7)	8 (6.7)	*	0 (0.0)
PEI	0 (0.0)	0 (0.0)	5 (11.4)	20 (45.5)	10 (22.7)	6 (13.6)	*	0 (0.0)
Nova Scotia	0 (0.0)	0 (0.0)	134 (29.3)	170 (37.2)	90 (19.7)	50 (10.9)	13 (2.8)	0 (0.0)
Ontario	13 (0.3)	55 (1.2)	851 (18.5)	1,863 (40.5)	1,072 (23.3)	618 (13.4)	114 (2.5)	14 (0.3)
Manitoba[73]	0 (0.0)	0 (0.0)	17 (18.5)	38 (41.3)	20 (21.7)	12 (13.0)	5 (5.4)	0 (0.0)
Saskatchewan	0 (0.0)	0 (0.0)	56 (15.2)	171 (46.3)	102 (27.6)	33 (8.9)	7 (1.9)	0 (0.0)
Alberta[74]	*	*	100 (8.5)	450 (38.4)	340 (29.0)	230 (19.6)	49 (4.2)	0 (0.0)
Yukon	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[71] Numbers are based on fiscal-year admissions only.

[72] Includes AHS direct services only. There are no AHS-funded/contracted agencies that offer opioid dependency treatment services. Opioid dependency treatment services in Alberta are intended for individuals 18 and older. Younger clients may be admitted depending on circumstance.

[73] See 71 above.

[74] See 72 above.

Indicator 9

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

Tables 27 and 28 provide a breakdown of the number (and percentage) of individuals served within driving-while-impaired (DWI) programs by gender and age, respectively.

The 2011 Canadian Alcohol and Drug Use Monitoring Survey found that 7.7% of respondents reported driving after consuming two or more drinks in the past hour (CCSA, 2013).

Table 27. Unique individuals served within driving-while-impaired programs by gender, 2010–2011

Jurisdiction	Total	Male n (%)	Female n (%)
Nova Scotia	1,462	1,246 (85.2)	216 (14.8)
New Brunswick	1,387		
Quebec	10,383	8,876 (85.5)	1,507 (14.5)
Manitoba[75]	1,618	1,374 (84.9)	243 (15.0)
Saskatchewan	3,907	3,149 (80.6)	753 (19.3)
Alberta[76]	5,413	4,606 (85.1)	806 (14.9)
Yukon	54	43 (79.6)	11 (20.4)

[75] Data provided by AFM. Clients who have received an impaired-driving charge are required to attend AFM for an assessment. Assessments in the impaired-drivers program consist of two phases: client-reported information gathering (i.e., clients fill in a core intake form and the Substance Abuse Life Circumstance Evaluation [SALCE]) followed by an assessment interview between the client and counsellor, after which the counsellor will make a referral recommendation.

[76] The count reflects drivers that have completed a *Planning Ahead* or *IMPACT* course in Alberta between April 1, 2010, and March 31, 2011. Data provided by the Alberta Motor Association.

Table 28. Unique individuals served within driving-while-impaired programs by age, 2010–2011

Jurisdiction	Age Group							
	<15 n (%)	15–17 n (%)	18–24 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)	55–64 n (%)	65+ n (%)
Nova Scotia	0 (0.0)	*	288 (19.7)	406 (27.8)	321 (22.0)	270 (18.5)	140 (9.6)	36 (2.5)
Quebec[77]	0 (0.0)	19 (0.2)	2,025 (19.5)	2,596 (25.0)	1,879 (18.1)	2,306 (22.2)	1,092 (10.5)	466 (4.5)
Manitoba[78]	N/A	9 (0.6)	400 (24.7)	450 (27.8)	334 (20.6)	296 (18.3)	101 (6.2)	28 (1.7)
Saskatchewan	10 (0.3)	44 (1.2)	1,005 (28.5)	1,147 (32.6)	585 (16.6)	480 (13.6)	194 (5.5)	57 (1.6)
Alberta[79]	*	*	987 (18.2)	1,813 (33.5)	1,154 (21.3)	994 (18.4)	362 (6.7)	98 (1.8)

