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Addiction Treatment in Canada: The National Treatment Indicators Report

2014–2015 Data

December 2017

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Conflict of Interest

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

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Executive Summary

The current National Treatment Indicators (NTI) report is the sixth in the series. This report presents aggregate-level descriptive information on individuals who accessed publicly funded services for substance use treatment in Canada during 2014–2015. The NTI report remains the only national, accessible source of information on publicly funded substance use treatment centres in Canada. It illustrates the type of treatment information that is currently being collected, and helps to identify information gaps. The intent of this report is to contribute to the system-level information required by decision makers to plan, implement, monitor and evaluate evidence-informed services and supports for the treatment of substance use in Canada. The current report is the first in the series to include data from the National Youth Solvent Abuse Program (NYSAP). Findings from this year's analysis are presented in two components. The first component includes aggregate data across jurisdictions to provide an overview of what we currently know about treatment service use in Canada, highlighting, where possible, the consistent trends that occur across the jurisdictions. Following this, jurisdiction specific treatment information is provided separately for each jurisdiction.

What We Know About Treatment Services in Canada

The current NTI report includes data on publicly funded substance use treatment services from eight provinces across Canada; Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland and Labrador. These data reveal that between April 1, 2014, and March 31, 2015, a total of 150,222 unique individuals (excluding New Brunswick)[1] accessed publicly funded substance use treatment services, which accounted for 203,629 treatment service events. In addition, 464 First Nations and Inuit youth attended treatment centres under the NYSAP.

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

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

Treatment for Friends and Family

In 2014–2015, the majority of individuals 92.0% (n = 138,108) accessed treatment services for their own problematic substance use; however, 8.0% (n = 12,044) of individuals accessed treatment for a friend or family member (these data exclude New Brunswick).

Gender

The majority of treatment service events were accessed by males in 2014–2015. Across the jurisdictions, males accounted for 63.9% (n = 120,940) of the treatment service events, while females accounted for 35.9% (n = 67,928) (Figure 1). This trend has been consistent from 2011–2012 to 2014–2015 (Figure 2).

1 New Brunswick data could not be included in the aggregate counts due to differences in data collection procedures.

Figure 1. Treatment service events by gender (own use)[2,3,4]

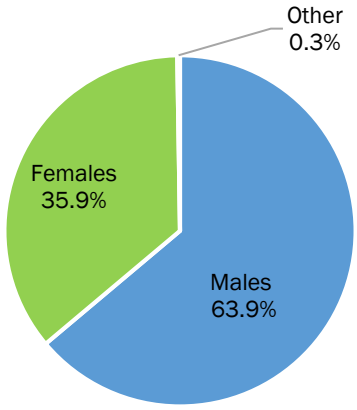
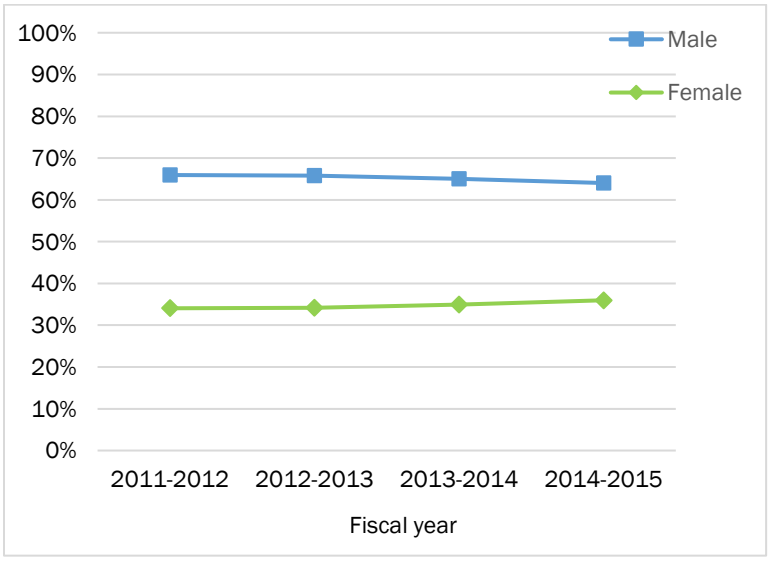


Figure 2. Trends in treatment services events by gender from 2011–2012 to 2014–2015[5]



Employment Status

The greatest proportion of individuals who accessed treatment noted their employment status as unemployed (38.0%), followed by those who reported full-time employment (27.5%) at the time of treatment (Figure 3). Alberta and Nova Scotia do not include "student" as an employment status in their data, and therefore the percentage of students in treatment could be under-represented.

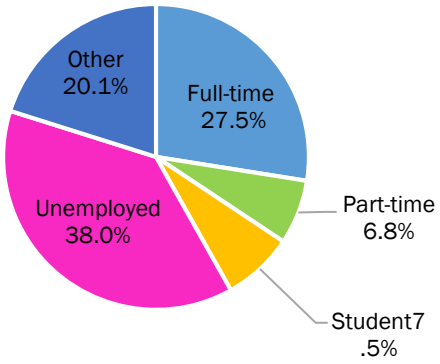
2 These data exclude New Brunswick.

3 Figures labeled with "own use" reflect service events or unique individuals who accessed treatment for themselves and not for friends or family members.

4 Not all jurisdictions collect "other gender" as shown in their separate jurisdictional chapters.

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

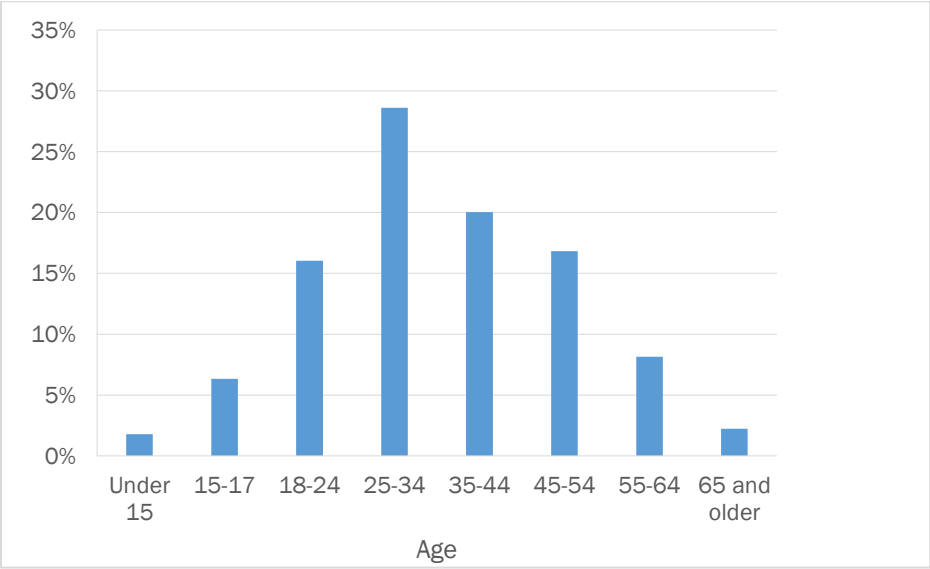
Figure 3. Employment status of individuals (own use)[6,7]



Age

Individuals aged 25–34 years accounted for the greatest percentage of all treatment service events (28.6%) in 2014–2015 (Figure 4). This trend for age has been consistently found from 2011–2012 to 2014–2015.

Figure 4. Treatment service events by age (own use)[8]



6 These data excluded Newfoundland and Labrador, New Brunswick and Manitoba.

7 Other employment can include child, disabled, homemaker, retired, seasonal employment, other, unknown or blank missing employment status. These vary according to the jurisdictions and are specified within the individual jurisdictional summaries.

8 These data exclude New Brunswick.

Treatment Type

Non-residential treatment (NRT) accounted for the majority (67.4%) of treatment service events in 2014–2015, followed by residential withdrawal management (RWM), residential treatment (RT) and non-residential withdrawal management (NRWM; Figure 5). Of the reporting jurisdictions, NRWM services are only offered in Ontario and Prince Edward Island.

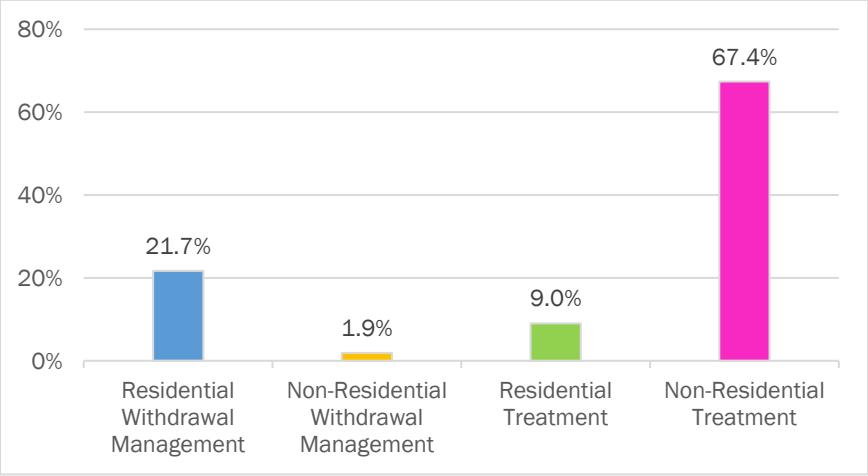
These trends in treatment type have been consistent from 2011–2012 to 2014–2015 (Figure 6). However, despite these overall trends across jurisdictions, there are some variations in the patterns for treatment type within jurisdictions (please see individual jurisdictional sections for detailed breakdowns). High rates of service use do not necessarily reflect or indicate adequate service availability relative to the treatment need in the population.

Non-residential treatment (NRT) refers to 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.

Residential treatment (RT) 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.

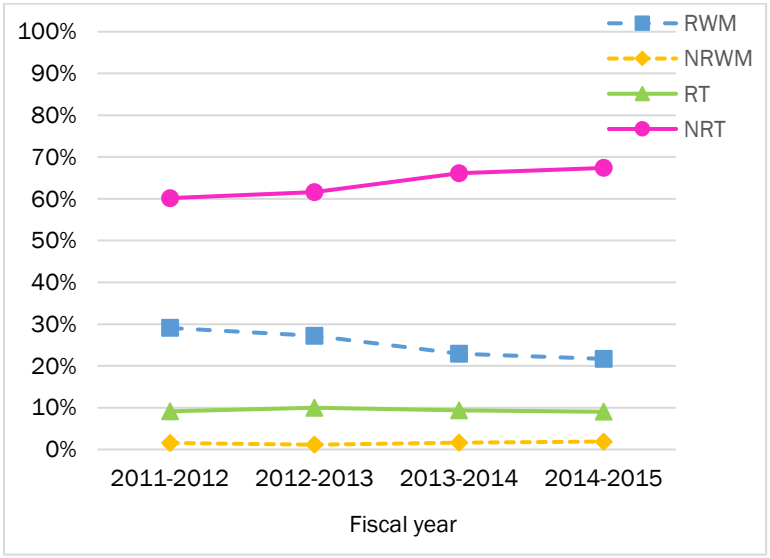
Withdrawal management refers to the initial supervised, controlled period of withdrawing from substances. **Residential withdrawal management (RWM)** includes programs where clients spend nights at a withdrawal management facility, treatment facility or hospital. **Non-residential withdrawal management (NRWM)** includes daytox and home or community detox.

Figure 5. Service events by treatment type (own use)[9]



9 These data exclude New Brunswick.

Figure 6. Trends in service events by treatment type from 2011–2012 to 2014–2015[10]



Alcohol and Other Drugs[11]

Ontario, Nova Scotia and Prince Edward Island are the only provinces able to provide information on the primary substance for which treatment was sought, as other jurisdictions do not collect this data. Overwhelmingly alcohol was the primary substance for which treatment was sought across these three provinces. Table 1 reveals that cannabis was the second most common substance for which treatment was sought in Ontario, whereas opioids were second in both Nova Scotia and Prince Edward Island.

Table 1. Primary substance for which treatment was sought (own use)

Ontario	Nova Scotia	Prince Edward Island
#1 Alcohol	#1 Alcohol	#1 Alcohol
#2 Cannabis	#2 Opioids	#2 Opioids
#3 Cocaine	#3 Cannabis	#3 Cannabis
#4 Opioids	#4 Cocaine	#4 Cocaine

Alberta, Saskatchewan and Manitoba do not collect data on the primary substance for which treatment was sought; however, they are able to provide the substances used in the past 12-months among individuals accessing treatment. Alcohol was the most common substance reported being used, followed by cannabis across the three provinces (Table 2).

