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FOREWORD

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.

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. Currently, there are 12 sites that participate to varying degrees in this project. Additional sites are under development.

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 as well as epidemiological organizations in the Caribbean, Central and Southwest Asia, Europe, Mexico, and South Africa.

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.

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
DVL	Driver and Vehicle Licensing
e.s.v.	estimated street value
FASD	Fetal Alcohol Spectrum Disorder
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
M3P	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 tenth compilation of information from 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
Raymond Au	Manitoba Public Insurance Corporation
Marc Samson	RCMP
Susan Lessard-Friesen	Manitoba Pharmaceutical Association
Gordon Holens	Chief Medical Examiners 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

The report was written by Kristin Stevens, who coordinated the data collection and review processes.

EXECUTIVE SUMMARY

With a population of just over 706,000, Winnipeg is a vibrant, growing city located near the geographical centre of North America. It is a major transportation and distribution centre, economically diversified, and has a growing economy and population base. Approximately 60% of the provincial population lives in the Winnipeg CMA (Census Metropolitan Area).

Now in its eleventh 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 individuals using alcohol, and then choosing to drive. Driver and Vehicle Licensing (DVL) report high but decreasing numbers of alcohol-related incidents. Hospital admissions concur that alcohol is a major factor in the community. There were a total of 1,397 hospitalization cases that were alcohol related. The most recent national report published by CCSA, which used data collected in 2002, notes that alcohol use remains the highest priority. The Chief Medical Examiner (CME) reports 204 deaths that were "alcohol related" based on levels of ethanol found in the body that exceeded the legal limit of 80 mg% or the cause of death being "alcohol related".

Non-potable intoxicating substances (including solvents and inhalants) are widely abused. For the most part it is estimated that 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 prevention 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. The Non-Potable and Inhalant Abuse Committee has been working to arrange amendments which will combat the sale and use of these substances.

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 consistently high numbers of clients using drugs at some time, and hospital admissions with drug-related diagnoses show that cocaine and other psychoactive drugs are the drugs implicated in the largest number of admissions. It is difficult to make interpretations based on the seizure statistics due to inconsistent data collection within and across agencies. The CME reported 86 deaths that were determined to be "drug related", including drug overdoses, drug toxicity, and drug use/abuse.

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. Other drugs more commonly reported are cocaine, steroids, hallucinogens, narcotics other than heroin, and stimulants. The Addictions Foundation of Manitoba (AFM) reports high usage of cocaine among client populations, and Winnipeg Police Services reported high seizure values for cocaine in 2006. Methamphetamines are a problem, especially among youth populations, although the overall prevalence of use is low.

In Manitoba, prescriptions for narcotics and other controlled drugs are tightly controlled and monitored through the Manitoba Prescribing Practices Program (M3P). The past two years represent a large departure from the stable trend in the incidences of forged prescriptions. This significant increase is likely due to the combined effects of increased drug theft and improved reporting by pharmacies.

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. In addition, the AFM has incorporated a needle exchange into their methadone program. In 2006, Manitoba Health reported maintenance in

Hepatitis B incidence from 2004. However, there was a large decrease in cases of Hepatitis C. These statistics show an encouraging trend emerging. The incidence of AIDS and deaths from AIDS had risen slightly in 2006. The number of cases testing positive for HIV decreased from 116 to 83, with risky heterosexual activity listed as the leading cause of HIV infection.

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 of the AFM - to enhance the health of Manitobans by reducing the harm of alcohol, other drugs and gambling, through leadership in education, prevention, rehabilitation and research - may seem lofty; 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 2007 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 and 2000-2006 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, 1998-2006. The 2007 report presents the available information on substance use and abuse in Winnipeg, and to some extent in Manitoba. Changing 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.

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DESCRIPTION OF THE CITY[1]

Winnipeg lies near the geographic centre of North America and has become the largest distribution centre between Vancouver and Toronto. Winnipeg is serviced by over 30 motor freight carriers. Having developed and maintained its position as a transportation centre, Winnipeg is the headquarters for eight of the top ranking interprovincial general freight carriers. 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 10th largest freshwater 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 numerous golf courses throughout the city. A new arena has been built downtown to house the Manitoba Moose (AHL hockey) and other entertainment events.

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 Headingley, East St. Paul, West St. Paul, Ritchot, Rosser, St. Francois-Xavier, St. Clements, Springfield and Tache. These adjacent municipalities, while rural in nature, have many residents who commute to Winnipeg.

According to the 2006 Census[2], the total populations of Manitoba and the Winnipeg CMA had generally increased by 2.6% over the five-year period (2001 to 2006). Residents of the Winnipeg CMA continue to comprise 60.0% of the population of Manitoba. The total land area comprising the Winnipeg CMA is 5,302.98 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%. In 2001, 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, 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 400,700 in the CMA, and 382,200 persons were employed. The

1 Winnipeg Fast Facts, Destination Winnipeg Inc., www.destinationwinnipeg.ca.
2 Statistics Canada. 2007. *Winnipeg, Manitoba* (table). *2006 Community Profiles*. 2006 Census. Statistics Canada.

unemployment rate was 4.6%. In 2001, the field of employment recording the greatest number of jobs was manufacturing.

Regarding education, of the 571,500 people 15 years and over in the CMA. In 2001, 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 in 2001 was $64,422, and the median family income was $55,634. This is based on 2000 families and is only 20% sample data.

All information without a date indicated is from 2006 data. More recent information for replacement of the 2001 information will be available throughout 2007 and 2008.

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 [3]

A recent report by the CCSA, which was published in 2006 but focused on 2002, notes that measured in terms of the burden on services such as health care and law enforcement, and the loss of productivity in the workplace or at home resulting from premature death and disability, the overall social cost of substance abuse in Canada in 2002 was estimated to be $39.8 billion. This overall estimate represents a cost of $1,267 to every man, woman and child in Canada. Productivity losses amounted to $24.3 billion or 61% of the total, while health care costs were $8.8 billion (22.1%). The third highest contributor to total substance-related costs was law enforcement with a cost of $5.4 billion or 13.6% of the total.

For various methodological reasons or simply because data were not available, some costs associated with substance abuse were not included. For the most part, private costs are not estimated. This could include the cost to individuals of purchasing their alcohol, tobacco and illegal drugs. Also not counted are welfare benefits paid to individuals disabled by substance abuse, although the administrative costs of welfare programs and other transfer payments are included. For the most part, intangible costs are also not included. These include the costs of pain and suffering associated with substance abuse. Also not counted are the costs associated with the abuse and misuse of pharmaceuticals. Finally, this study does not assess the lost productivity of people in prison convicted of a substance-related crime. Thus, the overall costs to society are actually higher than reflected here.

3 Canadian Centre on Substance Abuse, March, 2006.

THE WINNIPEG SITE NETWORK TEAM

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ADMISSIONS (Table 1)

There were 3042 substance related disorder hospital admissions in the Winnipeg CMA in 2005/2006. This represents a slight increase from 2004/2005 when there were 2949 admissions. Approximately 46% of the cases were alcohol related (1397 cases). This percentage of alcohol related cases is comparable to previous years.

In 2006/2007, there were a total of 9,809 individuals involved in 15,977 admissions to the AFM programs: 9,255 admissions to the Adult Treatment Program, 1,783 admissions to the Impaired Drivers Program (IDP), and 2,637 admissions to the Youth Program. About two thirds of all admissions are from Winnipeg residents. All figures represent an increase in admission to AFM programs, consistent with a general trend of slight yearly increases in admissions. The average of admissions per client remains steady at 1.6. Alcohol is by far the predominant substance ever used by both youth (97.1%) and adult (99.3%) clients, followed by cannabis. However, cannabis is rarely identified as the primary drug of choice in adult populations.

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 2005/2006[4]. Sales of beer, wines and coolers/ciders have increased slightly from the previous year, as has been the general trend in other years. The consumption per capita for all products increased as well, with the exception of coolers/ciders.

There were 517 alcoholic beverage retail outlets in Manitoba in 2005/2006. This figure includes 46 Manitoba Liquor Control Commission (MLCC) Liquor Marts, 175 private liquor vendors and duty free stores, 288 private beer stores, and 8 wine stores. This represents a decrease in the number of outlets from 2004/2005, and a continuing trend toward fewer outlets.

Less occasional permits were issued in 2005/2006. MLCC is still issuing photo ID cards to young adults for the purposes of identity and proof of age in licensed establishments, however the number issued was not available this year.

In 2005/2006, the MLCC issued 26 suspensions, issued 228 warnings or other action, and 13 warnings for infractions of The Liquor Control Act. These numbers all represent increases from the previous year.

Price

The estimated street value (e.s.v.) for a dozen bottles of domestic beer is less than $20.

Law Enforcement

Licensed and suspended drivers

The number of active drivers in 2006 was 725,755. Of these, 20,799 were suspended drivers. Favorably, this represents an increase in the number of drivers, and a decrease in the number of suspended drivers. The rate of suspension for drivers aged 75 and older was four times higher than all other age groups (11.9/100 licensed drivers versus 2.8/100). This is primarily due to the fact that higher proportions of older drivers were indefinitely suspended for medical reasons. Among males, the 45-54 age group had the highest number of active drivers while the 35-44 age group accounted for the highest number of suspended drivers. Males of all ages accounted for 3 times as many suspended drivers as females of all ages. Among females, the 45-54 age group accounted for the highest number of active drivers while there were the same number of suspended drivers in the 35-44 and 45-54 age groups.

Charges (Table 3)

In 2006, a total of 492 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. Thus, there appears to have been a steady decline in the number of people charged by WPS. Caution should continue to be exercised when making such comparisons with recent years, as due to complications arising from the implementation of the new computer systems. For example, 2004 data is from the period April 20, 2003 to April 19, 2004. The majority of individuals charged were charged with impaired operation of a motor vehicle or over .08 BAC (470), while 9 drivers were charged with failing/refusing to provide breath/blood samples, 11 drivers with impaired driving causing bodily harm and 2 drivers with impaired driving causing death.

Information on impaired driving charges as per the RCMP interventions was not available in 2006 due to staffing

4 MLCC 83rd Annual Report, 2006.

changes. Although more recent information was not available, in 2005, there were a total of 1,908 incidents of impaired operation of a motor vehicle reported by the RCMP in Manitoba, of which 744 were charged or cleared by other. There were 498 incidents of driving with a BAC of more than .08, 488 of which were charged or cleared other. All incidents of impaired operation of a motor vehicle causing death and injury, 9 and 60 respectively, were dealt with by charge or other.

Also in 2005, a total of 2,039 Liquor Control Act open liquor incidents were reported, 1,508 of which were cleared by charge or other. There were 7,710 Intoxicated Persons Detention Act incidents. The number of incidents where alcohol abuse/use or substance abuse/use was a factor were not reported last year. No comparisons can be made with previous years as the RCMP has changed reporting tools and that the scoring of occurrences has changed making such comparison very difficult. The data integrity and ability to observe trends will improve with use and familiarity with the new system. No information related to these charges was available for 2006.

Seizures (Table 4)

According to Canada Border Services Agency, alcohol represents approx 12% of all CBSA seizures in Manitoba in 2006. There were a total of 108 alcohol seizures during 2006, with an e.s.v. for duty of $5,760. Spirits account for sixty-five of the seizures.

Checkstop - WPS (Table 3)

Checkstop continues to charge drivers with impaired driving and other violations. In 2005, the Checkstop program operated from November 30 – December 31/05. During that time, 82 WARNs (a 24-hour suspension for registering between .05 and .08) were issued. In addition, 77 individuals were charged 'impaired/over' or 'impaired/refused'. The age range of the drivers charged was 18-62 years. In 2005 there was a continued decrease in the number of vehicles stopped, as strategic locations were targeted. The program put less emphasis on random vehicle stops and focused more closely on people driving away from drinking establishments and Christmas parties, which resulted in an increase in the number of charges laid, and appears to be a more efficient use of resources.

