Recovery Journey Project
Recruitment & Data Collection Procedures (2015-2017): Technical Report

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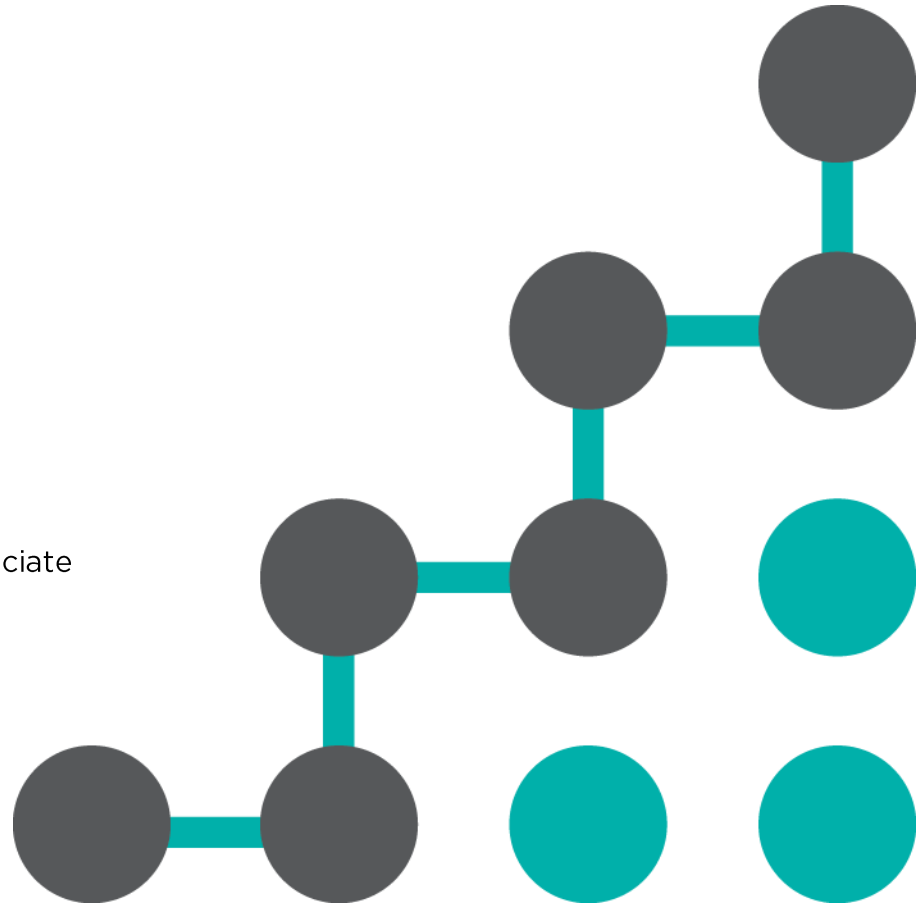

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For more information about the Recovery Journey Project, please visit:
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TABLE OF CONTENTS

1. INTRODUCTION

The Recovery Journey Project (RJP), is a research study designed to measure recovery outcomes among individuals who receive inpatient treatment for mental health and addictions (MHA). The primary goal of the RJP is to provide evidence that can guide and continually improve MHA practice. This multi-year, longitudinal study is conducted and led by researchers at Homewood Research Institute (HRI), an independent, not-for-profit charitable research organization. HRI worked directly with treatment providers to collect data from former patients and clients to better understand the recovery process and inform improvements to MHA treatment. This research study received ethics approval from the Regional Centre for Excellence in Ethics, Research Ethics Board in Guelph, Ontario, Canada (Protocol #15-03).

The data collected in the RJP can be used to:

- Monitor and evaluate program quality and effectiveness;
- Inform program planning and quality improvement efforts;
- Generate new knowledge about the recovery process; and,
- Shape future improvements across the MHA systems.

The RJP was first launched in what was formerly known as the Addiction Medicine Service (AMS) at Homewood Health Centre (HHC) in 2015. The program is now known as the Addiction Medicine Program, but this document will refer to the AMS name of the program. This report refers to the first generation of the project, where AMS patients were invited to complete a series of self-reported questionnaires administered at admission (baseline), end of treatment (discharge) and 1-, 3-, 6- and 12-month time points after treatment (post-discharge follow-up). All patients admitted to the program were invited to participate in the project. Participation in the project was voluntary.

Key indicators of recovery were measured including substance use, mental and physical health, occupational performance, social relationships and functioning, and overall quality of life and life satisfaction. Several other measures were collected for exploratory purposes given their expected link to recovery, including therapeutic alliance, craving, physical activity and continuing care involvement. The development and implementation of the recovery monitoring system, has been previously documented by Costello et al. (2016).

2. REPORT PURPOSE

The purpose of this report is to provide an overview of the RJP recruitment and data collection procedures during the first two years of the study (2015-2017), including response and retention rates, and an overview of key sample characteristics.

3. STUDY SETTING

Participants were recruited from the AMS, an inpatient substance use disorder (SUD) treatment program located in a large MHA treatment setting (HHC) in Guelph, Ontario, Canada. At the time of the study, the program offered a 35-day, group-based treatment to adults aged 19+ with alcohol and/ or other SUDs and a 56-day integrated programming for patients with concurrent post-traumatic stress. Operating under a medical monitoring/ management model, including 24-hour nursing care and daily physician availability, the program provided recovery-oriented education and skills training led by a multidisciplinary team of clinicians and health professionals. Treatment was largely abstinence-based (e.g., 12-Step facilitation), however, medications to support abstinence including opioid agonist therapy were provided, as necessary. The program accommodated up to 105 patients, at any given time, through a combination of private, semi-private, and public (i.e., provincial) funding.

4. ELIGIBILITY

Patients were eligible to participate in the study if they:

a) were admitted to AMS between April 2015 and March 2017
b) were in AMS for at least two days
c) were aged 19+ at the time of admission
d) were not already enrolled in the RJP study from a previous admission (See 5.4 Readmissions)

5. RECRUITMENT AND CONSENT PROCEDURES

An active consent model was used to recruit participants into the study. Eligible patients had two opportunities to enroll into the study – at admission (within the first week of treatment) and at discharge (within the last week of treatment, prior to discharge) (**Figure 1**). Recruitment groups were held once per week – one for those eligible at admission and one for those eligible at discharge.

5.1 Recruitment and Consent at Admission

Admission recruitment groups were held on the AMS unit once a week. Each week, research staff were provided with a program admission list with administrative information. This information was recorded in an electronic participant tracking database (Microsoft Access) and used to invite patients to the recruitment group during their first week of treatment. A group attendance list was posted on the unit, and the recruitment group was also indicated on patients' program schedule. Although participation in the study was voluntary, through consultation with the AMS leadership team, it was decided that attendance at the admission and discharge

groups was mandatory in order to comply with program rules indicating mandatory attendance at all groups and activities.

Attendance was recorded at the beginning of each group. Patients were provided an information letter containing material about the study, participation requirements and rights. To enhance comprehension of the information letter, research staff provided a verbal overview of the information letter, answered any questions regarding the letter, and then concluded with an invitation to patients to participate in the study. Patients who declined participation in the study were permitted to leave the group, given the Homewood Personal Health Information pamphlet to remind them of their health information rights, and reminded to attend the discharge recruitment group later in their treatment stay.

For patients who wanted to participate in the study, written consent was obtained. In addition, a separate, optional consent was obtained to use a portion of their provincial health card number obtained from HHC, to link their unidentifiable RJP questionnaire responses to external healthcare databases for future research and evaluation purposes. This consent was collected, for example, to provide study investigators with the ability to evaluate whether the treatment and support received outside of their treatment in AMS had contributed to the participant's recovery.

Participants then completed a Re-contact Form to be used for contact at the post-discharge time points. Preferred contact method (telephone, email or both) and preferred contact time were captured. Participants were also asked to voluntarily provide contact information for an alternate contact such as a relative or close friend in the event that the participant was unreachable at the post-discharge time points. In compliance with Canadian Anti-Spam Legislation (CASL), participants were directly informed that their contact information would only be used for the purpose of contacting them to complete the follow-up questionnaires. Research staff recorded the consent status of each patient on the paper-based attendance list, which was later entered into the electronic participant tracking database.

5.2 Re-Consent, Recruitment and Consent at Discharge

Discharge recruitment groups were held on the program unit once a week. Each week, research staff were provided with list of patients planned for discharge and required to attend the discharge recruitment group that week. An attendance list was posted on the unit, and the recruitment group was also indicated on patients' program schedules. In preparation for the group, research assistants reviewed the discharge list to identify participants who had enrolled in the study during the admission recruitment group. Consent and Re-contact forms were retrieved for each respective participant.

Attendance was recorded at the beginning of the group. Patients who had enrolled in the study at the admission recruitment group were provided with their completed Consent and Re-contact forms. Patients who did not have the opportunity to join the study upon admission to the program, or declined participation at admission were given an information letter containing material about the study, participation requirements and rights. Similar to the admission recruitment group, the research staff provided an overview of the study, and concluded with an invitation to participate in the study. Those who declined participation in the study were permitted to leave the group and given the Homewood Personal Health Information pamphlet to remind them of their health information rights.