Table 2. Substances used in the past 12 months

Alberta	Saskatchewan	Manitoba
#1 Alcohol	#1 Alcohol	#1 Alcohol
#2 Cannabis	#2 Cannabis	#2 Cannabis
#3 Cocaine	#3 Opioids	#3 Opioids
#4 Opioids	#4 Hypnotics	#4 Cocaine

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

11 Substance specific data exclude New Brunswick and Newfoundland and Labrador.

The current data highlight the individuals accessing treatment for substance use issues in Canada, revealing that publicly funded treatment services are being accessed by a diversity of individuals (e.g., males, females, youth, older adults, employed and unemployed) with varying substance use profiles. While capturing this diversity, these data also identify a number of consistent trends. For example, individuals aged 25–34 consistently account for the largest number of treatment service events compared to all other age groups, identifying the need for prevention and early intervention efforts that focus on youth.

Although the NTI project has helped improve our understanding of the usage of substance use treatment in Canada, there are still many knowledge and information gaps that need to be addressed. The NTI working group together with CCSA continue to work towards improving data accuracy and completeness. Despite limitations and gaps, the current data identify a number of trends that have been consistent across the previous NTI reports and can help inform treatment system planning.

Introduction

Problematic substance use is a significant health, economic and social issue in Canada. According to the 2015 Canadian Tobacco Alcohol and Drug Survey (CTADS), 11.7% of individuals aged 15 years and older exceeded the low-risk drinking guidelines within the past seven days and 12.3% reported using cannabis in the past 12-months. Thirteen percent of Canadians aged 15 years or older reported using at least one illicit drug in the past 12-months,[12] with 15% of these individuals reporting experiencing one or more types of drug-related harms (Statistics Canada, 2017). In addition, 4.4% of Canadians age 15 and older (approximately 1.3 million persons) met the criteria for a substance use disorder in 2012 (Statistics Canada, 2014). One way to reduce the burden of substance use is through evidence-informed treatment. However, several sources, including the National Treatment Indicators (NTI) project and the needs-based planning project (Rush, Tremblay, Fougere, Behrooz, Perez, & Fineczko, 2014) indicate a gap between individuals who could benefit from treatment services and those who access them. Indeed, in the United States, only one in ten individuals with a substance use disorder receive specialty services (Surgeon General Report, 2017).

Providing Canadians with appropriate and timely access to treatment requires reliable data to inform effective system and service planning. The NTI project addresses a need for more rigorous treatment data by implementing a set of measures to collect treatment system data according to common categories across Canada. The sixth NTI report provides aggregate-level descriptive information from the 2014–2015 fiscal year on access to publicly funded substance use treatment services in Canada. The NTI report remains the only national, accessible source of information on publicly funded substance use treatment centres in Canada. It illustrates the type of treatment information that is currently being collected, and helps to identify information gaps. This report is intended for a broad audience including researchers, analysts, leaders, decision makers and advisors looking for information to support service planning, development and communications.

National Treatment Indicators Project

The NTI project was established in 2009 and builds on previous work by the Canadian Institute for Health Information (2001), the Canadian Centre on Substance Use and Addiction (CCSA) (Thomas, 2005) and the National Treatment Strategy Working Group (2008). This project was developed to work towards collecting consistent information across jurisdictions to fill the information gaps and help improve the quality, range and accessibility of treatment in Canada.

The project is led by CCSA and the NTI Working Group (NTIWG), which was formed in 2009. The NTIWG is comprised of representatives from Canadian jurisdictions that have treatment service delivery responsibilities. As of January 2017, the NTIWG includes representatives from ten provinces, one territory, federal and provincial departments with treatment delivery responsibility, the Youth Solvent Addictions Committee (YSAC) and the Canadian Institute for Health Information (for a list of NTIWG members, see Appendix A).

This year, the NTIWG expanded its membership to include representation from the YSAC, which oversees the National Youth Solvent Abuse Program (NYSAP), and further enhanced the comprehensiveness of the report by capturing 2014–2015 data from New Brunswick and the NYSAP. The goal of the NTIWG is to continue to expand membership and to expand and strengthen data collection to provide a comprehensive national picture. Improvements will include obtaining data

12 Drugs included are cannabis, cocaine/crack, speed/methamphetamine/crystal meth, ecstasy, hallucinogens, salvia, inhalants and heroin; abuse of pain relievers, stimulants and sedatives to get high.

from all provinces, territories and national agencies with responsibility to deliver substance use services including services provided in hospital settings, and non-specialized services offered by community and private sector partners.

Funding for the NTI project is provided through Health Canada's Substance Use and Addictions Program.

Contributing to a National and International Understanding of Treatment in Canada

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. There are also federal agencies that provide treatment for specific populations, which include Correctional Service of Canada for federally incarcerated offenders; Veterans Affairs Canada for veterans, Canadian Forces members and the Royal Canadian Mounted Police; and Health Canada's First Nations Inuit Health Branch (FNIHB), which funds the National Native Alcohol and Drug Abuse Program (NNADAP) and NYSAP for First Nations and Inuit peoples. Additionally, there are privately funded treatment providers that are not captured in the current data.[13]

Jurisdictions are free to tailor their healthcare systems to best meet the unique needs of their populations. However, autonomy also results in a number of inter-jurisdictional differences in how services are funded and delivered, which affect the range of available treatment options across the country. Although all jurisdictions collect information to monitor system activities and performance, the nature and sophistication of these efforts varies substantially. As a result, the data collected are often not comparable across jurisdictions, but brought together they begin to form a pan-Canadian picture of substance use treatment utilization that can inform system and resource planning.

In addition, Canada has international reporting responsibilities. The United Nations Office on Drugs and Crime, the World Health Organization, the Pan-American Health Organization and the Inter-American Drug Abuse Control Commission all have annual or semi-annual reporting requirements that include national treatment data. Prior to the NTI project, much of the information Canada provided on substance use services was based on partial data from some provinces and territories, or estimates derived by taking data from a small number of jurisdictions and extrapolating to the national level. Therefore, the NTI project builds Canada's capacity to provide meaningful, reliable information on national substance use services to the international level.

Methods

This report provides aggregate-level descriptive information on individuals who accessed publicly funded services for substance use treatment in Canada during 2014–2015. The NTI report collects information on four treatment categories: residential treatment (RT), non-residential treatment (NRT), residential withdrawal management (RWM) and non-residential withdrawal management (NRWM). Working group members were asked to provide information on 47 indicators. For a complete list of indicators collected for this report, see Appendix B, and for the indicator definitions see Appendix C. Not all jurisdictions were able to provide information on each indicator, as some jurisdictions are not

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

able to consistently collect this information (Appendix D describes availability of indictors for each jurisdiction.) The subset of indicators presented in this report are those agreed upon by the NTIWG.

The data presented are the outcome of a multi-stage process. First, service providers enter client-level data, which are then submitted at the regional or provincial level according to reporting requirements. The data are then analyzed at the provincial level according to the definitions and data-collection protocols developed by CCSA in consultation with members of the NTIWG.[14] Next, data are entered into a secure, online platform specially designed for the NTI project. Finally, CCSA conducts data analysis and produces the report in close consultation with the NTIWG.

Data Collection

This sixth NTI report provides information on individuals who accessed publicly funded substance use treatment services during 2014–2015. Specifically, provincial-level treatment service data were provided by Alberta, Saskatchewan, Manitoba, Ontario, Nova Scotia, Prince Edward Island, New Brunswick, and Newfoundland and Labrador. Jurisdictional information was provided by Yukon and federal data and information were provided by the NNADAP, NYSAP and FNIHB.

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

Limitations

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

- **Services included:** The data represent only publicly funded services. Private treatment is not included. Many people with problematic substance use also have a number of other health-related issues that can account for their contact with the healthcare system. The report, however, does not capture most substance use treatment in primary care or hospital settings. As the NTI project evolves, CCSA intends to better capture data reflecting the full continuum of substance use treatment services provided in Canada (e.g., community supports, primary care).
- **Jurisdictional participation:** Nine of the 11 Canadian jurisdictions that are part of the NTIWG were able to participate in this year's report. The reasons for not contributing to the current report included not being able to collect or share jurisdictional data. CCSA and the NTIWG will continue to work with all jurisdictions to improve and enhance data collection as well as identify additional sources of information to include in future reports (e.g., privately funded treatment centre data).

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

- **Reliability:** The accuracy of aggregate data depends on the accuracy and consistency of the individual case data being entered at the frontline level. In many provinces and territories, there are different data-collection systems in place across regions, creating inconsistencies in data definitions and data-entry practices. Service-level data-collection capacity is developing and will help improve consistency in future reports.
- **Service definitions:** The collection of consistent information relies on the use of a standard, agreed-upon set of definitions. However, service delivery models vary widely across Canada. The core indicator definitions continue to be revisited as the project progresses to ensure that they best reflect work in the field.
- **Administrative variation:** Small differences in how cases are recorded can result in tremendous variations at the aggregate level. For example, some jurisdictions consider a case to be "open" at first contact, whereas others wait until the formal treatment intake.
- **Comparability:** The limitations listed above mean that although all jurisdictions are using the same data collection protocols, the data being provided across jurisdictions are not yet comparable.

Results

The following sections of the report display treatment data and information for the 2014–2015 fiscal year separately by jurisdiction. The results include the ratio of service events to individuals, recognizing that an individual can have several events in a given year. The ratio, however, indicates an average that can be affected by variations in how a service event is measured between jurisdictions or by a small number of individuals with a high number of service events.

Yukon

Population: 36,872[15]
Gender: 18,754 Male; 18,118 Female

Overview and Summary

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

In August 2016, Alcohol and Drug Services (ADS) in Whitehorse moved into a new building and largely expanded their programs within Whitehorse and the 14 rural communities of the Yukon. The need for a functional database to allow for the seamless movement of clients into programs has been emphasized. The implementation of a database that can house a client's electronic file in one central location, thereby reducing the volume of duplicate information recorded and the accessibility to client information, would enable staff to provide better services to clients. Further, a central system will allow ADS to gather data that can be used to understand the movement of clients throughout the system, as well as their use of services, to inform programming and service provision decisions.

Current ADS Services

Community Addiction Services: provides supports and services to rural Yukon communities in the areas of addiction education, prevention, counselling and aftercare.

Prevention Services: provides training on a range of addiction-related topics. Workshops are designed for allied professionals and community groups.

Treatment Services

Counselling Services: provides individual counselling and support to families, drop-in counselling, brief counselling, screening and assessment, pre-treatment, treatment of concurrent disorders, case management, referrals to appropriate resources, aftercare support, recovery support groups and psycho-educational groups.

Intensive Treatment: provides a residential program that is gender specific for adults (10 beds for the women's program and 10 beds for a men's program) and that run simultaneously. The programs are a minimum commitment of five weeks, as the program material cycles every five weeks, and a maximum stay of 15 weeks. The length of stay is determined by the participant's need and the recommendations of the interdisciplinary team.

Youth Services: offers addiction prevention, education and counselling services to students in grades 5–12 in Whitehorse schools and at ADS. Youth not involved in school can also access this service. The youth addiction counsellors work in partnership with community youth organizations to provide counselling, training and capacity building.

15 All demographic data for the Yukon and the provinces are for 2014 and are taken from Statistics Canada, Table 051–0001: www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&tabMode=dataTable&srchLan=-1&p1=-1&p2=9.

Withdrawal Management Services (detoxification): provides support for clients to medically and emotionally withdraw safely from substances. There is a unit for adults (14 beds) and a separate unit for youth (four beds for those aged 14–18). Licensed Practical Nurses and Residential Attendants are on shift 24 hours/day. During the week, two social workers run day programming that includes group discussions, educational material, referrals and support in developing recovery plans.

Alberta

Population: 4,108,283
Gender: 2,089,081 Male; 2,019,202 Female

Overview and Summary[16]

Alberta Health is the ministry responsible for treatment services in Alberta. Alberta Health Services (AHS) is primarily responsible for delivering services, both directly and through AHS community contracted services. Mental health services are integrated with substance use services at the administrative level. Two data systems are currently being used to collect treatment data in Alberta. AHS uses the Addiction System for Information and Service Tracking (ASIST), while AHS contracted agencies use the Service Tracking and Outcome Reporting System (STORS). ASIST is a web-based system,[17] while STORS is an electronic database compiled using paper-based data capture. Provincial-level data are reported on an annual basis.

Important Considerations and Limitations

- Although the vast majority of AHS direct operated services are captured through ASIST, some parts of the province (i.e., health zones) have additional addiction programs that do not report to ASIST. These data are not included in this analysis due to a lack of access to this data.
- AHS does not offer non-residential withdrawal management.
- Starting with the current report using 2014–2015 data, AHS has stopped including AHS contracted addiction treatment data (STORS) and provided only the results of AHS direct operated treatment. This will reduce the total service events by approximately 15% compared to previous reports, but will not have an impact on unique individual data as unique individuals are not identifiable in STORS or reported for contracted agencies. Comparisons of certain indicators to results in previous reports are not recommended.
- For the current report, a new case is defined as a unique individual who began treatment during the fiscal year. This definition excludes clients with treatment service events that began in the previous fiscal year.