RoadWatch (Table 3)

For 2006 MPI RoadWatch Check Stop Program was operational from May1 to November 30. Participating police agencies held 71 check stop dates during the program period, at 191 locations. They provided 454.8 visibility hours, and screened 37,628 vehicles during the program period. Enhanced police enforcement resulted in 45 impaired driving charges, 966 HTA offence notices issued, 89 Liquor Control Act offences, and 21 Controlled Drug Substance Act offences. In addition, 25 twenty-four hour suspensions were issued.

In the 2006 program year, the Roadside Screening Device was administered to 153 motorists. Over one half (54.3%) of male drivers failed the RSD test when it was administered, whereas almost one-half (43.2%) of female drivers failed. Male drivers represented 75.8% of drivers tested. The highest BAC recorded during the program period was .25 for male drivers and .14 for female drivers.

Treatment and Prevention[5]

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 first time offenders involved in the program, and a similar number of 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 1,783 admissions to the IDP program at the AFM, the majority (69.3%) of whom had a presumptive problem (non-active full-blown addiction).

Of the clients for whom blood alcohol level was available (1,179), the client's BAC on the last charge ranged from .08 to greater than .23+. The most common category recorded (36.3%) 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 (30.0%). These figures are consistent with previous years.

Of the total clients admitted, most were between 35 and 50 years old (34.5%), while those aged between 18 and 24 represented approximately one-quarter of the clients admitted to the IDP. This is consistent with previous years.

Of those clients involved in the IDP, approximately 76.2% attended for the first time. Of those who had been involved in IDP before, 78.5% had attended only once before, about 18% had attended twice before and 3.7% reported attending three or four times. Nearly two-fifths of these individuals had attended the program more than eleven years prior (38.2%). In addition, on their last involvement with the IDP, approximately 79% were referred to other treatments and programs. The most common subsequent referrals were Educational Workshop, High Risk Program, and self-help group.

Approximately 20% of clients had previously attended an alcohol rehabilitation treatment or counseling program. In these instances, approximately 76.6% completed the program they were attending. Following the 2006/2007 program, most clients were referred to other programs, workshops or treatments, while 7.0% warranted no further action.

Of all the clients participating in AFM IDP, the Driver and Vehicle Licensing (DVL) referred 73.7%. This represents slight decrease, and is down from the 99.4% that were referred by DVL five years ago.

AFM adult clients (Table 6)

In 2006/2007, 99.3% of adult clients reported using alcohol at some time in their lifetime. Of those who had consumed alcohol in the year prior to admission, 14.1% reported using daily, while 16.1% reported consuming during binges or sprees. These figures are quite similar to those found in previous years.

Similarly, 22.9% of clients reported that their alcohol use had increased during the previous 6 months, while 60.4% reported it had stayed the same or decreased. Heavy, episodic drinking is also a problem for many AFM clients. Approximately 10.2% of clients drank more than five drinks in a sitting more than 16 times in the past month. Although these figures have remained quite steady over the past few years, there is a slight trend in the direction of increased use.

Roughly 63.6% of the individuals were determined to have dependent involvement, and 51.0% were currently in the contemplation stage of change. Approximately 86% of the clients had previously tried to quit or cut down on alcohol or other drug use at some point.

5 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.

AFM youth clients (Table 7)

Among youth clients, alcohol had been consumed at some time by about 97.1%. Approximately 24.5% reported using alcohol less than once a month, with nearly 30.0% using weekly and 32.2% using monthly.

The majority of clients were 14-17 years of age when they were admitted (86.6%), and most of the clients were aged between 12 and 14 when they first used alcohol (68.2%), and 3.5% were aged 9 or less. Approximately 38.7% have been charged with a Criminal Offense, with 46.2% being alcohol/drug related, and 58.2% reporting being under the influence of alcohol/drugs during the offense. These figures have remained relatively stable throughout the past few years.

Student Use

In the most recent survey of students sampled from a cross-section of Manitoba schools conducted by the AFM (2004)[6], almost 70% reported they had used alcohol at some point, and of the total students sampled (grade 7 through grade 12), 59% used alcohol in the past year and about 11.1% reported drinking once a week or more. The rates are much lower in the earlier grades. About 52% of male and 51% of female drinkers in this group began drinking before age 15, and when we look at their consumption level it is much higher than those who did not begin drinking until they were 15 years of age or older. Almost 25% of the students in grade 7 were current drinkers, compared with over 80% of the students in Senior 4. About 30% of males and 25% of females usually drink five or more drinks when they consume alcohol. When compared to previous studies, there is an apparent lack of variation in the prevalence of alcohol use.

Very few of the younger students show any signs of alcohol dependence, with less than 5% of students in the three younger grades reporting symptoms of alcohol dependence. However, about 5% of the students in Senior 2, 7% of both male and female students in Senior 3 and 12% of the males and 7% of the females in Senior 4 have signs of alcohol dependence. A new survey will be conducted this fall.

Other AFM school-based data from 2006/2007, with 625 clients reported, showed that 97.3% of the clients had used alcohol. Of these, 3.5% had first used by age nine years or less. Almost sixty-eight percent had first used between the ages of 12 and 14 years.

Operation Red Nose

In 2005, the Manitoba Safety Council became the provincial host for Operation Red Nose. In 2006, with 861 volunteers, Operation Red Nose Winnipeg provided a total of 1,189 rides within five communities. This represents decrease in the number of individuals they drove home, but still reflects an encouraging number of drivers opting not to drive drunk. In Manitoba, 1,962 volunteers took part in the campaign, providing a total of 2,904 rides in the 6 communities hosting the program. Province-wide, this was an overall increase.

Impact

Hospital data (Table 8)

Of the 3042 substance related disorder hospital admissions in the CMA in 2005/2006, there were 1397 cases in which alcohol was a responsible diagnosis. Specific diagnoses are no longer available for comparison, but the overall number of cases where alcohol was a responsible diagnosis decreased from 1424 in 2004/2005. The number of cases where alcohol was the primary diagnosis remained relatively stable (532 in 2005/2006; 539 in 2004/2005).

Presence in road accidents

According to the Road Safety Monitor of the Traffic Injury Research Foundation[7], who interviewed 1,201 drivers drinking and driving is a priority social issue for Canadians and they believe it is the most important road safety issue they face. About 8 out of 10 Canadians believe it is a “serious problem”. Overall, Canadians overestimate the chances of getting caught, but feel that the sanctions for those who are caught are minimal. The vast majority of Canadians (over 82%) say they have not driven after drinking at any time in the past month. On the other hand, at least 17.5% of

6 Patton, D., Mackay, T., & Broszeit, B. Alcohol and Other Drug Use by Manitoba Students, 2005.
7 Road Safety Monitor: Drinking and Driving, Traffic Injury Research Foundation, 2006.

Canadians said they have driven after drinking sometime in the past month. The vast majority of Canadians (over 92%) say that in the past year, they have not driven when they felt they were over the legal limit. On the other hand, 7.7%, or an estimated 1.7 million, said that they had done so, meaning there were over 10.2 million trips in the past year during which the driver felt they were over the legal limit – 3 million more than the year prior. Over ninety two percent of these trips are made by just over 4% of drivers. Since those who did not view drinking and driving as a significant issue were more likely to self-report drinking and driving behaviour, it is suggested that a certain level of concern may facilitate restraint and could be a focus of future initiatives. Trends show that the reported number of persons killed in an alcohol related crash has been declining. However, the extent of this decline has been more limited sine the 1990s, and the figures are still high. The prevalence of individuals reporting driving after drinking and "driving while impaired" had increased this year as compared to last year, suggesting caution be used in assuming that the general decline between 1998 and 2003 will continue.

According to the most recent Alcohol Crash Statistics, which focused on 2003, in Manitoba 49 persons died in alcohol-related crashes. The majority of these individuals were aged 20-35 (59.2%), were male (77.6%), were the driver/operator of the vehicle (69.4%), and were driving "trucks/vans" (44.9%).[8]

Manitoba has the most comprehensive drinking and driving program in Canada, composed of legal sanctions, driver treatment and assessment programs, public awareness, 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.

Driver and Vehicle Licensing (DVL) reports that there were 1,681 alcohol-related Criminal Code offences for 2005, including blood alcohol concentration (BAC) more than .08 (1,089), impaired driving (474, 16 - injury, 4 - death) and refuse sample (98). These figures represent a continued decrease from 2004. Overall, there has been a 66.3% decrease in the number of alcohol-related Criminal Code convictions between 1989 and 2005, 4,984 to 1,681 respectively. There was a steady decline in convictions until 1994. After a stable period between 1997 and 1999, the decline continued through to 2005. All age groups 16-49 and 70+ recorded such declines.

Licensed drivers, in Manitoba, under the age of 25 consistently record the highest rate of total alcohol offenses, and they account for consistently double their portion of the licensed driver population. 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.

These statistics provide a positive outlook, as the number of offenses has continued to decrease. These 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)[9]

Fetal Alcohol Spectrum Disorder (FASD) is the overall term currently used to describe the entire range of disabilities, birth defects, etc. associated with damages resulting from alcohol use by a mother during pregnancy. This range includes Fetal Alcohol Syndrome and partial Fetal Alcohol Syndrome (FAS/pFAS), Alcohol Related Brain Disorder, Alcohol Related Neurological Disorder, etc. Partial Fetal Alcohol Syndrome (pFAS) was previously known as Fetal Alcohol Effects therefore FAS/FAE = is now better defined by the terms FAS/pFAS.

Fetal Alcohol Syndrome (FAS) is a cluster of birth defects caused by consumption of alcohol during pregnancy. The damage caused by fetal alcohol exposure is permanent. FAS is 100% preventable and should be determined by a medical diagnosis. Babies may grow at a slower than normal rate during pregnancy and after birth. Children are typically small and skinny, growing into short adults. The FAS child has distinct facial features; these may include some or all of the following: shortened eye slits, flattened mid-face, a flattened midline ridge between the nose and lip, thin

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8 Alcohol-Crash Problem in Canada: 2003, Canadian Council of Motor Transport Administrators and Transport Canada, Traffic Injury Research Foundation, 2005.
9 It Takes a Community Resource Manual - Aboriginal Nurses Association of Canada & Health Canada.

upper lip, and other features. Facial features may fade as the child grows. Using facial features alone to identify FAS is not advised, as this can promote a stereotypical image of the FAS affected person. The most critical effect of alcohol on the fetus is the permanent damage to the brain and central nervous system. This can include: Small brain and head circumference, developmental delay and/or intellectual impairment, behavioral disorders, learning disabilities, and/or Attention Deficit Hyperactivity Disorder. No specific statistics on the impact of FAS were available this year.

Partial Fetal Alcohol Syndrome (pFAS) previously referred to as FAE refers to an individual who has been exposed to maternal drinking and has one or two FAS characteristics. Like FAS, pFAS is entirely preventable. pFAS is not the less severe form of FAS. A child with pFAS may look normal but still suffer damage to the brain and nervous system. The most critical effect of alcohol is permanent damage to the fetal brain and central nervous system. The learning and behavioral characteristics of FAS and pFAS are similar. pFAS will show itself in the child as developmental delay, intellectual impairment, behavioral disorders, learning disabilities, attention deficit disorder and hyperactivity. Persons with pFAS may function far below their actual age in school and socially. Poor judgment, learning difficulties, impulsive behavior and poor social and communications skills are common characteristics.

