WINNIPEG 2004 CCENDU REPORT
TABLE OF CONTENTS

Foreword ... 1

Acronyms used in this report ... 2
Acknowledgements ... 3

Executive Summary ... 4

Introduction ... 6

Description of the City ... 7
Demographics ... 7
Alcohol and Drug Treatment Services in Manitoba ... 8
Contributing Institutions, Programs and Initiatives ... 8
Costs of Substance Abuse ... 8
The Winnipeg Site Network Team ... 9

Admissions ... 10

Alcohol ... 11
- Presence and availability ... 11
- Law enforcement ... 11
- Treatment and prevention ... 12
- Impact ... 14

Non-potable Intoxicating Substances ... 16
- Presence and availability ... 16
- Law enforcement ... 17
- Treatment and prevention ... 17
- Impact ... 17

Drugs Other Than Alcohol ... 18
- Presence and availability ... 18
- Law enforcement ... 19
- Treatment and prevention ... 21
- Impact ... 24

Prescription Drug Use ... 25
HIV and AIDS ... 26
- Impact ... 27

Hepatitis ... 27
- Impact ... 27

Tobacco ... 28
Gambling ... 28
Co-Occurring Issues ... 29

Discussion and Conclusions ... 30
References ... 33
Limitations ... 34

Appendix 1 Demographics ... 36
Appendix 2 Contributing institutions, programs and initiatives in Manitoba ... 37
Appendix 3 Report statistics ... 41
Appendix 4 How to set up CCENDU in your community ... 52

FOREWORD

A Canadian Community Epidemiology Network on Drug Use (CCENDU)

CCENDU was established in response to a 1995 feasibility study that identified the need for a Canada-wide surveillance system on substance use. Spearheaded by the Canadian Centre on Substance Abuse (CCSA) and guided by a steering committee, CCENDU is a collaborative project involving federal, provincial and community agencies, with intersecting interests in drug use, health and legal consequences of use, treatment, and law enforcement.

The primary goal of CCENDU is to coordinate and facilitate the collection, organization, and dissemination of qualitative and quantitative information on drug use among the Canadian population at the local, provincial, and national levels. Further CCENDU aims to foster networking among key multi-sectoral partners, to improve the quality of data being gathered, and to serve as an early warning system concerning emerging trends. Ultimately, CCENDU strives to support and encourage sound policy and program development related to drug use. One means by which the network achieves this is working together with the Health, Education and Enforcement in Partnership (HEP) network. In November 2002, the CCENDU and HEP networks were awarded funding from the National Crime Prevention Centre for their collaborative Community Action Project. This joint venture is assisting communities across Canada in collecting information to understand substance use and abuse at the local level and to determine how to respond.

At the national level, CCENDU's Steering Committee includes representatives from the CCSA, Health Canada, the Canadian Public Health Association, the Royal Canadian Mounted Police, and the Canadian Association of Chiefs of Police. Locally, 12 urban sites participate to varying degrees Vancouver, Whitehorse, Permberton/Mount Currie, B.C., Winnipeg, Edmonton, Regina, Windsor, Brockville, Toronto, Montreal, Fredericton and St John's, Newfoundland. An additional site, Moose Cree First Nation in Ontario, is currently under development but they will not be producing a typical CCENDU report.

Each local site collects, collates, and interprets data and information in eight major drug use areas (alcohol, cocaine, cannabis, heroin, sedative-hypnotics and tranquilizers, hallucinogens other than cannabis, stimulants other than cocaine, and licit drugs) and in six indicator areas (prevalence, law enforcement, treatment, morbidity, mortality and HIV/AIDS/HEP C, which includes injection drug use and needle exchange information) to produce local reports. Resources pending, a national report is produced each year as a compilation of local data, with special focus given to current, high-priority issues.

Soon after its inception, CCENDU recognized the importance of having international links with relevant organizations to exchange information and ideas. This has led to useful meetings and exchanges with the Community Epidemiological Working Group (CEWG) of the United States and the International Epidemiological Work Group.

According to the 2002 National Report, several steps have been taken since the 2000 national report and CCENDU evaluation towards stabilizing and expanding the network. CCENDU has continued to advance in *establishing its national framework* in several key ways. CCENDU has also continued *facilitating data analysis.* Areas identified in the 1999 CCENDU review as requiring increased attention (data limitations, methodological inconsistencies, timeliness of reporting, and linkages between researchers and program planners) have been addressed to varying degrees. *Methodological inconsistencies* have similarly been addressed through the identification of standardized data sources and collection techniques. *Timeliness of reporting* is a continued obstacle due to inconsistent data availability, and so a Web-based format for regular updates at the national, provincial and local levels is in the development phase. The suggested need for *linkages with program planners* is being addressed through the development and release of the on-going series of joint quarterly newsletters with the HEP network, hosting of a combined annual meetings, and funding from the National Crime Prevention Centre (NCPC) for CCENDU's joint funding proposal with HEP. In addition, as mentioned last year, Mona Wynn has been appointed as the CCENDU coordinator at a national level. She will be working on the NCPC project, allocating funds to different sites, and selecting future sites, all with the hope of expanding and improving the quality of the network.

CCENDU is the first network of its kind in a country typically limited in its nationwide approach to substance use. This limitation is due to health issues being a provincial, rather than national mandate.

Acronyms used in this Report

AFM	Addictions Foundation of Manitoba
BAC	blood alcohol concentration
CBS	Canada Border Services
CCENDU	Canadian Community Epidemiology Network on Drug Use
CCSA	Canadian Centre on Substance Abuse
CEWG	Community Epidemiological Working Group
CMA	Census Metropolitan Area
CME	Chief Medical Examiner
CODI	Co-Occurring Disorders Initiative
DDVL	Division of Driver and Vehicle Licencing
e.s.v.	estimated street value
FAS/pFAS	Fetal Alcohol Syndrome and partial Fetal Alcohol Syndrome
ICD	International Code of Diseases
IDP	Impaired Drivers Program
IDU	injection drug use
MLCC	Manitoba Liquor Control Commission
MPhA	Manitoba Pharmaceutical Association
MPI	Manitoba Public Insurance
MPPP	Manitoba Prescribing Practices Program
NCPC	National Crime Prevention Council
NPAIAC	Non-potable Alcohol and Inhalant Abuse Committee
RCMP	Royal Canadian Mounted Police
RNYIS	Rural and Northern Youth Intervention Strategy
SAPP	Solvent Abuse Prevention Program
Ts and Rs	talwin and ritalin
WPS	Winnipeg Police Service

ACKNOWLEDGMENTS

The Winnipeg Report is the eighth compilation of information from many different Winnipeg-based agencies affected in varying ways by substance use and abuse. This Report reflects a renewed commitment to information-sharing by the agencies involved, and is a useful tool for the dissemination of information as well as contributing to the national report. Many individuals and organizations have provided considerable support to this project, including members of the local Winnipeg Site Network Team and other individuals/organizations who contributed their time in providing data for this report:

David Patton	Addictions Foundation of Manitoba
Rachel McPherson	Manitoba Health
Jeff Dunk	Canada Border Services
Raymond Au	Manitoba Public Insurance Corporation
Don Thibideau	RCMP
Bill Hanysh	RCMP
Susan Lessard-Friesen	Manitoba Pharmaceutical Association
Gord Holens	Chief Medical Examiner's Office
John Ormondroyd	Winnipeg Police Service, Vice
Danielle Martin	Winnipeg Police Services, Traffic
Darlene Romani	Division of Driver and Vehicle Licencing
David Kitchen	Drug Analytical Services Laboratory
	Manitoba Liquor Control Commission
	College of Physicians and Surgeons

The report was written by Kristin Stevens, with special acknowledgment to Jenny Gates, of 'get it write', for all her background work, and for getting the report to its current quality.

EXECUTIVE SUMMARY

With a population of approximately 680,000, Winnipeg is a vibrant, growing city located at the geographical centre of North America. It is a major transportation and distribution centre, economically diversified, and has a stable economy and population base. Approximately 60% of the provincial population lives in the Winnipeg CMA (Census Metropolitan Area).

Now in its eighth year in Winnipeg, CCENDU continues to report relatively consistent trends in the use and abuse of alcohol and drugs. Increased availability of these substances is indicated by the large seizures reported by law enforcement agencies, and treatment and prevention programs have expanded as necessary to deal with a variety of client needs.

Alcohol continues to be the most prevalent substance used and abused in Manitoba. Alcohol use is equally high among adult and youth populations, and the various harm-reduction and treatment centres in Winnipeg report the majority of clients were admitted for alcohol abuse. Law-enforcement agencies report continuing high numbers of alcohol involvement in traffic incident. However, overall these numbers seem to be decreasing. Similarly, Division of Driver and Vehicle Licencing (DDVL) report high but decreasing numbers of alcohol-related accidents. Hospital admissions and deaths investigated by the Office of the Chief Medical Examiner (CME) concur that alcohol is a major factor in the community. There were a total of 1,087 hospitalization cases, which were alcohol related as a primary diagnosis, and 2,488, which were alcohol related. This does not include HIV diagnosis, Hepatitis (unspecified), or unspecified noxious substance via placenta/milk since the contributing factor can not be determined. Of the deaths investigated by the CME that were alcohol or drug related, the majority involved alcohol to some extent. The most recent national report, current to 2002, notes that alcohol use remains the highest priority.

Non-potable intoxicating substances (including solvents and inhalants) are widely abused. For the most part, the degree of usage of these substances is grossly under-reported, in part because many users tend to be loners and are not linked with social service agencies. Also, it is generally recognized that recorded statistics represent only a small percentage of actual usage. Few treatment programs are available, although various programs (particularly targeting youth) have been established in recent years. Also, various groups in the community are working together to monitor and combat the problem, and educate against and provide alternatives to solvent and inhalant abuse. The main focus at this point has been training sales staff to stop sales in as safe a manner as possible.

Drugs continue to play a major role in the health of the community, and the impact is both significant and widespread. Treatment programs generally report increased numbers of clients using drugs at some time, and hospital admissions with drug-related diagnoses show that cocaine, sedatives and tranquilizers are the most prevalent illicit drugs reported. Cannabis and cocaine remain among the most commonly used drugs and seizures of both have continued to increase.

The most prevalent illicit drug in Manitoba is marijuana, and law enforcement agencies continue to effect large seizures of the drug, especially in the form of grow operations. Treatment centres report high self-reported levels of use among their clients in general. Despite its presence, heroin is still not considered a major drug in Winnipeg, and other drugs more commonly reported are cocaine, steroids, hallucinogens, narcotics other than heroin, and stimulants. Cocaine was seized by law enforcement in very large quantities, and the Addictions Foundation of Manitoba (AFM) reports high usage of cocaine among client populations. Canada Border Services (CBS) and CMP reported large seizures of steroids, and its use and availability is considered a significant problem in some areas. According to the 2002 National Report, some sites have continued to experience significant increases in hallucinogen use among youth. Cocaine was also mentioned as a growing concern by many sites.

In Manitoba, prescriptions for narcotics and other controlled drugs are tightly controlled and monitored through the Manitoba Prescribing Practices Program (MPPP). Consequently, recent years have seen a stable trend in the incidences of forged prescriptions. There was a slight increase in the number of forgeries filled in 2003.

In an effort to reduce the harm associated with drug use, Street Connections continues to provide needle exchange and other services to clients, and is now administered by the Winnipeg Regional Health Authority. Unfortunately, no data was available on the success of the program. In 2003, Manitoba Health reported a continued increase in the incidence of Hepatitis A (due largely to one particular outbreak in May, 2003) but a substantial decrease in Hepatitis B incidence. Subsequently, there was a significant decrease in cases of Hepatitis C. These statistics show a reversal in the trends found in previous years. According to recent reports, the predominant risk factors among Hepatitis C-infected

individuals are risky heterosexual activity and injection drug use. It was also noted that Hepatitis incidence - in particular, Hepatitis C - is of common concern. The incidence of HIV has jumped from 8 in 2002 to 12 in the first six months of 2003. In more recent reports, it seems that heterosexual activity and injection drug use are both leading causes of HIV infection, with incidence rates as close as 22 and 21, respectively, in 2001, and 21 and 22 , respectively, in 2002.To June 2003, the incidence was comparable, at 12 and 10, respectively.

INTRODUCTION

The CCENDU Initiative aims to identify the type and degree of substance use and abuse in Winnipeg and Manitoba. Members of the local site network team provide both factual and anecdotal information for this report to present as clear a picture as possible of the current situation.

Behind the facts and figures, there are a multitude of individuals, groups and institutions working to provide prevention, treatment and harm-reduction programs. While these programs do not represent all aspects of substance abuse in Manitoba, they go a long way toward impacting the current situation. In some cases, there are simply not enough resources to accommodate the number of users, nor the varying levels of use, but steps are being taken to correct this through, in part, the dissemination of information provided in the CCENDU reports.

The ultimate goal - to lead the way toward an addiction-free society - may seem unattainable and unreasonable; however, the CCENDU reports play a major role in this regard by providing data from various agencies in a single publication. Similarly, the network team strives to develop a collaborative voice and portray, understand and act on the varying types and degrees of addiction, and more directly impact the use and abuse of substances in the community. Awareness and information are often the first steps, and it is in this regard that the local site team and the 2004 CCENDU Report hope to succeed. A website is now completed, as part of our mandate to increase the profile of both the local and the national CCENDU group. The 1996, 2000, 2001, 2002 and 2003 Winnipeg Reports are available online at www.ccsa.ca/ccendu/, as well as many other publications, including the 2002 National Report.

Previous reports were produced in 1996, 1998, 1999, 2000, 2001, 2002 and 2003. The 2004 report presents the available information on substance use and abuse in Winnipeg, and to some extent in Manitoba. Volatile staffing arrangements and standard data collection schedules frequently affected the continuity of data collected; nevertheless, every effort has been made to present the most recent and complete available data and portray as complete a picture as possible of the substance use and abuse situation in Winnipeg and Manitoba. With some exception, the information in this report was promptly received and in a highly helpful format.

Indeed, the most significant challenge facing CCENDU and the Winnipeg Site Team continues to be public profile and data collection. Although the group has been operating in Winnipeg for several years, little is known about it outside our immediate contacts. We continue to focus our efforts on increasing that profile and awareness of what we are trying to achieve. This will also assist in the area of data collection with more organizations recognizing the importance of CCENDU and providing whatever relevant data they have.

In this report, substances are divided into three groups: Alcohol, Non-Potables (Solvents and Inhalants), and Drugs. Each group is then considered under four headings: Presence and Availability, Law Enforcement, Treatment and Prevention, and Impact. The drug subgroups are not separated, but rather listed and examined together under these four headings. Finally, Prescription Drug Use, HIV and AIDS, and Hepatitis are considered separately because of their simultaneous uniqueness from and relationship to substance use and abuse. Tobacco, Gambling, and Co-Occurring Issues are also included in the Winnipeg report, in part because this data is widely collected by the AFM, but also because of their direct and indirect relevance to, or relationship with, substance use and abuse.

To advise of any corrections or omissions, or to suggest any improvements to this report, please contact the editor, Kristin Stevens, 242 Barnham Crescent, Winnipeg Manitoba Canada R2R 2T6, phone: (204) 694-3235, fax: (204) 694-4093, email: stevens_kristin@hotmail.com. Copies of the report are available by contacting David Patton at the Addictions Foundation of Manitoba, email: dpatton@afm.mb.ca.

DESCRIPTION OF THE CITY[1]

Winnipeg lies at the geographic centre of North America and has become the largest distribution centre between Vancouver and Toronto. Of the major trucking companies, 32 are interprovincial/international carriers and ten of these firms maintain regional or corporate head offices in the province. Two of Canada's ten largest for-hire trucking organizations are headquartered in Winnipeg. In addition, Winnipeg is centrally located on the main lines of the two national railways, Canadian National Rail and CP Rail and has the only centrally located 24-hour international airport between Toronto and Calgary.

Winnipeg is economically diversified, steadily growing, and has a stable economy. The city is the headquarters for Canada's grain industry, prominent investment firms, and insurance companies. Winnipeg has a large and diversified aerospace centre, is an important centre for health industry technology and research, a growing centre for information technology, and supports a variety of manufacturing.

Winnipeg enjoys more than 2,300 hours of sunshine per year, and boasts four distinct seasons, vast forests, and 100,000 lakes throughout its province. Lake Winnipeg, the 14th largest lake in the world, is an hour north of the city and bounded by kilometres of sand beaches.

Housing costs and the cost of living in Winnipeg are among the lowest in the country, and residents and tourists alike are attracted to the more than 930 parks and the extensive, and expanding, shopping networks within the city. The beautiful, historical buildings continue to attract film makers from all over the world.

Winnipeg is a city with a rich arts and cultural life, including professional ballet, a world-class symphony orchestra, and numerous live theatres and art galleries. Music and sports are also prominent, including professional and amateur ethnic dance groups, music and cultural festivals, internationally successful musicians and artists, and professional and amateur football, hockey, baseball and basketball. More than 80 amateur sport organizations are represented, and there are 24 golf courses throughout the city. Presently there is a new arena in the process of being built to house the Manitoba Moose (AHL hockey) and other entertainment.

Winnipeg has two gambling casinos, the McPhillips Street Station and Club Regent, and video lottery terminals (VLTs) are commonplace in licensed beverage establishments. In addition, the Assiniboia Downs is located on the west side of the city and provides a racetrack for horse betting and additional electronic gaming machines.