Results

Service Events and Unique Individuals

In 2014–2015, 31,321 unique individuals accessed publicly funded (AHS direct operated) substance use treatment services in Alberta, which accounted for 41,089 service events. Of these individuals, 76.0% (*n* = 23,807) were new cases. Males accounted for the majority, 64.2% (*n* = 23,008), of the treatment service events, while females accounted for 35.2% (*n* = 12,626) (Figure 7). As shown in Figure 8, the majority of individuals (*n* = 27,092) accessed treatment

16 In addition to monitoring service use, AHS tracks other indicators related to care, including client satisfaction, access times and outcomes. More information related to addiction and mental health services performance monitoring can be found in *System Level Performance Report for Addiction and Mental Health Services in Alberta 2014/15* (Alberta Health Services, 2016).

17 A web-based system has the ability to connect to a central data-collection system that allows all users to enter data directly from various locations and that can generate summary reports.

services for their own problematic substance use; however, 4,229 individuals accessed treatment for a friend or family member.

Figure 7. Treatment service events by gender (own use)

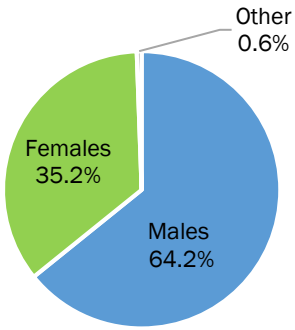
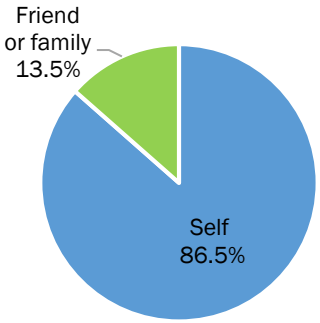
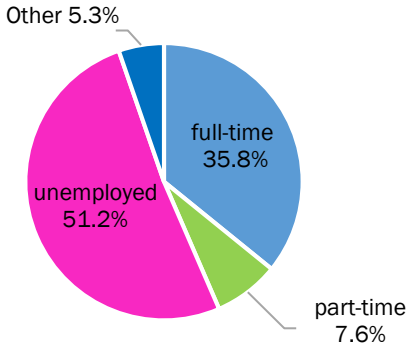


Figure 8. Unique individuals accessing treatment for their own or for others' substance use



Employment status of individuals was collected at the time of treatment and is reported in Figure 9.

Figure 9. Employment status of individuals (own use)[18],[19]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 78.8%, were for non-residential treatment, 14.6% were for residential withdrawal management and 6.6% were for residential treatment. As shown in Table 3, this trend is similar for males and females.[20]

18 Alberta does not assess student status as part of their collection process and thus it cannot be reflected in employment status.

19 Other employment refers to missing employment status.

20 Too few individuals reported their gender as other, so numbers per cell were too small to show by treatment type.

Table 3. Service events and unique individuals by gender[21] and treatment type (percentage and counts provided),[22] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts
Service Events: Total (including unknown gender)	78.8%	14.6%	6.6%	*n* = 35,838
Males	78.2%	14.8%	7.0%	*n* = 23,008
Females	79.8%	14.1%	6.1%	*n* = 12,626
Unique Individuals: Total (including unknown gender)	80.7%	12.0%	7.3%	*n* = 31,146
Males	80.6%	11.9%	7.6%	*n* = 20,139
Females	81.0%	12.2%	6.8%	*n* = 10,820

The ratio of service events to individuals for each of the treatment categories is presented in Table 4. As shown, on average individuals accessed non-residential treatment once per year.

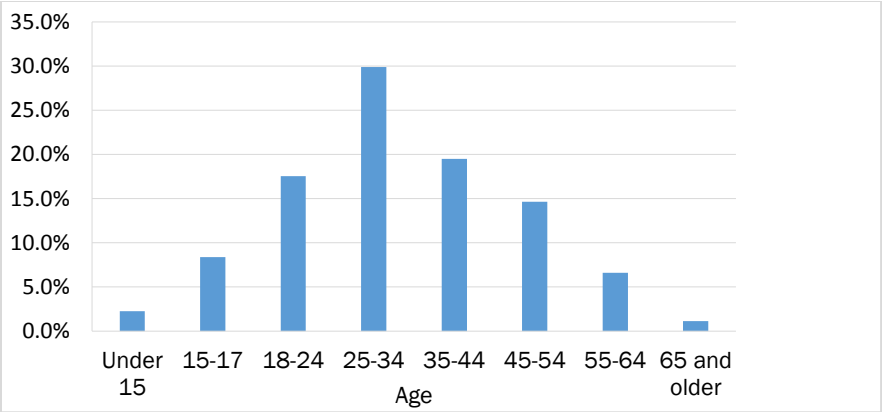
Table 4. Ratio of service events to individuals (own use)

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

Service Events by Age

As shown in Figure 10, the highest percentage of treatment service events occurred among those aged 25–34 years.

Figure 10. Treatment service events by age[23] (own use)



21 Missing rate of gender (proportion of unknown gender) is under 1%.

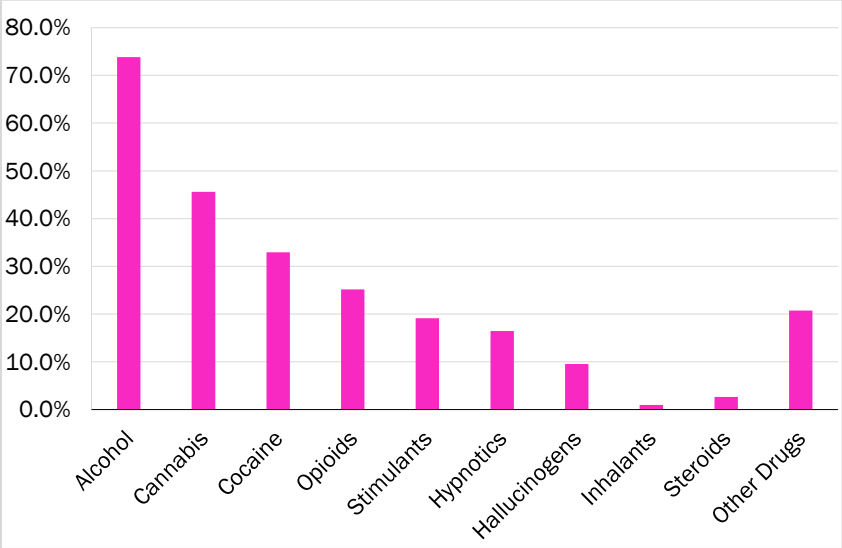
22 Numbers represent service events and unique individuals who accessed treatment for oneself and not for friends or family members.

23 Numbers represent treatment service events for oneself and not for friends or family members.

Past-year Substance Use among Unique Individuals Seeking Treatment

Among individuals accessing treatment services in Alberta during 2014–2015, alcohol was the most common substance used in the 12 months preceding treatment, followed by cannabis, cocaine and opioids (Figure 11).

Figure 11. Past-year substance use among unique individuals seeking treatment (own use)[24,25,26,27]



Note: Individuals can report a number of different substances used in the past 12 months. A complete list of substance categories and examples can be found in Appendix E.

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

25 Alberta does not assess over-the-counter medication and prescription drugs and thus they are not reflected in Figure 11.

26 In Alberta anti-depressants are included in "other drugs."

27 Not all clients reported substances used in the past year, so all percentages reflect an underestimate.

Saskatchewan

Population: 1,121,285
Gender: 565,493 Male; 555,792 Female

Overview and Summary[28]

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

Important Considerations and Limitations

- All regional health authorities and community-based organizations funded by the Ministry of Health to provide alcohol and drug treatment services in the province submit data through the ADG system, except for Saskatoon Health Region, although all regional health authorities and community-based organizations are included in the data presented. Saskatchewan's ADG data system tracks service events rather than new admissions, so its data does not reflect the number of discrete (i.e., new) cases for the fiscal year of interest.
- The ADG data system captures gender as male or female.
- Saskatchewan's withdrawal management programs are residential programs.
- Not all treatment providers were able to submit data on each of the indicators. For this reason, data discrepancies might be present in the data below.

Results

Service Events and Unique Individuals

In 2014–2015, 13,038 unique individuals accessed publicly funded substance use treatment services in Saskatchewan, which accounted for 19,112 service events. Males accounted for the majority, 61.2% (*n* = 10,886), of the treatment service events, while females accounted for 38.7% (*n* = 6,889) (Figure 12). As shown in Figure 13, the majority of individuals (*n* = 11,851) accessed treatment services for their own problematic substance use; however, 987 individuals accessed treatment for a friend or family member.

28 In addition to monitoring service use, the Ministry of Health, in collaboration with the regional health authorities, developed benchmarks for the maximum length of time a client should wait for outpatient services, according to their level of need represented by four triage categories: very severe, severe, moderate and mild. In 2013–2014, the benchmark was set at 70% for all triage categories. As of April 1, 2013, regional health authorities began to submit monthly data to the Ministry of Health to assess how often these targets were met. In 2014–2015, the target was increased to 85% for all four categories.

Figure 12. Treatment service events by gender (own use)

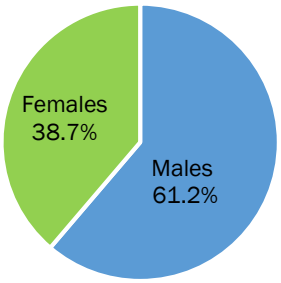
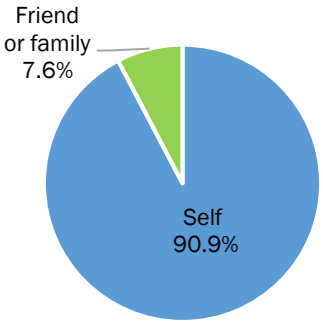
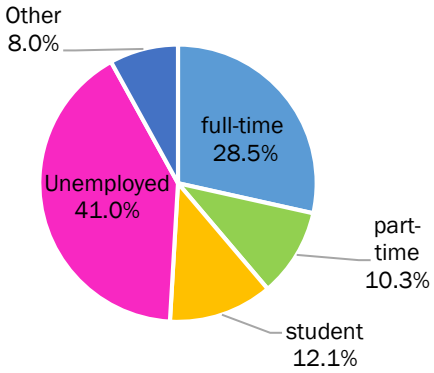


Figure 13. Unique individuals accessing treatment for their own or for others' substance use [29]



Employment status of individuals was collected at the time of treatment and is reported in Figure 14.

Figure 14. Employment status of individuals (own use)[30]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 65.0%, were for non-residential treatment, 24.1% were for residential withdrawal management, and 10.8% were for residential treatment. As shown in Table 5, this trend is similar for males and females.

[29] Percentages are less than 100% as there were 208 instances of missing data for this indicator.
[30] For employment, "other" includes homemaker, retired and seasonal employment.

Table 5. Service events and unique individuals by gender and treatment type (percentage and counts provided),[31] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts
Service Events: Total	65.0%	24.1%	10.8%	*n* = 17,785
Males	65.4%	24.2%	10.5%	*n* = 10,886
Females	64.5%	24.1%	11.3%	*n* = 6,889
Unique Individuals: Total	66.1%	21.6%	12.3%	*n* = 14,946
Males	65.9%	21.8%	12.2%	*n* = 8,972
Females	64.4%	22.5%	13.1%	*n* = 5,621

The ratio of service events to individuals for each of the treatment categories is presented in Table 6. As shown, on average individuals accessed non-residential treatment once per year.

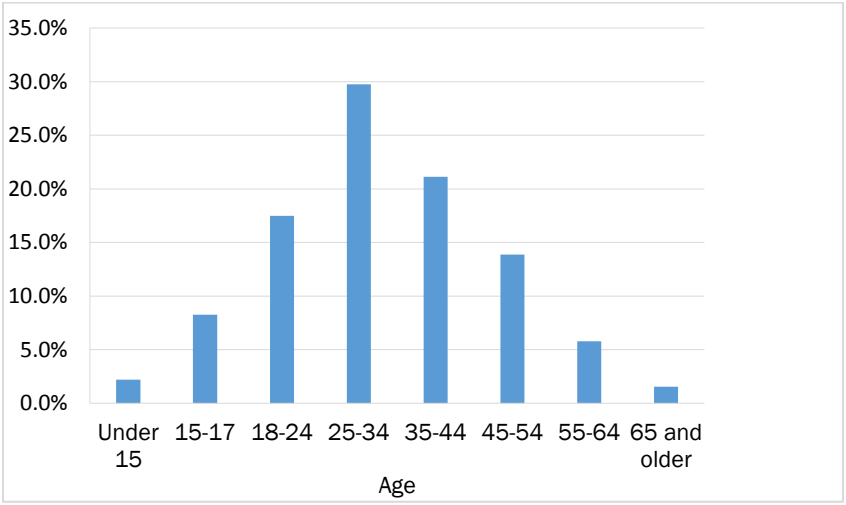
Table 6. Ratio of service events to individuals (own use)

Non-residential treatment	1.2
Residential withdrawal management	1.3
Residential treatment	1.0

Service Events by Age

As shown in Figure 15, the highest percentage of treatment service events occurred among those aged 25–34 years.