At this time, there is a lack of population level FASD incidence data for Canada, which in turn means we do not have this information available for Manitoba as well. A consistent methodology for FASD diagnosis was a necessary precursor and it is only in the last two years that Canada has created national guidelines for FASD diagnosis. However, in Manitoba, at least 200 children per year receive a diagnosis on the spectrum. The current recommendation in Canada and the U.S.A is to abstain from alcohol completely during pregnancy. Women who drink and have an unplanned pregnancy should quit drinking as soon as they suspect that they are pregnant. All women of childbearing age who consume alcohol are at risk of having a child with Alcohol Related Birth Defects. Women planning a pregnancy should receive the support of their partners, family, friends and community to stop drinking before conception and to not drink throughout pregnancy and breast-feeding. Seventy-seven percent of Canadian women of childbearing age report alcohol consumption and 25% of pregnant women report that they have consumed alcohol in the previous month.

Various projects and organizations address the urgent need to develop strategies to prevent FAS and support improved health for women. The prevention of Fetal Alcohol Syndrome (FAS) and support of individuals already affected is one of the core commitments of Healthy Child Manitoba. Work is focused on a comprehensive and culturally sensitive plan for prevention, intervention, and support. 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.

Some of Manitoba's FAS Initiatives include STOP FAS and Support in the Classroom for Students with FAS. In addition, there are a number of partnership organizations including the Coalition on Alcohol and Pregnancy, Canada Northwest FASD Partnership, and the Healthy Child Committee in Cabinet. Winnipeg currently has two sites that provide the FAS prevention program known as STOP FAS and recently two more Manitoba 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 through one-on-one supportive relationships with at-risk individuals.

Based on the last information received, 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 information was available on whether 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.

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.

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 3,123 deaths in 2006 recorded as naturals, accidents, motor vehicle collisions, suicides, homicides, and undetermined in Manitoba. This figure is consistent with the number of deaths investigated last year. Of the 581 deaths where toxicity results were generated, ethanol was detected at levels over the legal limit, or the cause of death was stated to be related to alcohol, in 204 cases. These would be considered "alcohol related" deaths. Alcohol and drugs were found in a number of the cases investigated, but due to complexities in the current data collection method, it is difficult to determine the exact number of cases that would be considered both "alcohol and drug related".

NON-POTABLE INTOXICATING SUBSTANCES

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

Presence and Availability

Non-Beverage Alcohol Substances and Inhalant Abuse 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%). Such products contain many chemicals and other ingredients that make them more harmful than alcoholic beverages when consumed. These chemicals include butane, methylene chloride, and nitrous oxide. Abused products include Lysol spray, hairspray, mouthwash, Chinese cooking wine, rubbing alcohol/muscle massage, and aftershaves.

According to the Non-Potable 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, lighter fluid, nail polish remover, gasoline, paint and cleaning fluids, paint thinner, and plastic wood.

There are very few statistics on the sale or consumption of these products, and what is available is assumed to be an underrepresentation of the problem. What is known is that the use of such substances is a nation-wide and world-wide problem with a number of harmful effects to users and the community. This problem often affects the youngest and most vulnerable.

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. The original agencies included 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. Since then a variety of agencies have participated to curb the continued abuse of non-potable alcohol problems and now includes inhalant abuse.

NPAIAC had three working groups - Community Action and Prevention (CAP), Harm Reduction and Rehabilitation, and Legislation and Law Enforcement that have since disbanned. The committee will be meeting only as needed, for issue driven objectives.

They have a website at www.inhalants.ca. They have information on their current efforts and mission statement, as well as recent news stories related to inhalant use and abuse. 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. The NPAIAC developed information kits for retailers with contact information and information on the use and abuse of solvents and inhalants, and continue to focus on workshops for retailers.

Price

The e.s.v. of various solvents (lacquer, glue and airplane glue) ranges from less than $5 to about $20. 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. These focus on many issues, including retailer safety and the rights of the customer. The messages are: If anyone is at danger, make the sale and strategize for the next time and decisions at the till have to made by individual merit only i.e. actions, not by race, religion, etc. Law enforcement does not appear to be making non-potable and inhalant abuse a priority. However, "impaired" driving convictions have resulted in other provinces where the individual driving was found to be under the influence of these products.

Most recently, the NPAIAC has focused on the New Public Health Act of Manitoba and the inclusion of a section for Intoxicating Substances. Hopefully proclaimed in the fall of this year, this Act could help curb the abuse of these products. This would allow public health inspectors and peace officers to seize intoxicating substances when there is reasonable grounds to believe that it has been repackaged for the purpose of facilitating its use as an intoxicant, it has been provided to a person where there was a reasonable basis to believe that the person would use it as an intoxicant, or a person has possession of it for the purpose of using it as an intoxicant or providing it to another person to use as an intoxicant. They could seize that inhalant as well as any other in their possession. A hearing would follow to determine if the intoxicant should be forfeited. In addition, if a retailer fails to use the appropriate safeguards to prevent sale of these products to a potential abuser, they could have their products seized. This may be followed by action by the Deputy Minister of Finance to suspend or cancel a licence, permit, or certificate issued pursuant to The Gasoline Tax Act, The Motive Fuel Tax Act, or The Retail Sales Tax Act.

Treatment and Prevention

AFM clients (Tables 6, 7, and 10)

In 2006/2007, 6.4% of AFM youth clients and 6.1% of adult clients reported using solvents at some time. This percentage is consistent with previous years.

On a national level, another interesting development is consideration of alternate products that do not contain intoxicating agents. The intent is to reduce access to solvents and inhalants.

Impact

According to the NPAIAC, the effects of non-potable alcohol and inhalant use include short term memory loss, hearing and sight loss, limb spasms, brain damage, liver and kidney damage, bone marrow damage, dementia, lung damage and hepatitis. In addition, sudden death can occur – often at the time of first experimentation.

Hospital data (Table 8)

Of the 3042 substance related disorder hospital admissions in the CMA in 2005/2006, there were 19 cases where volatile solvents were considered responsible, this represents a decrease from the 27 cases reported last years. Specific diagnostic information is no longer available.

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 are estimated below (based on 2004 and 2007 WPS data):

COCAINE	cocaine	$80 (1 gm)
		$150-$225 (1/8 oz)
		$30,000 - $38,000 (1 kg)
HEROIN/MORPHINE/ NARCOTICS	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	$10-$15 (1 gm)
	Marijuana	$2,000 - $2,400 (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	$10 - $20
	psilocybin (mushrooms)	$15 (1 gm)
		$1,500 - $2,000 (1 lb)
	PCP pill*	$20 per point (point 1/10 gm)
STIMULANTS	methamphetamine	$20 per point (point 1/10 gm)
	Ts and Rs*	$25 - $30 (2 set)
		$40 - $50 (1 set)

Note: * signifies information from 2004 sources.

Law Enforcement

Charges and seizures

Winnipeg Police Services (WPS)

In 2006 (see Table 10) the WPS Vice Division reported the following seizures and e.s.v. related to drugs in the Winnipeg CMA:

GENERAL -The most common drug seized, in terms of weight and e.s.v., was cannabis products; cocaine, crack cocaine, hash, psilocybin, ecstasy, LSD, crystal methamphetamines, and various tablets, were also reported. The approximate e.s.v. of all drugs seized in 2006 was $5,290,170. Of the 1,728 individuals from whom the drugs were seized, the majority were adult males.

COCAINE and CRACK COCAINE - The total amount of cocaine seized was 26,083 gm, and the total amount of crack cocaine seized was 12,795 gm. The combined e.s.v. was $2,598,440. This represents a considerable increase in the weight and e.s.v. of these drugs as compared to 2005. Over the last few years, there has been a continuing trend of increased cocaine and crack cocaine seizures by the Winnipeg Police Service.

TABLETS – Approximately 3,030 tablets of various types (percocet, clorazepam, oxycontin, clembuterol, Sudafed, diazepam, valium, Tylenol 3, Viagra, naproxin, morphine, and liquid steroids [212 vials]) were seized in 2006, with an e.s.v of $60,600. Although the e.s.v. can not be compared with last year, as it was unavailable at that time, the number of tablets seized has decreased. The variety of tablets seized has increased, however.

CANNABIS - The total amount seized of marijuana was 192,568 gm and hash was 1,428 gm, with a combined e.s.v. of $2,435,660. The weight of cannabis seized increased from 2005, in addition, the weight of hash increased by nearly 500%.

HALLUCINOGENS - A total of 2,768 gm of psilocybin, 1,075 units of LSD, and 5,341 tabs of ecstasy were seized, with a combined e.s.v. of $154,790. These figures represent a considerable increase (nearly three times the e.s.v.) from 2005 in all areas.

STIMULANTS - There were 4,068 gm of crystal methamphetamine seized in 2006 with an e.s.v. of $40,680. This represents an increase in weight, but decrease in e.s.v. from 2005.

Canada Border Services

In 2006 (see Table 11) Canada Border Services Agency reported the following offences, seizures, e.s.v.[16], charges and other information related to drugs in Manitoba. Specific comparisons cannot be made with 2005 as data was unavailable last year, however, some general information has been provided.

GENERAL - There were 8 seizures of ‘other controlled drugs’ (376 dosages; 1.03 grams) with an e.s.v. of $8,080. CBSA also affected 5 seizures of khat (112,173 gms) with an e.s.v. of $56,907. This suggests a growing popularity of this drug in Winnipeg. Due to its short shelf life, the drug has been sent in freeze-dried form in

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.

order to maintain its potency longer. It appears that khat is used almost exclusively in the Somali community within the city.

Seizures affected by CBSA in Manitoba may not necessarily be that valuable when conducting an analysis of the current drug trends in the City of Winnipeg. For example, there were large seizures made by CBSA at Vancouver and Toronto in the courier mode where it appeared that the drugs were destined to Manitoba. These seizures are not captured in the data that follows.

Drugs represent approx 15% of all CBSA seizures in Manitoba in 2006. There was a major decrease in all drugs seized except for steroids.

COCAINE and CRACK COCAINE – There were 3 seizures of cocaine, and 2 seizures of crack cocaine in 2006. The cocaine seizures totaled 6.5 gm, with an e.s.v. of $888.

CANNABIS – Marijuana is the most commonly seized drug by CBSA. CBSA affected 46 seizures of marijuana totaling 278 gm, representing an e.s.v. of $5,560. This is a substantial decrease in quantity and value from previous years. No seizures of hashish were reported.

HALLUCINOGENS - There were two seizures of ecstasy, totaling 8 dosages, with an e.s.v. of $280.In addition, there was one seizure of psilocybin, totaling 14.64 dosages, with an e.s.v. of $220.

STIMULANTS - There were four seizures of almost 1 gm plus 6 dosages of this drug at CBSA during 2006. This represents an e.s.v. of $233. Information from other law enforcement agencies in Winnipeg indicate that methamphetamine use in the City is growing rapidly, however this is not reflected in border related seizures. No seizures of amphetamines/barbiturates were reported by CBSA. There were 7 seizures of ephedrine (780 dosages; 7 grams) and 1 seizure of pseudoephedrine (21 dosages). There was no e.s.v. for these drugs.

STEROIDS - There were approx 70 steroid seizures in the mail stream at Vancouver, Montreal and Southern Ontario for residents of Manitoba. Steroids were seized from various countries with Czechoslovakia and India being the most common countries of export. Several of the shipments were destined to the same individuals with the biggest shipment valued at $12,300. At Manitoba ports of entry, there were 25 seizures of steroids (1,460 dosages; 1,112 grams), with an e.s.v. of $8,080.

Royal Canadian Mounted Police (RCMP)

In 2006 (see Table 12), the RCMP Drug Awareness position was vacant. Thus, no precise data was available, but some general trends are outlined below:

GENERAL – The RCMP reports that they have not seen any new drugs enter the market and that the distribution networks remained fairly consistent.

The mandate of the Integrated Proceeds of Crime Units is to disrupt and dismantle organized crime groups by identifying, seizing and forfeiting the wealth that is accumulated from their criminal activity. All drug-trafficking activity is related to organized crime at varying levels. In 2006, this unit seized approximately $1.3 million dollars, with the largest individual seizure being $734,000. The funds that were seized were related primarily to the trafficking of cocaine and marihuana.