DEMOGRAPHICS (Appendix 1)

The Winnipeg CMA, as defined by Statistics Canada, includes the City of Winnipeg and adjacent municipalities of East St. Paul, West St. Paul, Ritchot, Rosser, St. Francois-Xavier, Springfield and Tache. These adjacent municipalities, while rural in nature, have many residents who commute to Winnipeg.

According to the 2001 Census[2], the total populations of Manitoba and the Winnipeg CMA had generally increased by 0.6% over the five-year period (1996 to 2000). The largest age segment was 25-44 (30.1%). Residents of the Winnipeg CMA comprised 60.0% of the population of Manitoba. The total land area comprising the Winnipeg CMA is 4,151.48 km^2.

Individuals aged 24 and under represented about one-third of the CMA, with seniors aged 65 and over representing slightly more than 13%. There were 182,190 families located in the CMA, of which more than three-quarters were married or common-law with/without children, and about 17% were lone-parent families. Of these lone-parent families, the majority were headed by women. The predominant ethnic origins were English, Scottish, Canadian, German,

---

1 Winnipeg Fast Facts, Destination Winnipeg Inc., www.destinationwinnipeg.ca.

2 Statistics Canada, Census 2001. Statistics for Winnipeg (City), Manitoba. Only the stats for total population of Manitoba and Winnipeg CMA and total land area for 2001 were available in 100% data at the time of publication. Other stats are from 20% sample data.

Ukrainian, French and Irish, with English the predominant language spoken in homes. Other major languages spoken were French, Tagalog, Chinese, German, Polish, and Portuguese.

There was an active labour force population of 383,300 in the CMA, and 362,800 persons were employed. The unemployment rate was 5.3%, and the field of employment recording the greatest number of jobs was manufacturing.

Regarding education, of the 533,360 people 15 years and over in the CMA, slightly less than one-third did not have a high school diploma, approximately 30% had a university degree or a certificate from a non-university education institution, and about 10% had a trades certificate or diploma.

The average family income in the CMA was $64,422, and the median family income was $55,634. This is based on 2000 families and is only 20% sample data.

New census information will be available in 2006, although tests are already being run in 2004.

ALCOHOL AND DRUG TREATMENT SERVICES IN MANITOBA

Alcohol and drug treatment services are delivered by a wide variety of public and private organizations in Manitoba. The AFM is the provincial authority responsible for providing prevention and treatment programs, conducting research, and promoting the health and well-being of all Manitobans. Other organizations provide substance abuse clients with services ranging from street level needle exchange programs to extensive therapeutic community programming requiring several months of treatment services. Most are non-profit with independent Boards of Directors, and funded through a variety of United Way, government, religious, and foundation grants and per diem sources.

CONTRIBUTING INSTITUTIONS, PROGRAMS AND INITIATIVES

Many institutions and groups in Manitoba are affected in some way by the use and abuse of drugs and alcohol. The majority of these have developed treatment, monitoring, and/or assessment programs and initiatives, which impact and report on the current situation in our city and province. Contributing institutions, programs and initiatives are identified in Appendix 2.

COSTS OF SUBSTANCE ABUSE

A recent report by the CCSA[3] notes that more than one in three deaths in Canada and hundreds of thousands of hospitalizations result from the use and misuse of alcohol and illicit drugs each year. The cost to the economy is at minimum $10 billion per year, including more than $2 billion in direct health costs and $2 billion for law enforcement. Substance abuse is a significant component of a multitude of social issues, ranging from family violence to homelessness, hepatitis C, child welfare, victimization, AIDS, delinquency and crime.

A major new study is underway to address the need for up-to-date information on the social and economic impact of alcohol, tobacco and illicit drugs on Canadian society. The Canadian Substance Abuse Cost Study (CSACS) will examine both direct costs to health care and the criminal justice system, and indirect costs associated with productivity losses from substance abuse-related death and ill health. A final report is expected June 2005.

---

3 Canadian Centre on Substance Abuse, February 28, 2002.

THE WINNIPEG SITE NETWORK TEAM

Coordinator:

Dr. David Patton, Director, Research and Quality Monitoring, Addictions Foundation of Manitoba

Members:

Mr. Gord Holens, Statistician, Office of the Chief Medical Examiner, Manitoba
Dr. Susan Lessard-Friesen, Assistant Registrar, Manitoba Pharmaceutical Association
Mr. Jeff Dunk, Regional Intelligence Officer, Canada Border Services
Sgt. Don Thibideau, Drug Awareness Coordinator, RCMP 'D' Division Headquarters
Staff Sgt. John Ormondroyd, Vice Division, Winnipeg Police Service
Mr. Raymond Au, Impaired Driving Issue Specialist, Manitoba Public Insurance Corporation
Ms Darlene Romani, Research, Alcohol/Drug Abuse Section, Division of Driver and Vehicle Licencing
Mr. David Kitchen, Drug Analytical Services Laboratory, Health Canada
Ms Kristin Stevens, Report Editor, contracted by Addictions Foundation of Manitoba

ADMISSIONS (Table 1)

There were 81,379 hospital admissions in the Winnipeg CMA in 2002/2003 (excluding day admissions and emergency room patients). Alcohol and/or drugs and related conditions were considered the primary reason for admission in 2.07% of cases, and involved to some extent in 5.16% of cases. These percentages represent a slight increase from 2001/2002 in terms of primary diagnoses, but a slight decrease for involvement to any extent. Alcohol was considered primarily responsible and responsible to some extent for approximately 66% of admissions attributed to alcohol and/or drugs. This is a rise from last year.

In 2003/2004, there were a total of 9,788 individuals involved in 15,576 admissions to the AFM programs: 8,669 admissions to the Adult Treatment Program, 2,275 admissions to the Impaired Drivers Program (IDP), and 2,405 admissions to the Youth Program. Figures represent an increase in all the AFM programs, which defies the previous trend of decreasing IDP admissions since 1997. The increase in adult admissions is consistent with the increase found last year; however, a steady decrease had been reported in previous years. However, the increase in youth admissions continues to confirm the previous trend. The average of admissions per client generally remains steady at 1.6. Alcohol is by far the predominant substance ever used by both youth (95.5%) and adult (98.8%) clients, followed by cannabis. There are differences between youth and adult populations in terms of which substances follow, but basically hallucinogens, cocaine/crack cocaine, over the counter drugs, and narcotics/opium, were the next most commonly used among both.

ALCOHOL

Alcohol in this section refers to beverages intended to be consumed. Household products (not intended for human consumption) containing high levels of alcohol that are consumed or inhaled are discussed in 'Non-potable intoxication substances', and not included in the 'Alcohol' category.

Presence and Availability

Sales and consumption (Table 2)

Beer was the most popular alcoholic beverage in the province, by sales, consumption and litres sold in 2002/2003[4]. Sales of beer, wines and coolers/ciders have increased from the previous year. Consumption per capita has decreased very slightly for beer and for spirits, and increased slightly for wine and coolers/ciders.

There were 527 alcoholic beverage retail outlets in Manitoba in 2002/2003, including 44 Manitoba Liquor Control Commission (MLCC) Liquor Marts, 179 liquor vendors, 296 beer vendors, and 8 wine stores. This is a slight decrease from 2001/2002, when there were 532 outlets.

Fewer occasional permits were issued in 2002/2003, and 5,379 photo ID cards were issued to young adults for the purposes of identity and proof of age in licensed establishments. This represented a 2.2% increase in photo cards over the previous year.

In 2002/2003, the MLCC suspended 29 licenses and 7 occasional permits, issued 259 warnings or other action, and 30 warnings for infractions of The Liquor Control Act. The increase in actions was significant; however, 134 of these were attributable to the "It's Good Business" training program (see Appendix 2 for a program description).

Price

The estimated street value (e.s.v.) for a dozen bottles of beer is approximately $25.

Law Enforcement

Licensed and suspended drivers

The number of licensed drivers in 2003 was 720,099. Of these, 33,673 were suspended drivers. The rate of suspension for drivers aged 75 and older was more than four times higher than all other age groups. This is primarily due to the fact that higher proportions of older drivers were indefinitely suspended for medical reasons.

The Division of Driver and Vehicle Licencing (DDVL) reports that there were 2,433 alcohol-related Criminal Code offences for 2002, including blood alcohol concentration (BAC) more than .08 (1,655), impaired driving (635, 20 - injury, 4 - death) and refuse sample (143). These figures represent a 5.7% decrease from 2001, and a continuing decrease since 1986. Possible reasons for the decrease include the introduction of stiffer penalties in 1986 and Manitoba's countermeasure program in 1989, as well as the level of law enforcement[5].

Charges (Table 3)

In 2003, a total of 778 drivers were charged with Criminal Code impaired driving offences by the Winnipeg Police Service (WPS), representing a decrease in the number of impaired driving related charges from last year, which already represented a decrease from prior years. The majority were charged with impaired operation of a motor vehicle or over .08 BAC (729), while 37 drivers were charged with failing/refusing to provide breath/blood samples, 1 driver with impaired driving causing death, and 11 drivers with impaired driving causing bodily harm.

In 2003, there were a total of 1,560 impaired driving offences (cleared by charge) reported by the RCMP in

4 MLCC 80th Annual Report, 2003. Covers fiscal year from April, 2002 to April, 2003.
5 Division of Driver and Vehicle Licencing, Research Department, Alcohol-Related Criminal Code Offenses: 1986-2002.

Manitoba, including 452 for impaired operation of a motor vehicle and 1,108 for driving with a BAC of more than .08.

A total of 3,997 Liquor Control Act open liquor incidents were reported (2,917 cleared by charge), 8,947 Intoxicated Persons Detention Act incidents, and 17,967 other incidents were reported where alcohol abuse/use was a factor. However, these statistics are considered to be under-reported by as much as 30%.

Seizures (Table 4)

According to Canada Border Services, smuggling of alcohol continues, although almost all seizures were of a personal quantity amount. Smuggling organizations continue to utilize the vast open areas between border ports of entry to bring contraband into the province.

A total of 90 seizures by CBS during 2003 secured liquor with an e.s.v. for duty of $4,882. This represents an increase in the number of seizures but a decrease in the e.s.v., as was the case last year.

Checkstop - WPS (Table 3)

Checkstop continues to charge drivers with impaired driving and other violations. In 2003, the program operated from December 1 to January 4 (2004), and 53 WARNs (a 24-hour suspension for registering between .05 and .08) were issued. In addition, 23 individuals were charged ‘impaired/over’ or ‘impaired/refused’. The age range of the drivers charged was 23-52 years.

RoadWatch (Table 3)

For 2003 MPI RoadWatch Check Stop Program was operational from mid-May to mid-November. Participating police agencies held 196 check stops, provided 484.5 visibility hours, and screened 42,488 vehicles during the program period. Enhanced police enforcement resulted in the removal of 87 impaired drivers, over 1,306 HTA offence recorded and 79 motorists charged for Liquor Control Act and Controlled Drug Substance Act offences.

In the 2003 program year, the Roadside Screening Device was administered on 153 occasions. Overall, four drivers in ten (40.5%) failed the RSD test when it was administered. Male drivers represented 86.3% of drivers tested. The highest BAC recorded during the program period was .31 for male drivers and .27 for female drivers.

Treatment and Prevention[6]

Impact of the AFM

Assessment, treatment and follow-up programs offered by the AFM continue to positively impact the number of repeat driving offences related to alcohol consumption. Similarly, the AFM is instrumental in reporting on various significant aspects of impaired driving.

Compared to last year, the AFM’s Impaired Drivers Program report a similar number of second offenders involved in the program, and a decrease in those clients seen with a non-apparent problem with alcohol.

Impaired Drivers Program (IDP) (Table 5)

In Manitoba, a driving suspension due to alcohol use results in mandatory tenting through the AFM IDP. This requires an evaluation to determine the extent of the need for treatment and education about drinking and driving. There were a total of 2,275 admissions to the IDP program at the AFM, the majority (76.2%) of whom had a presumptive problem (non-active full-blown addiction).

Of the clients for whom blood alcohol level was available (1,576), the client’s BAC on the last charge ranged from .08 to greater than .23. The most common category recorded (37.8%) was for having a BAC of between .13 and .17, which is approximately twice the legal limit. This was followed closely by the range .08 to .12 (29.8%).

Of the total clients admitted, those aged between 35 and 50 represented the majority of the client population

6 Additional information on AFM clients with relevance to alcohol and drug use, including family history, personal stats and issues, and general statistics, can be obtained directly from the AFM.

(35.7%), while those aged between 18 and 24 represented less than one-quarter. However, the proportion of older clients has fallen slightly from previous years, and the younger representation has grown. This year, both the 35-50 and the 18-24 populations decreased in proportion, while the 25-34 increases slightly.

Of those clients involved in the IDP, approximately 76.3% attended for the first time, 18.8% had attended once before, while less than 1% reported attending three or more times. More than one quarter of these individuals had attended the program more than eleven years prior (29.1%). In addition, on their last involvement with the IDP, more than 85% were referred to other treatments and programs. The most common subsequent referrals were educational workshop, high risk program, and self-help group.

Approximately 17.7% of clients had previously attended an alcohol/drug rehabilitation treatment or counseling program. In these instances, almost 76.8% completed the program they were attending. Following the 2003/2004 program, most clients were referred to other programs, workshops or treatments, while 6.6% warranted no further action.

Of all the clients participating in AFM IDP, 84.1% were referred by The Division of Driver and Vehicle Licencing (DDVL). This represents a continuation of the decrease from the 99.4% that were referred by DDVL two years ago.

AFM adult clients (Table 6)

In 2003/2004, 98.8% of adult clients reported using alcohol at some time in their lifetime. Of those who had consumed alcohol in the past year (prior to admission to AFM), 14.6% reported using daily or almost daily, while 17.1% reported consuming during binges or sprees.

Similarly, 23.2% of clients reported that their alcohol use had increased during the previous 6 months, while 60.3% reported it had stayed the same or decreased. Approximately 11% of clients reported consuming more than five drinks in a sitting more than 16 times in the past month, while 66.2% said not at all or only 1-3 times. Roughly two-thirds of the individuals were determined to have dependent involvement, and 45.2% were currently in the contemplation stage of change.

When asked about the reasons for their use, more than half answered ‘yes’ to relieving emotional pain, for the high, to relax/sleep, to relieve anxiety, to socialize and have fun, to relieve boredom, to deal with loneliness, to cope with problems and out of habit. It should be noted however that although over 50% indicated these reasons, in some cases the percentage was just over this mark. Over 85% of the clients had previously tried to control their problem at some point.

AFM youth clients (Table 7)

Among youth clients, alcohol had been consumed at some time by about 95.5%. Approximately 27% reported using alcohol less than once a month, with nearly 30% using weekly and 27% using monthly.

The majority of clients were 14-17 years of age when they were admitted (83.3%), and most of the clients were aged between 12 and 14 when they first used alcohol (63.5%), and about 5% were aged 9 or less. Approximately 45% have been charged with a Criminal Offense, with approximately 49% being alcohol/drug related, and 55% reporting being under the influence of alcohol/drugs during the offense.

Student Use

The most recent Rural and Northern Youth Intervention Strategy (RNYIS) Student Data was collected in 2003/2004, and 1175 clients were reported. Of clients admitted to rehabilitation programs, approximately 95% reported consuming alcohol at some time, and more than three quarters reported they were aged between 12 and 15 when they first used alcohol.

A previous survey of students sampled from a cross-section of Manitoba high schools conducted by the AFM revealed that more than half the students considered alcohol and drug use to be a major problem at their school. About 6% of students reported moderate or serious problems with the use of alcohol. Also, 87.4% reported they had used alcohol at some point, and of students who had ever had a drink, 92.2% used alcohol in the past year (80.4% of all students surveyed) and about 26% reported drinking one a week or more. The average age of first use is 13.3 years of age. However, these statistics need to be updated, and a new survey will be conducted fall of 2004.

Operation Red Nose

In 2003, Operation Red Nose provided 1,137 rides within Winnipeg over the 14 nights it operated. This represents a 20.6% decrease in the number of individuals they drove home, but still reflects an encouraging number of drivers opting not to drive drunk.

Impact

Hospital data (Table 8)

Of all hospital admissions in the CMA in 2002/2003, there were 1026 cases in which alcohol was the most responsible diagnosis and 2,472 instances where alcohol was responsible to some extent. The most common diagnoses included 'other alcohol psychosis' (360 cases; ICD9 291.8), 'alcohol dependence NEC/NOS' (195 cases; ICD9 303.9), and 'alcohol abuse' (230 cases; ICD9 305.0). Among newborns and infants, the most common diagnosis was 'maternal alcohol affecting newborn (transmitted by placenta)' (5 cases; ICD9 760.71)[7].

Presence in road accidents

According to the Traffic Injury Research Foundation, approximately 1.4 million Canadians drove in the past year when they thought they were over the legal limit. In Canada, young drivers (age 16 to 18) and older drivers (age 65 and over) are least likely to drive after drinking. Drivers between 25 and 34 are most likely to report driving after drinking.[8]

According to the most recent Traffic Injury Report, completed in 2001, among the at fault drivers involved in fatal crashes, 71.9% were reported to have consumed alcohol. Of these, 28.1% "had been drinking" while 43.8% had their "ability impaired by alcohol." In injury collisions, alcohol consumption was the second reported condition, 19.6% had their "ability impaired by alcohol", and 9.2% "had been drinking".[9] In nine out of ten fatalities, the victim was in or on the impaired driver's vehicle, and was male.[10] Despite the considerable prevalence of the behaviour, a small minority of drivers accounts for most of the "impaired driving". Indeed, 86% of all the "impaired" driving trips are accounted for by only 3% of licensed drivers.