Jurisdiction	Age Group						
	11–20 n (%)	21–30 n (%)	31–40 n (%)	41–50 n (%)	51–60 n (%)	61–70 n (%)	71–90 n (%)
New Brunswick	82 (5.6)	435 (29.6)	300 (20.4)	285 (19.4)	184 (12.5)	81 (5.5)	20 (1.4)

[77] Data provided by the Association des centres de réadaptation en dépendance du Québec (ACRDQ) mandated by the Société d'assurance automobile du Québec (SAAQ) to do the assessments required by the Programme d'évaluation et de réduction du risque (risk assessment and reduction program). Following an assessment, the ACRDQ makes a recommendation to the SAAQ regarding the compatibility of the driver's consumption behaviour and the safe driving of a vehicle.

[78] Data provided by AFM. Clients who have received an impaired-driving charge are required to attend AFM for an assessment. Assessments in the impaired-drivers program consist of two phases: client-reported information gathering (i.e., clients fill in a core intake form and the SALCE) followed by an assessment interview between the client and counsellor, after which the counsellor will make a referral recommendation.

[79] The count reflects drivers that have completed a *Planning Ahead* or *IMPACT* course in Alberta between April 1, 2010, and March 31, 2011. Data provided by the Alberta Motor Association.

Discussion

The data provided in this second National Treatment Indicators (NTI) report provide cross-Canada information on basic demographics and access to categories of treatment during the 2010–2011 fiscal year. The key findings from this report are as follows:

- The rate of treatment episodes varies considerably between jurisdictions in Canada, as does the number of unique individuals accessing such services.
- There were fewer problem gambling episodes during 2010–2011 than episodes related to substance use.
- Non-residential treatment services (e.g., day treatment) make up the majority of all substance use treatment episodes, accounting for approximately 60–70% in most jurisdictions.
- Between 4% and 13% of substance use treatment episodes are accounted for by persons seeking treatment for someone other than themselves, such as a family member. This rate is even higher for gambling, at approximately 20% in three provinces.
- Males are, on average, more likely than females to access specialized treatment services across all service categories.
- On average, individuals aged 25–34 make up the largest percent of persons accessing substance use treatment services (20–30%), followed closely by 35–44 year olds (17–25%).
- The majority of individuals accessing specialized treatment services who had used drugs by injection in the past year are male (52–67%).
- Most of the clients accessing public opioid substitution programs are males in the 25–35 age range.
- More than 80% of individuals who attended driving-while-impaired programs are male, with men aged 18–34 making up the largest percentage of these clients.

The findings in this report are consistent with the 2009–2010 findings presented in the inaugural report. By continuing to develop the knowledge base on substance use service provision, the results of this report will help contribute to system planning and provide an evidence base to guide investment of resources. For example:

- Given that substance abuse has effects beyond the individual accessing services, the proportion of individuals accessing services for someone else's substance might indicate the need for additional attention to services targeting families.
- Research indicates that women experience different barriers to service than men and the data do, in fact, reflect lower rates of service access for women. In the future, NTI data might be a resource for demonstrating the impact of efforts to reduce gender-related service barriers.
- The concentration of younger males in driving-while-impaired programs validates the need for effective education and prevention efforts targeting this population.

This report also illustrates that despite Canada's diversity, there is actually a great deal of consistency in substance use services. In most provinces, between 0.5% and 1.5% of the population accessed specialized substance use treatment in the past year. This is a conservative estimate given that it does not include, for example, private facilities or primary care. Service use on this scale demonstrates the burden that substance use places on health and other services in Canada. The NTI data also indicate that many people who access treatment enter and exit the system or access more than one type of service over the course of a year. This pattern of service use highlights the

importance of effective case management, screening and referral processes to ensure people have access to services that are matched to their characteristics and needs—and can transition smoothly as those needs change over time.