MARIHUANA - Marihuana is still the number one drug of choice in Manitoba. Marihuana grow operations have continued to surface everywhere, from isolated farm houses to expensive properties with acreage. The operators purchase the locations for the sole purpose of operating a marihuana grow. These locations have produced anywhere from 1000 to 3000 plants. The actual owners and brokers are very successful in isolating themselves from these locations. The only suspects that they normally arrest are the gardeners who will not disclose any further links to the operation due to fear of reprisals or simply their lack of knowledge.

METHAMPHETAMINE - Powder and crystal methamphetamine are available in Winnipeg and the surrounding area. This product is frequently used in our province but we have yet to see the repercussions experienced by our Western neighbors.

POWDER COCAINE / CRACK COCAINE – Crack cocaine has maintained it's popularity over the past 3 to 4 years and is still readily available in the City of Winnipeg. The price of crack cocaine varies from supplier to supplier and is dependent on how much product is available on the market.

The DAS Winnipeg Laboratory, part of the Healthy Environments and Consumer Safety Branch of Health Canada, analyses drugs seized by police agencies across Canada. The Winnipeg Lab primarily serves Manitoba, Saskatchewan, Northern Alberta (the 780 area code), Northwest Ontario, Nunavut and Northwest Territories, as well as the four Atlantic Provinces. This is an increase in the area served as compared to previous years, as the Winnipeg lab took over Northern Alberta from the DAS Burnaby laboratory in December 2006. They also receive samples from all provinces from time to time.

In Fiscal Year 2006/07 the laboratory analyzed over 16,700 exhibits (compared to about 13,000 in 2005/06). This represents an increase of about 28%[17]. DAS, nationally, received over 104,000 exhibits – an increase of 7%. In 2006/07 the DAS Winnipeg Laboratory received 4,117 suspected drug exhibits from police agencies in Manitoba. Among the most common drugs analyzed: cocaine (1442), cannabis marihuana (1337), cannabis resin (47), MDMA (159), methamphetamine (121),2C-I (35) and 2C-T-2 (17; designer phenethylamines), heroin (2), PCP (1), psilocybin (26), oxycodone (21), codeine (34), diltiazem (35), diazepam (18), lorazepam (7), clonazepam (18), morphine (13) and ketamine (10).

DAS completed purity (or quantitative) analysis on 36 marihuana exhibits. The average THC content was 9.1%. The highest results were 16% (2 exhibits), while all the remaining exhibits tested at or below 12%. The lowest result was 5%. Thirty-nine cocaine samples were analyzed for purity - 7 were cocaine base and 32 were cocaine powder. The average Cocaine purity was 64%. The highest result was 87%, while the lowest result was 25%. DAS have observed an increasing amount of cocaine being diluted with Benzocaine, Lidocaine and Procaine. Finally, thirteen tablets were analyzed for MDMA content. The average content was 60 mg/tablet and the range was 34mg to 91mg. No information was available on mixtures this year because of a change to the new database.

Treatment and Prevention

AFM adult clients (Table 6)

GENERAL - In 2006/2007, approximately 45.2% of clients were currently involved in the legal system, and of these, 82.3% reported that alcohol was related to their involvement and 34.3% reported that other drugs were related to this involvement. There is some overlap in these numbers as many clients are involved due to having both alcohol and other drug offenses. The most popular drugs other than alcohol used by AFM adult clients were cannabis, cocaine/crack cocaine, narcotics/opiates, and psilocybin.

COCAINE and CRACK COCAINE - Approximately 55.8% of adult clients reported using cocaine while 48.4% reported having used crack cocaine at some time in their lives. Many had not used in the past year (26.8% and 17.7%, respectively), however, second to alcohol, cocaine is the drug of choice of most clients.

HEROIN/MORPHINE, OPIATES and OTHER NARCOTICS - More than two-fifths (44.1%) of clients reported using a narcotic/opioid at some time, and most had not used in the past year.

CANNABIS - Over four-fifths (82.7%) of clients reported using cannabis *at some time, and 17.0% reported using daily.* However, 27.4% reported not having used cannabis in the past year, which also suggests that about three quarters had used cannabis in the past year.

SEDATIVE-HYPNOTICS and TRANQUILIZERS – Almost 30.5% of clients reported using some sedative-hypnotics/ tranquilizers at least once, with the most common being barbiturates. Of those that had used these drugs, a majority reported not using in the past year.

HALLUCINOGENS - Approximately 42.1% 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 18.5% of clients reported using stimulants (methamphetamines, speed), and a majority reported not using the past year.

AFM youth clients (Tables 7)

GENERAL - Exactly 92.1% of youth clients had used a drug other than alcohol at some point, and while 63.6% were aged between 12 and 14 when they first used drugs, 4.8% were aged 9 or less. It is somewhat encouraging that the percentage of individuals trying drugs before age 10 has decreased slightly.

Of the substances other than alcohol ever used, the majority of clients reported cannabis, hallucinogens, and cocaine/crack cocaine. About 16.1% of clients reported using substances other than those included in this report. This is an increase from last year (12.2%).

COCAINE and CRACK COCAINE – Almost 35% of youth clients reported using either cocaine or crack cocaine at some time. Less than once a month was the most frequently cited category of use (14.2% and 8.5%, respectively). The frequency of use among youth clients exceeds that of adult clients for this category of drugs.

HEROIN/MORPHINE, OPIATES, and OTHER NARCOTICS - Approximately 23% of youth clients reported using a narcotic/opioid at some time. Heroin was reportedly used by 2% of youth clients – a decline of over 10% from last year. Of those that had tried these drugs, the majority reported using less than once a month.

CANNABIS - Approximately 92% of youth clients reported having used marijuana at some time. The most frequently reported category of use was daily (32%), followed by weekly (27%).

SEDATIVE-HYPNOTICS and TRANQUILIZERS - Just over 11% percent of youth clients reported using tranquilizers/sleeping pills (i.e.: barbiturates, benzodiazepines). This is consistent with last year.

HALLUCINOGENS – Similarly to last year, slightly less than half of youth (45.5%) clients reported using hallucinogens (namely, psilocybin) at some time. Most reported using less than once a month.

STIMULANTS - Approximately 13.1% of youth clients reported using methamphetamines – a decline from last year, and 13.5% reported using Ritalin or Ts and Rs. Less than once a month was the most frequently cited category for both.

STEROIDS - Approximately 1.4% of youth clients reported ever using steroids.

Student use

The most recent AFM school-based data was collected in 2006/2007, and 625 clients were reported. Approximately

88% reported using drugs at some time, and 63.6% reported that they were aged between 12 and 14 when they first tried a drug other than alcohol. The most frequently cited drugs of choice other than alcohol were cannabis and psilocybin, 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, revealed that cannabis was the most commonly used illegal drug, thus the decision was made to include more questions about the consumption and consequences of cannabis use in the 2005 survey[10]. About 7% of the males and females in grade 7 have tried cannabis, however, as they approach high school the rates increase rather dramatically. By the end of high school almost half of the students have tried cannabis. About 10% of male students smoke about once a week or more frequently, compared with about 7% of females. What may be a greater concern is the number of students who are smoking cannabis daily. Almost 5% of the males and almost 3% of the females smoke at least daily. This type of frequent intoxication likely interferes with their ability to pay attention in class and retain the material that is being taught.

Overall, 90.2% of students did not report any signs of cannabis dependence, which includes most of those who are current users. Approximately, 8% of males and females had one of the three possible signs, and 1.7% of males and 1.6% of females had two or three signs of cannabis dependence. Heavy users are much more likely to have a variety of other difficulties. Well over half of the heavy users have failed a class. They are also twice as likely as the other users to have had to repeat a grade. They show signs of alcohol dependence, and were much more likely to score high on the delinquency measure.

The most commonly used drug, next to alcohol and cannabis, is magic mushrooms (psilocybin). As with other hallucinogens, very few of the younger students used mushrooms, however, by the time they near graduation about 20% of the males and 15% of the females have tried them in the previous year. This pattern, with mushrooms being the third most commonly used drug behind alcohol and cannabis use, is consistent with the 2001 survey findings. The use of "hard" drugs in this sample is very rare. Methamphetamine use is also quite uncommon, although about 3% of all high school students had used it in the past year. The use of inhalants is also uncommon, with again about 3% of all high school students using them in the past year. Club drug use is also a concern for adolescents, although many of the students in this sample would be too young to gain ready access to most dance clubs. There is some use of crack, with about 4% of the older students using it in the past year. However, cocaine use seems to be a little more common. A new student survey will be conducted this fall.

Methadone Intervention and Needle Exchange (m.i.n.e.)[11]

In 2003, the AFM's existing methadone maintenance program (MMP), was expanded to include a needle exchange component. The program was evaluated in 2002 [12], This expansion marked the formal start of the AFM's Methadone Intervention and Needle Exchange (m.i.n.e.) program as it exists today, and this report details an evaluation of the program.

The m.i.n.e. program operates under the philosophy of harm reduction, which recognizes that substance use is not simply a switch that can be turned from "on" to "off." Rather, substance use exists on a continuum ranging from harmful or dependent use, which is associated with severe problems and consequences, to abstinence. Programs that employ a harm reduction strategy encourage any and all movement on the continuum away from harmful use and toward (although not necessarily with the immediate goal of reaching) abstinence [13].

The goals of the m.i.n.e. program, which were evaluated in the 2005 report, are to:

1) Reduce the harmful use of opiates, thus improving the health of users.
2) Provide a doorway through which clients can access other services, including health care services, rehabilitation programs, and housing programs.
3) Reduce the spread of infectious diseases, including HIV/AIDS, hepatitis B and C.
4) Reduce the crime rate associated with opiate use.

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10 Patton, D., Mackay, T., Broszeit, B. Alcohol and Other Drug Use by Manitoba Students, 2005.

11 Bodnarchuk, J., Patton, D., & Broszeit, B. (2005, July). *Evaluation of the AFM's Methadone Intervention & Needle Exchange Program (m.i.n.e.)*. Winnipeg, MB: Addictions Foundation of Manitoba.

12 Patton, D., & Lemaire, J. (2002, July). *A preliminary evaluation of the AFM Methadone Maintenance Program (MMP).* Winnipeg, MB: Addictions Foundation of Manitoba.

13 Wenger, L. (2004). *Methadone intervention & needle exchange program: Moving best practices into action.* Winnipeg, MB: Addictions Foundation of Manitoba.

5) Improve the social functioning of those accessing the program. This includes employment status and the quality of personal relationships.

The m.i.n.e. program provides services for the largest number of methadone clients in the province. Other methadone clients receive services from private physicians, and organizations other than AFM provide needle exchange services. The estimated 900 to 1,500 Manitobans who struggle with opiate dependence are eligible for m.i.n.e.'s services, and m.i.n.e. has had approximately 100 clients at a given time over the past few years. Staff increases to address the waiting list have enabled the program to now accommodate almost 150 clients.

At intake, 66% of surveyed clients were using opiates other than the prescribed methadone on a daily basis, and at the time of the survey, 18% were doing so. Over 40% of clients reported improved eating habits, physical health, or mental health compared to before starting m.i.n.e. The second goal was harder to evaluate because while some clients were using services more than before starting m.i.n.e., other clients were using services less. Additionally, use of many services dropped after starting m.i.n.e., but the difference was only significant for five services: social assistance, hospitals, emergency rooms, pain management, and housing. The significant drop in these services suggests that the m.i.n.e. program may be helping to ease pressure on parts of the medical and social service systems. However, determining whether each client was accessing the services that he or she needed was not addressed by the current questionnaire, and future work should explore this issue in more depth.