Manitoba has the most comprehensive drinking and driving program in Canada, composed of legal sanctions, driver treatment and assessment programs, public awareness, server intervention and a designated driver program. In fact, MADD Canada rated Manitoba as one of the best provinces in terms of strategies for dealing with impaired driving. Recently, law enforcement has taken up the new policy of seizing and selling the vehicles of repeat impaired driving offenders. Ignition interlock devices have also been developed as a deterrent for repeat offenders. Education and awareness programs, enforcement, and changes to the Criminal Code have contributed to the decline of drinking and driving across Canada, but a substantial problem remains.

Overall, there has been a 57% decrease in the number of alcohol-related criminal code offenses between 1986 and 2002, 5,651 to 2,433 respectively, and the driver involvement rate declined by 60.9%.[11] All age groups between 16 and 74 recorded such declines, with substantial declines of 71.3%, 67.5% and 61.5% for those aged 21-24, 25-29, and 30-34 respectively.

Licensed drivers, in Manitoba, under the age of 25 consistently record the highest rate of total alcohol offenses, and the percentage of such offenses that they account for is consistently double their portion of the licensed driver population. The rates for young drivers are about 40% higher than the rates for drivers aged 25-44, and 75% higher than for drivers aged 45-64. Drivers between the ages of 25 and 44 years continue to record the highest number of alcohol-related Criminal Code offenses and the highest percentage of licensed drivers.

---

7 All codes are ICD-9 codes (International Codes of Diseases).
8 Canada Safety Council, Traffic Injury Research Foundation, 2003.
9 Traffic Collision Statistics Report, 2001.
10 Canada Safety Council, New Alcohol-Crash Stats, 2003.
11 Alcohol-Related Criminal Code Offenses, 1986-2002.

These statistics provide a positive outlook, as the number of offenses has continued to decrease. However, the numbers continue to illustrate which groups (specifically those under 24) should be targeted with further intervention and prevention programs.

Fetal Alcohol Syndrome and partial Fetal Alcohol Syndrome (FAS/pFAS)

FAS/pFAS babies born to mothers who drink during pregnancy show signs of physical, mental and behavioural abnormalities (e.g., mental retardation, heart defects, characteristic facial features). FAS/pFAS is considered Canada's #1 cause of birth defects; however, actual incidence statistics are inferred rather than determined. It is generally agreed that FAS/pFAS occurs in up to 3 per 1,000 births and is found in every economic and racial group. Each year in Manitoba, approximately 240 babies are born with FAS.[12] The life-time cost per child with FAS/pFAS is estimated to be approximately $1.4 million, for special education and care.

Various projects and organizations address the urgent need to develop strategies to prevent FAS and support improved health for women. FAS Information Manitoba responds to the need for information and strategy information and networking throughout the province, and various publications focus on issues associated with FAS. FAS conferences throughout Manitoba serve to increase awareness and provide resources and information, and thereby raise public awareness.

Winnipeg currently has two sites that provide the FAS prevention program known as STOP FAS and recently two more sites have been added, in Thompson and the Pas. Launched in 1998, Manitoba's STOP FAS program aims to prevent children being born with fetal alcohol syndrome. In July 2002, the program received increased funding and was able to expand its services to accommodate 150 women in total. No further expansions occurred in 2003.

The typical STOP FAS client is approximately 26 years old, has had four children, three of which are presently in care, and has not planned these pregnancies. The client's past history is often characterized by negative experiences such as abuse, early substance use, family addiction issues, frequent relocation and conflict with the law. Educational attainment past Grade 8 is uncommon and most clients are on social assistance of some form.

No further evaluations were carried out this year, however, the most recent evaluation (from 2002) reported that after completing three years in the program, 84% of the clients are no longer at risk of having a child with FAS; either because of birth control use, or abstinence from alcohol or drugs.[13] Of these individuals, 49% use birth control and 49% have stopped using alcohol, half of these for at least six months. In addition, 65% have completed an addictions treatment program, and 28% have completed an educational/training program. Benefits to the target children have been profound, with 100% of target children being fully immunized against childhood diseases, and 63% living with their own families. With continued support, funding, and evaluation, this program can only further help these women and their children.

Other developments such as With Child; Without Alcohol, a promotion of the MLCC, FAS Community Mobilization Project, RCMP and Corrections FAS awareness training programs, improved Child and Family Services (CFS) training, and the BabyFirst Screening form have all made an impact on this very preventable problem, and will be further fostered to continue toward the goal of a FAS/pFAS free population.

Deaths (Table 9)

The office of the CME investigated 2,993 deaths in 2003 recorded as naturals, accidents, suicides, homicides, and undetermined in Manitoba. This is a decrease from last year when there were 3,016 deaths investigated. Of the 301 deaths reporting drugs and alcohol to any extent, 163 involved alcohol, and 58 involved both alcohol and drugs.[14]

---

12 Thordarson, D. & L. Braum, 2001. Making the Right Choice: A Grade 5-8 Fetal Alcohol Syndrome Prevention Curriculum.

13 These stats are from the STOP FAS pamphlet and the Spring 2003 newsletter for the Coalition on Alcohol and Pregnancy.

14The definition of 'alcohol/drug related' is not well defined. For example, an alcohol-related death does not mean that the alcohol was the cause of death, but that it at least played some role in the person's death.

Of the deaths involving alcohol only, 29 were traffic accidents, 28 were home accidents, 20 were accidents in other places, 14 were homicides, 45 were suicides, 1 was an industrial accident, and 4 were undetermined deaths. Similarly, 22 deaths determined to be natural involved alcohol, although this was not considered the cause of death.

The average age for deaths involving alcohol only was approximately 41.1 years, with a range of 14-90 years of age. The gender ratio of males to females was approximately 3.5 to 1.

NON-POTABLE INTOXICATING SUBSTANCES

This section includes products containing alcohol but not intended for consumption.

Presence and Availability

Non-Beverage Alcohol Substances

Non-beverage alcohol substances are primarily household products. Although illegal to sell such products as a beverage, they are being used as an alternative to liquor because they are inexpensive, readily available, and have high alcohol levels (as much as 95%). The people who are most vulnerable are street alcoholics. Such products contain many chemicals and other ingredients that make them more harmful than alcoholic beverages when consumed. Abused products include Lysol spray, hairspray, mouthwash, Chinese cooking wine, rubbing alcohol/muscle massage, and aftershaves. Sales and abuse of these products continues to rise at an alarming rate.

Inhalant Abuse Substances

According to the Non-Potable (non-beverage) Alcohol and Inhalant Abuse Committee, there are more than 1,400 legitimate products on the market today with the potential for inhalant abuse. The top abused products are glue, nail polish remover, gasoline, paint and cleaning fluids, paint thinner, and plastic wood. There is growing evidence of the existence of Fetal Solvent Syndrome, which produces many different effects on the unborn child, depending on the nature of the abused chemical. According to a federal case study of users from the age of 12 through adulthood, the number of new users in Canada rose from 380,000 in 1991 to 805,000 in 1997 – most between the ages of 12 and 17.[15]

Non-Potable Alcohol and Inhalant Abuse Committee (NPAIAC)

The NPAIAC consists of a variety of agencies whose focus is the prevention of the continued abuse of non-potables and inhalants. These include Main Street Project, Klinic Incorporated/Substance Abuse Coalition, Manitoba Pharmaceutical Association, Manitoba Liquor Control Commission, a pharmacist/owner, a Member of Parliament, and various others.

NPAIAC has three working groups - Community Action and Prevention (CAP), Harm Reduction and Rehabilitation, and Legislation and Law Enforcement. CAP is initiating a needs assessment with two first nation communities - Paungassi and Swan Lake. Harm Reduction and Rehabilitation is working with and surveying 20 identified inhalant users in inner Winnipeg to examine their perceived needs and identify current resources and gaps. Legislation and Law Enforcement has been working with the federal and provincial government to provide direction and feedback on proposed legislation around inhalant use.

They now have a website at www.inhalants.ca. Revisions are anticipated to the Public Health Act, allowing for the seizure of inhalants in certain circumstances. The Safer Communities and Neighbourhoods Act was put into place to target solvent abuse among other community issues such as prostitution. The committee had also produced a video called 'The Fragile', which centres around four youth who have to make choices in their lives, including 'sniffing' to escape life's realities. Aimed at high-risk youth aged between 10 and 14, the video explores the reasons why some youth choose either a positive or negative lifestyle, and is another tool in combating solvent abuse. A second video in this series is currently under consideration.

15 Wheeler, Jordan, First Take, Winnipeg Free Press, July 2003.

Price

The e.s.v. of various solvents (lacquer, glue and airplane glue) ranges from $5 and $20 for a 275-350 ml jar. According to the WPS, other products frequently used as inhalants include gas-filled cream charges, which are inexpensive, making then affordable for new or chronic users.

Law Enforcement

Despite the abundance of information disseminated about the sale of non-beverage alcohol substances, stores continue to sell these products, although many have taken to selling them over the counter. Efforts are continuing to identify and prevent these products being distributed to users and potential users and to issue warnings about newly identified products. Workshops are continually carried out to educate store staff on how to identify a user and how to avoid confrontation while preventing the sale of such products.

Treatment and Prevention

AFM clients (Tables 6, 7, and 10)

In 2003/2004, over 5% of AFM youth clients and over 7% of adult clients reported using solvents at some time. This percentage has increased from previous years.

Impact

Hospital data (Table 8)

Of all hospital admissions in the CMA in 2002/2003, there were 9 cases where non-beverage products and solvents were considered primarily responsible and 16 cases where these substances were considered responsible to some extent. The most common diagnosis was ‘toxic effect of ethyl alcohol’ (4 cases; ICD9 980.0).

DRUGS OTHER THAN ALCOHOL

This section deals with drugs other than alcohol. The majority of these drugs are governed by the Controlled Drugs Substance Act. Non-prescription drugs are generally produced illegally through clandestine laboratories.

Presence and Availability

Price

The price of drugs on the streets of Winnipeg have changed slightly from previous years (based on WPS data):

COCAINE	cocaine powder	$80 (1 gm)
		$36,000 - $45,000 (1 kg)
	cocaine rock	$30 - $40 (1/4 gm)
HEROIN/MORPHINE/ NARCOTICS	Ts and Rs	$25 - $30 (2 set)
		$40 - $50 (full set) (2 Ts + 1 R)
	dilaudid	$50-$60 (per unit)
	heroin	$350 (1 gm)
		$7,500 (1 oz)
	morphine peeler	$5 (1 pill)
	demerol	$5 to $15 (1 pill)
CANNABIS	marijuana, hash oil	$25 (1 gm)
	marijuana	$3,500 - $4,000 (domestic lb)
	hashish	$3,500-$4,000 (domestic lb)
	marijuana plants	$1,120 (1 mature)
SEDATIVE-HYPNOTICS/ TRANQUILIZERS	tylenol #3 pill	$1
	valium or halcion pill	$1
HALLUCINOGENS	hit of LSD	$5 - $7
	ecstasy pill	$15 - $25
	PCP pill	$20 per point (point 1/10 gm)
STIMULANTS	methamphetamine	$10 per point (point 1/10 gm)
	Ts and Rs	$25 - $30 (2 set)
		$40 - $50 (1 set)
	psilocybin (mushrooms)	$15 (1 gm)
		$1,500 - $2,000 (1 lb)

Law Enforcement

Charges and seizures

Statistics Canada reports that, in 2002, Winnipeg CMA had a rate of drug-related incidents which is lower than the national average. The Juristat reports a rate of 200 per 100,000 population versus a national rate of 295 per 100,000. However, this still reflects a steady increase from previous years.

In 2003 (see Table 10) the WPS Vice Division reported that due to procedural changes, concrete statistical information was not available for the current year. They hope to rectify the present statistical situation as soon as possible. In terms of current trends, they reported that marijuana grow operations have increased within the city, increasing from 82 operations identified and destroyed in 2002 to 108 in 2003. This has become a highly profitable criminal enterprise, where the profits outweigh the penalties imposed by the justice system.

In 2003 (see Table 11) Canada Border Services reported the following offences, seizures, e.s.v.[16], charges and other information related to drugs in Manitoba (• - includes seizures made outside Province, confirmed as destined for Winnipeg):

GENERAL - There were 33 seizures of 'other controlled drugs' (2,993 dosages) with an e.s.v. of $3,067. Also, CBS effected 10 seizures of khat• (71,314 gms) with an e.s.v. of $28,525. This represents a substantial increase from previous years, indicated the increase popularity of this drug in Winnipeg. Due to its short shelf life, the drug has been sent in freeze-dried. It appears that khat is used almost exclusively in the Somali community within the city. Also, 2 seizures of diazepam• (valium) (30 dosages) with an e.s.v. of $90 were reported, this remained steady from last year.

Seizures affected by CBS in Manitoba may not necessarily be that valuable when conducting an analysis of the current drug trends in the City of Winnipeg. For example, during 2003 Customs made several large seizures of drugs at ports of entry outside Manitoba. In these cases the drugs were being imported by or showed a connection to a Winnipeg resident or company, however we were unable to determine with any certainty that the shipments were actually destined here. The majority of these cases have not been included in the statistics and only those where it was confirmed that Winnipeg was the final destination were included. Smuggling organizations continue to utilize the vast open areas between border ports to bring contraband into the province. The RCMP is responsible for enforcement at these locations and would best be able to provide statistics from these locations.

A review of seizures again shows that persons intercepted with small quantities were generally males between the age of 20 and 45. The seizures involved a wide variety of ethnic backgrounds. There were no instances where internal carry was used as the method to smuggle drugs into the province and there were no deaths reported of residents of Manitoba attempting to do this elsewhere in Canada. Internal carry did continue to be a popular method of concealment to smuggle drugs at other points of entry, particularly PIA in Toronto.

Winnipeg Airport Customs made several seizures where drugs were found concealed in various locations on commercial aircraft arriving from various destinations. The frequency of these seizures diminished in 2003. It is unknown whether the drugs in these cases were actually destined here and may in fact have been the remains of previous shipment already taken off the aircraft.

COCAINE and CRACK COCAINE - The value and quantity of cocaine and crack cocaine seizures in Manitoba decreased substantially in 2003, although the incidence was basically the same. CBS affected 6 seizures of cocaine (275 gms) and 1 seizure of crack cocaine (1 gm) against Winnipeg residents, with a total e.s.v. of $34,650. However, there were multi-million dollar seizures made on Winnipeg residents at ports outside of the province which were not included in these figures as it could not be determined with certainty that they were destined for Winnipeg. It is

16 The e.s.v. shown is based on a figure supplied by Canada Border Services Headquarters. Thus, the values used may not be the street value in Winnipeg.

important to recognize that there has been an increase in cocaine seizures nationwide and there is a huge cocaine problem in the city, despite any decreases reflected in provincial statistics.

CANNABIS – CBS effected 67 seizures of marijuana• totaling 6,972 gm, representing an e.s.v. of $139,440. This is a substantial increase in quantity and value, accompanied by a decrease in number of seizures. Similar to last year, only three seizures of hashish (509 gm) were reported, with an e.s.v. of $10,184.

This makes marihuana the most commonly seized drug by CBS. The majority of the seizures were in quantities considered to be personal amounts. During the past year there has been a huge increase in the amount of hydroponic marihuana being grown in Winnipeg. Winnipeg grown marihuana is a highly sought commodity in the United States. Winnipeg is known as a major supplier of high quality marihuana, and organized crime groups have set up operations in the city in order to supply the U.S. market demand. As a result of this marihuana has become an export issue for CBS.

HALLUCINOGENS - There was one seizure of ecstasy, totaling 4 dosages, with an e.s.v. of $140. This represents a marked decrease in quantity and value.

STIMULANTS - Two seizures of amphetamines/barbiturates were reported by CBS totaling 265 dosages with an e.s.v. of $1,325. Methamphetamine continues to be a large problem in North Dakota and Minnesota. It does not appear to have become a problem in Manitoba as there were only two small personal quantity seizures made at Customs in Manitoba, with an e.s.v. of $100. Unlike previous years, 180 seizures of ephedrine were also reported, totaling 45,560 dosages, with an e.s.v. of $45,560.

STEROIDS• - CBS has continued to seize increasing amounts of steroids and other controlled drugs. Steroids are being imported, both as injectibles and in pill form. Steroids have been seized coming from various countries, with the U.S.A. and Thailand being the most common countries of export. It appears that some of the shipments have been ordered from subjects who advertise steroids over the Internet.

The number of steroid seizures continues to be high, increasing further from last year, with CBS recording 200 seizures (21,996 dosages) with an e.s.v. of $69,448.

In 2003 (see Table 12), the RCMP reported the following offences, seizures, charges and other information related to drugs in Manitoba through the Drug Section:

GENERAL - The total recovery value of drugs seized was approximately $7,718,000, and drug offences included production, possession, trafficking, and importing/exporting. This is a substantial increase from previous years, primarily involving cannabis seizures. The large number of organized crime related grow operations discovered in up-scale neighbourhoods, as well as large cannabis and cocaine seizures from transport vehicles are the main reasons for this increase.

RCMP activities are strategically targeted toward drug trafficking at the national and multinational level. In many cases, projects span several months before seizures are effected, which directly impacts reported figures in this section.