For patients who were interested in participating in the study that had not enrolled during the admission recruitment group, written consent was obtained and the Re-Contact Form was completed (described in Section 5.1). Conversely, patients who had enrolled in the study at the admission recruitment group were asked whether they wished to continue their participation in the study (i.e., re-consent) and to verify the information on their Re-contact Form. Patients who had enrolled in the study at admission, but were discharged prematurely from the program (i.e., unplanned discharge) and/ or did not attend the discharge recruitment group, were automatically re-consented. Research staff recorded the consent status of each patient on the paper-based attendance list, which was later entered into the electronic participant tracking database.

6.0 DATA COLLECTION PROCEDURES

Data was collected at multiple points over time to capture the chronic nature of addiction, and changes to recovery over time. To monitor short-term treatment outcomes, data was collected at admission (baseline) and end of treatment (discharge). To measure longer-term outcomes over time, data was collected at 1-, 3-, 6- and 12-month time points after treatment (post-discharge) (**Figure 1**). It is important to note that we followed up with all participants, regardless of whether or not they completed treatment (i.e., prematurely discharged).

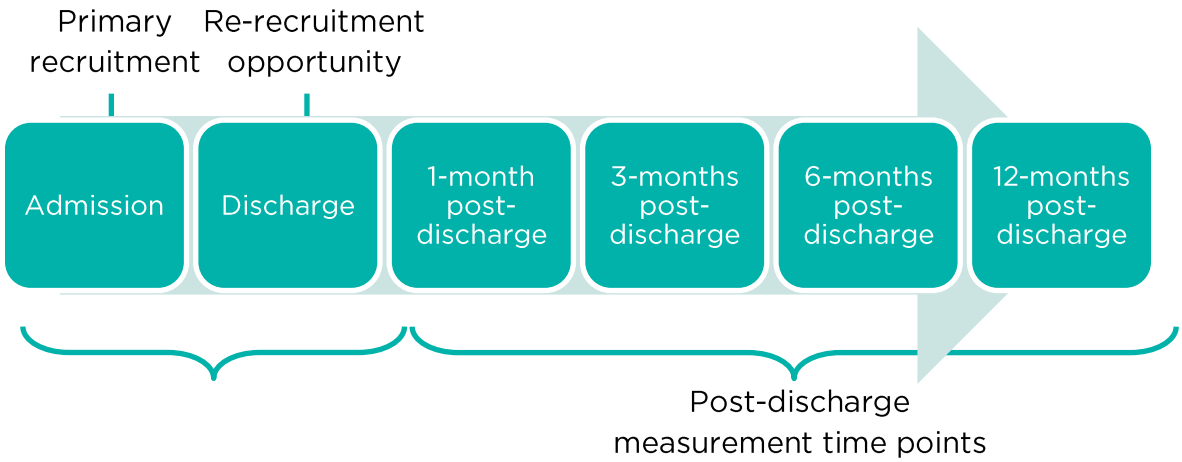


Figure 1. Data collection time points

6.1 Baseline Time Point

During the admission recruitment group, after consent was obtained, research staff administered an electronic version of the baseline questionnaire to participants via a handheld tablet. Research staff inputted the unique study identification number into the electronic questionnaire before the participant began. Participants then completed the questionnaire during the remaining group time (approximately 20-30 minutes). Research staff were available if participants required any assistance. Participants were encouraged to complete the entire questionnaire, but were permitted to skip questions or stop at any time. After the baseline data collection was complete, research staff updated the electronic participant tracking database with the consent and baseline participation information for each participant.

6.2 Discharge Time Point

During the discharge group, following the re-consent/re-recruitment process, research staff administered the electronic discharge questionnaire to participants via a handheld tablet. Research staff inputted the unique study identification number into the electronic questionnaire before the participant began. Participants then completed the questionnaire during the remaining group (approximately 20-30 minutes). Research staff were available if participants required any assistance. Participants were encouraged to complete the entire questionnaire, but were permitted to skip questions or stop at any time. Upon leaving the group, participants were provided with a wallet size reminder card containing anticipated follow-up dates.

Once the discharge data collection was complete, the research staff updated the electronic participant tracking database with any changes to participants' contact information, the discharge questionnaire completion date, scheduled discharge date and anticipated dates for the follow-up questionnaires. Participants who were discharged prematurely from the program and/ or did not attend their scheduled discharge data collection group were still scheduled to be followed up with at the 1-, 3-, 6-, and 12-month periods based on the initial anticipated discharge date provided by HHC at admission.

6.3 Post-Discharge Time Points

Participants were asked to complete follow-up questionnaires at 1-, 3-, 6- and 12-months, post-discharge. The date of their follow-up questionnaire was based on the anticipated discharge date from the AMS program. Two methods of contact were tested: email and telephone. Participants who provided *both* an email address *and* a telephone number on their re-contact form, and selected *both* telephone *and* email as their preferred contact method were randomized to receive their each of their post-discharge follow-up questionnaires either by email *or* telephone. Those who

provided *only* an email address and/ or selected email as their preferred contact method on their re-contact form were contacted by email. Those who provided *only* a telephone number and/ or selected telephone as their preferred contact method on their re-contact form were contacted by telephone. Assignment to a contact method was done after the discharge data collection time point (See **Appendix B** for flow chart). Once participants were assigned to a contact method, they could not be moved to a different contact method.

6.3.1 Post-Discharge Email Follow-up

Following the discharge data collection time point, the research coordinator pre-scheduled the distribution of the 1-, 3-, 6-, and 12-month post-discharge follow-up questionnaires via an online survey software platform (FluidSurveys) based on the dates populated in the electronic participant tracking database. On the scheduled follow-up date, the participant was automatically sent an initial email. Three days after the initial email, if the questionnaire was not completed, a automatic reminder email was sent. This reminder process was repeated two more times (three days apart) for a maximum of three reminders. This reminder process was decided on through reviewing research literature and consulting with groups implementing similar outcomes monitoring systems.

The email was sent from the "Health Survey Group" email address, an alias address not affiliated with HRI or HHC, that was created to ensure privacy and confidentiality. The body of the email introduced the research group, the purpose of the project, and provided a link to the questionnaire, as well as reminded participants that they could withdraw from the study at any point. Upon opening the link, the participant could complete the questionnaire in one sitting (20-30 minutes), or partially complete the questionnaire, and re-open it at later time, continuing from where they left off. An email address and an unlisted local telephone number were provided for participants to speak directly with a member of the research team, if needed.

6.3.2 Post-Discharge Telephone Follow-up

Each week, the research coordinator generated a weekly follow-up call list for participants assigned to telephone post-discharge follow-up, based on the anticipated follow-up dates recorded in the electronic participant tracking database. Post-discharge follow-up calls were placed from an unlisted local telephone number and research assistants were instructed to introduce themselves as members of the "Health Survey Group" so to ensure privacy and confidentiality. Participants were called up to three times, after which the alternate contact person could have been called. A maximum of five call attempts was made. Each call was documented in the electronic participant tracking database using a call log.

If the participant was reached, the research assistant re-introduced themselves as being from the RJP team and participants were reminded of their agreement to participate in the study. The research assistant reviewed the limits of confidentiality

for the study with the participant, including the need to intervene if the participant were to reveal they intended to harm themselves or another person (See Section 9: Safety Protocols). The research assistant would then administer the post-discharge follow-up questionnaire (20-30 minutes). Participants could skip questions and/ or complete the questionnaire at another time. Once the questionnaire administration was complete, participants were asked to verify and update their contact information if necessary. Participants were then reminded of the approximate date of their next follow-up.

If a participant was unreachable at the time of the call, the research assistant left a voicemail introducing themselves as from the "Health Survey Group", the general purpose for the call, inviting the participant to call back at a convenient time at the unlisted phone number. If, upon being reached, a participant declined participation in the questionnaire or asked to withdraw from the study, the research assistant thanked them for their participation to date and followed the withdrawal procedure (See Section 6.4).

6.4 Withdrawal Procedures

Participants were able to withdraw at any point in the study, and were reminded of this at each of the follow-up time points. Participants contacted by telephone were given the opportunity to withdraw prior to beginning the questionnaire. Participants who were contacted by email were given the opportunity to withdraw via an unsubscribe option in the body of all emails. Participant withdrawal was recorded electronically and via a paper-based form kept in their participant folder.

6.5 AMS Readmissions

Patients who had been readmitted to the program (over an indefinite time period) were identified each week using the program admission list; the electronic database would notify research staff when a duplicate patient was entered into the database. Readmitted patients (i.e., readmissions) to the program were eligible to participate in the RJP if:

a) they had not consented to participate during their previous admission; or,
b) they consented during their previous admission, but their participation in the study had concluded (i.e., completed the entire 12-months of post-discharge follow-up, or withdrew their participation).