Figure 15. Treatment service events by age[32] (own use)



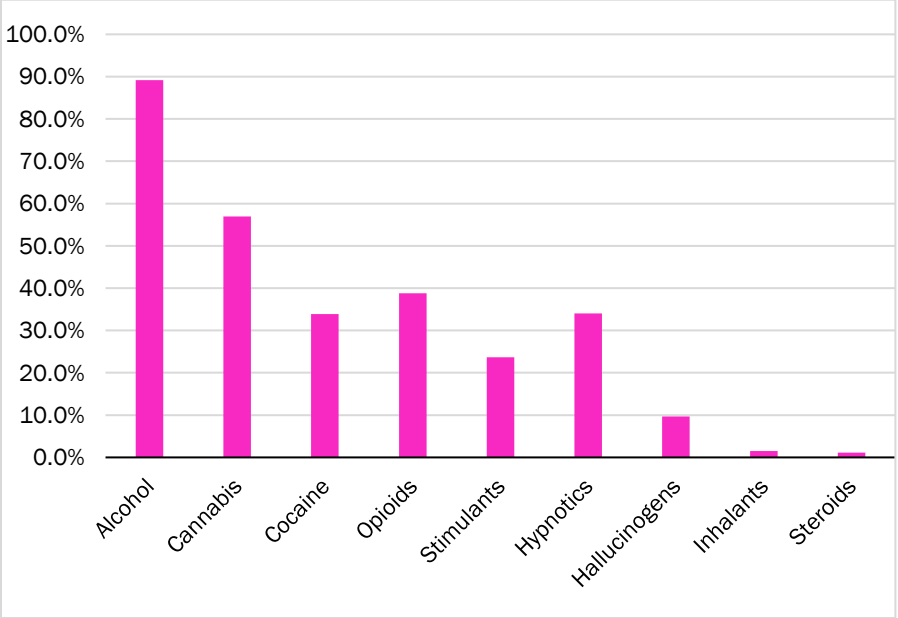
31 Numbers represent service events and unique individuals who accessed treatment for oneself and not for friends or family members.

32 Numbers represent treatment service events for oneself and not for friends or family members.

Past-year Substance Use among Unique Individuals Seeking Treatment

Among individuals accessing treatment services in Saskatchewan during 2014–2015, alcohol was the most common substance used in the 12 months preceding treatment, followed by cannabis, opioids, hypnotics and cocaine (Figure 16).

Figure 16. Past-year substance use among unique individuals seeking treatment (own use)[33],[34]



Note: Individuals can report a number of different substances used in the past 12 months. A complete list of substance categories and examples can be found in Appendix E.

[33] Numbers represent unique individuals who accessed treatment for oneself and not for friends or family members.
[34] Saskatchewan does not capture prescription drugs or over the counter medications and had no "other drugs" to report.

Manitoba

Population: 1,280,953
Gender: 636,674 Male; 644,279 Female

Overview and Summary

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

Important Considerations and Limitations

- Manitoba does not offer non-residential withdrawal management.
- Some agencies were unable to provide data for certain indicators of interest. Manitoba submitted data only for indicators that most agencies including AFM were able to report.
- Manitoba is currently improving agency-level data collection processes.
- There are limited common data collection processes in Manitoba, making it difficult to fully validate the data provided by agencies.
- Because Manitoba's publicly funded agencies do not share data from agency to agency, new cases cannot be tracked at a system level.
- Carry over data (i.e., cases that began in 2012–2013 and continued into 2013–2014) are not reported by all agencies in Manitoba and so were not submitted for 2014–2015.

Results

Service Events and Unique Individuals

In 2014–2015, 9,726 unique individuals accessed publicly funded substance use treatment services in Manitoba, which accounted for 16,064 service events. Males accounted for the majority, 58.1% (n = 8,731), of the treatment service events, while females accounted for 41.9% (n = 6,290) (Figure 17). As shown in Figure 18, the majority of individuals (n = 9,290) accessed treatment services for their own problematic substance use; however, 528 individuals accessed treatment for a friend or family member.

Figure 17. Treatment service events by gender (own use)

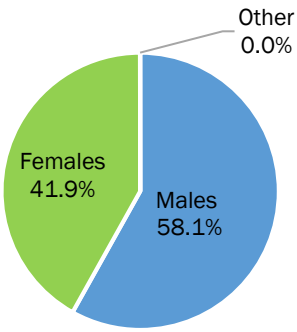
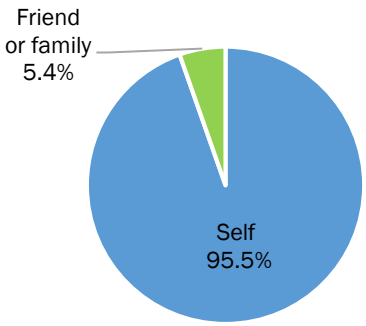


Figure 18. Unique individuals accessing treatment for their own or for others' substance use[35]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 74.1%, were for non-residential treatment, 8.8% were for residential withdrawal management and 17.1% were for residential treatment. As shown in Table 7, this trend is similar for males and females.

Table 7. Service events and unique individuals by gender[36] and treatment type (percentage and counts provided),[37] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts
Service Events: Total	74.1%	8..8%	17.1%	*n* = 15,036
Males	73.9%	10.4%	15.8%	*n* = 8,731
Females	74.5%	6.5%	19.0%	*n* = 6,290
Unique Individuals: Total	66.6%	10.9%	22.4%	*n* = 10,549[38]

The ratio of service events to individuals for each of the treatment categories is presented in Table 8. As shown, on average individuals accessed non-residential treatment more than once per year.

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

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

35 Percentages can add up to greater than 100% as an individual can seek treatment both for their own and for a family member's substance use issue.

36 Other was reported as a gender in Manitoba, but the numbers per cell by treatment type were too small to show.

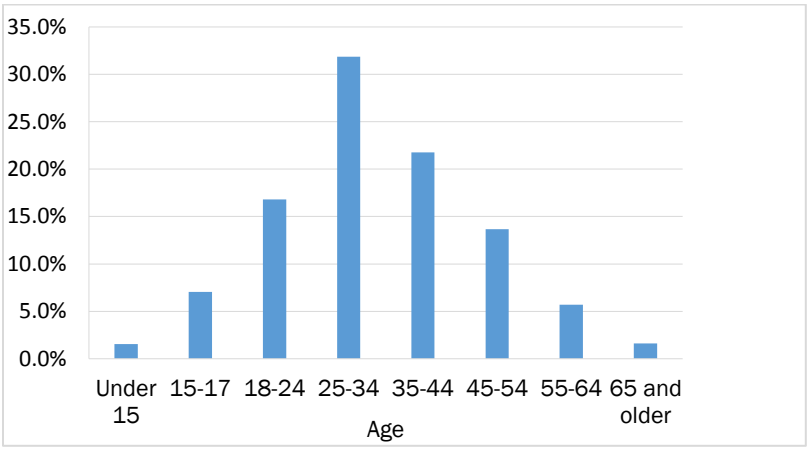
37 Numbers represent service events and unique individuals who accessed treatment for oneself and not for friends or family members.

38 Gender and age breakdown for unique individuals were not provided by one of the service providers contributing data and so are not shown for Manitoba.

Service Events by Age

As shown in Figure 19, the highest percentage of treatment service events accessing treatment occurred among those aged 25–34 years.

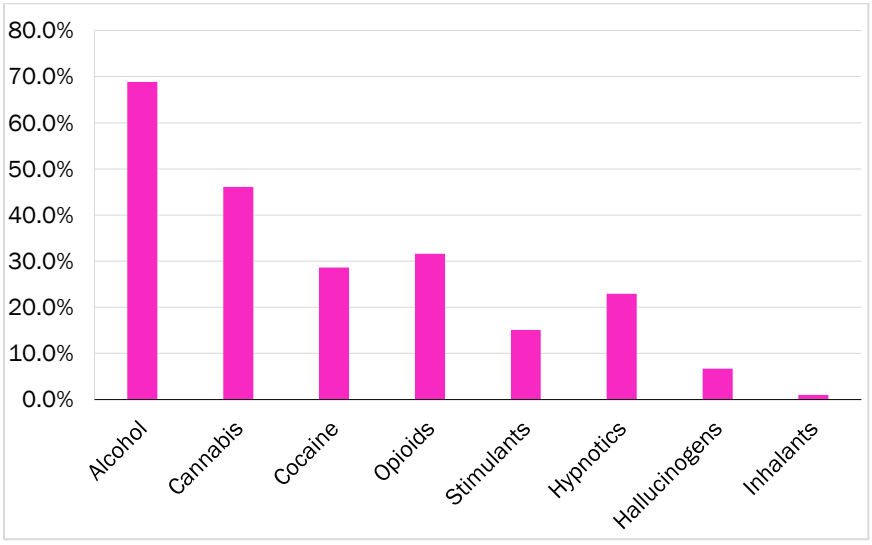
Figure 19. Treatment service events by age[39] (own use)



Past-year Substance Use among Unique Individuals Seeking Treatment

Among individuals accessing treatment services in Manitoba during 2014–2015, alcohol was the most common substance used in the 12 months preceding treatment, followed by cannabis, opioids and cocaine (Figure 20).

Figure 20. Past-year substance use among unique individuals seeking treatment (own use)[40],[41]



Note: Individuals can report a number of different substances used in the past 12 months. A complete list of substance categories and examples can be found in Appendix E.

39 Numbers represent treatment service events for oneself and not for friends or family members.

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

41 Manitoba does not collect steroids, prescription drugs, over-the-counter medication or "other drug" categories and so these are not reflected in Figure 19.

Ontario

Population: 13,685,171
Gender: 6,723,083 Male; 6,962,088 Female

Overview and Summary

The Ministry of Health and Long-Term Care is responsible for treatment services in Ontario. Treatment services in Ontario are administered through 14 Local Health Integration Networks (LHINs), which in turn plan and fund the services delivered through community agencies. Mental health services are often integrated with substance use services at the administrative level. Ontario uses the Drug and Alcohol Treatment Information System (DATIS), to provide online heath data management systems[42] to collect its treatment data. DATIS figures are available to the ministry and LHINs monthly, quarterly and annually.

Important Considerations and Limitations

In Ontario, a new case is defined as an admission to services at a participating agency that begins within a given reporting period.

Results

Service Events and Unique Individuals

In 2014–2015, 82,430 unique individuals accessed publicly funded substance use treatment services in Ontario, which accounted for 107,920 service events. Of these individuals, 73.7% (n = 60,741) were new cases. Males accounted for the majority, 64.4% (n = 65,768), of the treatment service events, while females accounted for 35.5% (n = 36,237) (Figure 21). As shown in Figure 22, the majority of individuals (n = 76,966) accessed treatment services for their own problematic substance use; however, 5,464 individuals accessed treatment for a friend or family member.

Figure 21. Treatment service events by gender (own use)

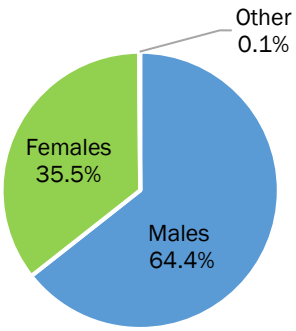
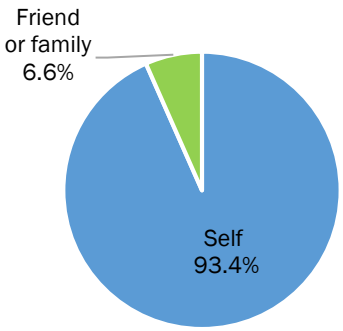


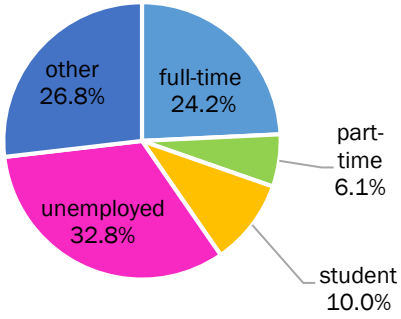
Figure 22. Unique individuals accessing treatment for their own or for others' substance use



42 A web-based health data management system and third-party emergency medical records interface system connect to a central database. These systems allow users to manage client health records and plan and deliver services, and report on mandated data from locations across Ontario. Aggregated summary reports are generated from this data.

Employment status of individuals was collected at the time of treatment and is reported in Figure 23.

Figure 23. Employment status of individuals (own use)[43]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 61.8%, were for non-residential treatment, 25.8% were for residential withdrawal management, 9.5% were for residential treatment and 2.9% were non-residential withdrawal management. As shown in Table 9, this trend is similar for males and females.