Assets seized in the 2003 calendar year by the Integrated Proceeds of Crime Unit (IPOC) totaled $2,122,094. This includes cash ($1.3 million), restrained property ($210,000), and vehicles ($466,000) including those seized as conveyances. The remaining assets included jewelry, electronic equipment, and machinery. Forfeiture on these assets is being sought and in some cases the investigations are still continuing. Forfeitures to the Crown for 2003 totaled approximately $117,641, a figure that is expected to change in 2004 as several cases are pending and awaiting disposition. The figure for 2003 does include items seized in past years, but only forfeited in the current year. In addition, during the 2003 year, 117 Suspicious Currency Transactions were received from area financial institutions, casinos and other businesses/agencies. A significant portion of these seizures involved "Pipeline"

investigations targeting organized crime groups from Quebec, Ontario, and BC, as well as large cash seizures at the US Border and Winnipeg International Airport. This trend is expected to carry on well into 2004 and 2005, especially with increased attention to intercept couriers at strategic points within the province.

COCAINE and CRACK COCAINE – Approximately 4,500 grams of cocaine was seized throughout the province during 2003. The total e.s.v. of these seizures was $450,000. In addition, in January of 2004, the largest cocaine seizure in Manitoba's history occurred, when 37 kg's were seized at Falcon Lake.

CANNABIS – Approximately 7,600 plants and 983,487 grams of marijuana were seized throughout the province in 2003, with a total e.s.v. of $6,900,000. The substantial increase from previous years in attributable to an increase in indoor grow operations in up-scale neighbourhoods and large seizures from semi-tractors traveling eastbound through the province. The trend has continued into 2004, with approximately 500 kg's already seized.

HEROIN/MORPHINE and OTHER NARCOTICS – There were no seizures for heroin/morphine in 2003.

STIMULANTS - The total e.s.v. of methamphetamines seized was $3,500, attributable to approximately 100 grams.

STEROIDS - The total e.s.v. of steroids seized in 2003 was $350,000, the majority of which was through Customs mail inspections.

OTHER SCHEDULE III DRUGS - The total e.s.v. of these drugs seized was $14,500. Approximately $10,000 (1,050 grams) of which was magic mushrooms, and $4,500 (90 grams/units) of which was ecstasy.

In 2003/2004, the Drug Analytical Service (DAS) in Winnipeg analysed 7400 various drug samples (compared to 7600 in 2002/03).[17] The majority were cannabis products (4,873), followed by cocaine products (1497). Ninety-five quantitative analyses were performed to determine potency or strength of a drug in a sample (down from 201 in 2002/03). Fifty quantitations were done on cocaine and 45 were done on cannabis products. DAS Winnipeg identified 641 mixtures (combinations of more than 1 drug per sample). Mixtures also include samples where in addition to the actual drug, the substance used to dilute the sample was determined (i.e., sucrose, lactose). Some mixtures are accidental, but the majority are intentional. In some mixtures, other drugs were added to enhance the effect, but in many other cases, they were used to dilute the product and increase the profit margin.

Treatment and Prevention

AFM adult clients (Table 6)

GENERAL - In 2003/2004, approximately 46.3% of clients were currently involved in the legal system, and of these, 86.4% reported that alcohol was related to their involvement and 28.6% reported that other drugs were related to this involvement. There is some overlap in these numbers as some from one group would also fall in the other. The most popular drugs other than alcohol used by AFM adult clients were cannabis, hallucinogens, narcotics/opiates, and cocaine/crack cocaine.

COCAINE and CRACK COCAINE - Approximately 45.9% of adult clients reported using either cocaine or crack cocaine at some time in their lives. Not using in the past year was the most commonly reported category (24.9% and 14.3%,

17 DAS Winnipeg analyses samples from Manitoba, Saskatchewan, Northwestern Ontario, The North West and Nunavut Territories and the 4 Atlantic provinces.

respectively).

HEROIN/MORPHINE and OTHER NARCOTICS - Slightly more than two-fifths of clients reported using narcotics/opiates at some time, and a majority reported not using in the past year (19.3%).

CANNABIS - Nearly four-fifths (79.5%) of clients reported using cannabis at some time, and 14.3% reported using daily. However, 28.6% reported not having used cannabis in the past year.

SEDATIVE-HYPNOTICS and TRANQUILIZERS - Exactly 28% of clients reported using some sedative-hypnotics/ tranquilizers at least once, with the most common being benzodiazepines. A majority reported not using in the past year.

HALLUCINOGENS - Approximately 39% of clients reported using a hallucinogen at some time (LSD/acid, PCP, STP, MDA, Angel dust, magic mushrooms, others), and a majority reported not using in the past year.

STIMULANTS - Approximately 18% of clients reported using stimulants (methamphetamines, speed), and a majority reported not using the past year.

AFM youth clients (Tables 7)

GENERAL - Over 93% of youth clients had used a drug other than alcohol at some point, and while almost 60% were aged between 12 and 14 when they first used drugs, slightly more than 6% were aged 9 or less.

Of the substances other than alcohol ever used, the majority of clients reported cannabis, hallucinogens, cocaine/crack cocaine, and narcotics (namely opiates). The most popular drug of choice was cannabis (93.6%). When asked how often they usually used particular substances, clients admitted to mainly using cannabis on a daily basis (31.4%), followed closely by weekly use (27.4%). Also, about 10.4% of clients reported using substances other that those included in this report.

COCAINE and CRACK COCAINE - Slightly less than one-quarter of youth clients reported using cocaine/crack cocaine at some time. Less than once a month was the most frequently cited category of use.

HEROIN/MORPHINE and OTHER NARCOTICS/OPIATES - Approximately 18% of youth clients reported using narcotics/opiates. There was no reported percentage for youth use of products containing codeine.

CANNABIS - Approximately 94% of youth clients reported having used marijuana at some time. The most frequently reported category of use was daily (31.4%), followed by weekly (27.4%).

SEDATIVE-HYPNOTICS and TRANQUILIZERS - Just under 10% percent of youth clients reported using tranquilizers/sleeping pills.

HALLUCINOGENS - Slightly less than half of youth clients reported using hallucinogens at some time. Most reported using less than once a month (12.2%), followed by monthly (10%).

STIMULANTS - Approximately 16% of youth clients reported using methamphetamine and speed, and 8.2% reported using other stimulants, 11.8% reported using ritalin or Ts and Rs.

STEROIDS - Approximately 1.1% of youth clients reported ever using steroids.

Student use

The most recent RNYIS student data was collected in 2003/2004, and 1175 clients were reported. Of clients admitted to rehabilitation programs, approximately 92% reported using drugs at some time, and 74% reported that they were aged between 12 and 15 when they first tried a drug other than alcohol. The most frequently cited drugs of choice other than alcohol were cannabis, hallucinogens, opiates, and cocaine, and more than half reported using cannabis on a daily or weekly basis.

A previous survey of students, sampled from a cross-section of Manitoba high schools, by the AFM, revealed that more than half the students considered alcohol and drug use to be a major problem at their school. About 6% of students reported moderate or serious problems with the use of other drugs. More than 47% of students reported using drugs at some point, and of these, 83.8% used in the past year. The drug most often used is cannabis, with 38% of students reporting cannabis use in the past year. The average age at which students started to use drugs was 14.1 years of age. As was the case with the alcohol data, an update is expected soon, as a new survey will be conducted fall of 2004.

Methadone Maintenance Program (MMP)

Although it is difficult to determine an exact number, it is estimated that there are between 900 and 1,500 opiate abusers in Manitoba, and the number is increasing.

In 2003/2004 there were 86 clients participating in the MMP, and there is a waiting list for others who want to be part of the program. The first formal evaluation of the MMP [18, 19] reported that a large majority of clients found the program useful for helping them to reduce their drug use, particularly opiates and cocaine, although increased marijuana use was indicated. Good indicators showed that client health was improving, and none of the clients who participated in the evaluation reported shared needle use. Methadone produces minimal tolerance and alleviates craving and compulsive drug use. In addition, methadone therapy tends to normalize many aspects of the hormonal disruptions found in addicted individuals. [20]

The MMP was originally only located at the Misericordia Health Centre, however one was opened in Brandon at the new Health Access Centre. The Program uses a low threshold harm-reduction approach initially, with more intensive rehabilitation offered as clients stabilize. Program clients receive methadone within three hours of walking in the door. Clients on a stabilized dose can be maintained for 24 to 36 hours without experiencing any of the withdrawal effects associated with opiate abuse. Methadone is a substitute for heroin without the buzz or high generally associated with heroin use.

According to the AFM, there is a lack of services outside the Winnipeg area, which creates pressure for expansion to rural communities. The RNYIS program is succeeding in the regard, although it is limited to youth populations. MMP has been successful in engaging pharmacists as partners in the program for clients who have stabilized and can manage “carry” privileges. The full program has four stages from daily administration to full-managed withdrawal if appropriate and desired by the client.

---

18 Patton, D. & J. Lemaire, 2002. A Preliminary Evaluation of the AFM Methadone Maintenance Program (MMP). AFM, 26pp.

19 Results determined by self-reporting and urine analysis.

20 Kosten, T.R. & T.P. George, 2002.The Neurobiology of Opioid Dependence: Implications for Treatment. Science Practice & Perspectives, 1(1): 3-21.

Impact

Hospital data (Table 8)

Of all hospital admissions in the CMA in 2002/2003, the following were reported for drugs generally and individually:

GENERAL - There were 537 cases in which drugs in general were the most responsible diagnosis, and 1383 cases where drugs in general were involved to some degree.

COCAINE and CRACK COCAINE (304.2, 305.6, 760.75) - There were 172 cases in which cocaine/crack was considered the most responsible diagnosis, and 253cases where cocaine/crack was responsible to some extent. The most common diagnosis was 'non-dependent cocaine abuse' (129 cases; ICD9 305.6), and among newborns and infants, two admissions were reported for 'cocaine affecting fetus' (ICD9 760.75).

HEROIN/MORPHINE and OTHER OPIATES (304.0, 304.7, 305.5, 760.72, 965.00, 965.02, 965.09) - There were 57 cases in which heroin/morphine and other opiates was the most responsible diagnosis, and 91instances where these drugs were involved to some extent. The most common diagnosis was 'opioid type dependence' (26 cases; ICD9 304.0), and among newborns and infants, one admission was reported for 'maternal narcotic affecting newborn' (ICD9 760.72).

CANNABIS (304.3, 305.2) - There were 22 cases in which cannabis was considered the most responsible diagnosis, and 130 instances where cannabis was responsible to some extent.

SEDATIVE-HYPNOTICS, BARBITUATES and TRANQUILIZERS (304.1, 305.4, 967, 967.8, 969.0, 969.1, 969.2, 969.3, 969.4, 969.5) - There were 117 cases in which sedative/hypnotics and tranquilizers was the most responsible diagnosis, and 231 instances where these drugs were involved to some extent. The most common diagnoses were 'barbiturate dependence' (ICD9 304.1) and 'barbiturate abuse' (ICD9 305.4) with 34 cases each.

HALLUCINOGENS (304.5, 305.3, 760.7) - There were 4 cases in which hallucinogens were the most responsible diagnosis, and 11 cases where hallucinogens were involved to some extent. The most common diagnosis was 'hallucinogen abuse' (2 cases; ICD9 305.3).

STIMULANTS (304.4, 305.7, 969.7) - There were 2 cases in which stimulants was the most responsible diagnosis, and 10 cases where stimulants were involved to some extent. The most common diagnosis was 'amphetamine abuse' (2 cases; ICD9 305.7).

OTHER DRUGS UNCLASSIFIED (292.0, 304.6, 304.8, 304.9, 305.8, 305.9, 779.5, 969.0, 969.8, 969.9) - There were 223 cases in which other drugs were the most responsible diagnosis, and 654 cases where such drugs were involved to some extent. The most common of these diagnoses was 'drug abuse NEC/NOS' (122 cases; ICD9 305.9).

Deaths (Table 9)

The office of the CME investigated 2,993 deaths (excluding deaths reported in personal care homes) in 2003 recorded as naturals, accidents, suicides, homicides, and undetermined in Manitoba. This is a decrease from last year when there were 3,016 deaths. Of the 301 deaths reporting drugs and alcohol to any extent, 80 involved drugs alone, and 58 involved both alcohol and drugs.

Of the deaths involving only drugs, 3 were traffic accidents, 16 were home accidents, 1 was an accident in another place, 3 were homicides, 29 were suicides, and 12 were undetermined deaths. Similarly, 16 deaths determined to be

natural involved drugs, although this was not considered the cause of death.

The average age for deaths involving drugs only was approximately 41.1 years, with a range of 14-82 years of age. Approximately thirty percent more males died of such causes than females.

Presence in Road Accidents

Recently, with discussions of de-criminalizing marijuana possession laws, ‘drug impaired driving’ has become a major interest and concern. No concrete data was available at this time regarding rates of drug impaired driving, but it’s estimated that one out of every ten impaired drivers is impaired by a substance other than alcohol.

Detection is a major issue which requires addressing, and some training programs have been proposed to allow law enforcement officers better techniques from identifying drivers who are impaired by drug use. The Federal Government has just announced plans to tighten the drug-impaired driving laws. It's considering setting a legal limit for drug impairment like with alcohol, allowing police to take samples of blood, urine, sweat or saliva, and allowing police to lay charges if the driver refuses to cooperate. In addition, more research needs to be done on the effects of specific drugs on driving.

PRESCRIPTION DRUG USE

Programs

The Manitoba Prescribing Practices Program (MPPP) (established in 1990 as the Manitoba Multiple Prescription Program) and the Drug Program Information Network (DPIN) are two provincial government programs designed to monitor the dispensing of drugs in Manitoba. The goal is to monitor, gain a scope of any misuse issues, and then curb the problem. Presently, the major drug of interest is OxyContin (“Hillbilly Heroin”), a painkiller that can be crushed for snorting or injection and is highly addictive. The scope of the problem in Winnipeg is not clearly known although some addicted individuals are now appearing for treatment. Measures have been put into place in the Atlantic Provinces specifically for monitoring this drug.

MPPP (Table 13)

The triplicate prescription portion of the MPPP monitors specific narcotic and controlled drugs in Manitoba. Through the advisory committee to MPPP, guidelines for prescribing and dispensing medication and enhanced patient care are developed. Trends of drug use are identified that suggest the need for analysis, monitoring, and/or education in order to promote more responsible prescribing, dispensing and use of medicines. With this system, the activities of the physicians, pharmacies and patients are computer-monitored by a multidisciplinary team, including Manitoba Health, the Manitoba Pharmaceutical Association (MPhA), and the College of Physicians and Surgeons of Manitoba. Patients must present a triplicate prescription form in order to receive a drug covered under the program, such as a narcotic.

In Manitoba in 2003 there were four incidents of forged prescriptions presented to pharmacies but not dispensed, and eleven incidents of forged prescriptions presented to pharmacies that were dispensed. Of these latter eleven, only one was for drugs monitored with a triplicate prescription of the MPPP. There were also two break and enters into pharmacies from which drugs were stolen and three reports of unexplained loss of drugs. However, there were no armed robberies of pharmacies reported.

Although no exact statistics were kept this year, the MPPP assumes there were more prescriptions issued and monitored this year than in previous years. The MPPP did report issuing 720 more prescription books this year as compared to last year. There were eight forgeries in 2003, which is three more than in 2002. These included one altered non-triplicate prescription, three non-triplicate forgery attempts, two triplicate forgery attempts, and two lost/stolen prescriptions. The MPPP continues to review the prescribing for all narcotic and controlled drugs requiring a triplicate prescription.

DPIN

The DPIN, established in 1994, monitors the dispensing of all prescriptions in Manitoba. The DPIN system is a network-based computer system operated by the government of Manitoba. All medications dispensed pursuant to a prescription are entered into the system by the dispensing pharmacists. Each Manitoba resident has a Personal Health Insurance Number (PHIN) that allows the pharmacist access to their computerized patient medication profile. DPIN allows the pharmacist and other health care professionals to review medication usage, drug utilization, adverse drug reactions, and drug interactions. There is an abundance of information in this system which could improve the amount and quality of knowledge surrounding the state of prescription drug misuse in Manitoba, however this resource has yet to be tapped.

HIV and AIDS

Prevalence (Table 14)

According to Manitoba Health[21], there were 42 individuals who tested HIV antibody positive between January and June of 2003. During this time period, the majority of new cases, both male and female, were between the ages of 20 and 39 (29 cases), although, as was the case in 2002, for females, there has been an increase in the age range of 20-49. The majority of cases continue to involve males (61.9%), however, the number of females becoming infected with HIV from 1995 to June 2003 (31%) has nearly quadrupled over the numbers recorded for 1985 through 1994 (8%). In addition, while an average of 7 females tested positive between 1985 and 2000, 20 and 24 were identified in 2001 and 2002, respectively. The number is expected to be high once again in 2003. To June of 2003, the percentage of cases residing in Winnipeg (at the time of testing) was approximately 95%. However, with the exception of 2001, there has been a gradual but consistent increase in the percentage of cases residing outside of Winnipeg. This observation has important implications regarding the availability of HIV prevention and education resources outside of the major urban centre. Further, this finding encourages health care providers to continue to offer HIV testing and counseling.