Readmissions who consented during their previous admission and had not concluded their participation in the study (i.e., were still within the 12-month post-discharge follow-up timeframe), were not eligible to participate again. These participants were still required to attend the recruitment groups, where instead, they were asked whether they wished to continue their participation in the study (i.e., re-consent), and then were permitted to leave the group. These participants received their post-

discharge follow-up questionnaires on the original follow-up trajectory of their previous admission.

7. RECOVERY QUESTIONNAIRE (RQ)

Using the Recovery Questionnaire, key indicators of recovery were measured at each of the data collection time points. **Table 1** describes the high-level constructs and domains measured at each of the time points.

8. COMPENSATION

Participants were not provided any compensation for their participation in the study.

9. SAFETY PROTOCOLS

Overall, the study was low risk to participants. However, given the sensitive nature of some of the measures (e.g., mental health symptoms), some questions may have led to uncomfortable, upsetting or triggering feelings. Safety protocols were developed to manage any distress among participants during data collection.

9.1 Within-treatment Data Collection: Baseline and Discharge

During data collection groups on the unit, where research staff were always present, if a participant self-reported immediate distress, during or after completing the questionnaire, the research staff referred the participant to the AMS nursing station, located near the data collection group room.

9.2 Post-discharge Data Collection

9.2.1 Email Follow-up

For participants completing post-discharge follow-up questionnaires via email, a note was included in the body of the email and the footer of the questionnaire advising participants to contact #911 or to go to the nearest emergency department if they were in immediate distress. As part of the mental health questions, participants were asked if they have experienced suicidal ideation in the past 30 days. If a participant endorsed this item, a prompt would immediately appear including telephone numbers for their respective provincial crisis/ referral organization, encouraging participants to contact them if needed or desired. Following completion of the questionnaire, a thank you page with a similar referral prompt appeared for all participants.

Table 1. Overview of Recovery Questionnaires

		Time point/ Time frame		
Construct/Domain	Primary Measures	Admission *90 days before treatment*	Discharge* *Past 30 days*	Post-discharge *Past 30 days*
Demographics	Gender, age, education, employment (status, job type, reason for not currently working), marital status, sexual orientation, housing, number of days in a confined living situation	✓	×*	✓ Only employment questions
Substance use	Any use and frequency of use: tobacco, alcohol, and drugs (i.e., marijuana, hallucinogens, cocaine, other stimulants, sedatives, heroin or heroin mix, methadone, other opioids, steroids, inhalants, and any other drug used for the purpose of getting high) Degree of alcohol/drug cravings during past 7-days Drug(s) of choice	✓	✓	✓ Reference to since left treatment & past 30 day use
Social Wellness	Degree to which one is able to fulfil social roles and responsibilities Number of people with whom one regularly socializes and number of those people who weekly get drunk or use drugs	✓	×	✓
Psychological Wellness	Degree of motivation; confidence to engage in/maintain a recovery program Degree of hopefulness; meaningfulness of life Degree of readiness to engage in a recovery program	✓	✓	✓
Physical Wellness	Perceived physical health status Presence and perceived severity of physical or medical problems	✓	✓	✓
Physical Activity	Engagement in physical activity during past 7 days	✓	✓	✓
Mental Health	Perceived mental health status Presence and perceived severity of problems related to depression, sleep disturbance, anxiety, distress, suicidality, delusional thinking	✓	✓	✓

Daily Life Functioning	Ability to perform everyday living activities Degree of financial problems Engagement in leisure activities during the past 7 days	✓	×	✓
Occupational Wellness	Degree to which one is able to meet regular responsibilities at work/school Attendance at work/school Receipt of work/school disciplinary measures	✓	×	✓
Aftercare Involvement (Health Services)	Receipt and type of psychotherapy or counseling for emotional or mental health problems Receipt and type of treatment or services for drug or alcohol use	✓	×	✓
Aftercare Medication Use (related to mental health, use of alcohol or drugs and/or physical health or other medical problems)	Medication recommendations, medication adherence, reasons for non-adherence	×	×	✓
Aftercare Involvement (Twelve Step affiliation)	Engagement in 12-step program and activities	✓ Past 90 days, current, lifetime	✓ Past 30 days & current	✓ Past 30 days & current
Use of Health Services	Number of visits to a medical doctor or nurse Number of visits to an emergency room Admissions to hospital	✓	×	✓
Criminal Engagement	Involvement in criminal behavior Number of times arrested and charged with breaking the law	✓	×	✓
Quality of Life and Life Satisfaction	Perceived overall quality of life Degree of life satisfaction (i.e., intimate relationships, family relationships, level of happiness, living situation, how life is going, work/school situation, and friends, recreation and social activities)	✓	✓	✓
Therapeutic Alliance		×	✓	×

*Participants who joined the study at the discharge time point, and did not complete a baseline questionnaire, received a version of the discharge questionnaire that included demographic questions from the baseline questionnaire.

9.2.2 Telephone Follow-up

For participants completing post-discharge follow-up questionnaires via telephone, at the beginning of the telephone call, the research assistant explained the limits of confidentiality including the need to intervene if the participant were to reveal they intended to harm themselves or another person. The research assistant would then verify and record the participant's current location in the event of an emergency where the research assistant was obligated to call #911. In this event, the RA would respond by indicating their obligation to call #911 and stay on the line with the participant.

As part of the mental health questions, participants were asked if they have experienced suicidal ideation in the past 30 days. If a participant endorsed this item, the research assistant asked if the participant would like to speak with someone about this. If yes, the research assistant transferred the participant to their respective provincial crisis/ referral organization. If not, the research assistant proceeded with the remainder of the questionnaire. Once administration of the questionnaire was complete, all participants were offered the contact information for their provincial crisis/ referral organization, prompting participants to contact them if needed or desired.

10. SUMMARY OF KEY STUDY PARTICIPATION STATISTICS

10.1 Recruitment Rates

Recruitment rates are described more fully below and summarized in a flow diagram (Appendix A)

10.1.1 Attendance Rates

The attendance rate is defined by the number of patients who attended a baseline recruitment session divided by the total number of patients admitted to the AMS program. Between April 1, 2015 and March 31, 2017, 1963 patients were admitted to the AMS program at HHC. Of all patients admitted to the program, 87.5% (n=1717) attended a baseline recruitment session and were invited to participate in the study. Patients did not attend baseline recruitment for reasons including appointment conflicts, feeling unwell/ experiencing withdrawal, or no shows (10.9%; n=214). The remaining 1.7% of patients (n=35) had a missing baseline attendance status (i.e., due to administrative error) (Table 1).

10.1.2 Consent Rate

The consent rate is defined by the number of patients who consented to participate in the study divided by the total number of patients who attended the baseline recruitment group. Of the 1717 patients who attended a baseline recruitment session, 48.3% (n=829) consented to participate in the study (Table 2).

Table 2: Consent rates by year

	Admitted to program	Consented at baseline (BL) %(n)	Consented at discharge (DC)[1] %(n)	Declined at both BL and DC %(n)	Missed/ Not eligible %(n)
Year 1 (Apr 2015 – Mar 2016)	981	42.3% (415)	4.9% (48)	48.2% (473)	4.6% (45)
Year 2 (Apr 2016 – Mar 2017)	982	42.1% (414)	4.3% (42)	51.1% (501)	2.5% (25)
Total	1963	42.2% (829)	4.6% (90)	49.6% (974)	3.6% (70)

[1]This rate applies only to participants who had not already consented at admission (i.e., newly consented at discharge). See section 5.2 for re-consent procedures.

10.1.3 Representation Rate

The representation rate is defined by the number of participants who provided baseline data (i.e. completed a recovery questionnaire at the baseline time point) and completed treatment, divided by the total number of patients admitted to the AMS program. The data collected represents 41.1% of the population of patients admitted and discharged from AMS between April 1, 2015 and March 31, 2017.

10.2 Analysis: Participants vs. Non-participants

Of those admitted and discharged from AMS between April 1, 2015 and March 31, 2017, 41.1% consented to participate in the study and provided baseline data. Since a considerable proportion of patients did not participate, we examined the potential differences between those who participated and those who did not to recognize how these groups differed on key characteristics. As non-participants did not have any RJP data, the following analyses was conducted using hospital administrative databases as well as data from the Resident Assessment Instrument – Mental Health (RAI-MH)© tool that HHC collects for all patients admitted to the program.

Table 3 demonstrates which characteristics are significantly associated with consenting to participate in the RJP at admission. Patients who consented to participate in the study at admission differed significantly from those who did not by age category ($p = 0.007$), education level ($p = 0.001$), employment status ($p < 0.001$) and discharge type ($p < 0.001$). No other significant differences were detected between groups in key demographics or other baseline measures under study.