The NTI data presented are not intended to be examined in isolation, but as contributions to the information available about substance use and its impacts in Canada, including, for example, CADUMS information on self-reported rates of substance use in the population and CIHI information about hospital-based discharges associated with substance use. Collectively, the information provided through these initiatives will provide the comprehensive picture required to inform policy, resourcing and service development.

Conclusions and Next Steps

The data in this report are intended to provide analysts, researchers, leaders, decision makers and advisors with a better understanding of specialized treatment services in Canada. The National Treatment Indicators Working Group has made significant progress in moving toward a comparable set of treatment indicators. This report has already expanded on the inaugural report by enhancing the scope of data available with data submission from three additional jurisdictions (Yukon, Manitoba, and Newfoundland and Labrador) and a new indicator (access to DWI programs). Data collection for the next report is underway and has been expanded to include data on substances used and employment status. These additions will create opportunities to compare prevalence rates of certain substances at the population level to their prevalence among individuals accessing treatment. In the coming year, CCSA will also work more closely with the Canadian Institute for Health Information to identify methods for measuring access to community-based and primary care services.

As participation and consistency in the definition and collection of NTI data continues to increase, future reports will be able to compare trends over time and across jurisdictions. The next NTI report (the third in this annual series) will be able to begin speaking to trends observed within the NTI data. A complete Canadian dataset will also strengthen comparisons with treatment systems internationally. The role of the NTIWG will be to continue to improve data collection while supporting accurate and appropriate interpretation and use of NTI data.

Investments in evidence-based services and supports are an effective way to reduce the health, social and economic burden of substance use and gambling in Canada. To ensure efficacy, efficiency and transparency, programs and services need to be supported by evidence-based system planning. The data presented in this report represent a step toward a comprehensive national picture of the provision of services and supports for substance use in Canada.

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Appendix A: National Treatment Indicators Working Group Membership

Name	Organization
Anderson, Brent	Manitoba Healthy Living, Youth and Seniors
Chen, Debra	Canadian Institute for Health Information
Desrosiers, Pierre	Association des centres de réadaptation en dépendance du Québec
Dupuis, Robin	First Nations and Inuit Health Branch, Health Canada
Edwards, Mark	Health Canada
Estey, John	New Brunswick Department of Health
Farrell MacDonald, Shanna	Correctional Service of Canada
Gallant, Stephen	Health PEI
Hansen, Rebecca	Yukon Addiction Services, Alcohol and Drug Services
Hay, Laura	First Nations and Inuit Health Branch, Health Canada
James, Darlene	Alberta Health Services
Jesseman, Rebecca	Canadian Centre on Substance Abuse
McCallum, John	Saskatchewan Ministry of Health
Pellerin, Annie	New Brunswick Department of Health
Pirie, Tyler	Canadian Centre on Substance Abuse
Rideout, Gina	Newfoundland and Labrador Department of Health and Community Services
Rocca, Claudio	Drug and Alcohol Treatment Information System (Ontario)
Ross, David	Veterans Affairs Canada, National Centre for Operational Stress Injuries
Ross, Pamela	Nova Scotia Department of Health and Wellness
Rush, Brian	Centre for Addiction and Mental Health
Snell, Anita	BC Ministry of Health Services
West, Randi	BC Ministry of Health Services

Membership is current as of January 6, 2013.

Appendix B: Green, Yellow and Red Light Indicators

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

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

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

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

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

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

Appendix C: Definitions

Closed case

Closure criteria vary from province to province.