Ignoring gender and ethnicity, heterosexual contact with person(s) at risk of HIV was reported as the primary mode of transmission (12 cases). For males, two of the most prevalent transmission categories were heterosexual activity with a person(s) at risk of HIV infection and IDU (injection drug use), whereas for females they were endemic and risky heterosexual activity. Interestingly, there also seems to be a difference in most common mode of transmission when examined by ethnicity. For Caucasians, heterosexual activity was the most common cause, whereas for Aboriginals it was IDU, and for Africans/African-Americans it was endemic. In total, risky heterosexual activity, IDU, and homosexual activity account for 90% of all HIV cases between 1985 and 2002. This is important information as it assists in tailoring prevention and treatment strategies.

According to the monthly communicable disease summaries, there were 111 new cases of HIV in total in 2003. This represents an increase of 59% from 2002. In addition, as of April 2004, there had already been an additional 40 new positive cases of HIV. No descriptive data was available on these cases.

There were a total of 12 AIDS cases reported between January and June 2003.[22] Seven cases were male and 5 cases were female. This represents an increase from the number reported in 2001 and 2002 (8 cases each). The majority of these case were aged 30-39 (8 cases), were attributable to IDU transmission (7 cases), and were residing in Winnipeg at the time of testing (11 cases). The number of reported AIDS cases has declined somewhat over recent years, due in part to early diagnosis and improved treatment of individuals with HIV infection. Seventy-six percent of individuals reported with AIDS have died. However, delays in reporting in both cases and deaths make it difficult to determine precisely the annual incidence and mortality rate.

Impact

21 Manitoba Health Statistical Update on HIV/AIDS, 1985-2003.

22 Delays in reporting of both cases and deaths make it difficult to determine precisely the incidence and mortality rates.

Hospital data (Table 8)

Of all hospital admissions in the CMA in 2002/2003, there were 36 cases in which HIV and/or AIDS was considered primarily responsible and 42 instances where HIV/AIDS was responsible to some extent. The most common diagnoses were 'HIV with specific infection' (13 cases; ICD9 042.0) and 'HIV infection NOS' (7 cases; ICD9 044.9). There was no significant change from the figures in 2001/2002 except that the number of diagnoses involving AIDS with no other conditions to any extent has continued to decrease, with the number falling from 14 to 7 cases.

Deaths

Manitoba Health reported 3 deaths related to AIDS from January to June 2003, although this is presumed to be under-reported.

HEPATITIS (Table 15)

Manitoba Health monitors hepatitis infections in Manitoba. A general decline in acute Hepatitis B incidence has been observed since the mid-1990s, which is probably due to intensive immunization efforts among high-risk individuals and increased awareness.

Between January 1999 and April 2004, there were 3,030 newly identified cases of Hepatitis C reported in Manitoba. There was no annual review available for 2003, however some statistics were attainable. Although the incidence of Hepatitis C is still much higher than either A or B, it declined drastically (13%) between 2002 and 2003. This may be due to the large number of cases reported in 2001/2002 as a result of the Blood Recipient Notification Project. The incidence of Hep A grew by approximately 50% between 2002 and 2003 and the incidence of Hep B decreased significantly from 10 to 2 cases. This somewhat defies the previous trend of increasing incidence of Hep C, with decreasing incidence of Hep A and B. The vast majority of the cases of Hepatitis A reported were traced to one particular restaurant – thus partially explaining the dramatic increase. In 2003, Manitoba Health reported 33 cases of Hep A, 2 cases of Hep B, and 461 cases of Hep C. Consistently, over the last few years, of the reported cases of Hep C, age-specific rates were highest among individuals aged 30 to 49 years, and roughly three-quarters of the cases were reported in Winnipeg. This remained true in 2003. In addition, males accounted for approximately 62% of the cases where gender was known, and females accounted for the remaining 38%. In 2004, up to the end of April, there had already been 5 and 168 cases of Hep A and C, respectively, and there were no reported cases of Hep B. Fifty-seven percent of those reported cases were male, while 43% were female.

Impact

Hospital data (Table 8)

Of all hospital admissions in the CMA in 2002/2003, there were 64 cases in which hepatitis was the most responsible diagnosis and 129 instances where hepatitis was responsible to some extent. Nineteen cases were the most responsible diagnosis and 59 cases were responsible to some extent (ICD9 573.3) of hepatitis unspecified. The most common diagnosis was 'acute alcoholic hepatitis' (45 cases; ICD9 571.1).

TOBACCO

It is still illegal to sell tobacco products to persons under the age of 18 years, although the penalties are not considered a strong deterrent. Recently, the Manitoba government passed a by-law stating there would be no smoking in any public place. These initiatives have also resulted from the increased public awareness about the dangers of second hand smoke.

Among the AFM adult clients in 2003/2004, approximately 91.3% have used tobacco, with almost 73.1% reporting daily use. Less than 10% reported using less than once a month or not in the past year. Youth clients used tobacco less consistently, less than sixty-percent of the 82.1% that reported using tobacco reported doing so daily, while over 15% used less than once a month or not in the past year.

According to Canada Border Services, tobacco smuggling continues at a steady rate, although almost all seizures were of a personal quantity. The increased value of the Canadian dollar may make cross border smuggling of tobacco more attractive to persons involved in this activity. The interprovincial movement of illegal tobacco remains attractive given the price differences between provinces. There were 91 seizures of tobacco in 2003 by CBS with an e.s.v. of $6,518. This is an increase from the number of seizures in 2002.

Customs and Excise of the RCMP also report that smuggling of tobacco continues to be an emerging trend in Manitoba. With the recent tax increases implemented in April 2004, the tax level has exceeded the 1994 levels when smuggling tobacco was considered to be a national problem. The Canadian Tobacco Use Monitoring survey indicates a drop of 4% in smoking over the last 4 years (averaging approximately 1% per year). However, the sales of tobacco in Manitoba have decreased by 16%. Although some people may have lowered their consumption a 12% difference between the use and sale of tobacco indicates that smuggling continues to be a problem. A recent seizure of $27,000 worth of unmarked tobacco at the Manitoba weigh station highlights the lucrative nature of tobacco smuggling.

Tobacco use disorder (ICD9 305.1) for 2002/2003 had one reported case as most responsible diagnosis, and 229 instances where it was responsible to some extent. The latter figure is down substantially from 2001/2002, when 851 instances were reported.

GAMBLING

Gambling is often associated with abused substances - alcohol and drugs - and information on dual diagnoses have been collected by the AFM and is therefore pertinent to this report. Past AFM studies on gambling, alcohol and other drugs[23] indicate that there is a high likelihood that people with gambling problems will also have a substance abuse problem. Clients with dual problems were also seen to have a unique set of needs that may require more intensive interventions. Consideration of these differences should be taken into account when designing and developing programs and services, and staff-training incentives. Alcohol was the primary drug of choice for both substance only and dual problem clients.

For instance, in 2003/2004, approximately 75% of Gambling Services clients had used alcohol and drugs. Of these, approximately 44% had felt a need to cut down on said drugs/alcohol. Alternately, over 35% of adult rehabilitation clients reported that they gambled, and approximately a quarter of these clients reported having troubles because of the gambling. Interestingly, 46.1% of the AFM youth clients also reported gambling, despite age restrictions, but very few (3.1%) reported having troubles because of it.

23 Kaplan, G. & Davis, 1997. Gambling, Alcohol & Other Drugs: Prevalence & Implications of Dual Problem Clients. AFM, September 1997.

CO-OCCURRING ISSUES

Co-Occurring Mental Health and Substance Use Disorders Initiative (CODI)

This initiative was launched in January, 2002 in Winnipeg. It is co-sponsored by The Addictions Foundation of Manitoba (AFM), The Winnipeg Regional Health Authority (WRHA) and Manitoba Health. A review concluded that the needs of individuals with co-occurring mental health and substance use disorders must be acknowledged and addressed across service settings in both systems. Training is aimed to offer a comprehensive array of services delivered in a coordinated and continuous fashion - a system where there would be NO WRONG DOOR. A long-term systems change project was recommended and approved that would result in comprehensive, continuous, integrated service delivery for persons with co-occurring disorders.

DISCUSSION and CONCLUSIONS

ALCOHOL

Alcohol continues to be the most popular substance used and abused in Manitoba, and remains the focus of attention for many institutions and groups in the province. Studies conducted by the AFM show a high prevalence of alcohol among its clients and survey participants. In 2003/2004, nearly all of the adult clients and more than 95% of youth clients at the AFM reported using alcohol at some time in their lives. Of clients admitted to the Impaired Drivers Program at the AFM, almost three-quarters had a presumptive problem with alcohol (not a full-blown addiction), and more than a third reported BACs ranging from .13 to .17.

Despite ongoing publicity campaigns, continuing high numbers of drivers are still choosing to drink and drive. RCMP reported 1,108 drivers were charged with driving with a BAC in excess of .08; however, RCMP statistics are generally considered to be under-reported by as much as 30%. Canada Border Services seized an e.s.v. of alcohol of $6,518 resulting from 90 seizures in 2003, and report that liquor seizures continue at a steady rate. This represents an increase in the number of seizures, with a decrease in the e.s.v. and thus the quantity.

Overall, there has been a 57% decrease in the number of alcohol-related criminal code offenses between 1986 and 2002, 5,651 to 2,433 respectively, and the driver involvement rate declined by 60.9%. All age groups between 16 and 74 recorded such declines. Licensed drivers under the age of 25 consistently record the highest rate of total alcohol offenses, and the percentage of such offenses that they account for is consistently double their portion of the licensed driver population.

Alcohol was the most prevalent of all substances used and abused among hospital admissions, with dependent and non-dependent alcohol abuse common causes. Approximately half of the deaths investigated by the CME that involved alcohol and drugs to any extent involved alcohol, and more than 19% involved both drugs and alcohol.

FAS/pFAS

Although actual incidence statistics are considered not truly indicative of the current situation, the evidence and impact of FAS and pFAS continues to be more widely acknowledged than in past years and many initiatives are endeavouring to increase public awareness of this problem. Various projects and organizations address the urgent need to develop strategies to prevent FAS and support improved health for women.

NON-POTABLES

The use of non potable substances is increasingly a problem, and despite recording lower numbers of users than some other drugs, the impact is severe, especially among chronic users. Over 5% of AFM youth clients and over 7% of adult clients reported using solvents at some time. The number of hospital admissions attributed to non-potable substances was low, compared to that for other drugs, although it is generally recognized that statistics concerning these substances are largely under-reported.

DRUGS

The figures for drug seizures and charges are underreported due to an inability to obtain concrete statistics from Winnipeg Police Services. Thus, comparisons with previous years are inappropriate.

Cannabis continues to be one of the most prevalent drugs in Winnipeg. More than $7 million of cannabis was seized by law enforcement in 2003 by the RCMP and Canada Border Services, with plants accounting for most of this amount. Over three-quarters of adult clients and approximately 94% of youth clients at the AFM reported using cannabis at some time.

Crack cocaine and powdered cocaine continued to be seized in large quantities by law enforcement, netting a total e.s.v. of approximately $500,000. Winnipeg Police accounted for over $2 million in seizures in 2002, indicating that the number would have probably been high again this year. Nearly half of adult and nearly one-quarter of youth clients at

the AFM reported using these substances, and cocaine abuse and cocaine dependence were the most common diagnoses of hospital admissions for substance abuse.

Regarding heroin and other narcotics, the Winnipeg user population is still thought minimal, and seizures seem to support this conclusion. More than two-fifths of adult clients at the AFM who are drug users reported using these drugs at some time (although not in the past year), 18% of youth clients reported using heroin and other opiates.

It is estimated that there are between 900 and 1,500 opiate abusers in Manitoba, and the number is increasing. Indeed, opiates were one of the mostly commonly cited categories of drug use among both youth and adult AFM clients. The Methadone Maintenance Program provided methadone to 86 clients, and efforts are underway to expand the Program to accommodate additional clients.

The use of sedative-hypnotics and tranquilizers and stimulants is low, compared to other, more prevalent drugs in Winnipeg; however the percentages are still high. Hallucinogens have been increasingly used, especially among youth clients. In fact, over one-third of AFM adult clients and nearly half of AFM youth clients reporting drug use have used hallucinogens at some time. Seizures by the RCMP and Canada Border Services reported an e.s.v. of $14,640 and psilocybin ('magic mushrooms') accounted for most of this amount. The usage and availability of ecstasy is reported to be widespread and increasing, but seizures remain low. However, the RCMP seized $4,500 worth of the drug, whereas they had not seized any in 2002. More methamphetamine was seized by the RCMP than in previous years, and it is expected that WPS would have seized a large amount as well, based on previous data.

Steroids continue to be seized in high numbers, and its use is considered to be continuing and increasing. Canada Border Services reported 200 seizures with an e.s.v. of $69,448, and RCMP seizures had a reported e.s.v. of $350,000.

PRESCRIPTION DRUGS, HIV/AIDS AND HEPATITIS

Of the approximately 75,000 prescriptions for drugs monitored by the MPPP in Manitoba, there were 4 incidents of forged prescriptions presented and not filled, 11 incidents of non-triplicate drug forgery filled, 3 incidents of non-triplicate forgery attempts, 2 incidents of triplicate forgery attempts, and two lost/stolen and one altered prescription. OxyContin misuse is on the rise, especially in the Atlantic Provinces. Monitoring programs have been put into place to assess and curb the problem.

Between January and June 2003, there were 42 persons diagnosed HIV positive and the majority of new cases were in the 20-39 year age group. Twelve persons were reported with AIDS and there were 3 AIDS deaths. Heterosexual activity with a person(s) at risk of HIV infection and IDU are still the most prevalent transmission categories of the HIV virus. For females, the most prevalent mode of transmission was endemic.

A decline in acute Hepatitis B incidence has been observed since the mid-1990s, which is probably due to intensive immunization efforts among high-risk individuals. Hepatitis A incidence again increased dramatically in 2003; however, this increase was due largely to one particular outbreak transmitted through food. Hepatitis C appears to be continuing to decrease. In 2003, there were 33 reported cases of Hep A, 2 of Hep B, and 461 cases of Hep C.

CHALLENGES

The major challenge of the Winnipeg reports continues to be data collection. Delays in receiving information, varying time periods of data collection, duration of seizure operations (law enforcement), difficulty collecting data during holiday months, and staffing changes in some cases compromises direct comparison of reported data.

Nevertheless, this Report continues to provide most of the available data, both actual and anecdotal, to reflect the extent and impact of substance abuse in our community. There are a few agencies that will be pursued for further information in coming years. Efforts to address data limitations and apparent inconsistencies, improve the timeliness, usability and application of our local reports, and raise CCENDU's profile in the community remain major goals for the Winnipeg Site Network Team.

As awareness and understanding of the goals and potential of CCENDU increases, so too will the benefit of information exchange between the various centres across Canada. The following are some of the issues that are

presently being dealt with on a national level due to increased information exchange. Many of these issues were discussed in the 2002 National Report, and should be covered in future annual reports:

- national and local trends (increases in the use and availability of designer drugs);
- new substances and combinations (‘blunts’, stimulant drinks);
- misuse of prescription drugs (OxyContin);
- issues with drug purity and potency;
- updates on new approaches to drug treatment and prevention (FAS programs, safe injection sites, drug treatment court); and
- new early warning initiatives (e.g., similar to the U.S. ‘DAWN’ - Drug Abuse Warning Network).

The continued compilation and exchange of this information, both locally and nationally, will greatly enhance the ability of CCENDU to serve as an early warning system concerning emerging trends.

As support for and involvement in CCENDU at the Winnipeg site increases, new sources become available, offering new and more in-depth data for inclusion in the annual reports. The author of the 2004 Report acknowledges the efforts by site team members and others to continue to enhance and expand on the quality and quantity of data currently presented in the annual reports.

REFERENCES

Information for this Report was compiled from various sources, including published and unpublished data. In some cases, information was provided specifically for this purposes of this Report, and not available in a published format.

Addictions Foundation of Manitoba, 1999. Canadian Community Epidemiology Network on Drug Use. Winnipeg, 1999 Report.
___. 2000. Canadian Community Epidemiology Network on Drug Use. Winnipeg, 2000 Report.
___. 2001. Canadian Community Epidemiology Network on Drug Use. Winnipeg, 2001 Report.
___. 2002. Canadian Community Epidemiology Network on Drug Use. Winnipeg, 2002 Report.
___. 2003. Canadian Community Epidemiology Network on Drug Use. Winnipeg, 2003 Report.
Canadian Centre on Substance Abuse, 2002. Establishing a Proactive Model for Identifying and Developing Community Specific Responses to Substance Abuse. Report submitted to the National Crime Prevention Centre, National Strategy on Community Safety and Crime Prevention, and Crime Prevention Partnership Program. February 28, 2002.
Canada Safety Council, New Alcohol-Crash Stats, 2003. www.safety-council.org/info/traffic/impaired/stats.html.
Division of Driver and Vehicle Licencing, 2003. Driver Licencing Statistics.
Division of Driver and Vehicle Licencing, 2002. Alcohol-related Criminal Code Offences, 1986 - 2002.
Kaplan, G. & Davis, 1997. Gambling. Alcohol & Other Drugs: Prevalence & Implications of Dual Problem Clients. Addictions Foundation of Manitoba, September 1997.
Kosten, T.R. & T.P George, 2002. The Neurobiology of Opioid Dependence: Implications for Treatment. Science Practice and Perspectives, Vol. 1, No. 1 (July 2002): 13-21.
Manitoba Health, 2004. Statistical Update on HIV/AIDS, 1985 – June 2003.
Manitoba Liquor Control Commission, 2003. 80th Annual Report.
Patton, D. & J. Lemaire, 2002. A Preliminary Evaluation of the AFM methadone Maintenance Program (MMP). AFM, 26 pp.
Statistics Canada, Census 1996, Statistics for Winnipeg (City), Manitoba.
Statistics Canada, Census 2001, Statistics for Winnipeg (City), Manitoba.
Thordarson, D. & L. Braun, 2001. Making the Right Choice: A Grade 5-8 Fetal Alcohol Syndrome Prevention Curriculum.
Traffic Collision Statistical Report, 2001.
Traffic Injury Research Foundation of Canada, 2003.
Wheeler, J. First Take. Winnipeg Free Press, July 7, 2003.
Winnipeg Fast Facts, Destination Winnipeg Inc., www.destinationwinnipeg.ca.