Table 3: Sample demographics – Participants vs. Non-participants

		All AMS patients (n=1963) %(n)	Non-participant[1] (n=1155) %(n)	Participant[2] (n=808) %(n)	Chi-square/ T-test (*p*-value)
Age	19-29 years	17.5 (339)	18.2 (206)	16.5 (133)	**14.2 (0.007)**
	30-39 years	26.1 (506)	27.0 (305)	24.9 (201)	
	40-49 years	28.4 (550)	27.4 (309)	29.8 (241)	
	50-59 years	22.0 (427)	20.2 (228)	24.6 (199)	
	60+ years	6.0 (116)	7.3 (82)	4.2 (34)	
	Mean (SD), years	41.6 (11.6)	41.4 (11.9)	41.8 (11.2)	-0.7 (0.489)
Gender	Male	65.1 (1278)	64.7 (747)	65.8 (531)	0.26 (0.607)
	Female	34.9 (684)	35.3 (408)	34.2 (276)	
Education	Completed high school or less	27.4 (536)	30.4 (350)	23.1 (186)	**13.36 (0.001)**
	Some college/ university	27.5 (538)	27.1 (312)	28.1 (226)	
	Diploma/ degree	45.2 (884)	42.6 (491)	48.8 (393)	
Employment	Not employed	33.4 (655)	37.9 (438)	26.9 (217)	**26.18 (<0.001)**
	Employed	66.6 (1308)	62.1 (717)	73.1 (591)	
Marital status	Not married or not partnered	56.3 (1106)	57.9 (669)	54.1 (437)	2.85 (0.092)
	Married or partnered	43.7 (857)	48.6 (42.1)	45.9 (371)	
Program stream	Addiction	81.6 (1579)	81.4 (917)	81.9 (662)	0.10 (0.752)
	Addiction + Post-Traumatic Stress	18.4 (356)	18.6 (210)	18.1 (146)	
Discharge type	Planned	82.7 (1601)	79.1 (891)	87.9 (710)	**25.59 (<0.001)**
	Unplanned	17.2 (334)	20.9 (236)	12.1 (98)	

		All AMS patients (n=1963) %(n)	Non-participant[1] (n=1155) %(n)	Participant[2] (n=808) %(n)	Chi-square/ T-test (*p*-value)
Past 14-day alcohol use (any use)	Alcohol	69.3 (1360)	70.3 (812)	67.8 (548)	1.38 (0.241)
Past 3-month (90-day) substance use[3] (any use)	Cannabis	37.1 (729)	38.3 (442)	35.5 (287)	1.54 (0.215)
	Stimulants (incl. cocaine and crack cocaine)	29.3 (576)	30.3 (350)	28.0 (226)	1.25 (0.264)
	Opiates	19.5 (382)	20.4 (235)	18.2 (147)	1.41 (0.234)
	Other drugs (i.e., hallucinogens or inhalants)	2.5 (49)	2.8 (32)	2.1 (17)	0.87 (0.352)
Lifetime psychiatric admissions	One or more lifetime psychiatric admission	51.7 (1015)	53.1 (613)	49.8 (402)	2.10 (0.147)
Self-reported physical health	Poor or Fair	44.0 (864)	45.5 (525)	42.0 (339)	2.41 (0.120)
	Good or Excellent	56.0 (1098)	54.5 (629)	58.0 (469)	

[1]Non-participant = did not provide baseline data. [2]Participant = provided baseline data. [3]Groups are not necessarily mutually exclusive.

10.3 Analysis: Planned vs. Unplanned Discharges

Ninety-eight participants (12.1%) were discharged prior to completing treatment due to family or financial reasons, leaving against medical advice, or non-compliance with program terms and conditions. We examined the potential differences between participants who completed treatment (i.e., planned discharge), and those who did not (i.e., unplanned discharge).

As shown in **Table 4,** participants who were discharged as planned differed significantly from those who were discharged prematurely by mean age (42 vs. 38 years, $p < 0.001$), program stream ($p < 0.05$), self-reported mental health status ($p < 0.05$), lifetime psychiatric admissions ($p < 0.05$) and most frequently used substance: alcohol (66% vs. 56%, $p < 0.05$), cannabis (13% vs. 28%, $p = 0.001$) and stimulants (8% vs. 15%, $p < 0.05$). No other significant differences were detected between groups in key demographics or other baseline measures under study.

Table 4: Sample demographics – Planned vs. Unplanned Discharges

		Full baseline sample (n=808) %(n)	Planned discharge (n=710) %(n)	Unplanned discharge (n=98) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	16.5 (133)	15.1 (107)	26.6 (26)	**14.74 (0.005)**
	30-39 years	24.8 (200)	23.9 (169)	31.6 (31)	
	40-49 years	29.7 (239)	30.7 (217)	22.5 (22)	
	50-59 years	24.6 (198)	25.9 (183)	15.3 (15)	
	60+ years	4.4 (31)	2.1 (6)	5.9 (25)	
	Mean (SD), years	41.8 (11.2)	42.3 (11.0)	38.0 (11.9)	**3.61 (<0.001)**
Gender	Male	66.1 (521)	66.4 (459)	63.9 (62)	0.24 (0.625)
	Female	33.9 (267)	33.6 (232)	36.1 (35)	
Ethnicity	White	94.1 (727)	94.3 (641)	92.5 (86)	0.47 (0.493)
	Racialized	6.0 (46)	5.7 (39)	7.5 (7)	
Education	High school or less	23.4 (187)	22.2 (156)	32.0 (31)	4.58 (0.102)
	At least some college	34.8 (279)	35.4 (249)	30.9 (30)	
	At least some university	41.8 (335)	42.5 (299)	37.1 (36)	
Employ-ment	Not employed	21.6 (167)	20.8 (141)	27.4 (26)	2.12 (0.145)
	Employed	78.4 (606)	79.2 (537)	72.6 (69)	
Marital Status	Married or partnered	53.1 (409)	54.1 (369)	45.5 (40)	2.34 (0.126)

		Full baseline sample (n=808) %(n)	Planned discharge (n=710) %(n)	Unplanned discharge (n=98) %(n)	Chi-squared/ T-test (*p*-value)
Program stream	Addiction only	81.9 (662)	83.1 (590)	73.5 (72)	5.39 (0.020)
	Addiction + PTSD	18.1 (146)	16.9 (120)	26.5 (26)	
Most Frequently used substance in past 90 days[1]	Alcohol use	65.1 (525)	66.3 (470)	56.1 (55)	7.54 (0.023)
	Cannabis use[2]	14.9 (120)	13.1 (93)	27.6 (27)	14.59 (<0.001)
	Stimulant use (incl. cocaine)[2]	8.9 (72)	8.0 (57)	15.3 (15)	6.35 (0.042)
	Opioids use (incl. heroin and non-prescription methadone)[2]	7.4 (60)	7.3 (52)	8.2 (8)	1.17 (0.557)
Self-reported mental health	Poor or fair	60.9 (482)	59.6 (413)	70.4 (69)	4.28 (0.039)
	Good, Very good, or Excellent	39.7 (309)	40.4 (280)	29.6 (29)	
Self-reported physical health	Poor or fair	41.2 (331)	40.0 (282)	50.0 (49)	3.55 (0.060)
	Good, Very good, or Excellent	58.8 (472)	60.0 (423)	50.0 (49)	
Lifetime psychiatric admissions[4]	One or more lifetime psychiatric admission	49.8 (402)	48.5 (344)	59.2 (58)	3.97 (0.046)

[1]Groups are not necessarily mutually exclusive. [2]Excludes prescription drugs being used as prescribed. [3]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended. [4]Data obtained from a separate HHC dataset (RAI-MH).

10.4 Analysis: Participants with Only Baseline Data vs. with Post-Discharge Follow-up Data

Of the 710 participants who completed treatment and provided baseline data, 60% (n = 426) completed at least one post-discharge follow-up questionnaire (i.e., at 1-month, 3-months, 6-months, and/ or 12-months post-discharge). We examined the potential differences between participants who had completed at least one post-discharge follow-up questionnaire (i.e., had follow-up data), and those who did not (i.e., had only baseline data) to test for possible selection bias.

Table 5 demonstrates that participants who had follow-up data differed from those who did not by age category ($p < 0.0001$), mean age (44 vs. 40 years, $p < 0.0001$), gender ($p < 0.05$), ethnicity ($p < 0.05$), marital status ($p < 0.05$) and if their most frequently used was alcohol ($p < 0.05$). No other significant differences were detected between groups in key demographics or other baseline measures under study.