Over two-thirds (69%) of surveyed clients reported at intake that they had taken drugs by injection at some point in their lives. At the time of the survey, one-third (33%) of clients reported injecting drugs in the year prior. In addition to fewer clients injecting drugs, three-quarters of m.i.n.e. clients (75%) reported using safe sexual practices. Thus, the m.i.n.e. program is making progress toward its third goal of reducing the spread of infectious diseases. Compared to the time of intake, at the time of the survey a lower percentage of respondents reported three aspects of legal involvement: pending court appearances (intake: 14%, survey: 6%), probation (intake: 22%, survey: 6%), and parole (intake: 8%, survey: 2%). Given the lengthy criminal histories of some of these individuals, these findings reflect a significant lifestyle improvement.

Surveyed clients showed a trend toward improved outcomes in education and employment. For example, while 20% reported losing a job or being suspended from school within a year before intake, 11% reported this at the time of the survey. Regarding changes in social and family relationships since starting m.i.n.e., of the 45% of respondents who reported that their relationships had improved, several reported increased trust and honesty with family and friends, as well as other positive changes in their relationships.

Many clients (53% of the 60 clients who answered the question) named the supportive and non-judgmental staff as the aspect of m.i.n.e. that helped them the most, and of the 46 clients who answered the question regarding what aspects of m.i.n.e. needed the most improvement, 17 (37%) replied that nothing needed improvement. Clients also provided various suggestions for making the program better, including more convenient and flexible times to receive methadone and other services, and more educational and peer groups.

After an opiate dependent individual is admitted to the m.i.n.e. program, he or she receives information about methadone, including its possible side effects, the consequences of stopping methadone, the effects of taking other drugs with methadone, and the required dose adjustment after missing three doses. The client is seen by the m.i.n.e. physician, who prescribes an initial low dose of methadone. This methadone is adjusted over time until a stable, individualized dose is attained. During this initial phase, the client is required to visit the physician frequently and to attend m.i.n.e. six days a week to obtain the daily dose of methadone, which must be consumed in the presence of a m.i.n.e. staff member. The seventh daily dose is provided as a take-home dose, or a "carry", because m.i.n.e. is closed on Sundays. Another aspect to the early phase of the m.i.n.e. program is regular urine testing to confirm the clients' self-reports of substance use. Negative test results (showing no opiate use) over time may lead to additional take-home carries for the client, and as part of the harm reduction approach, positive test results do not cause clients to be discharged.

Clients are allowed to receive their methadone from a community pharmacy rather than commuting to the Misericordia Health Centre site. Clients receiving their methadone from pharmacies continue to visit a m.i.n.e. physician on a regular basis. Clients have no time limit on their stay in the m.i.n.e. program, and involuntary discharges from the program are rare. Such a discharge can occur because of violence or threats of violence toward staff members or other clients, missing three consecutive days at the clinic, ongoing erratic attendance, or diversion of methadone to other people. When clients are involuntarily discharged, they are provided with decreasing dosages of methadone (i.e., tapered) over 10 days. Voluntary discharge results from a joint decision between a client and the m.i.n.e. staff members.

When such discontinuance of methadone is desired, tapering is conducted at a slow and individualized rate under close medical supervision, and the client is fully counselled and supported throughout the process.

Counselling and support are available to all clients throughout their term in the m.i.n.e. program. Counselling is provided both one-on-one and in group settings, as well as at most community pharmacies that dispense methadone to clients. M.i.n.e.'s counselling strategy follows the philosophy of client-centered harm reduction, where all efforts of the client to move toward a healthier lifestyle are supported, and abstinence is not necessarily the goal for every client. The counselling and support includes referrals to other agencies, such as hospital services, other substance use and treatment programs, community mental health programs, food banks, and social service agencies. Such referrals are fundamental to fulfilling m.i.n.e.'s two-pronged strategy of harm reduction and being a gateway to other services.

Impact

Hospital data (Table 8)

Of the 3042 substance related disorder hospital admissions in the CMA in 2005/2006, the following were reported for individual drug categories. Specific details on diagnoses are no longer available.

COCAINE - There were 230 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of cocaine. Of these, there were 59 cases where mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and 171 cases where it was diagnosed as a co-occurring condition, along with other diagnoses. Last year, there were 275 such cases (112 where most responsible and 163 where somewhat responsible).

OPIOIDS - There were 111 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of opioids. There were 55 cases where a mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and 56 cases where it was diagnosed as a co-occurring condition, along with other diagnoses. This represents a slight increase from the 102 cases reported in 2004/2005, at which time there were 48 cases where this was the primary diagnosis and 54 where it was a co-occurring condition.

CANNABINOIDS - There were 180 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of cannabinoids. In 17 cases, a mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and in163 cases it was diagnosed as a co-occurring condition, along with other diagnoses. This represents an increase from the 156 cases reported in 2004/2005 (10 where most responsible and 146 where somewhat responsible).

SEDATIVE OR HYPNOTICS - There were 79 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of sedative or hypnotics. Of these, there were 21 cases where mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and 58 cases where it was diagnosed as a co-occurring condition, along with other diagnoses. Last year, there were 73 such cases. For 23 cases, it was the primary diagnosis and in 50 cases it was a co-occurring condition.

HALLUCINOGENS - There were 9 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of hallucinogens. There were 5 cases where a mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and 4 cases where it was diagnosed as a co-occurring condition, along with other diagnoses. This figure remained unchanged from 2004/2005 (3 where most responsible and 6 where somewhat responsible).

BARBITUATES - There was 1 case in which a patient was diagnosed with a mental or behavioural disorder due to the use of barbituates. This one case was diagnosed as a co-occurring condition. No such cases were reported last year.

OTHER PSYCHOACTIVE DRUGS - There were 482 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of other psychoactive drugs. In 138 cases, a mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and in 344 cases it was diagnosed as a co-occurring condition, along with other diagnoses. This represents an increase from the 403 cases reported in 2004/2005. For 113 cases, it was the primary diagnosis and in 290 cases it was a co-occurring condition.

POISONING BY NARCOTICS – There were 56 cases in which a patient was diagnosed for poisoning by narcotics. Of these, there were 29 cases where mental or behavioural disorder due to the use of cocaine was the most responsible diagnosis when admitted to hospital and 27 cases where it was diagnosed as a co-occurring condition, along with other diagnoses. Last year, there were 32 such cases (12 where the narcotics were seen as "most responsible" for the admission, and 20 where narcotics were seen as "somewhat responsible" for the admission).

Deaths (Table 9)

The office of the CME investigated 3,123 deaths (excluding deaths reported in personal care homes) in 2006 recorded as naturals, accidents, industrial accidents, motor vehicle collisions, suicides, homicides, and undetermined in Manitoba. This total is consistent with last year. Of the 581 deaths where toxicology was performed, 86 were determined to be "drug related" causes of death. This includes drug toxicity, drug intoxication and drug use/abuse. Some of these 86 cases are alcohol related as well.

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 specific to Manitoba is available at this time regarding rates of drug impaired driving, but a national survey conducted by CCSA in 2004 found that 4.8% of the population of licensed drivers had driven within two hours of using cannabis in the past 12 months. According to this same survey, the average age of those driving under the influence of cannabis is approximately 11 years younger than those who drive under the influence of alcohol. Cannabis is the most commonly detected drug in fatally and seriously injured drivers, and in over half these cases alcohol is also detected. Over-the-counter drugs are also implicated in many road accidents.

Drugs can generally affect a person in three ways. They can accelerate or decelerate one's physiological system and can distort one's perceptions. Drug usage in combination with alcohol consumption can impair one's driving ability and significantly increase the likelihood of a vehicle collision. The Canadian Criminal Code prohibits any motorist from driving impaired, not only by alcohol, but also by drugs. These include illicit drugs, as well as misuse of prescription and non-prescription medications. If caught while driving impaired by drugs, the motorist will be charged for impaired driving under the Canadian Criminal Code. The code includes operating motorized vehicles such as snowmobiles, all-terrain vehicles, watercraft and off-road motorcycles.

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 recently announced plans to tighten the drug-impaired driving laws, but plans for a bill have been put on hold until proper identification process can be put in place. There is no agreed upon legal limit for drug impaired driving, as there is 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. Furthermore, THC (the active ingredient in cannabis) is detectable in the blood stream for up to one month after consumption, which also makes it difficult to identify a cut-off point that defines "impairment". In addition, more research needs to be done on the effects of different levels of specific drugs and their impact on driving. The Drug Recognition Expert program is now being used to determine impairment objectively.

PRESCRIPTION DRUG USE

Programs

The Manitoba Prescribing Practices Program (M3P) (previously known as both the Multiple Prescription Program and the Triplicate Drug 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.

The Manitoba Prescribing Practices Program (M3P) (Table 13)

The Manitoba Pharmaceutical Association, the Manitoba College of Physicians and Surgeons, the Manitoba Dental Association, the Manitoba Veterinary Association, the Manitoba Medical Association, the Manitoba Health Services Commission and the Drug Control Unit of the Health Protection Branch have jointly developed the Manitoba Prescribing Practices Program (M3P). A multiple prescription program has been successful in other jurisdictions in Canada and the United States, in decreasing the amount of prescription forgeries and alterations, double doctoring and injudicious prescribing. The aim of the program is to promote and support appropriate drug use management. It is a prospective at-source risk management system to minimize drug diversion for controlled and narcotic medications and facilitates communication among health care professions, regulatory authorities, and federal, provincial and territorial governments regarding drug utilization issues and information. The program was introduced in Manitoba in 1990 and is in effect for the entire province. Other provinces currently employing a multiple prescription program include British Columbia, Alberta, Saskatchewan, Nova Scotia, Newfoundland and Labrador.

The duplicate prescription portion of the M3P monitors specific narcotic and controlled drugs in Manitoba. Through the advisory committee to M3P, 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 physicians, pharmacists and patients are computer-monitored by a multidisciplinary team through use of the Drug Programs Information Network (DPIN). The original copy of an M3P form must be presented by the patient in order to receive a drug covered under the program. The pharmacist must ensure the prescription is valid and that all requirements with respect to information recorded on the M3P prescription are met, before dispensing the drug. Where requirements regarding patient care and patient safety or information on the M3P prescription form are not met, the pharmacist can refuse to fill the prescription. All M3P prescriptions dispensed must be entered into the DPIN system. A duplicate copy of the prescription remains in the prescriber's office for their records and prescription pads are personalized and numerically recorded for the prescriber.

In Manitoba in 2006 there were seventy-eight incidents of forged prescriptions presented to pharmacies but not dispensed, and eighteen incidents of forged prescriptions presented to pharmacies that were dispensed. Of these latter thirty-four incidents drugs monitored by the duplicate prescription program of the M3P were involved. Also in 2006, there were reports of four break and enters in pharmacies, two armed robberies of a pharmacy, one grab and theft, and nineteen reports of unexplained loss of drugs in pharmacies. In all of these incidents, drugs monitored by the duplicate prescription program were included with those drugs either stolen or lost.

Methamphetamine

Currently, there are strategies underway in the province to target the growing problem of methamphetamine production and use. These strategies focus on awareness, education, prevention and treatment. Tighter controls and enhanced enforcement regarding the distribution and sale of nonprescription precursor drug products and chemicals used in the illicit production of methamphetamine are presently in place. Amendments to the legislation governing the

sale of these precursor drug products have been enacted at both provincial and federal levels. In Manitoba, single entity nonprescription pseudoephedrine and ephedrine products are now classified as Schedule II products according to the National Drug Schedules. This Schedule II status means that these products may only be sold by a pharmacist in licensed pharmacy and only after the pharmacist has had an opportunity to counsel the individual on the appropriate use of the product. As well, nonprescription combination drug products containing either pseudoephedrine or ephedrine have now been classified as Schedule III products. The Schedule III status of these combination drug products means that they may only be sold from a licensed pharmacy in an area adjacent to the dispensary and under the supervision of a pharmacist. The MPhA continues to work with the Government of Manitoba and the Manitoba Society of Pharmacists to develop educational resources and tools for pharmacists to facilitate taking an active role in education, prevention and treatment efforts against methamphetamine use and production in their communities.