Non-published Information Sources

Addictions Foundation of Manitoba
Canada Border Services, Intelligence and Contraband Division
Chief Medical Examiner's Office
College of Physicians and Surgeons
Division of Driver and Vehicle Licencing, Research Section
Drug Analytical Services Laboratory
Manitoba Health
Manitoba Pharmaceutical Association
Manitoba Public Insurance
Methadone Maintenance Program
RCMP, Information Management, Records Section, and Winnipeg Drug Section
RCMP, Winnipeg/Brandon Customs & Excise
Winnipeg Police Service, Traffic and Vice

Limitations of the Report

1. There are differences in the time periods for data provided by various agencies and institutions. Some data represents calendar years, while other data coincides with the fiscal year ending March 31. Accordingly, data must be compared cautiously, because data sets may not represent the same time period. It is also important to recognize that wide fluctuations frequently occur from year to year, and where possible, explanations are provided throughout the text.

2. Information from Decision Support Services (Manitoba Health) includes the first record (most responsible diagnosis) and all records of selected ICD-9 codes in all 16 diagnostic levels. The level of complexity of the ICD-9 codes varies.

3. The epidemiological information from Decision Support Services (Manitoba Health) on hospital admissions only includes in-patient admissions, and is not reported by the number of patients but by the number of cases. For example, one patient may have been admitted numerous times over the year, and this is not represented in the data by reporting the number of cases.

4. Some of the information compiled for this report has been sourced from publications, draft reports, anecdotal information, and other information that has been compiled for the purposes of inclusion in this report, and has been interpreted as correctly as possible. Queries should be directed to the editor.

5. In keeping with the standards set by the national CCENDU office, this Report specifically excludes, at the present time, persons residing on military bases, in penal institutions, and on aboriginal reserves.

6. The Office of the CME keeps records of alcohol and drugs related to deaths that are investigated through its office; however, the extent to which alcohol and/or drugs are implicated in each death is not necessarily known or available for this report. There is a variety of issues in determining whether or not the substances actually cause the death, whether this is accidental or purposeful, and to what degree they actually played a role.

7. Any references made to trade names of products, over-the-counter, or prescription drugs are used as examples only of the types of substances that are used on the street.

8. Concrete drug statistics were not available from Winnipeg Police Services, making comparisons with previous years impossible. This was due to procedural changes and is expected to be rectified soon.

APPENDICES

Appendix 1 - Demographics 36

Appendix 2 - Contributing institutions, programs and initiatives in Manitoba 37

Appendix 3 - Report statistics 42

Appendix 4 - How to set up CCENDU in your community 53

APPENDIX 1

Demographics

All information is based on the 1996 and 2001 Census. All whole figures are actual numbers; all decimal figures are percentages.

Populations	**1996**		**2001**	
	MB	**CMA**	**MB**	**CMA**
population	1,113,898	667,093	1,119,583	671,274
CMA of prov. pop.	59.9	-	60.0	-
population < 24 years	-	33.9	-	32.8
population > 65 years	-	13.3	-	13.7

Family indicators	**1996 (CMA)**	**2001 (CMA)**
families	176,945	182, 190
married and common-law couples	84.2	82.3
lone-parent families	15.8	17.7
lone-parent families headed by women	85.0	82.6

Labour force	**1996**	**2001**
active labour force population	379,300	383,300
persons employed	355,200	362,800
participation rate	67.2	61.2
unemployment rate	8.5	5.3
unemployment (15-24)	14.0	13.6
unemployment (25 +)	6.7	6.5
employ. providing greatest no. of jobs	Wholesale and retail trades	Manufacturing

Education	**1996**	**2001**
15 years +	525,125	533,360
with less than high school diploma	35.3	31.8
with university degree	14.7	16.5
with cert. non-uni educ	16.3	14.0
trades cert. or diploma	3.2	10.5

Income	**1996**	**2001**
average family income	$53,759	$64,422
median family income	$47,307	$55,634
economic families low income	18.4%	n/a
unattached individuals low income	48.4%	

APPENDIX 2

Contributing Institutions in Manitoba

Addictions Foundation of Manitoba (AFM)

The AFM is a provincial authority responsible for providing prevention and treatment programs related to addictions to individuals and communities, for conducting research into the negative effects of addictions, and, in so doing, for promoting the health and well-being of all Manitobans. The AFM delivers services within a Continuous Improvement process, where everyone in the organization is involved in improving the processes within and, as a result, meeting or exceeding the needs of its customers. These services are delivered from a provincial office in Winnipeg, three regional offices in Winnipeg, Brandon and Thompson, and offices in additional communities. Treatment services include residential programs, day programs, and community-based programs, as well as specialist services such as Impaired Drivers programs, gambling services, and family and affected persons programming. The AFM has one of the most comprehensive database systems in Canada with regard to addiction client statistics and services.

Manitoba Health Decision Support Services Unit

The Decision Support Services Unit is responsible for providing the necessary policy and infrastructure to conduct data dissemination and analysis in response to the information requirements of Manitoba Health management and staff, service providers, Regional Health Authorities, external researchers and the general public.

Manitoba Health Communicable Diseases Control Unit (CDC)

This Unit has as its primary responsibility the control of communicable diseases in Manitoba. Activities to meet this responsibility are conducted in consultation with those involved in the identification, diagnoses, treatment, and legal, ethical and social management of communicable disease.

Manitoba Pharmaceutical Association (MPhA)

The MPhA is empowered by the provincial Pharmaceutical Act and regulations. The association's primary role is for the protection of the public regarding the practice of pharmacy. For this purpose, the Association sets licencing requirements (for pharmacists and pharmacies), standards of practice, code of ethics, and complaint investigation. The Association liaises with the office of the Minister of Health, other health professional licencing bodies, government offices, and law enforcement agencies. The Association is quite involved in decreasing the abuse of non-prescription and prescription medication, and illegal drugs and drug-diversion tactics.

RCMP Drug Awareness Office

The Drug Awareness Office is responsible for initiatives within Manitoba to help decrease the demand for illicit drugs and reduce substance abuse. This Office is active in support of local officers in their community education activities. For the past few years, the RCMP 'D' Division Headquarters has provided video conferencing facilities to allow regular contact between the Winnipeg and national CCENDU site teams. The CCENDU team and coordinators in Winnipeg would like to extend their sincere thanks for this valuable service.

Winnipeg Police Service (WPS)

The WPS continues to recognize the important role of enforcement as one of the elements necessary to reduce impaired driving. By continuing to foster education in conjunction with enforcement, it is hoped the efforts of the WPS, along with those of government, the courts, and citizens' groups such as Mothers Against Drunk Driving (MADD), will reduce the trauma and expense caused by impaired driving. Similarly, WPS play a vital role in the early identification of substance abuse trends and impact. They generally have first-hand experience of the amount of crime that takes place related to substance abuse.

Manitoba Public Insurance (MPI)

Manitoba's coordinated approach to road safety is unique in Canada. Much of the success of road safety programs directed at mitigating the problem of impaired driving is credited to the sharing of information and resources related to the improvement of road safety that takes place among the members of the Manitoba Road Safety Coordination Committee. The Committee is currently co-chaired by MPI and the WPS. Committee members include representatives from law enforcement, the medical community, government, not-for-profit agencies, and private business.

Manitoba Liquor Control Commission (MLCC)

The MLCC is a customer-orientated organization providing services to the public and revenue to the Province through the effective and regulated sale of quality beverage alcohol. The Commission is actively involved with many programs, including the Responsible Driver Committee, MADD, Safe Grad, and Teens Against Drinking and Driving (TADD), and education of retailers about consumption of non-potable alcohol products. In addition, the MLCC was a major sponsor of Operation Red Nose and assisted in other programs. The Alcohol Education Committee promote the safe, healthy use of beverage alcohol, and members represent a cross-section of MLCC departments to ensure the alcohol education message is integrated into all activities.

Office of the Chief Medical Examiner (CME)

The Office of the CME in Manitoba is responsible under the Fatality Inquiries Act and Vital Statistics Act for the inquiry/investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. The area of jurisdiction is the province of Manitoba. In addition, the CME has jurisdiction over those who travel through the province.

Canada Border Services

Canada Border Services is responsible for seizures affected in Winnipeg and Manitoba ports of entry. Border Services information serves as an early warning of possible future trends in substance abuse products in Manitoba.

Non-Potable Alcohol and Inhalant Abuse Committee

The first meeting of the Non-Potable Abuse Coalition took place on November 29, 1991. This meeting included representatives from Main Street Project, Klinic Incorporated/Substance Abuse Coalition, MPhA a pharmacist/owner, a member of Parliament, and the MLCC. This committee was founded because of the high alcohol, non-potable products being consumed by street alcoholics as a beverage, and the unethical profiteering of some stores who sold these products to street people. Various other agencies, including the WPS, have participated to curb the continued abuse of non-potable alcohol problems and solvent abuse.

Contributing Programs and Initiatives in Manitoba

Operation Red Nose: This holiday-season program provides safe and free transportation to any motorist who has been drinking or feels unfit to drive. The service is community driven, supported, and helps to raise funds for worthwhile causes, and heightened public awareness of the impaired driving problem.

Photo Identification: MLCC photo identification cards issued to young adults that serve as proof of age and identification in licensed establishments.

The Responsible Server Committee: has membership from AFM, MLCC, Manitoba Hotel Association, Manitoba Restaurant Association, MADD and MPI, and developed and coordinates two major prevention programs: the Designated Driver program and the It's Good Business program.

Designated Driver: This voluntary program aims to prevent accidents by curbing impaired driving. A program kit provides material and information that encourages groups to identify a driver before consuming alcohol. That driver is provided non-alcoholic beverages for free in return for ensuring the others in the group get home safely.

It's Good Business: A server intervention program that targets owners, operators and serving staff in licenses premises to recognize impairment. An extension of the Designated Driver program, the emphasis is on education and how to sell and serve beverage alcohol in a socially-responsible manner.

Be Undrunk: The newest initiative of the MLCC, which intends to decrease the frequency and dangers associated with binge drinking in young adults. The program utilizes both television and radio advertisements as a medium for reaching these youth.

Safe Grad and Teens Against Drinking and Driving (TADD): Organized by the TADD/Safe Grad Coordinating Committee and chaired by Manitoba Association of School Trustees (MAST), the primary goal is to encourage students to think about drinking and driving, and make the right choices in drinking and driving situations. Co-supported by MLCC and MPI.

Mothers Against Drunk Driving (MADD): MADD is an international non-profit organization that provides victim support and lobbies for changes to laws relating to drinking and driving. MADD Canada is a non-profit grassroots organization run by volunteers across the country, and includes those who have lost a loved one, such as mothers, fathers, friends, business professionals, experts in the drunk-driving field, as well as concerned citizens who want to make a difference in the fight against impaired driving.

Show Your Age: The MLCC-initiated province-wide identification program that confirms the identification of young-looking customers, targeting ages 18-25. The program requires that young customers show their age whenever they purchase alcohol, and insists on the use of only government-issued photo ID.

Manitoba Addictions Awareness Week (MAAW): Held the third week of November each year, this is an opportunity for many communities and organizations to host local events to raise awareness of the dangers of harmful addictions. This program is coordinated provincially through an MAAW Committee of 18 independent organizations, agencies and private corporations. The Committee produces an extensive resource kit each year, conducts community consults on MAAW, and coordinates this annual initiative with the national initiative.

Committee on Alcohol and Pregnancy: This group spearheads the Fetal Alcohol Syndrome/partial Fetal Alcohol Syndrome initiative. A wide variety of community organizations and government agencies have joined forces to

help prevent FAS/pFAS.

With Child - Without Alcohol: This is an educational and awareness incentive of the MLCC, which assists in the prevention of prenatal alcohol exposure. Some of the initiatives include pamphlets on FAS, printed messages of 'With Child -Without Alcohol' on bags and bottles, an information kit on alcohol and pregnancy, and warning posters.

Checkstop: A stepped-up impaired driving surveillance program conducted by the WPS. The objective is to provide a highly-visible presence that is well advertised, and to provide efficient detection and enforcement. The intent is to provide a general deterrent for those who would need such warnings, and a specific deterrent in the form of enforcement action for those who would disregard the warnings.

RoadWatch: RoadWatch also continued as a major campaign enforcing anti-drinking laws in the apprehension of impaired drivers. It's goal is to reduce the number of alcohol-related collisions in Manitoba by increasing police presence to deter impaired driving activities. High visibility police enforcement supported by an expanded communication strategy is used to mount this campaign.

Impaired Drivers Program (IDP): Manitoba has one of the most comprehensive approaches in Canada to address the issue of impaired driving. IDP was established in 1980 by the AFM for persons convicted of a second or subsequent charge of driving while impaired. Since 1986, the program has been mandatory for first and subsequent impaired driving offenders prior to the reinstatement of their driving privileges. All costs associated with delivery of the program are payable by the offender at the time of assessment.

AFM Methadone Maintenance Program: The AFM Methadone Maintenance Program offers methadone as an alternate/replacement substance for long-time users of opiates. Methadone stops users from getting high on opiates, and is provided as a long-acting steady dose of opiate replacement. Once stabilized (i.e., once the craving and seeking of opiates is under control), users can begin normalizing their life by changing their lifestyle and/or engaging in rehabilitation. The Methadone Maintenance Program is the only recognized program of its kind in Manitoba.

Rural & Northern Youth Intervention Strategy (RNYIS): Initially a three-year demonstration project, RNYIS involves the placement of AFM Youth Counsellors in high schools throughout rural and northern Manitoba to provide education, assessment and counselling services to students with the primary aim of early intervention into alcohol and other drug-related problems. Acting on program experiences and the findings of an extensive program evaluation, the RNYIS demonstration project is now a core program of the AFM.

Co-Occurring Mental Health and Substance Use Disorders Initiative (CODI): Launched in January, 2002 in Winnipeg. It is co-sponsored by The Addictions Foundation of Manitoba (AFM), The Winnipeg Regional Health Authority (WRHA) and Manitoba Health. A review concluded that the needs of individuals with co-occurring mental health and substance use disorders must be acknowledged and addressed across service settings in both systems. Offers a comprehensive array of services delivered in a coordinated and continuous fashion - a system where there would be NO WRONG DOOR. A long-term systems change project was recommended and approved that would result in comprehensive, continuous, integrated service delivery for persons with co-occurring disorders.

APPENDIX 3

Report Statistics

NOTE: Where spaces in tables have no data, either data was not recorded or not known. (n/a - not available)

Table 1. Admissions to Winnipeg CMA hospitals (2002/2003), Addictions Foundation of Manitoba (2003/2004).

	2000/2001	2001/2002	2002/2003	2003/2004
Hospitals	83,842 *	81,379 *	81,379 *	n/a
all instances alcohol/drug related where primary diagnosis	3,714 º 828	4,927 º 981	3,871 º 1,643	
all instances alcohol related where primary diagnosis	2,631 § 582	2,586 § 580	2,488 § 1,087	
all instances drug related where primary diagnosis	1,033 º§ 238	1,449º§ 377	1,383 § 537	
AFM	14,550	14,711	15,182	15,576
adults	8,093	8,069	8,526	8,669
youth/RNYIS	1,764	1,880	2,155	2,405
IDP	2,379	2,236	2,040	2,275

* excluding day admissions and emergency room patients

º does not include HIV diagnosis because it is uncertain (injection) drug use was a contributing factor. Does not include Tobacco use disorder.

§ does not include 573.3 (hepatitis, unspecified) or 760.70 (unspecified noxious substance via placenta/milk) as it cannot be determined if alcohol or drugs were a contributing factor

Table 2. Manitoba Liquor Control Commission (2002/2003)

Sale and consumption	1999/2000	2000/2001	2001/2002	2002/2003
sales (millions of $)				
beer	175	181	193	199
spirits	152	153	154	154
wine	58	58	63	67
coolers/ciders	9	9	13	15
total	394	401	423	435
per capita consumption (litres)				
beer	60.0	60.5	62.0	61.3
spirits	5.6	5.6	5.5	5.4
wine	5.5	5.5	5.8	5.9
cooler/ciders	1.7	1.8	2.3	2.5
total	72.8	73.4	75.6	75.1
volume sales (millions of litres)				
beer	68.6	69.5	71.3	70.6

spirits	6.4	6.4	6.3	6.3
wine	6.2	6.3	6.7	6.8
cooler/ciders	1.9	2.0	2.6	2.9
total	83.1	84.2	86.9	86.6

licensed vendors	179	179	180	179
beer vendors	301	303	298	296
liquor marts	45	45	45	44
wine stores	8	8	8	8

photo ID cards	4,081	4,589	5,263	5,379
licence suspensions	25	25	36	29
warnings/other action	100	134	129	259 *
suspension of occasional permits	12	4	4	7
warnings	16	21	13	30

* 134 administrative warning letters specifically related to 'It's Good Business' training.