Table 5: Sample demographics – Participants with follow-up data vs. No follow-up data

		Full baseline sample (n=710) %(n)	Follow-up data (n=426) %(n)	No follow-up data (n=284) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	15.1 (107)	11.7 (50)	20.3 (57)	24.3 (<0.0001)
	30-39 years	23.9 (169)	21.1 (90)	28.1 (79)	
	40-49 years	30.7 (217)	31.2 (133)	29.9 (84)	
	50-59 years	25.9 (183)	30.1 (128)	19.6 (55)	
	60+ years	4.4 (31)	5.9 (25)	2.1 (6)	
	Mean (SD), years	42.3 (11.0)	44.1 (10.8)	39.7 (10.7)	-5.3 (<0.0001)
Gender	Male	66.4 (459)	62.5 (262)	72.4(197)	7.2 (0.007)
	Female	33.6 (232)	37.5 (157)	27.6 (75)	
Ethnicity	White	94.3 (641)	95.8 (391)	91.9 (250)	4.6 (0.031)
	Non-white	5.7 (39)	4.2 (17)	8.1 (22)	
Education	High school or less	22.2 (156)	19.3 (82)	26.5 (74)	5.2 (0.074)
	At least some college	35.4 (249)	36.2 (154)	34.1 (95)	
	At least some university	42.5 (299)	44.5 (189)	39.4 (110)	

		Full baseline sample (n=710) %(n)	Follow-up data (n=426) %(n)	No follow-up data (n=284) %(n)	Chi-squared/ T-test (*p*-value)
Employ-ment	Not employed	20.8 (141)	21.6 (88)	19.6 (53)	0.37 (0.543)
	Employed	79.2 (537)	78.4 (320)	80.4 (217)	
Marital status	Not married or partnered	45.9 (313)	42.5 (175)	51.1 (138)	**4.9 (0.027)**
	Married or partnered	54.1 (369)	57.5 (237)	48.9 (132)	
Program stream	Addiction only	83.1 (590)	81. 9(349)	84.9(241)	1.0 (0.307)
	Addiction + PTSD	16.9 (120)	18.1 (77)	15.1 (43)	
Most Frequently used substance in past 90 days[1]	**Alcohol use**	66.3 (470)	70.4 (300)	60.1 (170)	**8.3 (0.016)**
	Cannabis use[2]	13.1 (93)	12.2 (52)	14.5 (41)	1.5 (0.478)
	Stimulant use (incl. cocaine)[2]	8.0 (57)	6.8 (29)	9.9 (28)	2.9 (0.231)
	Opioids use (incl. heroin and non-prescription methadone)[2]	7.3 (52)	5.9 (25)	9.5(27)	4.2 (0.126)
	Other drug use[3]	4.9 (35)	4.5 (19)	5.7 (16)	1.1 (0.568)
Self-reported mental health	Poor or fair	59.6 (413)	60.2 (253)	58.6 (160)	0.2 (0.669)
	Good, Very good, or Excellent	40.4 (280)	39.7 (167)	41.4 (113)	

		Full baseline sample (n=710) %(n)	Follow-up data (n=426) %(n)	No follow-up data (n=284) %(n)	Chi-squared/ T-test (*p*-value)
Self-reported physical health	Poor or fair	40.0(282)	39.5 (168)	40.7 (114)	0.1 (0.753)
	Good, Very good, or Excellent	60.0(423)	60.5% (257)	59.3 (166)	
Lifetime psychiatric admissions [4]	One or more lifetime psychiatric admission	48.5(344)	49.3 (210)	47.2 (134)	0.3 (0.581)

[1]Groups are not necessarily mutually exclusive. [2]Excludes prescription drugs being used as prescribed. [3]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended. [4]Data obtained from a separate HHC dataset (RAI).

10.5 Response Rates

10.5.1 Overall response rates

Of the 710 participants who completed treatment and provided baseline data, 64.5% (n = 458) completed the discharge questionnaire, 47% (n = 333) completed the 1-month questionnaire, 39% (n = 278) completed the 3-month questionnaire, 38% (n = 267) completed the 6-month questionnaire and 33% (n = 235) completed the 12-month questionnaire. These responses rates are cross-sectional, meaning that the participants who responded at each time point are not mutually exclusive. (See **Appendix A** for Flow Diagram).

10.5.2 Response rates by contact method

Of the 710 participants who completed treatment and provided baseline data 29.6% (n = 210) provided only an email address and/ or listed email as their preferred contact method and 7.2% (n = 51) provided only a telephone number and/or listed telephone as their preferred contact method and so were contacted by email or telephone, respectively. Due to administrative error, 28 participants had missing preferred contact method data. Of these, 17 participants were contacted post-discharge via email, and 11 had no post-discharge data so were not assigned any method of contact. The remaining 59.3% (n = 421) of participants who provided both an email address and a telephone number on their re-contact form were randomized to be contacted post-discharge by either telephone (27.6%, n = 116) or email (72.4%,

n = 305). In total, of the 710 participants who completed treatment and provided baseline data, 23.5% (n = 167) were contacted post-discharge by telephone, and 74.9% (n = 532) by email (See **Appendix B** for Flow Diagram). No significant differences were detected between participants who were contacted post-discharge by telephone or email in key demographics or other baseline measures under study (results not shown here).

Table 6 demonstrates the differences in response rates by contact method at each time point. Response rates were significantly higher for participants who were contacted by telephone at 1-month ($p < 0.0001$), 3-months ($p < 0.05$), and for those that completed at least one post-discharge follow-up questionnaire ($p < 0.001$). No significant differences were detected between response rates for telephone and email at 6- and 12-months (**Table 5**).

We examined the potential differences between participants who completed at least one post-discharge follow-up questionnaire by telephone to those by email. Participants who completed at least one post-discharge follow-up by telephone differed significantly to those by email by gender ($p < 0.05$) (See **Appendix C** for full results). We also examined the potential differences between participants who completed the post-discharge follow-ups at each of the time points by telephone and email. Results were inconsistent across time points, however participants tended to differ by education and/ or marital status (See **Appendix C** for full results). No other significant differences were detected between groups in key demographics or other baseline measures under study at 1-, 3-, 6-, and 12-month time points, or post-discharge follow-up at any time point for participants who completed the questionnaire by telephone and by email.

Table 6: Response rates by contact method

	Full baseline sample (n=710) %(n)	Telephone (n=167) %(n)	Email (n=532) %(n)	Chi-squared (*p*-value)
1-month	46.9 (333)	61.1 (102)	43.4 (231)	**15.9 (<.0001)**
3-month	39.1 (278)	46.7 (78)	37.6 (200)	**4.4 (0.036)**
6-month	37.6 (267)	43.7 (73)	36.5 (194)	2.8 (0.093)
12-month	33.1 (235)	32.9 (55)	33.8 (180)	0.05 (0.830)
Any time point	60 (426)	71.9 (120)	57.5 (306)	**11.0 (0.0009)**

10.6 Retention Rates

Of the 710 participants who consented to participate in the study, completed treatment and provided baseline data, 46.9% (n = 333) completed a questionnaire at 1-month; 32.7% (n = 232) completed a questionnaire at 1- and 3-months; 25.9% (n = 184) completed a questionnaire at 1-, 3- and 6-months; and 21.1% (n = 150) completed questionnaire at 1-, 3, 6- and 12-month post-discharge time points (**Figure 2**). Retention rates are provided for information purposes.[1]