Drug Programs Information Network (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.

HIV and AIDS

Prevalence (Table 14)

According to Manitoba Health[21], in 2006, there were 83 new cases of HIV. This represents decrease from the 116 observed in 2005. During this time period, the majority of new cases, both male and female, were between the ages of 20 and 39 (54 cases). While females represent 25% of all HIV cases reported since 1985, comparing the 1985-1995 time period to the 1996-2006 time period, the proportion of newly diagnosed HIV cases that are female has almost quadrupled. Between 1996 and 2006, females accounted for over a third of all new HIV cases (301/876), compared to 8% (44/520) between 1985 and 1995. Beginning in 2001, the number of positive cases for females has consistently exceeded 20.

To the end of 2006, the percentage of cases residing in Winnipeg (at the time of testing) was approximately 84%. 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 in all areas of Manitoba.

Of the 32 females testing HIV positive between January 1, 2006 - December 31, 2006, the predominant exposure categories were having lived/traveled in an HIV endemic country (13/32 cases; 41%) and having sex with men who are at an increased risk (e.g., intravenous drug users) of HIV (9/32 cases; 28%). This latter category has decreased in percentage, while the former has increased slightly. Of the 51 males testing HIV positive in the same time period, the predominant exposure categories were having sex with men at an increased risk of HIV that had no evidence of IDU (13/51; 25%). Note that no identified risk was reported for 28% (9/32) of females and 27% (14/51) of males. Both of these figures are large increases from last year.

In 2006, 23% (19/83 cases) of newly diagnosed cases of HIV were self-reported as Aboriginal at the time of follow-up, 25% (20/83 cases) were self-reported as African/African-Canadian and 22% (18/83) were self-reported as Caucasian. These percentages are fairly consistent with previous years. The percentage of people self-reporting Asian and Other ethnicity has remained relatively stable since 1999, while the percentage self-reporting Aboriginal and

21 Manitoba Health Statistical Update on HIV/AIDS, 1985-2006.

Caucasian ethnicity has decreased in 2005 compared with earlier years, and the percentage reporting African/African-Canadian ethnicity has increased. The category with the largest increase, however, is 'unknown/missing'.

The proportion of men who have sex with men (MSM) without evidence of IDU decreased from 65% in the first time period (1985-1995) to 18% in the second time period (1996-2006). The largest increases (in terms of raw percentage) between the two time periods were seen in the Heterosexual (+22%), IDU (+12%) and Endemic (+12%) exposure categories. This is important information as it assists in tailoring prevention and treatment strategies and to correct public misconceptions about modes of transmission for HIV. As of June 2007, there had already been an additional 36 new positive cases of HIV.

In 2006, 13 new cases of AIDS were identified; 9 cases were male and 4 cases were female. These case reports bring the total number of AIDS cases to 258 since 1985. These cases are distributed over an age range of less than 15 to more than 50. Most were between the ages of 30 and 39 (9 cases). These cases were attributable to a range of transmission modes, including injection drug use, endemic, risky heterosexual and risky homosexual activity. All but one case were residing in Winnipeg at the time of testing. 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. In 2006, there were 7 reported AIDS deaths. Seventy-four percent of individuals reported with AIDS have died; however, delays in reporting of both cases and deaths make it difficult to determine precisely the incidence and mortality rate.

Impact

Hospital data (Table 8)

Of the 3042 substance related disorder hospital admissions in the CMA in 2005/2006, there were 81 cases in which a patient was diagnosed with Human Immunodeficiency Virus [HIV] disease was responsible. In 2004/2005, there were 65 such cases reported.

Deaths

Manitoba Health reported 7 deaths related to AIDS in 2006, 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 grade 4 students and high-risk individuals in the province and increased awareness. The figures for Hepatitis B have remained consistent over the past few years.

There was no annual review available for 2006, however some statistics were attainable. Although the incidence of Hepatitis C is still much higher than Hepatitis B, it has continued to decline, as well. The incidence of Hep C decreased by almost 100 cases between 2005 (421) and 2006 (325).

In 2006, Manitoba Health reported 7 cases of Hep B, and 325 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 59 years, and the majority of cases were reported in Winnipeg. In addition, males accounted for more of the cases than females, although this gap is narrowing (62% and 35%, respectively). In 2007, up to the end of June, there had already been 170 cases of Hep C, and 2 cases of Hep B. Sixty-three percent of those reported cases were male, while 34% were female.

Impact

Hospital data (Table 8)

Of the 3042 substance related disorder hospital admissions in the CMA in 2005/2006, there were 81 cases in which a patient was diagnosed with Human Immunodeficiency Virus [HIV] disease was responsible. In 2004/2005, there were

65 such cases reported.

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 2006/2007, approximately 92.5% have used tobacco, with 72.1% reporting daily use. Approximately 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 83.8% that reported having ever used tobacco reported doing so daily. However, 65% of the youth clients report that "use tobacco" currently.

According to a 2004 high school survey, conducted by the AFM, less than 8% of the grade 7 students have smoked in the past year, and about 13% of the grade 8 students. The rates for females in high school are much higher than for males, with almost 38% of the females in Senior 2 through Senior 4 smoking in the past year. The rate for males in these grades was less than 30%. Fortunately very few students are smoking heavily. About 3% smoke a pack per week, less than 2% smoke about two or three packs per week, and about 2% smoke more than 3 packs per week. Females are also smoking more heavily than males. Both male and female smokers report that the average age at which they began smoking was just over 12 years old. A new survey is being conducted this fall.

According to Canada Border Services Agency, tobacco represents 12% of all CBSA seizures in Manitoba in 2006. There were several very large tobacco seizures made at other ports of entry where the shipment was addressed to Manitoba, however the actual destination was not confirmed. There was an increase in tobacco seized especially in the courier system and consisting of Chinese cigarettes. There were 94seizures of tobacco in 2006 by CBSA, with an e.s.v. of $7,583.

Customs and Excise of the RCMP has noticed an increase in the interprovincial smuggling of tobacco, specifically from east to west. With the tax increase in 2004, the tax level has exceeded 1994, when smuggling levels were considered a national problem. The Canadian Tobacco Use Monitoring Survey (CTUMS) indicates a decrease in smoking of 4% over the past 4 years. However, overall sales have decreased 15%. Although many smokers may have lowered their consumption levels, a 12% difference between the number of smokers and sales suggests that smuggling may still be a problem. In addition, a new trend is homegrown tobacco. A recent seizure of 30 kgs in Western Manitoba was the first of it's kind recorded in Manitoba. Furthermore, a new type of cigarette, ITR, has recently surfaced in Manitoba. This product is not licensed for sale in Manitoba. This information is from 2004, as no new data was provided in 2006.

According to the data on hospital admissions for 2005/2006, there were 64 cases in which a patient was diagnosed with a mental or behavioural disorder due to the use of tobacco. This is consistent with previous years.

GAMBLING

Gambling is often associated with abused substances - alcohol and drugs - and information on dual diagnoses has 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.

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

For instance, in 2006/2007, over 31.9% of adult rehabilitation clients at the AFM reported that they gamble, 16.5% of whom reported having recurring problems due to their gambling. Interestingly, 41.6% of the AFM youth clients also reported having gambled, despite age restrictions. Note that this figure is larger than that of their adult counterparts. On the other hand, on 2006/2007, 80.2% of Gambling Services clients reported having ever used alcohol or other drugs.

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.

Whereas the Winnipeg project addresses systems change within the geographic area served by the WRHA, in the spring of 2003, Manitoba Health and AFM invited the 10 other regional health authorities from across Manitoba to join them in a cooperative initiative that would extend the project implementation province-wide. This phase of the Initiative is currently under way.

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 use among its clients and survey participants. In 2006/2007, as consistent with previous years, nearly all of the adult clients and more than 97% 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, just under 70% had a presumptive problem with alcohol (that is, they were not dependently involved), 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 did not provide figures this year, but other programs, such as Roadwatch saw 70 drivers suspended or charged for driving over the legal limit in a seven month period. Canada Border Services seized an e.s.v. of alcohol of $5,760.00 resulting from 108 seizures in 2006. This is a slight increase in the number of seizures from the previous year.

Overall, there has been a 66.3% decrease in the number of alcohol-related criminal code offenses between 1989 and 2005, 4,984 to 1,681 respectively. All age groups between 16 and 49 and 70+ recorded such declines. Licensed drivers under the age of 25 consistently record the highest rate of total alcohol offenses, they consistently account for double their proportion of the licensed driver population.

Alcohol was the most prevalent of all substances responsible for substance related disorder hospital admissions. The number of deaths attributed to alcohol, drugs or a combination of alcohol and drugs is not comparable with previous years due to changes in the precision of the information provided. These deaths are no longer specifically broken down as to the role alcohol and/or drugs played, but rather the toxicity levels are listed.

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. Just over six percent of AFM adult and youth 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 under-reported.

ILLICIT DRUGS

Cannabis continues to be one of the most prevalent drugs in Winnipeg. Nearly $2.5 million of cannabis was seized by Canada Border Services and Winnipeg Police Services in 2006. Specific seizure statistics for the RCMP were not available this year, or last year. Over 80% of adult clients and approximately 92% of youth clients at the AFM reported using cannabis at some time. This is consistent with previous years.

Winnipeg Police accounted for $2,598,440 of cocaine/crack cocaine seizures in 2006. This figure is approximately twice that of 2005. Over 55% of adult and over 34% of youth clients at the AFM reported using these substances, and cocaine was the drug most responsible for substance related disorder hospital admissions, aside from the “other psychoactive drug” category. These trends have remained stable over the last few years. The number of deaths attributed to drugs, or the combination of drugs and alcohol, is not comparable with previous years due to changes in data collection procedures.

Regarding heroin and other narcotics, the Winnipeg user population is still thought minimal, and what information

we have about seizures seems to support this conclusion. Almost 45% of adult clients at the AFM who are drug users reported using these drugs at some time (i.e: opiates), while approximately 23% of youth clients reported using a narcotic/opiate of some kind.

The use of sedative-hypnotics and tranquilizers and stimulants is low. Hallucinogens have been increasingly used. In fact, over two-fifths of AFM adult clients and approximately 45% of AFM youth clients reporting drug use have used hallucinogens at some time (i.e.: psilocybin). Seizures by CBS had an e.s.v of $500, an increase from 2004. RCMP statistics were not available, but WPS seized $154,760 in hallucinogens in 2006 – triple that seized in 2005. In addition, WPS continue to seize large amounts of methamphetamines (e.s.v. = $40,680), and have detected a number of methamphetamine labs. In addition, CBS seized an e.s.v. of $233. Steroid use appears to be slightly less of a problem. For example, CBS reported seizures with an e.s.v. of $8,088, a large decrease from previous years.

PRESCRIPTION DRUGS, HIV/AIDS AND HEPATITIS

In Manitoba in 2006 there were seventy-eight incidents of forged prescriptions presented to pharmacies but not dispensed, and eighteen incidents of forged prescriptions presented to pharmacies that were dispensed. Of these latter thirty-four incidents drugs monitored by the duplicate prescription program of the M3P were involved. Also in 2006, there were reports of four break and enters in pharmacies, two armed robberies of a pharmacy, one grab and theft, and nineteen reports of unexplained loss of drugs in pharmacies. In all of these incidents, drugs monitored by the duplicate prescription program were included with those drugs either stolen or lost. The reasons for the significant increase in the figures in recent years is likely due to the combined effects of increased drug theft and increased reporting by pharmacies.