Table 3. Alcohol-related charges and offences recorded by WPS and the RCMP (2003)

Winnipeg Police Service	2000	2001	2002	2003
impaired operation of a motor vehicle causing bodily harm	-	16	18	11
impaired operation of a motor vehicle causing death	1	1	2	1
individuals charged with impaired driving offences	1,034	882	821	778
failed or refused to provide breath samples	59	48	40	37

Checkstop - WPS	2000	2001	2002	2003
days conducted	n/a	32	33	35
no. of vehicles stopped		1,045	-	10,900
no. suspended registering a WARN for BAC between .05 and 0.1		23	80	53
no. charged 'impaired/over' or 'impaired/refused'		16	91	23
driving suspended or prohibited		8	-	-
other criminal code offences		4	-	-
avg. age of those charged		-	36 years	-
age range of those charged		-	-	23-52 years

RoadWatch	2000	2001	2002	2003
days conducted	102	98	64	87
vehicles checked	-	-	-	42,488
no. suspended registering a WARN for BAC between .05 and 0.1	290	178	56	-
no. charged 'impaired/over' or 'impaired/refused'	166	122	74	87*

* includes those registering a WARN

RCMP (Manitoba)	2000	2001	2002	2003
impaired operation of a motor vehicle	369	365	389	452
driving with a BAC in excess of .08	1,329	1,278	1,178	1,108
refuse rd 234.1 (refused roadside breathalyzer)	26	7	5	17

failed or refused breath test failed or refused a blood test	158 10	155 17	140 6	139 17
liquor offences	2,722*	4,580*	3,807*	3,997*

Table 4. Alcohol seizures recorded by Canada Border Services (2003)

Canada Border Services (ports of entry)	Jan - Dec 2000	Jan - Dec 2001	Jan - Dec 2002	Jan - Dec 2003
alcohol seizures e.s.v.	146 $8,271	75 $16,513	107 $7,266	90 4,882

Table 5. Addictions Foundation of Manitoba Impaired Drivers population (2003/2004)

	2000/2001	2001/2002	2002/2003	2003/2004
admissions to program	2,379	2,236	2,040	2,275
individuals by program	2,331	2,207	2,014	2,239
of these had a non-apparent problem (does not appear to have any real problem with alcohol)	13.5	10.5	8.6	6.8
had a presumptive problem (indicates a problem but not an active, full-blown addiction)	64.2	67.1	70.1	72.4
had an active problem (active alcohol problem that is interfering directly in life)	11.3	9.9	10.9	10.6
had a problem under control (in program or made lifestyle changes to control addiction)	10.9	12.1	10.4	10.0
clients for whom blood alcohol level available	1,629	1,537	1,448	1,576
reported blood alcohol levels ranging from .08 to .12	29.2	29.9	30.7	29.8
reported blood alcohol levels ranging from .13 to .17	38.4	36.1	38.5	37.8
reported blood alcohol levels ranging from .18 to .22	23.6	23.8	22.7	24.2
reported blood alcohol levels ranging from .23 or higher	8.8	10.1	8.1	8.2
first offenders ‘DDVL status’	84.3	85.1	84.0	81.2
referred by DDVL	98.9	99.4	85.5	84.1
males	87.2	86.4	86.9	85.7
between 18-24	23.4	22.0	23.0	22.6
between 25-34	28.2	29.0	27.8	29.0
between 35-50	36.6	37.8	36.4	35.7

Table 6. Addictions Foundation of Manitoba adult client population (2003/2004)

	2000/2001	2001/2002	2002/2003	2003/2004
admissions to program	8,093	8,069	8,526	8,669

individuals by program	4,458	4,514	4,791	4,861
male	71.1	70.0	69.8	69.8
18 - 24 years of age 25 - 50 years of age	22.4 67.8	22.4 67.8	22.5 69.9	24.0 30.9
self referred to treatment services, or by family/friends	37.2	39.1	41.6	47.7

Substance use (ever used)				
alcohol	90.0	86.3	98.9	98.8
cocaine/crack	36.2	36.0	44.7	45.9
narcotics/opiates	27.7	26.4	43.2	42.8
marihuana	63.5	63.0	77.6	79.5
tranquilizers	22.4	21.1	28.5	28.0
LSD/acid, mescaline, psilocybin, others	39.7	40.7	37.6	38.9
stimulants (speed, methamphetamines, other)	19.2	19.7	19	18.1
over the counter	18.3	16.9	37.0	37.1
other (Ts and Rs, ritalin, talwin)	6.6	5.9	8.9	8.5
steroids	-	-	3.5	3.9

Table 7. Addictions Foundation of Manitoba youth client population (2003/2004)

	2000/2001	2001/2002	2002/2003	2003/2004
admissions to program individuals by program	1,784 1,326	1,880 1,369	2,155 1,650	2,405 1,822
13 years of age or less 14 - 17 years of age	9.0 84.5	7.8 86.6	6.6 86.6	8.9 83.3
male	64.9	62.9	61.9	64.2
self referred to program referred by family/friends	9.7 15.7	7.4 19.2	9.2 15.9	9.2 17.8
ever charged with criminal offence of these - possession of narcotic/trafficking - underage drinking offence was alcohol/drug related	51.7 16.4 31.3 -	56.9 18.5 34.3 -	47.9 - - 57.8	44.6 - - 48.8

under influence of alcohol/drugs at the time of offence	58.1	61.9	57.5	54.6
ever consumed alcohol 9 or less 12 - 14 years of age	97.7 7.4 62.9	97.4 6.2 65.2	96.5 5.6 64.5	95.3 5.2 63.5
ever consumed drug other than alcohol 9 or less 12 - 14 years of age	90.2 5.9 62.0	92.2 6.9 59.8	92.6 4.2 64.3	93.1 6.1 57.6

Substance use (ever used)	2000/2001	2001/2002	2002/2003	2003/2004
alcohol	94.7	95.6	97.3	95.5
solvents	5.6	4.7	4.4	5.1
cocaine/crack	24.2	27.5	24.4	23.4
narcotics/opiates	4.2	3.9	18	18.3
marihuana	87.3	90.2	93.9	93.6
tranquilizers/sleeping pills	9.9	10.0	11.2	9.9
hallucinogens	51.2	48.1	50.8	45.3
stimulants (speed, methamphetamine)	13.0	13.0	14.2	15.5
other stimulants	6.2	6.0	7.5	8.2
ritalin/Ts and Rs	10.6	10.0	13	11.8
products with codeine	21.1	19.9	-	-
over the counter products	10.5	10.5	16.8	14.6
steroids	1.3	1.1	1.6	1.1

Table 8. Alcohol, drugs and related conditions diagnosed for admissions to hospitals in the Winnipeg CMA (Manitoba Health Epidemiology Unit, 2002/2003)

ICD-9	Diagnosis	2000/2001		2001/2002		2002/2003	
		A	B	A	B	A	B
042.0	HIV with specific infection	8	9	10	17	13	16
042.1	HIV causing other infection	6	11	5	6	6	7
042.2	HIV with spec. malignant neo	6	11	1	2	3	3
042.9	AIDS with NOS	19	29	6	14	6	7
043.1	HIV causing CNS disorder	-	-	2	2	1	2
043.3	HIV causing other disorder	-	-	1	1	-	-
044.9	HIV infection NOS	-	-	-	-	7	7
291.0	delerium tremens (previously with alcohol withdrawal)	8	37	12	56	15	35
291.1	alcohol amnestic syndrome (prev. Korsakowv's)	10	31	3	19	7	22
291.2	alcoholic dementia NEC	13	35	5	23	15	26
291.3	alcohol hallucinosis	15	23	9	13	5	6
291.5	alcoholic jealousy	-	-	-	1	-	-
291.8	alcohol psychosis NEC (composed of .81 and .89)	276	385	302	402	340	441
291.81	alcohol withdrawal (previously not a code)	-	-	-	-	359	439
291.89	other specific alcohol psychoses (prev. not a code)	-	-	-	-	1	2
291.9	unspecified alcoholic psychoses	1	2	1	3	1	2
292.0	drug withdrawal syndrome	20	37	17	39	19	37
303.0	acute alcohol intoxication	5	36	6	40	13	31
303.9	alcohol dependent NEC/NOS	62	694	54	740	195	651
304.0	opioid type dependence	12	39	16	40	26	36
304.1	barbiturates dependence	16	49	11	62	34	46
304.2	cocaine dependence	9	24	12	38	41	53
304.3	cannabis dependence	8	10	-	11	2	11
304.4	amphetamines dependence	-	-	-	-	-	2
304.5	hallucinogen dependence	-	-	-	-	1	1
304.6	drug dependence NEC	5	26	2	25	4	25
304.7	opioid and other drug dependence	2	3	10	15	5	7
304.8	combination drug dependence NEC (prev. no opioid)	3	15	10	16	9	17
304.9	drug dependence NOS	9	35	7	39	19	30
305.0	alcohol abuse (prev. non-dependent)	79	916	52	791	230	816
305.1	tobacco use disorder	-	-	-	-	1	229
305.2	cannabis abuse (prev. non-dependent)	7	93	1	98	20	119
305.3	hallucinogen abuse (prev. non-dependent)	-	-	-	4	2	4
305.4	barbiturate/tranquilizer abuse (prev. non-dependent)	10	30	2	24	34	44
305.5	opioid abuse (prev. (non-dependent)	7	13	3	8	16	27
305.6	cocaine abuse (prev. non-dependent)	21	95	31	106	129	194
305.7	amphetamine abuse (prev. non-dependent)	1	2	-	1	2	7
305.8	antidepressant abuse (prev. non-dependent)	-	-	-	1	-	1
305.9	drug abuse NEC/NOS	39	388	49	400	122	420
425.5	alcoholic cardiomyopathy	2	18	3	14	2	9

571.0	alcoholic fatty liver	1	21	1	21	8	15
571.1	acute alcoholic hepatitis	20	70	19	66	45	70
571.2	alcoholic cirrhosis of liver	75	263	96	319	98	262
571.3	alcoholic liver damage NOS	4	31	6	28	13	28
573.3	hepatitis unspecified	6	47	12	49	19	59
760.71	maternal alcohol affecting newborn	4	55	1	31	5	33
760.72	maternal narcotics affecting newborn	1	5	1	2	1	2
760.73	maternal hallucinogenic agents affecting newborn	2	3	1	4	1	6
760.75	cocaine affecting fetus	3	10	1	7	2	6
779.5	newborn drug withdrawal syndrome	12	25	14	26	9	21
965.00	poisoning by opium NOS	-	-	-	5	1	2
965.02	poisoning by methadone	3	3	2	3	4	5
965.09	poisoning by opiates NEC	-	-	4	10	4	12
965.1	poisoning by salicylate acid salts ¤	-	-	14	30	-	-
965.4	poisoning by aromatic analgesics unspecified ¤	-	-	57	108	-	-
965.61	poisoning by proprionic acid derivatives ¤	-	-	-	11	-	-
965.69	poisoning by antirheumatics ¤	-	-	-	1	-	-
965.7	poisoning by other non-narc analgesics unspecified ¤	-	-	-	2	-	-
965.8	poisoning by other specified analgesics/antipyretics ¤	-	-	3	7	-	-
967.0	poisoning by barbiturates	1	2	-	4	8	21
967.8	poisoning by other sedatives-hypnotics NEC	1	3	1	5	-	-
967.9	poisoning by sedatives-hypnotics NOS	2	6	2	7	-	-
969.0	poisoning by antidepressants	-	-	31	76	32	79
969.1	poisoning by phenothiazine tranquilizers	2	2	2	5	-	1
969.2	poisoning by butyrophenone tranquilizers	-	-	-	-	2	3
969.3	poisoning by antipsychotic NEC	1	11	1	9	4	12
969.4	poisoning by benzodiazepine tranquilizers	25	71	36	106	33	100
969.5	poisoning by tranquilizer NEC	2	5	1	2	2	4
969.6	poisoning by hallucinogens	-	-	1	1	-	-
969.7	poisoning by psychostimulants	-	-	3	5	-	1
969.8	poisoning by psychotropics NEC	-	-	6	21	9	22
969.9	poisoning by psychotropics NOS	-	-	-	-	-	2
977.8	poisoning by drug medication NEC ¤	-	-	12	31	-	-
977.9	poisoning by drug medication NOS ¤	5	9	13	23	-	-
980.0	toxic effect of ethyl alcohol	1	6	1	4	4	9
980.1	toxic effect of methyl alcohol	4	5	5	7	3	3
980.2	toxic effect of isopropyl alcohol	-	-	2	4	-	-
980.9	toxic effect of alcohol NOS	2	3	2	4	2	4
982.0	toxic effect of benzene ¤	-	-	-	1	-	-
982.8	toxic effect of other solvents ¤	6	8	-	6	-	-
TOTALS		867	3,774	997	4,952	1,688	4,198

A: instances where alcohol and drugs considered the most responsible diagnosis
B: instances where alcohol and drugs considered responsible to some extent
¤: no longer an ICD-9 code

Table 9. Deaths as reported by the Chief Medical Examiner's Office (2003)

	2001	2002	2003
total number of deaths investigated	3,183	3,016	2,993
involving alcohol only	159	155	163
involving drugs only	93	85	80
involving alcohol & drugs	37	47	58
total involving drugs/alcohol	289	287	301

Table 10. Drug charges and seizures recorded by the Winnipeg Police Service (2003)

CHARGES	2001	2002	2003
drug charges % charges effected against adult males	n/a	1,247 73.1	n/a
trafficking possession for purpose possession production possession proceeds of crime other related charges	n/a	150 352 526 97 123 9	n/a
most common drug seized e.s.v. of all drugs seized	marijuana $4,034,992	marijuana $3,690,125	marijuana n/a

SEIZURES	2001		2002		2003	
	A (gm)	B (e.s.v.)	A (gm)	B (e.s.v.)	A (gm)	B (e.s.v.)
cocaine crack/cocaine	20,873 3,093	$2,528,345 $204,030	26,747 3,631	$2,648,659 $219,995	n/a	n/a
heroin morphine morphine sulphate methadone [units]	5 84 - 75	$2,100 $240 - $100	2 14 - -	$500 $280 - -	n/a	n/a
ritalin [pills] talwin [pills] Ts and Rs [sets]	18 14 116	$90 $350 $5,800	43 .75 -	$0 $65 -	n/a	n/a
marihuana marihuana cultivation hashish/hash oil, resin	182,145 3,856 plants 5,105	$1,160,607 $6,523,950 $28,020	63,665 6,999 plants 522	$738,327 $11,641,254 $11,811	n/a	n/a
valium [units] codeine [units]	149 368	$149 $368	301 820	$311 $809	n/a	n/a
LSD [hits]	359	$2,205	175	$2,195	n/a	n/a

psilocybin ecstasy [units]	699 3,174	$10,485 $82,590	2,958 1,008	$34,485 $25,243		
methamphetamine	62	$9,363	78	$9,010	n/a	n/a
steroids [ml]	-	-	-	-	n/a	n/a
PCP/fiorinal/percocet	-	-	-	-	n/a	n/a
Lorazepam	-	-	29	$30	n/a	n/a
Khat	-	-	21,184	$0	n/a	n/a

Table 11. Drug seizures by Canada Border Services (2003)

SEIZURES	Jan. - Dec. 2001		Jan. - Dec. 2002		Jan. - Dec. 2003	
	A (gm/dose)	B	A (gm/dose)	B	A (gm/dose)	B
marijuana hashish hashish (liquid)	1,694 538 19,382	$34,440	436 679 0.5	$8,720	6,972 509 -	$139,440 $10,184 -
cocaine crack cocaine	10,340 23	$1,034,000 $5,750	2,734 2	$273,400 $500	275 1	$34,450 $200
khat	2,000	$400	17,500	$3,300	71,314	$28,525
methamphetamines amphetamines/barbiturates diazepam (valium) rohyphol ephedrine	- 120 1,650 23 -	- $600 $4,959 $184 -	- 201 30 - -	- $1,005 $90 - -	1 265 30 - 45,560	$100 $1,325 $90 - $45,560
steroids	14,875	$29,750	20,000	$40,000	21,996	$69,448
LSD psilocybin ecstasy	- - 1,005	- - $35,175	- - 35	- - $1,225	- - 4	- - $140
heroin opium	- -	- -	- 0.5	- $25	- -	- -
other controlled drugs	23,626	$23,626	8,715	$8,715	2.993	$3,097

Table 12. Charges, seizures and offences related to drugs recorded by the RCMP in Manitoba (2003)

CHARGES	2001	2002	2003
drug offences recorded in Manitoba	682	568	686
total recovery value of seized drugs	$5,206,092	$1,456,756	$7,718,000
charges laid against males charges laid against females	35 (79.5%) 9	50 (84.7%) 9	481(83.2%) 97

SEIZURES	2000	2001	2002	2003
	e.s.v.	e.s.v.	e.s.v.	e.s.v.
cocaine	$1,700	$480,400	$58,363	$450,000
heroin	$395	-	-	-
morphine	-	$120	$115	-
cannabis resin	$14,060	$3,999,525	$245	-
marihuana	$166,665	$632,340	$105,893	$3,100,000
marihuana individual plants	$71,600	$3,103,500	$950,486	$3,800,000
khat	-	-	-	-
LSD (units)	-	-	-	-
ecstasy	-	$440	-	$4,500
psilocybin	-	$15,770	-	$10,000
amphetamine	-	-	$21,100	-
methamphetamine	-	-	-	$3,500
steroids	$356,075	$210,145	$203,165	$350,000
hydroponic drug cultivation equipment	-	$3,000	-	-

Table 13. Drug diversion incidents reported to the Manitoba Pharmaceutical Association and the College of Physicians and Surgeons of Manitoba (2003)

	2000	2001	2002	2003
non-triplicate drug forgeries filled	1	6	3	11
forged prescriptions presented and not filled	53	23	12	4
pharmacy break/enter and theft for drugs	3	6	3	2
pharmacy armed robbery for drugs	0	1	0	0
pharmacies in Manitoba reported unexplained losses of drugs	B	5	0	3
number of prescriptions monitored by the MPPP in Manitoba*	68,764	73,553	n/a	n/a
number of forged prescriptions	0	5	5	8

* - as of 2002, no longer inputted and calculated

Table 14. HIV and AIDS data (Manitoba Health, 2003)

	2001			2002			Jan – June 2003		
	total	male	female	total	male	female	total	male	female
tested positive for HIV	65	39	26	70	41	29	42	26	16
IDU only testing HIV positive	21	12	9	22	12	10	10	7	3
heterosexual activity testing HIV positive	22	10	12	21	12	9	12	8	4
reported with AIDS	8	6	2	8	7	1	12	7	5
died from AIDS	7			5			3		

Table 15. Hepatitis data (Manitoba Health, 2004)

	2001	2002	2003	2004 (to April)
hepatitis A	6	22	33	5
hepatitis B	5	10	2	-
hepatitis C	735	532	461	168

APPENDIX 4

How to Set Up CCENDU in Your Community

WHY CCENDU WAS STARTED

Substance use has long been of concern to health, education and law enforcement professionals across Canada because of its negative impact on the physical, social, mental, spiritual and psychological health of the population. Measuring this impact, however, has not been easy, and our understanding of the Canadian situation and ability to improve it has been hampered by a lack of information. Consumption and behaviour patterns for drugs other than alcohol have been particularly difficult to assess, given the inherent illegal nature of these substances and the relatively small size of the population, among other factors.