Table 9. Service events and unique individuals by gender[44] and treatment type (percentage and counts provided),[45] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Non-Residential Withdrawal Management	Total Counts
Service Events: Total	61.8%	25.8%	9.5%	2.9%	*n* = 102,138
Males	57.4%	29.5%	10.3%	2.8%	*n* = 65,768
Females	69.7%	19.0%	8.1%	3.2%	*n* = 36,237
Unique Individuals: Total	68.5%	17.5%	10.6%	3.4%	*n* = 76,966
Males	66.2%	19.2%	11.3%	3.3%	*n* = 48,402
Females	72.4%	14.7%	9.4%	3.5%	*n* = 28,436

The ratio of service events to individuals for each of the treatment categories is presented in Table 10. As shown, on average individuals accessed non-residential treatment once per year.

43 Other employment includes disabled, retired, not in labour force, other, unknown or missing employment status.

44 Other was reported as a gender in Ontario, but the numbers per cell by treatment type were to small to show.

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

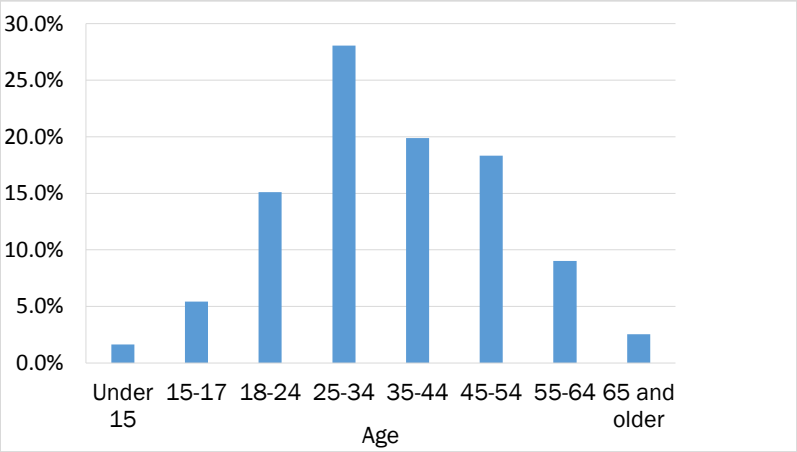
Table 10. Ratio of service events to individuals (own use)

Non-residential treatment	1.2
Residential withdrawal management	2.0
Residential treatment	1.2
Non-residential withdrawal management	1.1

Service Events by Age

As shown in Figure 24, the highest percentage of treatment service events occurred among those aged 25-34 years.

Figure 24. Treatment service events by age[46] (own use)

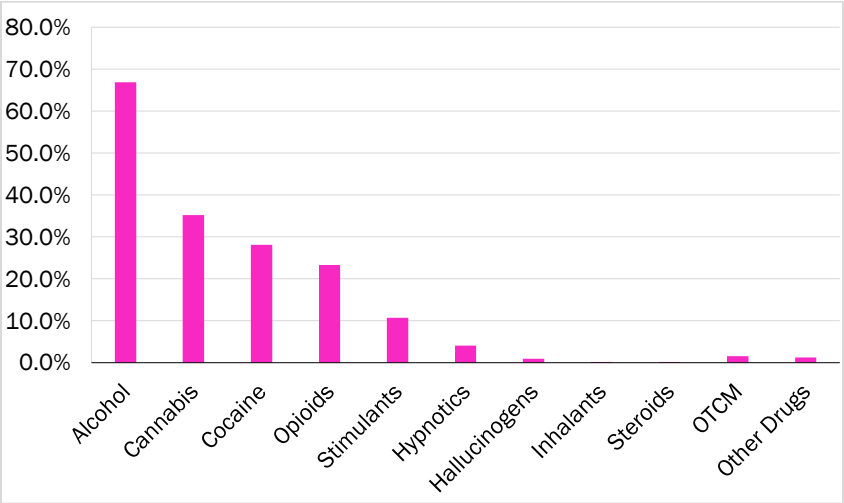


Service Events for Primary Substance for which Treatment Was Sought

As shown in Figure 25, alcohol was the substance most commonly reported as the reason for seeking treatment, accounting for 66.9% of treatment service events, followed by cannabis (35.2%) and cocaine (28.1%).

[46] Numbers represent treatment service events for oneself and not for friends or family members.

Figure 25. Primary substance for which treatment was sought[47] (own use)



Note: Individuals can present up to two primary substances. A complete list of substance categories can be found in Appendix E.

47 Numbers represent service events in which treatment was accessed for oneself and not for friends or family members.

Nova Scotia

Population: 943,294
Gender: 462,623 Male; 480,671 Female

Overview and Summary

The Department of Health and Wellness is responsible for treatment services in Nova Scotia. As of April 1, 2015, Nova Scotia joined all nine districts into one health authority, the Nova Scotia Health Authority, which includes Western, Northern, Eastern and Central zones, and the IWK Health Centre. Mental health and addictions are captured under one department; however, there is not a data system currently in place that contains information on clients who are in both addictions and mental health services. For this report, the province used the Addiction Services Statistical Information System Technology (ASsist) system database to report on the treatment indicators. ASsist is a browser-based system and data are submitted in real-time.

Important Considerations and Limitations

- In Nova Scotia, a new case is defined as an individual who did not previously exist within ASsist. The system searches for a case number or a combination of first and last name and date of birth. If neither one is not found, then a new individual case is created.
- In Nova Scotia, the number of individuals shown throughout this summary refers to those who were actively participating in a program within the given timeframe.
- All regions in Nova Scotia stopped offering non-residential withdrawal management services by the end of April 2014. Therefore, in the current report, which reflects 2014–2015 data, does not report on non-residential withdrawal management. For this reason, Nova Scotia data in the current report should not be compared to previous reports.[48]
- For the 2014–2015 year, it was determined that one region of Nova Scotia stopped entering withdrawal management data into ASsist. Therefore, residential withdrawal management data in the current report for Nova Scotia might underestimate actual numbers. Comparisons to results in previous reports are not recommended.

Results

Service Events and Unique Individuals

In 2014–2015, 8,553 unique individuals accessed publicly funded substance use treatment services in Nova Scotia, which accounted for 11,958 service events. Of these individuals, 68.1% (n = 5,824) were new cases. Males accounted for the majority, 68.7% (n = 7,857), of the treatment service events, while females accounted for 31.1% (n = 3,557) (Figure 26). As shown in Figure 27, the majority of individuals (n = 8,043) accessed treatment services for their own problematic substance use; however, 510 accessed treatment for a friend or family member.

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

Figure 26. Treatment service events by gender (own use)

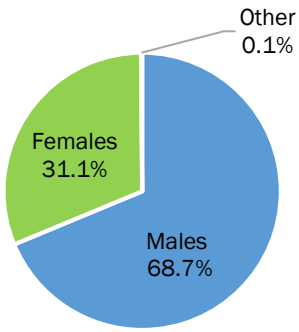
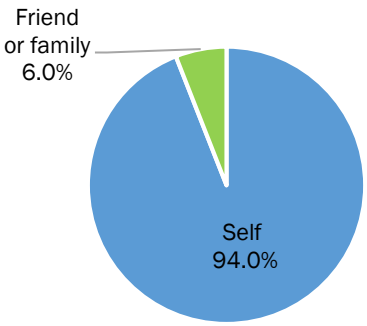
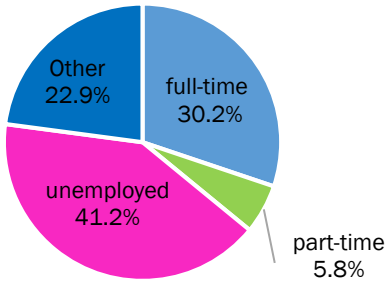


Figure 27. Unique individuals accessing treatment for their own or for others' substance use



Employment status of individuals was collected at the time of treatment and is reported in Figure 28.

Figure 28. Employment status of individuals (own use)[49]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 79.0%, were for non-residential treatment, 20.0% were for residential withdrawal management and 0.8% were for residential treatment. As shown in Table 11, this trend is similar for males and females.

49 The employment category "other" includes those who indicated they were disabled or on disability pension, employed seasonally, retired, or who did not report. As well, Nova Scotia does not capture student status as part of their collection process and thus it is not reflected in employment status.

Table 11. Service events and unique individuals by gender[50] and treatment type (percentage and counts provided),[51] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts[52]
Service Events: Total	79.0%	20.0%	0.8%	*n* = 11,430
Males	79.3%	19.9%	0.6%	*n* = 7,857
Females	78.6%	20.1%	1.1%	*n* = 3,557
Unique Individuals: Total	90.7%	8.9%	0.3%	*n* = 8, 043
Males	90.6%	9.1%	0.2%	*n* = 5,633
Females	91.1%	8.5%	0.4%	*n* = 2,413

The ratio of service events to individuals for each of the treatment categories is presented in Table 12. As shown, on average individuals accessed non-residential treatment once per year.

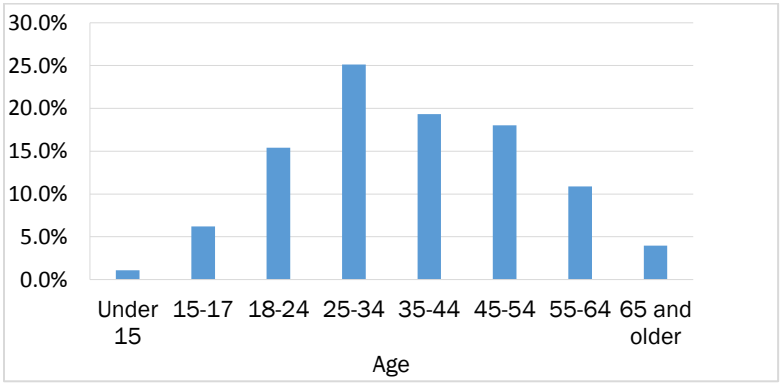
Table 12. Ratio of service events to individuals (own use)[53]

Non-residential treatment	1.2
Residential withdrawal management	3.2
Residential treatment	4.0

Service Events by Age

As shown in Figure 29, the highest percentage of treatment service events occurred among those aged 25–34 years.

Figure 29. Treatment service events by age[54] (own use)



50 Other was reported as a gender in Nova Scotia, but the numbers per cell by treatment type were too small to show.

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

52 Percentages will not add up to 100% as non-residential withdrawal management was stopped during the 2014–2015 fiscal year and therefore were not included in this table as these services do not represent the full year.

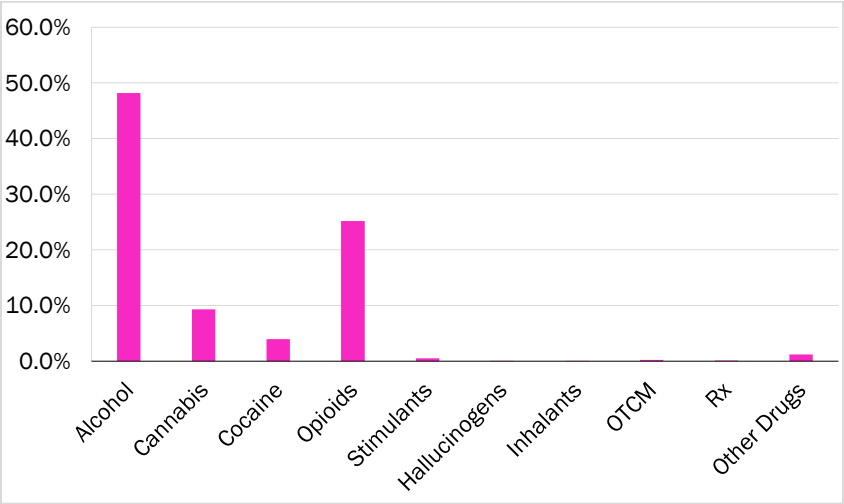
53 Ratios for residential withdrawal management and residential treatment are much higher than previous years. Fluctuations of ratios in the 2014–2015 data are due to increased readmission rates.

54 Numbers represent treatment service events for oneself and not for friends or family members.

Service Events for Primary Substance for which Treatment Was Sought

As shown in Figure 30, alcohol was the substance most commonly reported as the reason for seeking treatment, accounting for 48.2% of treatment service events, followed by opioids (25.2%) and cannabis (9.3%).

Figure 30. Primary substance for which treatment was sought[55] (own use)[56]



Note: Individuals can report multiple substances. A complete list of substance categories can be found in Appendix E.