As of June 2007, there had already been an additional 36 new positive cases of HIV. In 2006, 13 new cases of AIDS were identified; 9 cases were male and 4 cases were female. There were 7 reported deaths. 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 C appears to be continuing to decrease. In 2006, Manitoba Health reported 7 cases of Hep B, and 325 cases of Hep C. In 2007, up to the end of June, there had already been 170 cases of Hep C, and 2 cases of Hep B.

CHALLENGES

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

Nevertheless, this report continues to provide available current data, both actual and anecdotal, to reflect the extent and impact of substance abuse in our community. It can also be used to help track trends in both the use of substances and in the consequences of use. 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:

- national and local trends (increases in the use and availability of designer drugs);
- new substances and combinations ('blunts', stimulant drinks);
- increasing costs to society and users of crystal meth;
- misuse of prescription drugs (OxyContin);
- issues with drug purity and potency;
- updates on new approaches to drug treatment and prevention; 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 2006 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.

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Manitoba Public Insurance
Royal Canadian Mounted Police
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. The epidemiological information from Health Information Management Branch (Manitoba Health) from the Hospital Discharge Abstracting System has moved from ICD9 coding system to ICD10. As result not all diagnosis are directly comparable and individual information on specific diagnosis is no longer available.

3. A methodological change has been implemented starting with the 2004/2005 Manitoba Health data. Currently, one case represents a patient who was diagnosed with a certain disease or disorder within one admission (a patient may be admitted more than once during a year). For example if a patient was admitted for numerous related disorders/diagnosis during one admission it would be counted as one case. If they were admitted twice during the year for the same related disorder/diagnosis it would be counted as two cases. Prior methodology counted the number of diagnoses a patient had within one admission.

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. Starting in 2006, the number of deaths attributed to alcohol, drugs or a combination of alcohol and drugs is not comparable with previous years due to changes in the precision of the information provided. These deaths are no longer specifically broken down as to the role alcohol and/or drugs played, but rather the toxicity levels are listed.

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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. In April 2004 the WPS implemented a new records management and automated computer dispatch system. Since the WPS needed some time to adapt to the new system, caution should be exercised when comparing WPS from 2004 and on with previous years.

9. The Drug Awareness position of the RCMP has been vacant through 2006, and so, data is very limited and non-specific.

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APPENDIX 1

Demographics

All information is based on the 2001 and 2006 Census. All whole figures are actual numbers; all decimal figures are percentages.

Populations	2001		2004	
	MB	CMA	MB	CMA
population	1,119,583	676,594	1,148,401	694,668
CMA of prov. pop.	60.4	-	60.5	-
population < 24 years	-	32.8	-	31.9
population > 65 years	-	13.7	-	13.8

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	**2001**	**2006**
active labour force population	383,300	400,700
persons employed	362,800	382,200
participation rate	61.2	70.1
unemployment rate	5.3	4.6
employ. providing greatest no. of jobs	Manufacturing	n/a
Education	**2001**	**2006**
15 years +	533,360	571,500
with less than high school diploma	31.8	n/a
with university degree	16.5	
with cert. non-uni educ	14.0	
trades cert. or diploma	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%	
unattached individuals low income	48.4%	n/a

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. This position is currently vacant.

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 (2005/2006), Addictions Foundation of Manitoba (2006/2007).

	2003/2004	2004/2005	2005/2006	2006/2007
Hospitals	82,336 *	n/a	n/a	n/a
all substance related admissions~ where primary diagnosis	3,362 º 963	2,949~ 920	3,042~ 929	
all instances alcohol related where primary diagnosis	2,584 § 717	1,424 539	1,397 532	
all instances drug related where primary diagnosis	778 § 246	1,077^ 326	1,167^ 333	
AFM adults youth/RNYIS IDP	15,576 8,669 2,405 2,275	14,569 8,275 2,220 1,760	15,636 8,802 2,517 1,778	15,977 9,255 2,637 1,783

* 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

~ This is the total number of substance related disorders in Winnipeg hospitals, including HIV, Hepatitis C, and Tobacco.

^ drug related diagnoses, excluding Hep C, HIV, and Tobacco

Table 2. Manitoba Liquor Control Commission (2005/2006)

Sale and consumption	2002/2003	2003/2004	2004/2005	2005/2006
sales (millions of $)				
beer	199	212	215	215
spirits	154	159	164	170
wine	67	72	78	87
coolers/ciders	15	16	16	15
total	435	459	473	487
per capita consumption (litres)				
beer	81.6	83.3	79.9	83.5
spirits	7.3	7.4	7.1	7.2
wine	7.7	8.1	8.4	8.7
cooler/ciders	3.4	3.3	3.1	2.9
total	100.0	102.1	98.5	102.3

volume sales (millions of litres)				
beer	70.6	73.1	70.6	74.2
spirits	6.3	6.5	6.3	6.4
wine	6.8	7.1	7.4	7.7
cooler/ciders	2.9	2.9	2.7	2.6
total	86.6	89.6	87.0	90.9

licensed vendors	179	178	178	175
beer vendors	296	297	293	288
liquor marts	44	45	45	46
wine stores	8	8	8	8

photo ID cards	5,379	5,245	5,807	n/a
licence suspensions	29	26	20	26
warnings/other action	259 *	132	99	228
suspension of occasional permits	7	4	1	n/a
warnings	30	11	12	13

* 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 (2006)

Winnipeg Police Service	2003	2004	2005	2006
impaired operation of a motor vehicle causing bodily harm	11	15	13	11
impaired operation of a motor vehicle causing death	1	3	0	2
individuals charged with impaired driving offences	778	739	589	470
failed or refused to provide breath samples	37	42	11	9

Checkstop – WPS	*2002*	*2003*	*2004*	*2005*
days conducted	*33*	*35*	*16*	*32*
no. of vehicles stopped	-	*10,900*	*2,195*	*1,635*
no. suspended registering a WARN for BAC between .05 and 0.1	*80*	*53*	*40*	*82*
no. charged 'impaired/over' or 'impaired/refused'	*91*	*23*	*65*	*77*
avg. age of those charged	*36 years*	-	*37 yrs.*	*37.5 yrs.*
age range of those charged	-	*23-52 yrs.*	*15-67 yrs.*	*18-62 yrs.*

RoadWatch	2003	2004	2005	2006
days conducted	87	106	106	106
vehicles checked	42,488	37,794	34,471	37,628
no. suspended registering a WARN for BAC between .05 and 0.1	-	-	23	25
no. charged 'impaired/over' or 'impaired/refused'	87*	84*	37	45

* includes those registering a WARN

RCMP (Manitoba)	2003	2004	2005 ¤	2006
impaired operation of a motor vehicle*	452	418	744	n/a
driving with a BAC in excess of .08*	1,108	987	488	
refuse rd 234.1 (refused roadside breathalyzer)	17 139	10 128	n/a	n/a

failed or refused breath test failed or refused a blood test	17	7		
liquor offences	3,997	3,949	2,039	n/a

* These figures, for years prior to 2005, represent the number of charges or cleared other for that category, rather than the number of incidents. For impaired operation of a motor vehicle, the number of incidents is expected to be much higher.
¤ The RCMP has changed reporting tools and the scoring of occurrences has changed making the comparison of stats from previous years very difficult.

Table 4. Alcohol seizures recorded by Canada Border Services (2006)

Canada Border Services (ports of entry)	Jan - Dec 2003	Jan - Dec 2004	Jan - Dec 2005	Jan - Dec 2006
alcohol seizures e.s.v.	90 4,882	148 $7,819	n/a	108 $5,760

Table 5. Addictions Foundation of Manitoba Impaired Drivers population (2006/2007)

	2003/2004	2004/2005	2005/2006	2006/2007
admissions to program individuals by program	2,275 2,239	1,760 1,729	1,778 1,747	1,783 1,766
of these had a non-apparent problem (does not appear to have any real problem with alcohol)	6.8	6.3	7.7	6.2
had a presumptive problem (indicates a problem but not an active, full-blown addiction)	72.4	74.1	71.3	69.3
had an active problem (active alcohol problem that is interfering directly in life)	10.6	9.1	10.3	13.4
had a problem under control (in program or made lifestyle changes to control addiction)	10.0	10.2	10.4	10.9
clients for whom blood alcohol level available	1,576	1,248	1,206	1,179
reported blood alcohol levels ranging from .08 to .12 reported blood alcohol levels ranging from .13 to .17 reported blood alcohol levels ranging from .18 to .22 reported blood alcohol levels ranging from .23 or higher	29.8 37.8 24.2 8.2	29.4 39.8 21.9 8.9	28.4 36.3 26.8 8.5	30.0 36.3 23.7 9.9
first offenders ‘DVL status’	81.2	79.7	79.8	81.3
referred by DVL	84.1	79.7	80.3	73.7
males	85.7	86.9	86.3	83.6
between 18-24 between 25-34 between 35-50	23.0 27.8 36.4	22.1 28.8 36.4	24.5 26.6 34.2	24.4 26.4 34.5

Table 6. Addictions Foundation of Manitoba adult client population (2006/2007)

	2003/2004	2004/2005	2005/2006	2006/2007
admissions to program individuals by program	8,669 4,861	8,275 4,728	8,781 5,052	9,255 5,167
male	69.8	66.1	63.2	64.3
18 - 24 years of age 25 - 50 years of age	24.0 30.9	25.9 66.1	25.2 65.8	25.0 66.6
self referred to treatment services, or by family/friends	47.7	48.1	51.5	50.9

Substance use (ever used)				
alcohol	98.8	98.9	99.1	99.3
cocaine/crack	45.9	49.8	54.3	55.8
narcotics/opiates	42.8	44.1	45.5	44.1
marihuana	79.5	80.8	83.7	82.7
tranquilizers	28.0	29.7	31.3	30.7
LSD/acid, mescaline, psilocybin, others	38.9	41.9	42.2	42.1
stimulants (speed, methamphetamines, other)	18.1	18.9	19.7	18.5
over the counter	37.1	39.0	39.5	39.8
other (Ts and Rs, ritalin, talwin)	8.5	9.9	10.7	9.9
solvents	7.2	6.2	6.0	6.1
steroids	3.9	3.6	4.2	4.2

Table 7. Addictions Foundation of Manitoba youth client population (2006/2007)

	2003/2004	2004/2005	2005/2006	2006/2007
admissions to program individuals by program	2,405 1,822	2,220 1,708	2,517 1,835	2,637 1,967
13 years of age or less 14 - 17 years of age	8.9 83.3	8.3 84.7	10.5 84.4	7.3 86.6
male	64.2	60.1	61.3	59.1
self referred to program	9.2	10.8	9.1	8.4

referred by family/friends	17.8	19.7	17.2	16.4
ever charged with criminal offence offence was alcohol/drug related under influence of alcohol/drugs at the time of offence	44.6 48.8 54.6	38.7 49.6 59.3	38.4 49.7 59.8	38.7 46.2 58.2
ever consumed alcohol 9 or less 12 - 14 years of age	95.3 5.2 63.5	96.1 5.0 62.9	96.2 4.1 65.4	96.7 3.5 68.2
ever consumed drug other than alcohol 9 or less 12 - 14 years of age	93.1 6.1 57.6	90.2 5.7 61.1	92.0 6.9 62.3	92.1 4.8 63.6

Substance use (ever used)	2003/2004	2004/2005	2005/2006	2006/2007
alcohol	95.5	96.6	96.2	97.1
solvents	5.1	5.5	6.0	6.4
cocaine/crack	23.4	27.1	31.5	34.8
narcotics/opiates	18.3	19.6	20.2	23.3
marihuana	93.6	90.7	91.7	92.4
tranquilizers/sleeping pills	9.9	9.6	11.9	11.0
hallucinogens	45.3	47.7	46.8	45.5
stimulants (speed, methamphetamine)	15.5	18.5	18.0	13.1
ritalin/Ts and Rs	11.8	13.6	12.0	13.5
over the counter products	14.6	12.8	15.1	15.2
steroids	1.1	1.3	1.2	1.4