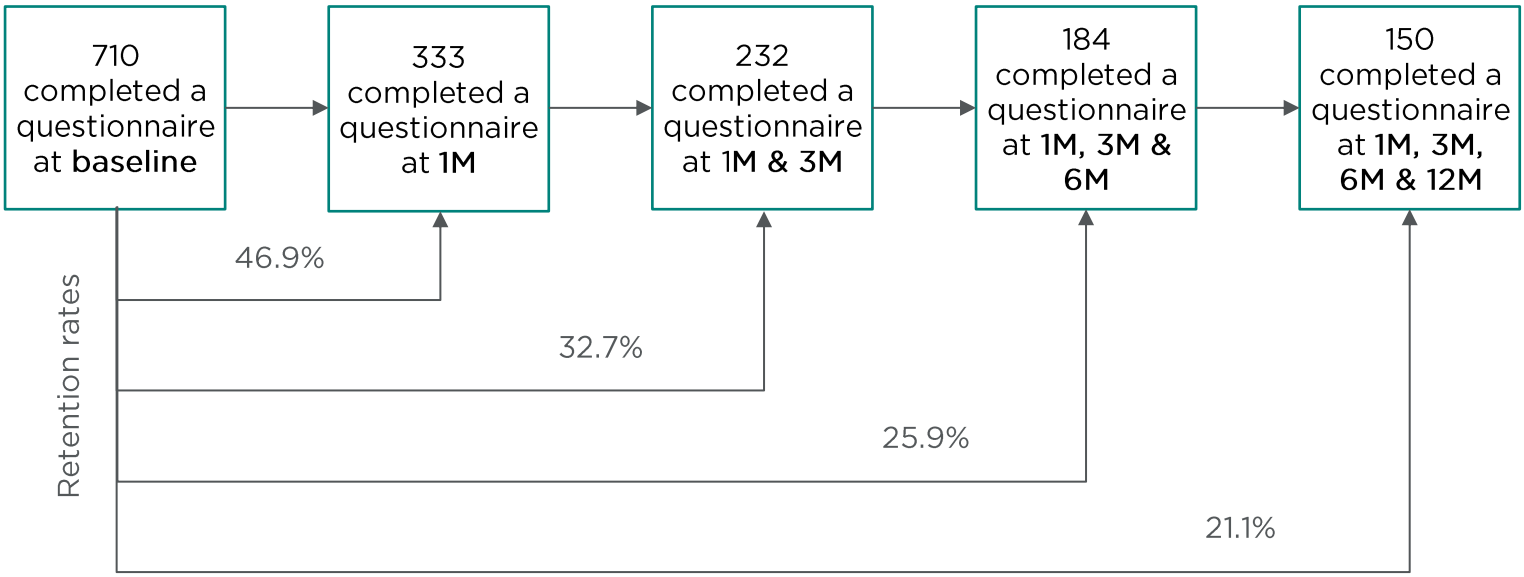


Figure 2: Retention Rates

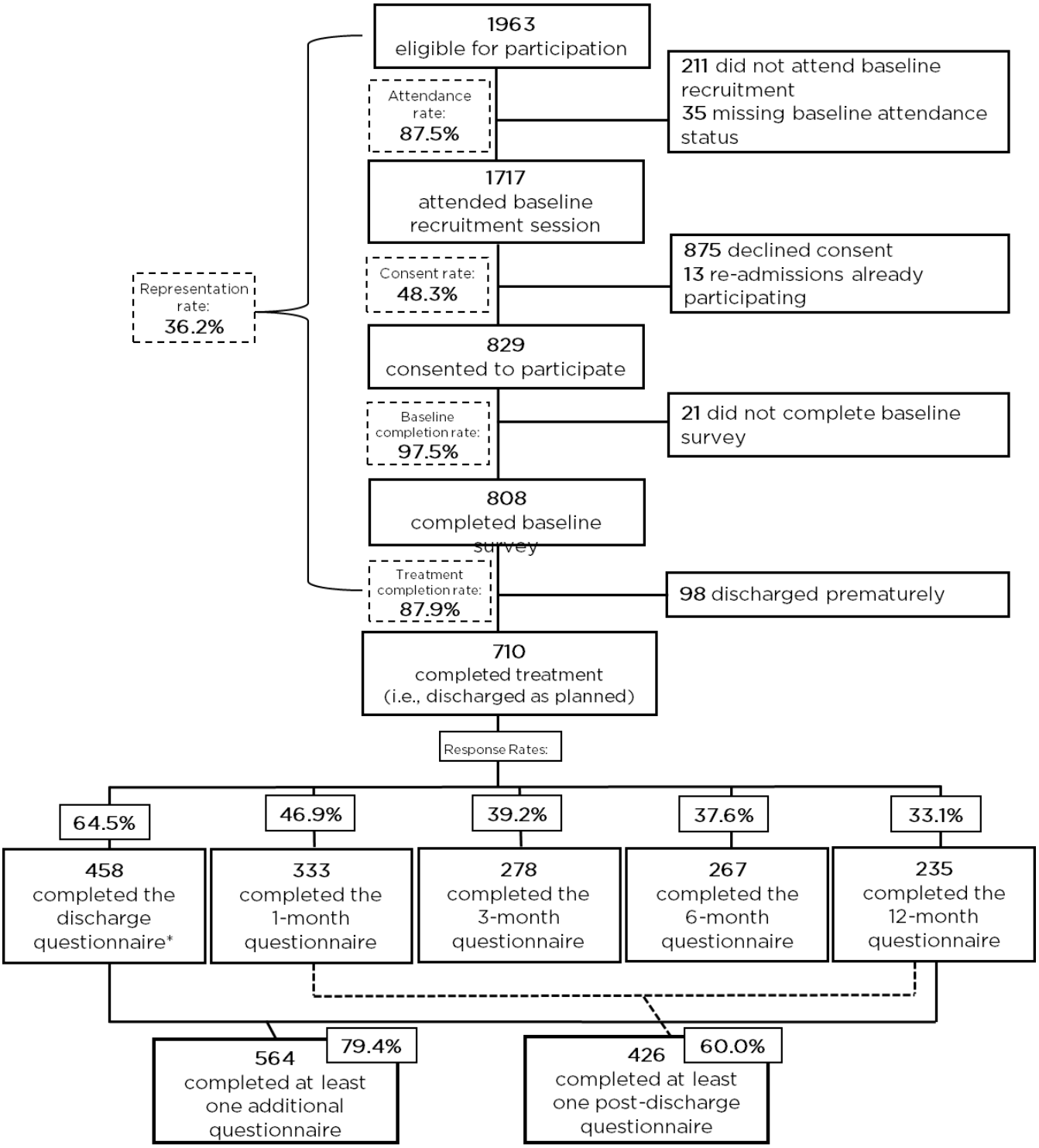
[1]To date, research and analyses using RJP data have used advanced statistical methods such as multiple imputation to account for missing data at each of the post-discharge time points, thus the subsample of participants who completed all post-discharge time points has not been used. For this reason, we did not examine the differences between participants who were retained in the study over time and those who were not.

REFERENCES

Costello, M. J., Ropp, C., Sousa, S., Woo, W., Vedelago, H., & Rush, B. (2016). The development and implementation of an outcome monitoring system for addiction treatment. Canadian Journal of Addiction, 7(3), 15–24.

APPENDIX A

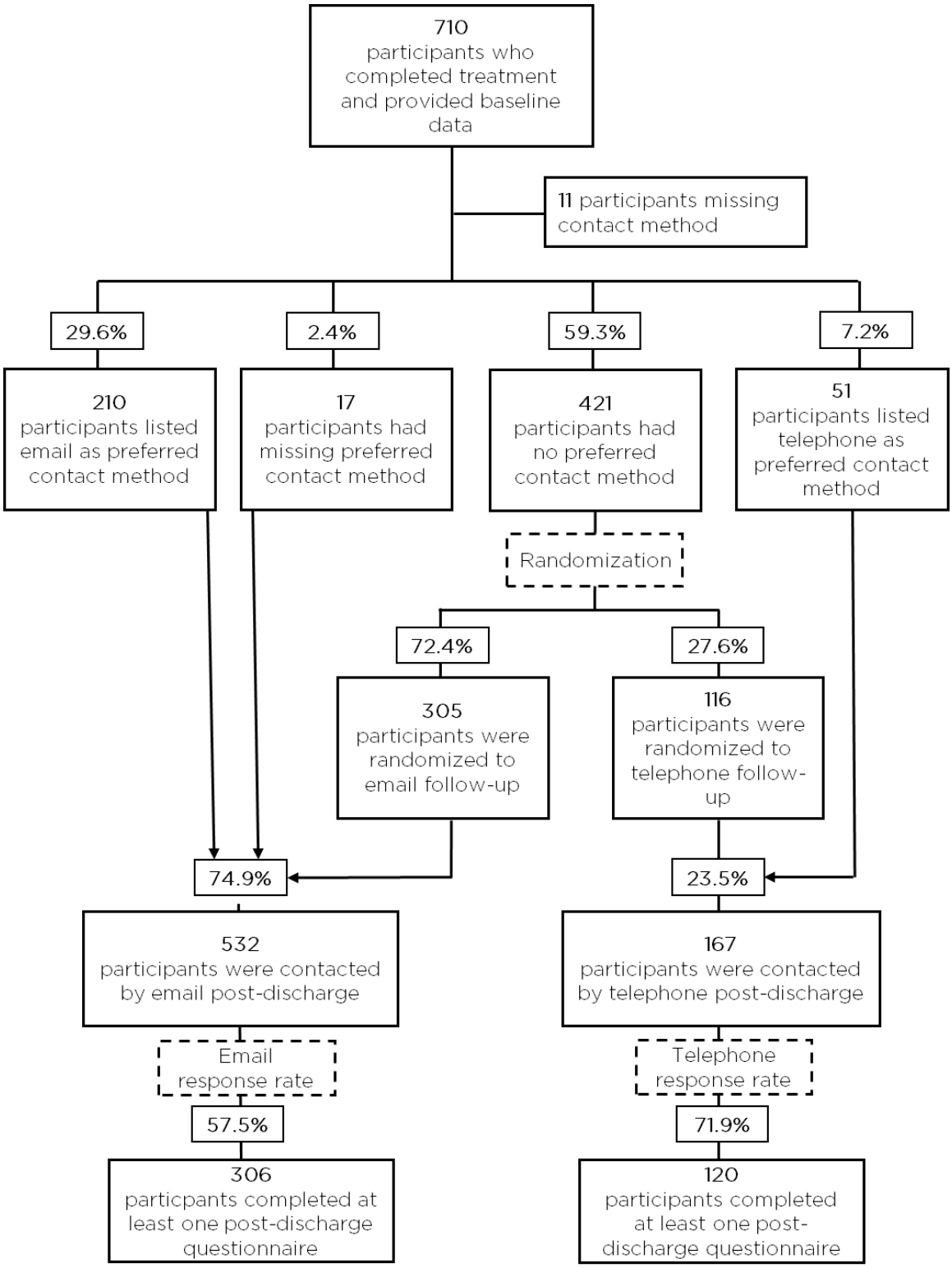
Figure A. Flow diagram depicting sample sizes and response rates, recruited between April 1, 2015 and March 31, 2017