55 Numbers represent service events in which treatment was accessed for oneself and not for friends or family members.

56 Nova Scotia does not capture hypnotics and steroids.

New Brunswick

Population: 754,865
Gender: 373,019 Male; 381,846 Female

Overview and Summary

The Department of Health is responsible for the planning, funding and monitoring of addiction services in New Brunswick, which is delivered through two regional health authorities. The following addiction services are offered through the regional health authorities across the province: two short-term residential treatment programs, one long-term residential treatment program for men only, seven residential withdrawal management programs (ranging from six to 20 beds) and non-residential treatment (out-patient counselling). The Client Service Delivery System (CSDS), which is owned by the Department of Health, is used to collect treatment data for addiction and mental health services. In 2012, addiction services were incorporated into the CSDS, allowing for better integration of care and treatment. Clinicians and other service providers use CSDS as the electronic clinical charting system throughout the province.

Important Considerations and Limitations

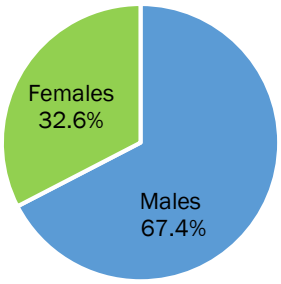
- All data was extracted for this summary from New Brunswick's internal reports for addiction and mental health service. Therefore, data that is collected, but not provided in these reports, such as age and substance specific information, could not be included in the current report.
- New Brunswick does not currently have the available data to report on whether individuals accessed treatment for oneself or for friends or family members, therefore data do not differentiate whether unique individuals or service events occurred for oneself or for friends or family members.
- For non-residential treatment, New Brunswick counts each counselling session as a service event. This reporting is not consistent with other jurisdictions in which a non-residential treatment service event includes multiple appointments. Counting each appointment as a service event inflates the number of service events for New Brunswick compared to other jurisdictions and so comparisons should not be made.
- New Brunswick does not offer non-residential withdrawal management.

Results

Service Events and Unique Individuals

In 2014–2015, 6,432 unique individuals accessed publicly funded substance use treatment services in New Brunswick, which accounted for 34,233 service events. Males accounted for the majority, 67.4% (n = 4,331), of the individuals who accessed treatment services, while females accounted for 32.6% (n = 2,099) (Figure 31).

Figure 31. Unique individuals by gender for self and others[57,58]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 90.4%, were for non-residential treatment, 8.5% were for residential withdrawal management, and 1.1% were for residential treatment (Table 13).

Table 13. Service events and unique individuals by treatment type (percentage and counts provided)[59] for self and others

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts
Service Events: Total	90.4%	8.5%	1.1%	*n* = 34,233
Unique Individuals: Total	66.1%	29.0%	4.9%	*n* = 6,432

The ratio of service events to individuals for each of the treatment categories is presented in Table 14. The ratio for non-residential treatment in New Brunswick is interpreted differently compared to other jurisdictions, and reveals that, on average, an individual receiving non-residential treatment receives seven appointments per year.

Table 14. Ratio of service events to individuals for self and others

Non-residential treatment	7.3[60]
Residential withdrawal management	1.6
Residential treatment	1.2

57 Gender includes both individuals who accessed treatment for oneself and for friends or family members.

58 Other was also reported as a gender in New Brunswick, but the numbers per cell by treatment type were too small to show.

59 Numbers represent service events and unique individuals who accessed treatment for oneself and for friends or family members.

60 As noted in the limitations, New Brunswick counts each counselling session for non-residential treatment as a service event. This reporting is in contrast to the other jurisdictions in which a non-residential treatment service event can include multiple appointments. Therefore, the high ratio for non-residential treatment is a reflection of unique individuals receiving on average seven counselling sessions, and does not reflect re-admission to treatment.

Prince Edward Island

Population: 145,832
Gender: 71,093 Male; 74,739 Female

Overview and Summary

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

Important Considerations and Limitations

- In Prince Edward Island, a client can be active in more than one of the treatment services throughout the year. Such a client would be counted as a unique individual in each treatment service, which might result in counting them more than once.
- Gambling service events and individuals are not excluded from withdrawal management programs in Prince Edward Island. Thus, the 35 service events and 34 individuals who received treatment for gambling will be reflected in the withdrawal management numbers.
- In Prince Edward Island, non-residential treatment is available in five communities, whereas residential withdrawal management is only available in Charlottetown, and recovery homes are present in the two largest communities of Charlottetown and Summerside.
- In previous reports, Prince Edward Island had included crystal meth, ecstasy, heroin, LSD and nicotine in the category "Other Drugs." However, each of these drugs more accurately fell within specific drug categories provided. The exception was nicotine, which was removed as it is not included in the NTI data collection protocols.

Results

Service Events and Unique Individuals

In 2014–2015, 2,606 unique individuals accessed publicly funded substance use treatment services in Prince Edward Island, which accounted for 3,466 service events. Of these individuals, 77.7% (*n* = 2,024) were new cases. Males accounted for the majority, 68.3% (*n* = 2,236), of the treatment service events, while females accounted for 31.7% (n = 1,037) (Figure 32). As shown in Figure 33, the majority of individuals (*n* = 2,405) accessed treatment services for their own problematic substance use; however, 211 individuals accessed treatment for a friend or family member.

Figure 32. Treatment service events by gender (own use)

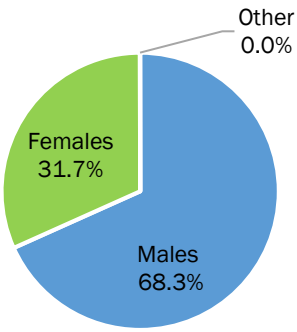
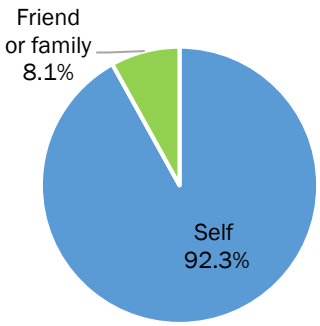
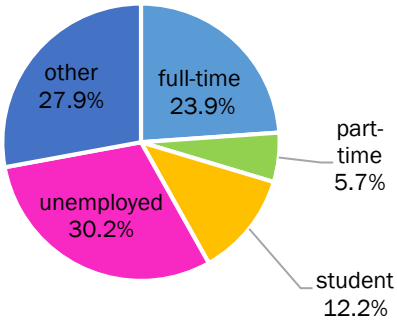


Figure 33. Unique individuals accessing treatment for their own or for others' substance use[61]



Employment status of individuals was collected at the time of treatment and is reported in Figure 34.

Figure 34. Employment status of individuals (own use)[62]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 47.6%, were for non-residential treatment, 30.3% were for residential withdrawal management, 3.2% were for residential treatment and 18.9% were non-residential withdrawal management. As shown in Table 15, this trend is similar for males and females.

61 Percentages can add up to greater than 100% as an individual can seek treatment both for their own and for a family member's substance use issue.

62 For employment, "other" includes the following categories: child, disabled, homemaker, retired, seasonal, other, unknown or not reported.

Table 15. Service events and unique individuals by gender[63] and treatment type (percentage and counts provided)[64], own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Non-Residential Withdrawal Management	Total Counts
Service Events: Total	47.6%	30.3%	3.2%	18.9%	*n* = 3,219
Males	45.9%	30.8%	3.5%	19.9%	*n* = 2,236
Females	53.9%	27.8%	2.4%	15.9%	*n* = 1,037
Unique Individuals: Total	53.6%	21.7%	3.7%	21.1%	*n* = 2,389
Males	52.7%	21.5%	3.9%	21.9%	*n* = 1,633
Females	57.4%	21.1%	3.0%	18.4%	*n* = 787

The ratio of service events to individuals for each of the treatment categories is presented in Table 16. As shown, on average individuals accessed non-residential treatment once per year.

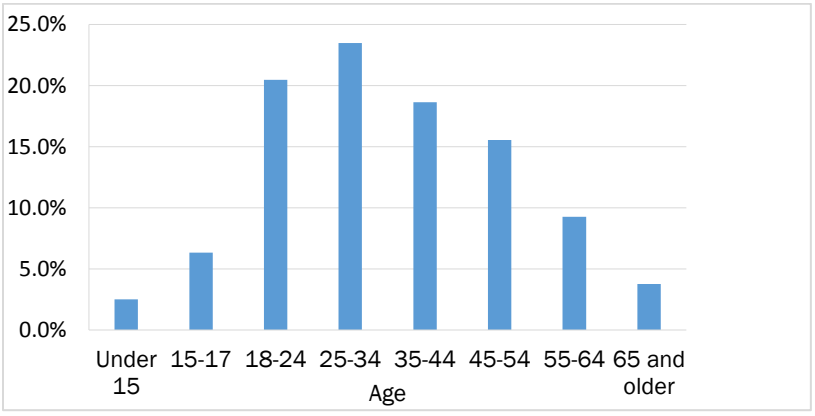
Table 16. Ratio of service events to individuals (own use)

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

Service Events by Age

As shown in Figure 35, the highest percentage of treatment service events occurred among those aged 25–34 years.

Figure 35. Treatment service events by age (own use)[65]



63 Other was reported as a gender in Prince Edward Island, but the numbers per cell by treatment type were too small to show.

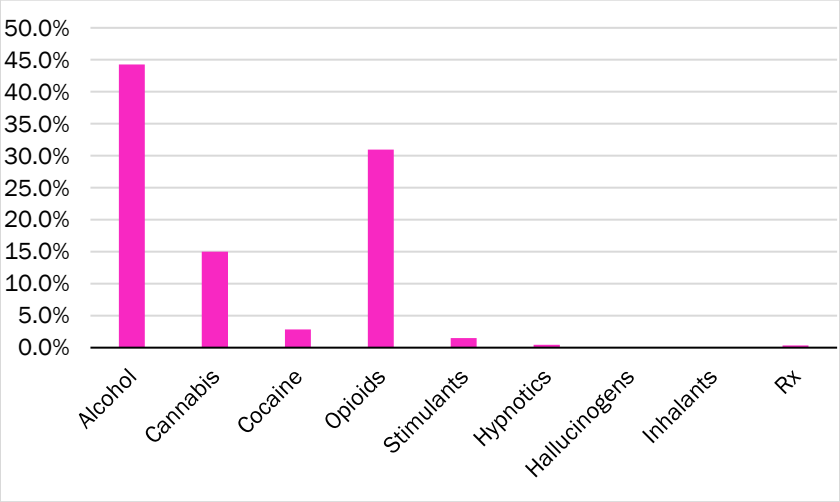
64 Numbers represent service events and unique individuals who accessed treatment for oneself and not for friends or family members.

65 Numbers represent treatment service events for oneself and not for friends or family members.

Service Events for Primary Substance for which Treatment Was Sought

As shown in Figure 36, alcohol was the substance most commonly reported as the reason for seeking treatment, accounting for 44.3% of treatment service events, followed by opioids (31.0%) and cannabis (15.0%).

Figure 36. Primary substance for which treatment was sought (own use)[66],[67],[68]



Note: Individuals can present one primary substance. A complete list of substance categories can be found in Appendix E.

[66] Numbers represent service events in which treatment was accessed for oneself and not for friends or family members.
[67] Primary substance for which treatment was sought is called drug of choice in Prince Edward Island.
[68] Prince Edward Island does not capture clients' use of steroids or over the counter medications and had no "other drugs" to report.

Newfoundland and Labrador

Population: 528,333
Gender: 260,575 Male; 267,758 Female

Overview and Summary

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

Important Considerations and Limitations

- All data were extracted from the CRMS. Any services provided but not documented in this system are excluded from this analysis.
- A client can be active in more than one of the treatment services throughout the year. Therefore, an individual would be counted as a unique individual in each applicable treatment service.
- Newfoundland and Labrador does not offer non-residential withdrawal management.
- Missing dates of birth are uncommon, but do contribute to minor inaccuracies in the age related indicators.
- CRMS is a provincial health information system. The accuracy and completeness of the demographic and clinical data is dependent on the information recorded by service providers in the client health record. Variations in clinical documentation practices among the mental health and addictions programs of the regional health authorities contribute to data quality issues. Provincial initiatives are ongoing to strengthen data and documentation standards and compliance with those standards, and these initiatives are positively impacting the quality of the data. As a result, readers should exercise caution when interpreting the findings reported for Newfoundland and Labrador.

Results

Service Events and Unique Individuals

In 2014–2015, 2,548 unique individuals accessed publicly funded substance use treatment services in Newfoundland and Labrador, which accounted for 4,020 service events. Of these individuals, 80.2% (n = 2,043) were new cases. Males accounted for the majority, 63.6% (*n* = 2,454), of the treatment service events, while females accounted for 33.5% (*n* =1,292) (Figure 37). As shown in Figure 38, the majority of individuals (n = 2,461) accessed treatment services for their own problematic substance use; however, 115 individuals accessed treatment for a friend or family member.