Population surveys have been beneficial to health planners and policy makers in identifying and understanding substance use within the general population. However, these studies have some limitations - they typically do not access much of the illegal-drug-using population, the release of this sort of data often takes some time, and resulting reports often have little relevance at the individual community level. There are, of course, some excellent exceptions to these limitations, with, for example, a number of reputable studies done on street youth.

Other countries and regions of the world, having recognized these data limitations, have developed a methodology to produce valuable, timely and relevant data at the community level. A feasibility study conducted in Canada in 1995 determined that there was a need for such an approach in this country - a community-based surveillance network spanning Canada to enhance information research capacity, and to gather and share data on all aspects of substance use. Such a network could also increase the knowledge of the overall harm associated with substance use, as well as obtain locally relevant information, which would inform policy decisions, programming and research agendas.

In response to this feasibility study, the Canadian Community Epidemiology Network on Drug Use (CCENDU) was created. CCENDU is a collaborative project involving agencies with intersecting interests in issues related to drug abuse. Accurate, timely and multifaceted information on the nature, extent and consequences of substance use is essential to understanding the local drug scene and is a prerequisite to the development of sound policy, effective programming and the evaluation of program impact. CCENDU provides unique data development that is meeting these information needs at the local level. Although designed in other countries to address primarily the issue of illegal drug use, Canada identified the need to include alcohol in its approach early in the developmental process, with tobacco being included through references to existing work done elsewhere.

CCENDU is attempting to provide an information bridge for the addiction field because of an identified data gap that existed for relevant survey data on alcohol and other drug information, particularly at the city level. Beyond coordinating and facilitating the collection, organization and dissemination of surveillance information, CCENDU was conceived to foster networking among key, multi-sectoral partners, to improve the quality of data currently being gathered, and to ultimately serve as an early warning network concerning emerging substances and trends.

CCENDU attempts to answer a number of questions: What drugs, including alcohol, are being used? In what geographic area are they being used? Who is using them? What are the consequences of use? What are the drug trends over time? Initially, six key data domains were identified to extract the answers to these questions. They are prevalence, treatment, law enforcement, morbidity, mortality, and HIV/AIDS.

GOALS

Epidemiology is the study of the incidence, distribution, and control of a disease in a population. In the case of CCENDU, we are attempting to monitor the developments within the field of substance use mainly concerning prevalence data. The goals of this epidemiological network were created through consultation, and accepted by the
steering committee and site representatives. They address both methodological and substantive needs.

The primary goal of CCENDU is to 'coordinate and facilitate the collection, organization, and dissemination of surveillance information on substance use among the Canadian population at the local, provincial, and national level.'

The secondary goals of CCENDU include:

Networking - to create and develop local networks of those whose work brings them in contact with the substance use field, and to develop partnerships with international epidemiological networks.

Data Development and Evaluation - to identify, develop and collect information indicators of substance use, including the identification and development of a core set of data indicators; standardization across all sites; ongoing evaluation and refinement of data indicators; and the inclusion of both quantitative and qualitative data.

Data Surveillance - to monitor the extent and character of drug use, and to disseminate this information in order to guide programming and policy.

NETWORK BENEFITS

The local benefits of a surveillance network on drug use include, but are not limited to:

- the provision and development of accurate and timely information on the nature, extent and consequences of substance use within the community;
- sharing of data, leading to more effective partnerships and higher quality information;
- better integration of efforts among multiple and diverse partners;
- guidance for policy and program development, as well as a research agenda;
- enhancement of community expertise and research capacity in substance use.

Data collection is important in order to understand the magnitude of the drug problem in your community, and to facilitate the development, implementation and evaluation of effective strategies to deal with substance use at the local level. Understanding factors related to drug use in the community leads to the support of research and better targeting and development of programs and policies that address local needs and build on its assets. Research has proven that to be maximally effective, prevention and treatment efforts must be designed to meet the current needs of the community. This can be achieved by building on existing community services and assets.

The goal of the CCENDU national report is to provide comparative data and the corroboration of information across Canadian cities. By gathering information about a range of substance use indicators in a timely manner, CCENDU can serve as a national warning network about emerging patterns and trends. This information exchange not only exists within the network, but is also communicated and disseminated to appropriate community stakeholders. The early notification allows network members to alert prevention, treatment, public health and enforcement officials and the community itself so that the appropriate action can be taken.

The data collection and report writing, despite being the main purpose of the project, is not the sole expected outcome. CCENDU facilitates partnerships among organizations and persons with intersecting interests in the addictions fields. The network is a forum to allow for sharing of data and collaboration among network members that may not have existed. The report is a common goal for the network members to work toward.

MEMBER RESPONSIBILITIES

Steering Committee

The Steering committee oversees the initiative, and acts both in an advisory and participatory capacity. It consists of representation from the Canadian Centre on Substance Abuse, Health Canada, the Canadian Public Health Association, the Royal Canadian Mounted Police, and the Canadian Association of Chiefs of Police. Their responsibilities include:

- general oversight;
- decision-making involvement for national-level issues;
- assisting in data development issues;
- resourcing, especially funding;
- assisting in local network-building, where required;
- attending national network meetings;
- attending steering committee meetings.

National Coordinator

The National Coordinator, on behalf of the Canadian Centre on Substance Abuse, coordinates the project. He/she provides overall guidance, logistical support for network meetings and the production of a national report. The specific responsibilities of the National Coordinator include:

- chairing the Steering Committee meetings;
- coordinating and chairing regular network meetings (face-to-face/video conferences);
- coordinating the work of the consulting epidemiologist to develop methodologies and address data quality issues;
- coordinating the production of reports (national and records of meetings);
- creating and maintaining international linkages;
- coordinating the development of new sites;
- coordinating the promotion of the network;
- listserv and website issues.

Site Representative

The activities of each site are coordinated by one key individual who can 'champion' the initiative. Some sites have evolved to a system of two co-representatives, one from health and one from law enforcement. This arrangement provides balance of perspective, greater opportunities for collaboration, and options for sharing the workload. Key responsibilities of the Site Representative include:

- developing a team with appropriate and broad representation;
- the production of a local report (data collection, maintenance of data files);
- representing the site at national meetings;
- disseminating information appropriately to potential end users (e.g., via reports, briefings); and
- initiating reporting or discussion of issues of special interest at local and national levels (e.g., HIV/AIDS, IDU, inhalants, Rohypnol).

Local Team Members

The composition of local CCENDU teams varies according to the interest, need and feasibility within the site. These groups gather and interpret data in the local context, and ensure the relevance of surveillance at the local and national levels. The responsibilities of team members include:

- attending local meetings;
- providing the needed data;
- city report writing (hiring consultant(s), division of labour);
- attending national video conferences;
- being part of special focus studies;
- being a productive team members by bringing important issues and information to the project.

RESOURCE EXPECTATIONS

At the national level, funding has been available to cover coordination, meetings, Internet communications, and the production of an annual report. Local sites are expected to be able to provide the needed time and funding to meet the basic responsibilities of network membership, as described earlier.

The greatest need at the local level is for human resources. Each site will require a Site Coordinator who will be responsible for the coordination of data retrieval and collection, attendance at and organization of local network meetings, attendance at national meetings and videoconferences, and report writing. This could account for 5-10% of a full-time equivalent (FTE), concentrated at certain times of the year. Aside from the Site Coordinator, each site will vary in the depth of involvement of individual team members, depending on the approach decided on, and the amount of delegation by the Site Coordinator.

The time required for the writing of the local report will also vary among sites, and will vary over time. There are several different ways to approach the writing of the report. The responsibility can be taken on by one team member, shared among several, or contracted to an outside person. Once a process is established, time required should be quite stable and predictable.

PROCESS

Community Profile

It is important to verify that you have the support of your local community as you consider involvement in CCENDU, and to understand its needs. For example, what is the nature of the substance use problem? What services exist? Where are the gaps in information and programs? Most important, are there interested participants who feel that CCENDU would be beneficial to the community? To determine the answers to these questions, you will need to identify and approach potential network members.

An 'assets inventory' can be done in conjunction with the needs assessment. Assessing community assets is as important as assessing community needs. It is done to identify existing community resources (e.g., organizations, data sources, etc.) that will be helpful in making CCENDU relevant and successful in the community.

Building the Network

Members should represent a cross-section of all those with a primary interest in substance use and the goals of CCENDU, including government departments and ministries, non-governmental organizations, key community stakeholders in the areas of prevention, treatment and counselling, research and information collection, and enforcement. Anyone who is interested in the same type of information and who has similar data should be approached, especially those who are in a position to share information, and who have knowledge and access to data sources related to CCENDU data indicators.

Team members could include personnel from:

addiction services,
needle exchange programs,
street outreach programs,
HIV/AIDS organizations,
poison control centres,
hospitals (including emergency rooms),
Coroners' office,
law enforcement agencies,
health planners,
researchers/epidemiologists.

City Report - Sources and Quality of Information

The information on drug use and drug problems to be indicated in the report is based on six indicator domains: prevalence of use, law enforcement data, treatment data, morbidity data, mortality estimates, and rates of HIV infection or AIDS. Although some information is only available at the provincial or regional level, data are aggregated primarily at the local level by each participating city. Some data are taken from national sources in order to facilitate and standardize data collection across sites. This can include social indicators obtained from Statistics Canada (population, income, ethnicity and crime statistics), morbidity data obtained from the Canadian Institute for Health Information, and prevalence data from Canada's Alcohol and Other Drugs Survey of 1994.

Indicators of drug use and drug problems have been chosen on the basis of access and availability of data, usefulness to persons working in the addiction field, and the need to keep data collection and interpretation manageable. Each type of data has advantages and disadvantages relative to alternative information sources. Survey data are the best source of information on drug use in the general population, but there are limitations with these data, such as the under-reporting of drug use by respondents and the under representation of those who have adopted a lifestyle of which drug use is an integral part. Treatment data may represent the availability of treatment facilities and the proportion of those with substance use disorders that are motivated to seek help rather than true prevalence of the problem. Enforcement data are similarly influenced by factors other than the incidence of drug-related problems. While a thorough review of reliability, validity and utility of each indicator is not within the scope of this report, the strengths and limitations of each indicator domain are briefly discussed below.

Data Indicators

The following are the 'domains' of substance use indicators that were identified and proposed in the feasibility study (p.11-14):

Site - Site-based social indicators build knowledge and understanding of substance use in order to grasp the context that is described and differences of interpretation among sites. This information is available from census data.

Prevalence - Prevalence data indicate the proportions of the population that are using alcohol and other drugs. Data can

be obtained from the most recent national, provincial and/or local epidemiological surveys.

Treatment - Drug abuse treatment programs have considerable variation in the reporting of information with regard to type of treatment (inpatient vs. outpatient, long-term vs. short-term stay, nominal vs. anonymous, individual vs. family vs. group therapy), criteria for admission, and availability. As well, methods of data collection differ according to the way clients are asked about their 'drug of choice', 'presenting drug problem' and 'drug most frequently used'. (This indicator has been identified since the feasibility study).

Law Enforcement - Canadian law enforcement agencies regularly report information on drug-related offences (unlawful acts which come to the official attention of the police), drug-related charges (unlawful acts in which a charge is laid against an individual) and drug seizures (including information on the purity of drugs seized).

The organization and authority of law enforcement agencies vary across Canadian cities. Enforcement in supply and demand reduction may operate at different intensities among federal, provincial and municipal police forces. Furthermore, rates of offences and charges may serve as a general indicator of the level of drug use and misuse in the general population, but they may also reflect the intensity of law enforcement. Thus, comparison of law enforcement indicators should be interpreted with considerable caution.

While there is little doubt that alcohol and other drug misuse is a contributory factor for some property crimes and violent crime, the relationship is not always causal. The fact that a crime is committed by someone drinking or using illicit drugs doesn't necessarily mean that his or her use of alcohol or drugs caused the crime to be committed. There are several plausible causal connections: the pharmacological effects of drugs, the need to commit crimes to support drug use, common underlying factors which account for both illicit drug use and criminality, and systemic violence inherent in the illicit drug trade:

Morbidity - Data about the burden of disease related to alcohol and other drug- related injuries is based on diagnosis at the time of hospital separation. Data about hospital admissions, diagnoses, duration, etc. is collected locally and nationally by the Canadian Institute for Health Information (CIHI). The number of hospital separations for a specific group of diagnostic codes of interest to CCENDU is used in local and national reports. Coding is on the basis of the International Classification of Diseases, Injuries, and Causes of Death, 9th revision, referred to as ICD-9 codes. The benefit of using one source of data for all CCENDU sites is the relative consistency and availability of the morbidity data. However the cost of purchasing these data can be prohibitive. Currently all sites collect their own ICD data.

Mortality - Data pertaining to the number of cases where death was directly attributed to alcohol or other drugs. This involves obtaining information from a doctor, coroner, medical examiner or hospital records, (e.g., for 'opiate poisoning', 'cocaine dependence/abuse', 'alcohol cirrhosis' or 'alcohol dependence syndrome'). National and provincial estimates of deaths and hospitalizations attributable to such causes have been reported by province for 1992 and nationally for 1995. However, it is impractical at this time to provide estimates at the city level using this method, as detailed data by ICD-9 categories are not readily available.

HIV/AIDS - Data from HIV serological testing. Anonymous HIV serological testing has been available in most Canadian cities since 1990. However, unlike AIDS, HIV infection is not a reportable disease in all sites. Thus, the rates of reported HIV/AIDS cases in the sites are likely to be conservative estimates.

Areas of Data Collection

Data and information, using the above-mentioned indicators, are collected in nine major areas: alcohol, cocaine, cannabis, heroin, sedative-hypnotics and tranquillizers, hallucinogens (other than cannabis), stimulants (other than cocaine), HIV and AIDS and needle exchange programs.

FREQUENTLY ASKED QUESTIONS

Why was CCENDU created?

CCENDU was created to foster networking among key, multi-sectoral partners, to improve the quality of data currently gathered, and to ultimately serve as an early warning network concerning emerging substances and trends.

Who is involved nationally?

The national Steering Committee is composed of members from the Canadian Centre on Substance Abuse, Canadian Public Health Association, Health Canada, Royal Canadian Mounted Police, and the Canadian Association of Chiefs of Police. The Canadian Centre on Substance Abuse coordinates the project.

Who should be involved in the community/Site?

Local team members could include personnel from: addiction services, needle exchange programs, street outreach programs, HIV/AIDS organizations, poison control centres, hospitals (including emergency rooms), Coroner's office, law enforcement agencies, health planners, and researchers/epidemiologists. Each site is coordinated by one or two representatives, from areas of health and/or enforcement.

How should potential members be approached?

First contact can be made by telephone. If the timing is not convenient for a discussion of CCENDU, arrange an alternative time for this discussion either by phone or face-to-face. Follow-up with an information package about CCENDU.

How can we ensure a 'buy-in' from potential partners?

It is important that potential partners understand the benefits the network can have for making contacts, developing programming and policy, and conducting research. It is also useful to point out that the networking that takes place may lead to the development of many other projects. Ask questions that would benefit them in their work and could be answered by being involved in a CCENDU network.

What will I need to contribute?

The largest requirement at the local level is human resources for data retrieval and collection, attendance at local and national meetings/videoconferences, and report writing. For the Site Coordinator, this could account for 5 to 10% of an FTE, concentrated at certain times of the year.