*Participants who did not complete the baseline survey but completed the discharge questionnaire are not included in this rate

APPENDIX B

Figure B: Flow diagram depicting post-discharge contact method and response rates



APPENDIX C

Table C.1: Sample demographics – Participants who completed at least post-discharge follow-up questionnaire by Telephone vs. Email

		Any follow-up data sample (n=426) %(n)	Telephone (n=120) %(n)	Email (n=306) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	11.7 (50)	12.5 (15)	11.4 (35)	4.0 (0.410)
	30-39 years	21.1 (90)	22.5 (27)	20.6 (63)	
	40-49 years	31.2 (133)	25.8 (31)	33.3 (102)	
	50-59 years	30.0 (128)	35.0 (42)	28.1 (86)	
	60+ years	5.9 (25)	4.2 (5)	6.5 (20)	
	Mean (SD), years	44.0 (10.9)	43.9 (11.2)	44.1 (10.7)	-0.19 (0.850)
Gender	Male	62.5 (262)	70.3 (83)	59.5 (179)	**4.3 (0.039)**
	Female	37.5 (157)	29.7 (35)	40.5 (122)	
Ethnicity[1]	White	95.8 (391)	96.5 (109)	95.6 (282)	0.1 (0.695)
Education	High school or less	19.3 (82)	23.5 (28)	17.6 (54)	3.4 (0.178)
	At least some college	36.2 (154)	38.7 (46)	35.3 (108)	
	At least some university	44.5 (189)	37.8 (45)	47.1 (144)	
Employment	Not employed	21.6 (88)	18.3 (21)	22.9 (67)	1.0 (0.309)
	Employed	78.4 (320)	81.7 (94)	77.1 (226)	
Marital status	Not married or partnered	42.5 (175)	48.3 (56)	40.2 (119)	2.2 (0.136)
	Married or partnered	57.5 (237)	51.7 (60)	59.8 (177)	
Program stream	Addiction only	81.9 (349)	86.7 (104)	80.1 (245)	2.5 (0.111)
	Addiction + PTSD	18.1 (77)	13.3 (16)	19.9 (61)	

		Any follow-up data sample (n=426) %(n)	Telephone (n=120) %(n)	Email (n=306) %(n)	Chi-squared/ T-test (*p*-value)
Most Frequently used substance in past 90 days[2]	Alcohol use	66.7 (284)	64.2% (77)	67.6% (207)	0.5 (0.493)
	Cannabis use[3]	12.0 (51)	13.3 (16)	11.4 (35)	0.3 (0.589)
	Stimulant use (incl. cocaine)[3]	6.8 (29)	6.7 (8)	6.9 (21)	0.0 (0.942)
	Opioids use (incl. heroin and non-prescription methadone)[3]	6.8 (29)	7.5 (9)	6.5 (20)	0.1 (0.722)
	Other drug use[4]	11.5 (49)	12.5 (15)	11.1 (34)	0.2 (0.686)
Self-reported mental health	Poor or fair	60.2 (253)	57.6 (68)	61.3 (185)	0.5 (0.494)
	Good, Very Good, Excellent	39.8 (167)	42.4 (50)	38.7 (117)	
Self-reported physical health	Poor or fair	39.5 (168)	41.2 (49)	38.9 (119)	0.2 (0.665)
	Good, Very Good, Excellent	60.5 (257)	58.8 (70)	61.1 (187)	
Lifetime psychiatric admissions[5]	One or more lifetime psychiatric admission	49.3 (210)	51.7 (62)	48.3 (148)	0.4 (0.540)

[1]Some categories are not shown due to cell counts less than 5. [2]Groups are not necessarily mutually exclusive. [3]Excludes prescription drugs being used as prescribed. [4]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended. [5]Data obtained from a separate HHC dataset (RAI-MH).

Table C.2: Sample demographics – Participants who completed the 1-month post-discharge follow-up questionnaire by Telephone vs. Email

		Full 1M sample (n=333) %(n)	Phone (n=108) %(n)	Email (n=225) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	11.7 (39)	11.1 (12)	12.0 (27)	1.7 (0.796)
	30-39 years	20.7 (69)	20.4 (22)	20.9 (47)	
	40-49 years	30.9 (103)	29.6 (22)	31.6 (71)	
	50-59 years	30.3 (101)	34.3 (37)	28.4 (64)	
	60+ years	6.3 (21)	4.6 (5)	7.1 (16)	
	Mean (SD), years	44.2 (10.9)	44.5 (10.9)	43.9 (11.0)	0.4 (0.658)
Gender	Male	64.7 (211)	67.9 (72)	63.2 (139)	0.7 (0.401)
	Female	35.3 (115)	32.1 (34)	36.8 (81)	
Ethnicity[1]	White	95.0 (302)	95.1 (97)	94.9 (205)	0.0 (0.942)
Education	High school or less	20.4 (68)	25.0 (27)	18.2 (41)	**6.2 (0.0454)**
	At least some college	36.6 (122)	41.7 (45)	34.2 (77)	
	At least some university	42.9 (143)	33.3 (36)	47.7 (107)	
Employment	Not employed	19.6 (62)	16.5 (17)	21.1 (45)	0.9 (0.332)
	Employed	80.4 (254)	83.5 (86)	78.9 (168)	
Marital status	Not married or partnered	40.9 (132)	44.8 (47)	39.0 (85)	1.0 (0.323)
	Married or partnered	59.1 (191)	55.2 (58)	61.0 (133)	
Program stream	Addiction only	81.9 (273)	84.3 (91)	80.9 (182)	0.7 (0.454)
	Addiction + PTSD	18.1 (60)	15.7 (17)	19.1 (43)	

		Full 1M sample (n=333) %(n)	Phone (n=108) %(n)	Email (n=225) %(n)	Chi-squared/ T-test (*p*-value)
Most Frequently used substance in past 90 days[2]	Alcohol use	66.1 (220)	63.9 (69)	67.1 (151)	0.3 (0.561)
	Cannabis use[3]	11.7 (39)	13.0 (14)	11.1 (25)	0.2 (0.623)
	Stimulant use (incl. cocaine)[3]	7.2 (24)	5.6 (6)	8.0 (18)	0.6 (0.419)
	Opioids use (incl. heroin and non-prescription (methadone)[3]	7.5 (25)	7.4 (8)	7.6 (17)	0.0 (0.962)
	Other drug use[4]	12.3 (41)	13.0 (14)	12.0 (27)	0.1 (0.802)
Self-reported mental health	Poor or fair	59.7 (197)	61.7 (66)	58.7 (131)	0.3 (0.610)
	Good, Very good, or Excellent	40.3 (133)	38.3 (41)	41.3 (92)	
Self-reported physical health	Poor or fair	39.6 (132)	42.6 (46)	38.2 (86)	0.6 (0.445)
	Good, Very good, or Excellent	60.3 (201)	57.4 (62)	61.8 (139)	
Lifetime psychiatric admissions[5]	One or more lifetime psychiatric admission	48.3 (161)	50.9 (55)	47.1 (106)	0.4 (0.514)

[1]Some categories are not shown due to cell counts less than 5. [2]Groups are not necessarily mutually exclusive. [3]Excludes prescription drugs being used as prescribed. [4]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended. [5]Data obtained from a separate HHC dataset (RAI-MH).

Table C.3: Sample demographics – Participants who completed the 3-month post-discharge follow-up questionnaire by Telephone vs. Email

		Full 3M sample (n=278) %(n)	Phone (n=82) %(n)	Email (n=196) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	1.1 (29)	12.2 (10)	9.7 (19)	2.5 (0.643)
	30-39 years	20.5 (57)	20.7 (17)	20.4 (40)	
	40-49 years	30.2 (84)	24.4 (20)	32.6 (64)	
	50-59 years	32.0 (89)	36.6 (30)	30.1 (64)	
	60+ years	6.8 (19)	6.1 (5)	7.1 (14)	
	Mean (SD), years	44.8 (11.0)	44.9 (11.4)	44.8 (10.7)	0.12 (0.901)
Gender	Male	62.4 (171)	68.3 (56)	59.9 (115)	1.7 (0.189)
	Female	37.6 (103)	31.7 (26)	40.1 (77)	
Ethnicity[1]	White	97.7 (257)	100.0 (76)	96.8 (181)	2.5 (0.114)
Education	High school or less	19.1 (53)	23.5 (19)	17.4 (34)	**6.6 (0.036)**
	At least some college	34.3 (95)	42.0 (34)	31.1 (61)	
	At least some university	36.6 (129)	34.6 (28)	51.5 (101)	
Employment	Not employed	20.5 (53)	17.5 (14)	20.7 (39)	0.4 (0.542)
	Employed	79.5 (215)	82.5 (66)	79.3 (149)	
Marital status	Not married or partnered	40.2 (109)	50.6 (41)	35.8 (68)	**5.2 (0.023)**
	Married or partnered	59.8 (162)	49.4 (40)	64.2 (122)	
Program stream	Addiction only	81.3 (226)	81.7 (67)	81.1 (159)	0.0 (0.909)
	Addiction + PTSD	18.7 (52)	18.3 (15)	18.9 (37)	