Figure 37. Treatment service events by gender (own use)

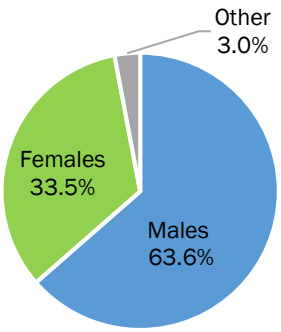
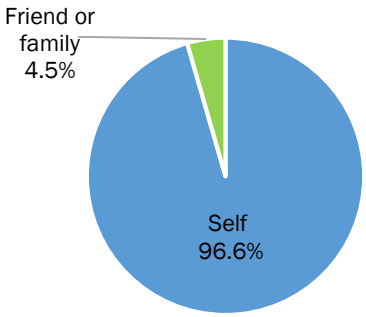


Figure 38. Unique individuals accessing treatment for their own or for others' substance use[69]



Service Events and Unique Individuals by Gender and Treatment Category

The majority of service events, 76.7%, were for non-residential treatment, 15.9% were for residential withdrawal management, and 7.4% were for residential treatment. As shown in Table 17, this trend is similar for males and females.

Table 17. Service events and unique individuals by gender[70] and treatment type (percentage and counts provided),[71] own use

	Non-Residential Treatment	Residential Withdrawal Management	Residential Treatment	Total Counts
Service Events: Total	76.7%	15.9%	7.4%	*n* = 3,824
Males	75.5%	17.2%	7.3%	*n* = 2,454
Females	79.1%	13.5%	7.4%	*n* = 1,292
Unique Individuals: Total	78.1%	12.3%	9.6%	*n* = 2,858
Males	77.5%	12.9%	9.6%	*n* = 1,820
Females	79.5%	11.1%	9.4%	*n* = 971

The ratio of service events to individuals for each of the treatment categories is presented in Table 18. As shown, on average individuals accessed non-residential treatment once per year.

Table 18. Ratio of service events to individuals (own use)

Non-residential treatment	1.3
Residential withdrawal management	1.7
Residential treatment	1.0

69 Percentages can add up to greater than 100%, as an individual can be active in more than one service when seeking service for their own and for a family member's substance use issue.

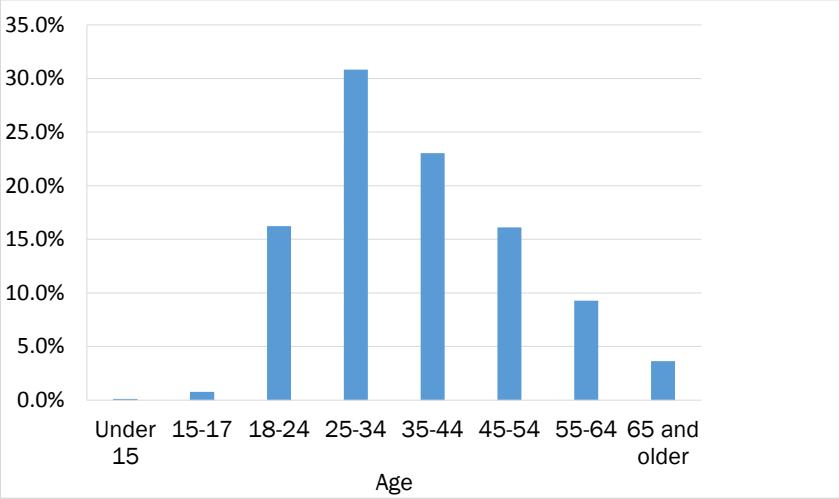
70 Other was reported as a gender in Newfoundland and Labrador, but the numbers per cell by treatment type were too small to show.

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

Service Events by Age

As shown in Figure 39, the highest percentage of treatment service events occurred among those aged 25–34 years.

Figure 39. Treatment service events by age (own use)[72]



72 Numbers represent treatment service events for oneself and not for friends or family members.

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

For this report, the NTI project has benefited from the participation of Health Canada's First Nations Inuit Health Branch (FNIHB) and Youth Solvent Addiction Committee as part of the NTIWG. FNIHB partners with Thunderbird Partnership Foundation and Youth Solvent Addictions Committee (YSAC) to support a national network of treatment centres in providing treatment services for substance use issues for First Nations and Inuit. For this year, FNIHB and YSAC are partnering to submit data for the National Youth Solvent Abuse Program (NYSAP) youth treatment centres. Although not able to contribute data for National Native Alcohol and Drug Abuse Program (NNADAP) adult treatment centres for this iteration, a comprehensive list of all current NNADAP treatment centres and types of programming these treatment centres offer has been included. The goal is to submit data from these treatment centres for future reports.

Overview and Summary

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

NNADAP and NYSAP treatment centres include a range of mainstream and culturally relevant approaches. Through these national programs, First Nations and Inuit individuals have access to inpatient, outpatient and day treatment services, as well as services for people with unique needs (e.g., programming for families, youth, solvent abusers, women and people with concurrent disorders). Culturally relevant approaches include land-based programming, which draws on cultural healing and connection with the land. Activities can include hunting and fishing, canoeing, preparing traditional and healthy foods, traditional crafts, storytelling and sharing circles, spiritual rituals such as sweats, families sharing their own cultures, and learning respect for the land, animals, fish, birds and plants.

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

Results[73]

For the year 2014–2015, there were a total of 464 admissions to the treatment centres under the NYSAP, which included 232 male and 232 female youth. As shown in Table 19, the average age of intake was 15.8 years of age.

Table 19. Treatment centre admissions and demographic data for the National Youth Solvent Abuse Program

Treatment Centre	Treatment Type	Average Age of Intake	Gender	Total Admissions
Charles J Andrew Youth Treatment Centre (Sheshatshiu, Labrador)	Residential (10 beds)	N/A (Families)	Gender Blocks[74]	72
Ka-Na-Chi-Hih Solvent Treatment Centre (Thunder Bay, Ontario)	Residential (12 beds)	20	Male	37
Nenqayni Wellness Centre (Williams Lake, B.C.)	Residential (10 beds)	16.1	Female	28
Nimkee NupiGawagan Healing Centre (Muncey Ontario)	Residential (9 beds)	15.25	Gender Blocks	22
Whiskyjack Treatment Centre (Hwy 373-374 Junction, Manitoba)	Residential (20 beds)	16	Gender Blocks	79
White Buffalo Youth Inhalant Treatment Centre (Sturgeon Lake, Saskatchewan)	Residential (10 beds)	16	Female	35
Young Spirit Winds Centre (Hobberna, Alberta)	Non-residential	14	Co Ed	46
Leading Thunderbird Lodge (Fort San, Saskatchewan)	Residential (15 beds)	14	Male	65
Siksika Medicine Lodge (Siksika Nation, Alberta)	Residential (10 beds)	15	Co Ed	45
Walgwan Centre (Gesgapegiag, Eastern Quebec)	Residential (12 beds)	15.6	Co Ed	35
National Totals/Averages:		15.8		464

The centres that are part of the NYSAP provide culturally appropriate holistic treatment approaches including traditional healing and teaching. A number of the centres complement residential services with land-based programs and youth–Elder gatherings. Centres include traditional therapies such as sweat lodges, smudging and drumming. Counselling focuses upon the strengths of Indigenous youth, their family and community.

Many specialized services are offered as part of, or in addition to, the residential treatment. For example, a number of the centres offer education and academic assistance through on-site learning centres. Family counselling is offered by a number of the centres, which focuses on parenting skills, parental support and family dynamics. Moreover, recreational opportunities such as swimming, biking, canoeing and camping are provided.

Clients are matched to their unique needs and availability of the treatment centres. Therefore, in 2014–2015 some individuals attended a treatment centre in their province/territory, while others

73 Results presented are from the YSAC 2014–2015 Annual Report.

74 Gender blocks refer to rotating genders such that intake is gender specific at varied cycles throughout the year.

travelled to attend treatment. Table 20 shows the provincial/territorial breakdown of where clients resided (region of origin) and the treatment centres they attended during the 2014–2015 year. For example, 57% of the youth who attended the Ka-Na-Chi-Hih Solvent Treatment Centre (located in Thunder Bay, Ontario) were from Ontario, 30% were from Manitoba, 5% from the Atlantic provinces, 5% from the territories and 3% from Saskatchewan.

Table 20. Region of origin of clients by treatment centre

Treatment Centre	Atlantic	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Territories
Charles J Andrew	100%	---	---	---	---	---	---	---
Ka-Na-Chi-Hih	5%	---	57%	30%	3%	---	---	5%
Nenqayni	11%	---	3%	---	---	3%	79%	3%
Nimkee	5%	---	95%	---	---	---	---	---
Whiskyjack	6%	---	22%	71%	1%	---	---	---
White Buffalo	9%	---	5%	49%	34%	3%	---	---
Young Spirit Winds	---	---	---	---	---	100%	---	---
Leading Thunderbird	8%	---	5%	18%	65%	3%	1%	---
Siksika	---	---	---	7%	9%	84%	---	---
Walgwan	20%	80%	---	---	---	---	---	---

Of the youth attending treatment in 2014–2015, 28.2% reported having attended a previous residential treatment program. In addition to youth treatment centres, Table 21 provides a comprehensive list of all current adult and family NNADAP treatment centres and types of programming these treatment centres offer.

Table 21. List of NNADAP treatment centres and types of treatment centre programming

NNADAP Treatment Centre	Type of Programming	Type of Centre
Beaver Lake Wah Pow Centre (Lac La Biche, Alta.)	In-patient	Adult
Blood Tribe Youth Wellness Centre (Standoff, Alta.)	In-patient	Youth
Footprints Healing Centre (Morinville, Alta.)	In-patient	Adult
Kainai Healing Lodge (previously St. Paul Treatment Centre) (Cardston, Alta.)	In-patient	Adult
Kapown Rehabilitation Centre (Grouard, Alta.)	In-patient	Adult
Wood Buffalo/Mark Amy Treatment Centre (Fort McMurray, Alta.)	In-patient and out-patient	Adult
Armand Bekkattla Treatment Centre (Clearwater River, Sask.)	In-patient	Adult
Cree Nations Treatment Haven (Canwood, Sask.)	In-patient and out-patient	Adult

NNADAP Treatment Centre	Type of Programming	Type of Centre
Ekweskeet Healing Lodge (Onion Lake, Sask.)	In-patient and out-patient	Adult
Leading Thunderbird Lodge (Fort Qu'Appelle, Sask.)	In-patient and out-patient	Youth
Mistahey Musqua Treatment Centre (Loon Lake, Sask.)	In-patient	Adult
Sakwatamo Lodge (Prince Albert, Sask.)	Family-based In-patient	Family
Saulteax Healing and Wellness Centre (Kamsack, Sask.)	Out-patient	Adult
Athabasca Health Authority Mental Health and Addictions Program (Black Lake, Sask.)	Out-patient	Adult
Native Addictions Council of Manitoba (Winnipeg, Man.)	In-patient and out-patient	Adult
Nelson House Medicine Lodge (Nelson House, Man.)	In-patient	Adult
Peguis Al-Care Treatment Centre Inc. (Peguis, Man.)	In-patient and out-patient	Adult
Sagkeeng Treatment Centre (Fort Alexander, Man.)	In-patient and out-patient	Family
Benbowopka Treatment Centre (Blind River, Ont.)	In-patient and out-patient	Adult
Anishnawbe Health Toronto (Toronto, Ont.)	Out-patient	Youth
Dilico Adult Residential Treatment Centre (Thunder Bay, Ont.)	In-patient	Adult
Migisi Alcohol and Drug Treatment Centre (Kenora, Ont.)	In-patient	Adult
Native Horizons Treatment Centre (Hagersville, Ont.)	In-patient	Adult
The Reverend Tommy Beardy Memorial Treatment Centre (Muskrat Dam, Ont.)	In-patient	Family
Ngwaagan Gamig Recovery Centre Inc. (Wikwemikong, Ont.)	In-patient and out-patient	Adult
Sagashtawao Healing Lodge (Moosonee, Ont.)	In-patient	Adult
Mawiomi Treatment Services (Gesgapegiag, Que.)	In-patient and out-patient	Adult
Centre Miam Uapukun (Moisie, Que.)	In-patient	Adult

NNADAP Treatment Centre	Type of Programming	Type of Centre
Onen'to:kon Treatment Centre (Kanesatake, Que.)	In-patient and out-patient	Adult
Wanaki Treatment Centre (Maniwaki, Que.)	In-patient	Adult
Centre de Readaptation Wapan (La Tuque, Que.)	In-patient	Adult
Eagles Nest Recovery House (Shubenacadie, N.S.)	In-patient and out-patient	Adult
Mi'kmaw Lodge (Eskasoni, N.S.)	In-patient	Adult
Lone Eagle Treatment Centre (Elsipogtog, N.B.)	In-patient and out-patient	Adult
Rising Sun (Eel Ground, N.B.)	In-patient and day program	Adult
Wolastoqewik Healing Lodge (Tobique, N.B.)	In-patient and out-patient	Adult

In addition to these centres, there are a number of treatment centres for First Nations peoples in British Columbia that are governed by the First Nation's Health Authority.