Driving-while-impaired (DWI) programs

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

Employment status

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

Episode[80]

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

Family member

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

Gambling

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

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

Housing status

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

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

Open case

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

Problem gambling

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

Residential treatment

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

New individuals

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

Non-residential treatment

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

Specialized services

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

Unique individual

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

Withdrawal management

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

Appendix D: System Administration and Data Collection

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[81]	Data Systems	Browser-based System[82]	Reporting
NL	Department of Health and Community Services	Four regional health authorities	Y	CRMS (Client Referral Management System)	N	Annually (provincial level)
PEI	Department of Health and Wellness	Health PEI (centralized provincial agency)	Y	ISM (Integrated System Management)	N	Annually
NS	Department of Health and Wellness	Nine district health authorities and the IWK Health Centre	Y	ASsist (Addiction Services Statistical Information System Technology)	Y	Real-time updates at regional and provincial levels
NB	Department of Health	Two regional health authorities	Y	RASS (Regional Addiction Service System)	N	Annually
QC	Ministry of Health and Social Services	16 addiction rehabilitation centres 95 community health and social service centres Also through more than 100 inpatient private and community resources, either certified or in the process of certification or renewal	N	SIC-SRD (Système d'information clientèle pour les services de réadaptation en dépendance)	N	Annually
ON	Ministry of Health and Long-Term Care	14 LHINs (Local Health Integration Networks) Also through community agencies	Y	DATIS (Drug and Alcohol Treatment Information System)	Y	DATIS figures are reported quarterly and annually

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

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

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[81]	Data Systems	Browser-based System[82]	Reporting
MB	Department of Healthy Living, Youth and Seniors (HLYS) Department of Health for Adult Residential Withdrawal Management Services and one Residential Treatment Program	Addictions Foundation Manitoba and 11 provincial grant-funded agencies Adult Residential Withdrawal Services and one Residential Treatment program are delivered through the two regional health authorities	N	HLYS statistical databases (SPSS-compatible) as well as an Excel-based system for provincial aggregate data	N	Data are provided monthly to the Addictions Management Unit by Addictions Foundation Manitoba and other provincially grant-funded addictions agencies Adult residential withdrawal management data is requested annually
SK	Saskatchewan Ministry of Health	12 regional health authorities	IP	ADG (Alcohol, Drugs and Gambling) System MHIS (Mental Health Information System) AMIS (Addiction and Mental Health Information System – Saskatoon Health Region)	N	
AB	Alberta Health and Wellness	Alberta Health Services Also through AHS community contracted services.	Y	ASIST (Addiction System for Information and Service Tracking) for AHS direct services STORS (Service Tracking and Outcome Reporting System) for AHS contracted agencies	Y	Annually (provincial level)
BC	Ministry of Health Services	One provincial health authority and five regional health authorities	Y	AIMS (Addictions Information Management System) MRR (Minimum Reporting Requirements), which will integrate substance use and mental health, is in pilot stage	N	N/A at provincial level
YT	Ministry of Health and Social Services	Ministry has service delivery responsibility	N	Access database (manual data entry into an Excel file)	N	Monthly
NWT	Department of Health and Social Services	Eight health authorities	Y	Excel-based system (manual data entry)	N	Monthly

Jurisdiction	Responsible Ministry	Service Delivery Structure	MH&A Integration[81]	Data Systems	Browser-based System[82]	Reporting
NU	Department of Health and Social Services	Community health centres Also significant reliance on out-of-territory services	N	No client or system data (except financial) are currently collected systematically	N	N/A
CSC	Public Safety Canada	Five regions, including institutions and Aboriginal healing lodges	N	OMS (Offender Management System)	Y	
NNADAP / NYSAP	Health Canada's First Nations & Inuit Health Branch	Network of addiction treatment and prevention programming Includes 55 First Nations addiction treatment centres and more than 550 NNADAP community-based prevention programs	N	Currently developing a new data-collection system	N	
VAC	Veterans Affairs Canada	VAC district offices provide service referrals to 10 operational stress injury clinics across Canada as well as private service providers	Y	National Centre for Operational Stress Injuries conducts performance management for the 10 operational stress injury clinics	N	Quarterly and annually