		Full 3M sample (n=278) %(n)	Phone (n=82) %(n)	Email (n=196) %(n)	Chi-squared/ T-test (*p*-value)
Most Frequently used substance in past 90 days[2]	Alcohol use	68.0 (189)	62.2 (51)	70.4 (138)	1.8 (0.181)
	Cannabis use[3]	10.8 (30)	13.4 (11)	9.7 (19)	0.8 (0.362)
	Stimulant use (incl. cocaine)[3]	6.1 (17)	7.3 (6)	5.6 (11)	0.3 (0.588)
	Opioids use (incl. heroin and non-prescription methadone)[3]	6.1 (17)	9.8 (8)	4.6 (9)	2.7 (0.101)
	Other drug use[4]	11.1 (31)	9.8 (8)	11.7 (23)	0.2 (0.633)
Self-reported mental health	Poor or fair	58.9 (162)	59.3 (48)	58.8 (114)	0.0 (0.939)
	Good, Very good, or Excellent	41.1 (113)	40.7 (33)	41.2 (80)	
Self-reported physical health	Poor or fair	38.5 (107)	43.9 (36)	36.3 (71)	1.4 (0.230)
	Good, Very good, or Excellent	61.5 (171)	56.1 (46)	63.8 (125)	
Lifetime psychiatric admissions[5]	One or more lifetime psychiatric admission	48.2 (134)	52.4 (43)	46.4 (91)	0.8 (0.360)

[1]Some categories are not shown due to cell counts less than 5. [2]Groups are not necessarily mutually exclusive. [3]Excludes prescription drugs being used as prescribed. [4]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended. [5]Data obtained from a separate HHC dataset (RAI-MH).

Table C.4: Sample demographics – Participants who completed the 6-month post-discharge follow-up questionnaire by Telephone vs. Email

		Full 6M sample (n=267) %(n)	Phone (n=75) %(n)	Email (n=192) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	10.9 (29)	12.0 (9)	10.4 (20)	5.0 (0.284)
	30-39 years	19.8 (53)	25.3 (19)	17.7 (34)	
	40-49 years	28.8 (77)	20.0 (15)	32.3 (62)	
	50-59 years	34.1 (91)	37.3 (28)	32.8 (63)	
	60+ years[1]	-	-	-	
	Mean (SD), years	44.7 (11.2)	44.3 (11.7)	45.1 (10.7)	-0.6 (0.562)
Gender	Male	61.3 (160)	67.6 (50)	58.5 (11)	1.7 (0.191)
	Female	38.7 (101)	32.4 (24)	41.2 (77)	
Ethnicity[1]	White	96.9 (248)	97.1 (68)	96.8 (180)	0.0 (0880)
Education	High school or less	19.5 (50)	25.3 (19)	16.2 (31)	**9.7 (0.008)**
	At least some college	37.0 (95)	44.0 (33)	32.3 (62)	
	At least some university	47.5 (122)	30.7 (23)	51.7 (99)	
Employment	Not employed	23.0 (59)	18.1 (13)	25 (46)	1.4 (0.236)
	Employed	77.0 (197)	81.9 (59)	75 (138)	
Marital status	Not married or partnered	41.5 (107)	52.0 (38)	37.3 (69)	**4.7 (0.030)**
	Married or partnered	58.5 (151)	48.0 (35)	62.7 (116)	
Program stream	Addiction only	83.5 (223)	85.3 (64)	82.8 (159)	0.2 (0.618)
	Addiction + PTSD	16.5 (44)	14.7 (11)	17.2 (33)	

		Full 6M sample (n=267) %(n)	Phone (n=75) %(n)	Email (n=192) %(n)	Chi-squared/ T-test (*p*-value)
Most Frequently used substance in past 90 days[2]	Alcohol use	67.8 (181)	64.0 (48)	69.3 (133)	0.7 (0.408)
	Cannabis use[3]	12.0 (32)	13.3 (10)	11.5 (22)	0.2 (0.672)
	Stimulant use (incl. cocaine)[3]	6.0 (16)	6.7 (5)	5.7 (11)	0.1 (0.772)
	Opioids use (incl. heroin and non-prescription methadone)[3]	5.2 (14)	8.0 (6)	4.2 (8)	1.6 (0.207)
	Other drug use[4]	11.2 (30)	12.0 (9)	10.9 (21)	0.1 (0.805)
Self-reported mental health	Poor or fair	58.5 (155)	57.5 (42)	58.9 (113)	0.0 (0.846)
	Good, Very good, or Excellent	41.5 (110)	42.5 (31)	41.2 (79)	
Self-reported physical health	Poor or fair	39.1 (104)	39.2 (29)	39.1 (75)	0.0 (0.985)
	Good, Very good, or Excellent	60.9 (162)	60.8 (45)	60.9 (117)	
Lifetime psychiatric admissions[5]	One or more lifetime psychiatric admission	46.4 (124)	50.8 (38)	44.8 (86)	0.7 (0.387)

[1]Some categories are not shown due to cell counts less than 5.
[2]Groups are not necessarily mutually exclusive.
[3]Excludes prescription drugs being used as prescribed.
[4]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended.
[5]Data obtained from a separate HHC dataset (RAI-MH).

Table C.5: Sample demographics – Participants who completed the 12-month post-discharge follow-up questionnaire by Telephone vs. Email

		Full 12M sample (n=235) %(n)	Phone (n=55) %(n)	Email (n=180) %(n)	Chi-squared/ T-test (*p*-value)
Age	19-29 years	11.9 (28)	16.4 (9)	10.6 (19)	6.5 (0.167)
	30-39 years	16.6 (39)	14.5 (8)	17.2 (31)	
	40-49 years	31.2 (73)	23.6 (13)	33.3 (60)	
	50-59 years	34.5 (81)	43.6 (24)	31.7 (57)	
	60+ years	5.9(14)	1.8 (1)	7.2 (13)	
	Mean (SD), years	44.6 (10.8)	43.9 (11.2)	45.2 (10.5)	-0.79 (0.432)
Gender	Male	59.1 (136)	67.3 (37)	56.6 (99)	2.0 (0.159)
	Female	40.9 (94)	43.4 (18)	43.4 (76)	
Ethnicity[1]	White	96.5 (218)	98.0 (49)	96.0 (169)	0.4 (0.504)
Education	High school or less	19.1 (45)	25.4 (14)	17.2 (31)	3.5 (0.172)
	At least some college	34.4 (80)	38.2 (21)	32.8 (59)	
	At least some university	46.8 (110)	36.4 (20)	50.0 (90)	
Employ-ment	Not employed	19.4 (44)	17.0 (9)	20.1 (35)	0.3 (0.613)
	Employed	80.6 (183)	83.0 (44)	79.9 (139)	
Marital status	Not married or partnered	41.2 (93)	53.7 (29)	37.1 (64)	**4.6 (0.031)**
	Married or partnered	58.8 (133)	46.3 (24)	62.8 (108)	
Program stream	Addiction only	80.9 (195)	89.1 (49)	81.1 (146)	1.9 (0.168)
	Addiction + PTSD	19.1 (40)	10.9 (6)	18.9 (34)	

		Full 12M sample (n=235) %(n)	Phone (n=55) %(n)	Email (n=180) %(n)	Chi-squared/ T-test (*p*-value)
Most Frequently used substance in past 90 days[2]	Alcohol use	67.6 (159)	69.1 (38)	67.2 (121)	0.1 (0.795)
	Cannabis use[3]	13.2 (31)	14.6 (8)	12.8 (23)	0.1 (0.735)
	Stimulant use (incl. cocaine)[2, 3]	-	-	-	-
	Opioids use (incl. heroin and non-prescription methadone)[2, 3]	-	-	-	-
	Other drug use[4]	11.9 (28)	14.6 (8)	11.1 (20)	0.5 (0.491)
Self-reported mental health	Poor or fair	58.1 (136)	61.8 (34)	57.0 (102)	0.4 (0.525)
	Good, Very good, or Excellent	41.9 (98)	38.2 (21)	43.0 (77)	
Self-reported physical health	Poor or fair	41.3 (97)	45.5 (25)	40.0 (72)	0.5 (0.472)
	Good, Very good, or Excellent	58.7 (138)	54.5 (30)	60.0 (108)	
Lifetime psychiatric admissions[5]	One or more lifetime psychiatric admission	46.0 (108)	49.1 (27)	45.0 (81)	0.3 (0.594)

[1]Some categories are not shown due to cell counts less than 5. [2]Groups are not necessarily mutually exclusive. [3]Excludes prescription drugs being used as prescribed. [4]Includes hallucinogens, sedatives, steroids, inhalants or any other drug (i.e., legal or illegal, prescribed or non-prescribed or over-the-counter) used for the purpose of getting high or for a use other than is intended.[5]Data obtained from a separate HHC dataset (RAI-MH).