Table 8. Alcohol, drugs and related conditions diagnosed for admissions to hospitals in the Winnipeg CMA (Manitoba Health Epidemiology Unit, Health Information Management, 2005/2006)

ICD-9 *	Diagnosis	2003/2004		2004/2005		2005/2006	
		A	B	A	B	A	B
B24*	Human Immunodeficiency Virus [HIV]			55	10	64	17
042.0	HIV with specific infection	7	9				
042.1	HIV causing other infection	9	9				
042.2	HIV with spec. malignant neo	6	9				

042.9	AIDS with NOS	6	7				
043.1	HIV causing CNS disorder	1	1				
043.3	HIV causing other disorder	-	-				
044.9	HIV infection NOS	6	7				
F10*	Alcohol			539	885	532	865
291.0	delerium tremens (previously with alcohol withdrawal)	15	54				
291.1	alcohol amnestic syndrome (prev. Korsakowv's)	10	39				
291.2	alcoholic dementia NEC	8	31				
291.3	alcohol hallucinosis	3	13				
291.5	alcoholic jealousy	-	-				
291.8	alcohol psychosis NEC (composed of .81 and .89)	298	435				
291.81	alcohol withdrawal (previously not a code)	297	433				
291.89	other specific alcohol psychoses (prev. not a code)	1	2				
291.9	unspecified alcoholic psychoses	4	4				
303.0	acute alcohol intoxication	18	59				
303.9	alcohol dependent NEC/NOS	136	749				
305.0	alcohol abuse (prev. non-dependent)	121	783				
425.5	alcoholic cardiomyopathy	1	12				
535.3	alcoholic gastritis	5	16				
571.0	alcoholic fatty liver	1	15				
571.1	acute alcoholic hepatitis	28	57				
571.2	alcoholic cirrhosis of liver	58	242				
571.3	alcoholic liver damage NOS	4	30				
F11*	Opioids			48	54	55	56
304.0	opioid type dependence	26	36				
304.7	opioid and other drug dependence	5	7				
305.5	opioid abuse (prev. non-dependent)	16	27				
F12*	Cannibinoids			10	146	17	163
304.3	cannabis dependence	2	11				
305.2	cannabis abuse (prev. non-dependent)	20	119				
F13*	Sedatives or hypnotics			23	50	21	58
304.1	barbiturates dependence	34	46				
305.4	barbiturate/tranquilizer abuse (prev. non-dependent)	24	44				
F14*	Cocaine			112	163	59	171
304.2	cocaine dependence	41	53				
305.6	cocaine abuse (prev. non-dependent)	129	194				
F16*	Hallucinogens			3	6	5	4
304.5	Hallucinogen dependence	1	1				
305.3	Hallucinogen abuse (prev. non-dependent)	2	4				
F19*	Other psychoactive substances			113	290	138	344
304.4	amphetamines dependence	-	2				
305.7	amphetamine abuse (prev. non-dependent)	2	7				
305.8	antidepressant abuse (prev. non-dependent)	-	1				
304.6	drug dependence NEC	4	25				
304.8	combination drug dependence NEC (prev. no opioid)	9	17				
304.9	drug dependence NOS	19	30				
305.9	drug abuse NEC/NOS	122	420				
F17*	Tobacco			0	65	0	64
305.1	tobacco use disorder	1	229				

Z2251*	Hepatitis C			0	318	0	333
573.3	hepatitis unspecified	19	59				
760.70	noxious substance NOS affecting newborn	-	-	n/a	n/a	n/a	n/a
760.71	maternal alcohol affecting newborn	5	33				
760.72	maternal narcotics affecting newborn	1	2				
760.73	maternal hallucinogenic agents affecting newborn	1	6				
760.75	cocaine affecting fetus	2	6				
779.5	newborn drug withdrawal syndrome	9	21				
T40*	Poisoning by narcotics			12	20	29	27
965.00	poisoning by opium NOS	1	2				
965.01	poisoning by heroin	-	-				
965.02	poisoning by methadone	4	5				
965.09	poisoning by opiates NEC	4	12				
965.1	poisoning by salicylate acid salts ¤	-	-				
965.4	poisoning by aromatic analgesics unspecified ¤	-	-				
965.61	poisoning by proprionic acid derivatives ¤	-	-				
965.69	poisoning by antirheumatics ¤	-	-				
965.7	poisoning by other non-narc analgesics unspecified ¤	-	-				
965.8	poisoning by other specified analgesics/antipyretics ¤	-	-				
967.0	poisoning by barbiturates	8	21				
967.8	poisoning by other sedatives-hypnotics NEC	-	-				
967.9	poisoning by sedatives-hypnotics NOS	-	-				
969.0	poisoning by antidepressants	32	79				
969.1	poisoning by phenothiazine tranquilizers	-	1				
969.2	poisoning by butyrophenone tranquilizers	2	3				
969.3	poisoning by antipsychotic NEC	4	12				
969.4	poisoning by benzodiazepine tranquilizers	33	100				
969.5	poisoning by tranquilizer NEC	2	4				
969.6	poisoning by hallucinogens	-	-				
969.7	poisoning by psychostimulants	-	1				
969.8	poisoning by psychotropics NEC	9	22				
969.9	poisoning by psychotropics NOS	-	2				
977.8	poisoning by drug medication NEC ¤	-	-				
977.9	poisoning by drug medication NOS ¤	-	-				
F18	Volatile solvents			5	22	9	10
980.0	toxic effect of ethyl alcohol	4	9				
980.1	toxic effect of methyl alcohol	3	3				
980.2	toxic effect of isopropyl alcohol	-	-				
980.9	toxic effect of alcohol NOS	2	4				
982.0	toxic effect of benzene ¤	-	-				
982.8	toxic effect of other solvents ¤	-	-				
TOTALS		1,688	4,198	920	2,029	929	2,113

Note: The introduction of ICD-10 caused major disruptions in the time series of health statistics resulting in a substantial changes to the layout of the report when compared to previous years.
A: instances where alcohol and drugs considered the most responsible diagnosis
B: instances where alcohol and drugs considered responsible to any extent, along with other diagnoses
¤: no longer an ICD-9 code
*: ICD-10 codes are now in effect. ICD-10 uses alphanumeric codes as opposed to just numeric codes.

Table 9. Deaths as reported by the Chief Medical Examiner's Office (2006)

	2003	2004	2005	2006
total number of deaths investigated	2,993	NA	3,131	3,123

involving alcohol only involving drugs only involving alcohol & drugs total involving drugs/alcohol	163 80 58 301		124 136 50 310	204* 86~ n/a 290°

* 2006 data is broken down into all cases where alcohol was listed as the cause of death or the level found was 80mg% or over.
~ 2006 data is broken down into all cases where drugs were listed as the cause of death (overdose/toxicity, intoxication, use/abuse).
° This number may represent an overlap of deaths related to drugs and deaths related to alcohol.

Table 10. Drug charges and seizures recorded by the Winnipeg Police Service (2006)

CHARGES	2004	2005	2006
drug charges % charges effected against adult males	n/a	1,054 76%	1,728 76%
most common drug seized e.s.v. of all drugs seized	marijuana n/a	marijuana $10,293,972*	marijuana $5,290,170

* - excludes marijuana grow operations

SEIZURES	2004		2005		2006	
	A (gm)	B (e.s.v.)	A (gm)	B (e.s.v.)	A (gm)	B (e.s.v.)
cocaine crack/cocaine	6,683 4,818	$534,647 $385,516	6.923 9,214	$553,840 $737,120	26,083 12,795	$2,086,640 $511,800
marihuana marihuana cultivation hashish/hash oil, resin	731,759 30,000 plants 29	$9,146,989 $33,829,540 $739	124,610 - 363	$1,869,150 - $7,260	192,568 - 1,428	$2,407,100 - $28,560
LSD [hits] psilocybin ecstasy [gm]	50 1,368 4,023	$300 $20,530 $80,465	1,221 441 1,880	$76,615 $6,615 $37,600	1,075 2,768 5,341	$6,450 $41,520 $106,820
tablets	5,411	-	4,904	-	3,030	$60,600
methamphetamine	1,386	$124,785	827	$74,430	4,068	$40,680

Note: categories that had no reported data over the time span of the table were removed and will only be reintroduced as such reports surface in coming years.

Table 11. Drug seizures by Canada Border Services (2006)

SEIZURES	Jan. - Dec. 2004		Jan. - Dec. 2005		Jan. - Dec. 2006	
	A (gm/dose)	B	A (gm/dose)	B	A (gm/dose)	B
marijuana hashish hashish (liquid)	2,214 - -	$44,280 - -	n/a	n/a	278 - -	$5,560 - -
cocaine crack cocaine	1 -	$50 -	n/a	n/a	5.5 1	$688 $200
khat	60,000	$60,000	n/a	n/a	112,173	$56,807
methamphetamines amphetamines/barbiturates diazepam (valium) rohyphol	1 - - -	$100 - - -	n/a	n/a	6 dosages; .9 gm - - -	$233 - - -

ephedrine pseudoephedrine	7,318 -	$7,318 -			780 dosages; 7gm 21	$0 $0
steroids	60,250	$60,205	n/a	n/a	1,460 dosages; 1,112 gm	$8,088
LSD psilocybin ecstasy	- - 5	- - $175	n/a	n/a	- 14.64 8	- $220 $280
heroin opium	- -	- -	n/a	n/a	- 25	- $1,250
other controlled drugs	9,265	$9,265	n/a	n/a	376 dosages; 1.03 gm	$378

Table 12. Charges, seizures and offences related to drugs recorded by the RCMP in Manitoba (2006)

CHARGES	2004	2005	2006
drug offences recorded in Manitoba	n/a	n/a	n/a
total recovery value of seized drugs	$4,000,000	n/a	n/a
charges laid against males charges laid against females	n/a	n/a	n/a

SEIZURES	2003	2004	2005	2006
	e.s.v.	e.s.v.	e.s.v.	e.s.v.
cocaine	$450,000	$35,479	n/a	n/a
heroin morphine	- -	n/a n/a	n/a n/a	n/a n/a
cannabis resin marihuana marihuana individual plants khat	- $3,100,000 $3,800,000 -	$845 $14,850 $2,034,000 -	n/a	n/a
LSD (units) ecstasy psilocybin	- $4,500 $10,000	n/a n/a -	n/a	n/a
amphetamine methamphetamine	- $3,500	n/a $1,518	n/a	n/a
ephedrine	-	$1,876,500	n/a	n/a
steroids	$350,000	$131,340	n/a	n/a

Table 13. Drug diversion incidents reported to the Manitoba Pharmaceutical Association (2006)

	2003	2004	2005	2006
forged prescriptions that were dispensed	11	5	34 *	18 *
forged prescriptions presented and not filled	4	6	73	78
pharmacy break/enter and theft of drugs	2	2	2	4
pharmacy armed robbery with theft of drugs	0	1~	0	3
number of grab and theft	n/a	n/a	n/a	1
pharmacies in Manitoba reporting unexplained losses of drugs	3	5	26	19
reports of false identity of individual attempting to fill prescription	-	-	9	n/a
number of forged prescriptions	8	11	107	96

~ - unarmed robbery
* includes duplicate drugs

Table 14. HIV and AIDS data (Manitoba Health, 2007)

	2004			2005			2006		
	total	male	female	total	male	female	total	male	female
tested positive for HIV	106	63	43	116	73	43	83	51	32
IDU only testing HIV positive	11	5	6	11	6	5	3	2	1
heterosexual activity testing HIV positive	18	11	7	35	20	15	22	13	9
reported with AIDS	8	4	4	8	6	2	13	4	9
died from AIDS	2			3			7		

Table 15. Hepatitis data (Manitoba Health, 2007)

	2004	2005	2006	2007 (to June)
hepatitis B	5	6	7	2
hepatitis C	432	421	325	170

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.