Discussion

The current findings indicate that publicly funded treatment services are being accessed by a diversity of individuals (e.g., males, females, Indigenous youth, older adults, employed and unemployed) with varying substance use profiles. To respond effectively to the needs of such a variety of clients by adopting a person-centred treatment approach, the availability of a comprehensive range of treatment services is required, including gender-based services, age- and culturally-appropriate services, housing and employment supports, and family services. The Life in Recovery from Addiction in Canada survey identified a lack of person-centred treatment programs in some instances that served as barriers to treatment. In this regard, some individuals identified a lack of supports or programs specifically for women, or a lack of quality services available in their community or in their preferred language, and others reported not receiving the right treatment for their addiction (McQuaid, Malik, Baydack, Stargardter, & Morrisey, 2017). These findings suggest improvements can be made in terms of person-centred treatment for substance use in Canada and that targeted investments to address the system-level barriers surrounding treatment could significantly improve the lives of individuals with substance use disorders in Canada.

In 2014–2015, the majority of treatment service events, 63.9%, were accessed by males. This finding about treatment is not surprising as it reflects the prevalence rates for substance use data. For instance, males have higher rates of illicit drug use including cannabis, cocaine/crack, speed/methamphetamine/crystal meth, hallucinogens and ecstasy compared to females. Additionally, a greater percentage of males exceed the low-risk drinking guidelines than females (Statistics Canada, 2017).

In terms of treatment type, non-residential treatment accounted for the majority, 67.4%, of treatment service events in 2014–2015, a trend consistent across all jurisdictions. This finding could be due, in part, to the fact that non-residential treatment is often the most accessible service (i.e., same community, town, etc.) compared to other service types, and is also a less intrusive form of treatment compared to residential services. As a result, non-residential treatment is typically the starting point for individuals concerned about their own or others' alcohol or drug use. However, it should also be considered that high rates of service use do not necessarily reflect or indicate adequate service availability, relative to the treatment need in the population. This highlights the importance of understanding and planning for treatment needs, an issue being addressed by the needs-based planning project, which is highlighted below in the complementary project section.

Individuals aged 25–34 account for the greatest number of treatment service events compared to all other age groups. This seems to be in-line with Canadian substance use data, where individuals just below this age range at 20–24 years display the highest past-year use of alcohol, cannabis, and many other illicit drugs compared to the other age groups (Statistics Canada, 2017). Problematic substance use and substance use disorders can occur at any age, but adolescence and young adulthood is a time of particularly high risk (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). It is suggested that the majority of those who meet criteria for a substance use disorder in their lifetime began using substances during adolescence (Kessler et al., 2005). In line with this suggestion, the Life in Recovery from Addiction in Canada report revealed that participants reported an early age for first substance use (median age of 13 years) and addiction (median age of 18 years) (McQuaid et al., 2017). Together, these data highlight the need for prevention and early intervention efforts that focus on youth. A number of studies have revealed the effectiveness of prevention programs, and early screening and brief interventions among adolescents, particularly with mild severity alcohol use disorders (Surgeon General Report, 2017).

In the current report, alcohol is overwhelmingly the most common substance used in the past 12 months among individuals accessing treatment. This finding is also supported by the Canadian Life in Recovery report, which found that alcohol was the most common substance used during active addiction (93.3%) and was the most common drug of choice during active addiction (50.5%) (McQuaid et al., 2017). In addition to substances used by individuals accessing treatment, the current report also examined the primary substance for which treatment was sought (i.e. the reason for treatment). Only Ontario, Nova Scotia and Prince Edward Island were able to provide this data, but once again alcohol was overwhelmingly the primary substance for which treatment was sought, a finding that was also reported for hospital-based services (Young & Jesseman, 2014). These data highlight the continued financial and health impact alcohol has on Canadian society, and the importance of investing in targeted treatment services such as early intervention, and screening, brief intervention and referral (College of Family Physicians of Canada & Canadian Centre on Substance Use and Addiction, 2012), as well as prevention and education initiatives such as the low-risk alcohol drinking guidelines (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011).

Together, the current data highlight the individuals accessing treatment, the reason for treatment and the types of treatment that are most often accessed. These trends have been consistent across the previous NTI reports and can help inform treatment system planning.

Although the NTI project has helped improve our understanding of the usage of substance use treatment in Canada, there are still many knowledge and information gaps that need to be addressed. The NTIWG is committed to improving the collection and reporting of substance use treatment service data in Canada to improve the accuracy and validity of treatment information supplied by the various jurisdictions. In addition, CCSA is working to obtain data on publicly funded treatment services from other jurisdictions not currently participating in the NTI project and privately funded treatment data to obtain a more complete understanding of treatment service use in Canada. These efforts will help to improve the relevance, uptake and use of the NTI report across Canada. The ultimate goal of this project is to produce a comprehensive picture of service use to inform effective policy, resourcing and development for substance use treatment in Canada.

Complementary Projects

Needs-based Planning Project

One of the limitations that currently exists in the treatment sector is the inability to accurately quantify service gaps and plan for comprehensive, evidence-informed systems of treatment and support. To obtain a better understanding of the gap between service need, current availability and utilization, the NTIWG is linking to a needs-based planning research team led by Dr. Brian Rush at the Centre for Addiction and Mental Health (CAMH), Dr. Jürgen Rehm (CAMH), Dr. Joël Tremblay (University of Quebec), Dr. Scott Patten (University of Calgary) and Dr. Daniel Vigo (Simon Fraser University). The needs-based planning project is funded by Health Canada until September 2018. The overall goal of this project is to develop a model that key decision-makers in health planning jurisdictions across Canada can use to estimate the resources required to address the needs for services and supports relating to substance use problems in their jurisdictions, including those linked with concurring mental health challenges.

This initiative is working to develop a model that estimates levels of treatment need based on population data derived from the Canadian Community Health Survey and other sources. It then translates these levels of need into required service categories in a stepped-care model. The needs-based planning and NTI service categories align, allowing a comparison of population need versus

service use. Although there are limitations within the NTI data, such as a lack of some data from various Canadian jurisdictions, these gaps can be addressed with additional data sources. Together, the two projects contribute information required for evidence-based system planning.

Estimating the Burden of Substance Use

There is currently a lack of comparable, valid data on the harms and societal costs associated with the use of psychoactive substances. The most comprehensive assessment of the burden of substance use in Canada was provided by CCSA's previous cost study (Rehm et al., 2006). This study estimated that in 2002 alcohol, tobacco and illicit drug use cost Canadians $22.8 billion, of which 20% ($4.2 billion) was attributed to direct healthcare costs, including substance use treatment.

An update to this study is currently being led by CCSA in collaboration with partners in order to provide up-to-date estimates of the burden of alcohol and other drug use on Canadian society, and is anticipated to be released in the spring 2018. The overall objectives of the project are to develop an online tool and accompanying research reports estimating trends in both harms and costs over time. Part of this work will include estimating the costs of residential and non-residential treatment for problematic substance use, which aligns with the NTI project that monitors and collects treatment service use data. The cost study is expected to increase awareness, access to and capacity for measuring substance use trends at the jurisdictional level. Ultimately, this work will contribute to the evaluation of the efficacy of drug policies, programs and services designed to reduce the harms associated with psychoactive substance use.

Conclusion

To date, this is the only report to provide information on publicly funded substance use treatment services across Canada and continues to make a significant contribution to our understanding of the use of substance use treatment in Canada. Considering that only one in ten individuals with a substance use disorder receive any type of specialty treatment, the data in the current report reflect a small proportion of the individuals struggling with substance use disorders in Canada. Moreover, the individuals that do seek treatment for substance use often experience a number of challenges navigating different treatment services and support (National Treatment Strategy Working Group, 2008). Jurisdictions in Canada need to work towards offering a comprehensive treatment model that offers a range of services and supports that meet the needs of individuals, as evidence reveals that substance use disorders can be effectively treated (Surgeon General Report, 2017).

References

Butt, P., Beirness, D., Gliksman, L., Paradis, C., & Stockwell, T. (2011*). Alcohol and health in Canada: A summary of evidence and guidelines for low-risk drinking.* Ottawa: Ont.: Canadian Centre on Substance Abuse.

Canadian Institute for Health Information. (2001). *Mental health and addiction indicators: prototype report.* Ottawa, Ont.: Author

College of Family Physicians of Canada & Canadian Centre on Substance Use and Addiction. (2012). *Alcohol screening, brief intervention and referral*. Retrieved from www-sbir-diba.ca.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 593-602.

National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: recommendations for a national treatment strategy.* Ottawa, Ont.: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.

McQuaid, R.J., Malik, A., Baydack, N., Stargardter, M., & Morrisey, M. (2017). *Life in Recovery from Addiction in Canada.* Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., . . . Taylor, B. (2006). *The costs of substance abuse in Canada 2002.* Ottawa, Ont.: Canadian Centre on Substance Use and Addiction.

Rush, B., Tremblay, J., Fougere, C., Behrooz, R., Perez, W., & Fineczko, J. (2014). *Development of a needs-based planning model for substance use services and supports in Canada*. Ontario, Canada: Centre for Addiction and Mental Health.

Statistics Canada. (2014). *Canadian Community Health Survey: mental health—public use microdata file, derived variable (DV) specifications*. Ottawa, Ont.: Author.

Statistics Canada. (2017). *Canadian Tobacco, Alcohol and Drugs Survey: Summary of results for 2015.* Ottawa, Ont.: Author.

Surgeon General Report (2017). *Facing addiction in America: the Surgeon General's report on alcohol, drugs, and health*. Washington, DC: U.S. Department of Health and Human Services.

Thomas, G. (2005). *Addiction treatment indicators in Canada: an environmental scan.* Ottawa, Ont.: Canadian Centre on Substance Abuse.

Young, M. M., & Jesseman, R. (2014). *The impact of substance use disorders on hospital use*. Ottawa, Ont.: Canadian Centre on Substance Abuse.

Appendix A: National Treatment Indicators Working Group Membership

As of January 2017

Name	Organization
Camiré, Martin	Institut national d'excellence en santé et services sociaux
Dell, Debra	Youth Solvent Addictions Committee
Di Gioacchino, Lisha	Canadian Centre on Substance Use and Addiction
Evans, Todd	Strategic Policy Branch, Health Canada
Hansen, Rebecca	Yukon Health and Social Services, Alcohol and Drug Services
Leggett, Sean	Manitoba Healthy Living and Seniors
McCon, Karen	Drug and Alcohol Treatment Information System (Ontario)
Macknak, Kelsey	Saskatchewan Ministry of Health
McQuaid, Robyn (co-chair)	Canadian Centre on Substance Use and Addiction
Outhwaite, Harlie	Strategic Policy Branch, Health Canada
Panait, Daniela	Healthy Environments and Consumer Safety Branch, Health Canada
Pellerin, Annie	New Brunswick Department of Health
Reddin, Shauna	Health PEI
Ridgeway, Diana	Canadian Institute for Health Information
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
Shen, Zhijie	Alberta Health Services
Stewart, Karrie	First Nations and Inuit Health Branch
Urbanoski, Karen (co-chair)	University of Victoria
Vivian-Beresford, Ann	Newfoundland and Labrador Centre for Health Information
Weekes, John	Correctional Service Canada

Appendix B: Indicators Collected for 2014–2015 Data Collection

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

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

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

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

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

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

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

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

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

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

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

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

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

Indicator 36-47: Total number of unique individuals attending public specialized treatment services (by primary substance for which treatment was being sought).

Appendix C: Definitions

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

Employed full-time, employed part-time, student, unemployed, other (i.e., retired, unpaid labour, employment assistance/insurance, disability, leave of absence)

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

Housing status

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

New Individuals

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

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.

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.

Service events

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

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 service events over the course of a year.

Withdrawal management

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

Appendix D: Availability of Treatment Indicators by Jurisdiction for 2014–2015 Data

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

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

Appendix E: Substance Categories

Category	Examples
Alcohol	beer, wine, liquor, cider, coolers
Cannabis	marijuana, hashish, hash oil
Cocaine	cocaine powder, crack
Opioids[75]	morphine, codeine, heroin, fentanyl, methadone, opium, Oxycontin™
Stimulants (excluding cocaine)	amphetamines, methamphetamines, ecstasy, methylphenidate
Hypnotics and sedatives	tranquillizers, anti-depressants, barbiturates, benzodiazepines, GHB, methaqualone
Hallucinogens	LSD, mushrooms, PCP, mescaline, salvia, ketamine
Inhalants and solvents	gasoline, glue, hairspray, aerosols, household cleaners, paint thinner
Steroids/performance enhancing drugs	human growth hormone, testosterone, winstrol, dianabol
Over the counter medication	antihistamine, ASA, ephedrine
Prescription drugs[76]	Concerta™, Ritalin™, Adderall™, Dexedrine™
Other drugs	non-beverage alcohol

[75] Includes prescription opioids.
[76] Excludes prescription opioids.