

HEROIN

Use

Indicators of heroin use in survey data have remained low among mainstream populations. From the 2000 CAMH Monitor, less than 1% of Toronto adults reported using heroin in the 12 months before the survey. Similarly, less than 1% reported that they had used heroin in their lifetime. This low rate of use was also reflected in the 2003 student survey, in which approximately 1% of Toronto students reported use of heroin in the past year.

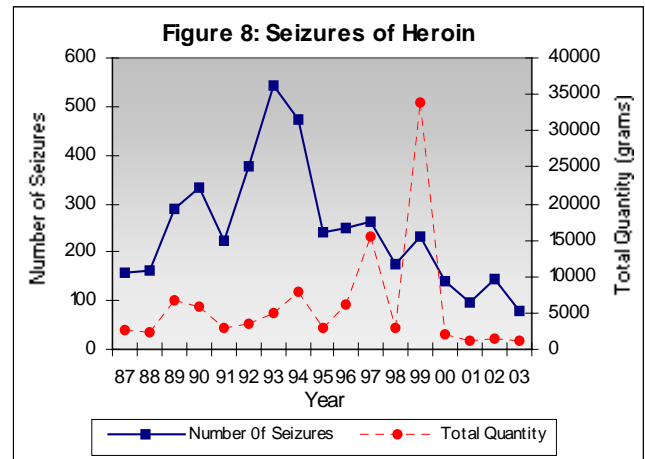
Evidence of the popularity of heroin and other opiate use among marginalized groups is found in The Works cumulative statistics for 2003.⁷¹ A summary of drug of choice data for nearly 4000 client visits indicated 49% mentioned heroin and other opiates as a drug of choice, while approximately 47% mentioned cocaine.

Unlike cocaine, heroin does not appear to currently be a significant drug of choice among street youth. It was not mentioned in the March, 2004 Youthlink survey of drug use among street youth.⁷⁷ It is interesting to note, however, that methadone, an opiate frequently prescribed as a replacement for heroin, was cited by 11% of respondents. More frequent use of heroin was noted by the respondents to the 1999 SHOUT street youth survey. In total, 11% of these youth reported using heroin at least once monthly. Anecdotally, street youth are also using oxycodone and other opiate formulations.^{58,59}

Enforcement Data

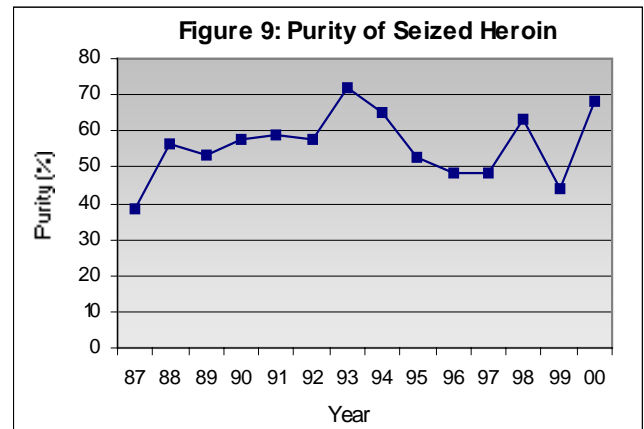
The total number of heroin seizures in Toronto peaked between 1992 and 1994. Since then, the numbers have declined and resemble those found in the late 1980s. In 2003, heroin accounted for about 2% of the total number of drug seizures. The total quantity of heroin seized has varied somewhat over time, but 1999 remains a peak year with a total of 34 kilograms seized (up from 3 kg in 1998). This unprecedented amount was likely attributable to

a few unusually large seizures. Since 1999, the quantity of heroin seized has declined, ranging between 1 and 2 kg.



The purity of the heroin seized in 2000 averaged 54.7%, higher than that seized in 1999 (44.3%). The average purity level of heroin has shown much fluctuation since data collection began, from a low of 38% in 1987 to a high of 72% in 1993.

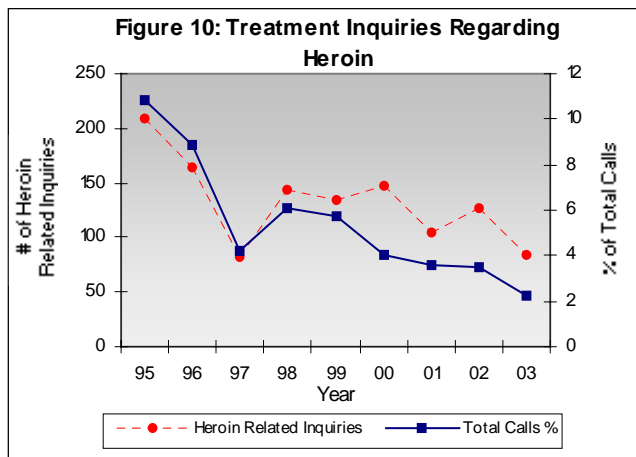
Although variation exists, the primary type of heroin in Toronto is white heroin, which originates in Asia.



Treatment Data

According to the most recent data from the Drug and Alcohol Registry of Treatment, approximately 2% of drug treatment inquiries from Toronto involve heroin as a primary substance of abuse. This percentage has

steadily decreased from 11% when recording began in September, 1994. A similar pattern has been observed in the rest of Ontario. The changes in the provincial methadone policies are widely cited as significant in the corresponding increase in numbers of methadone clients and decrease in heroin-related deaths.



Methadone Treatment

In July, 1996, the (former) Ontario Substance Abuse Bureau and the College of Physicians and Surgeons in Ontario (CPSO) agreed to administer the licensing of physicians to prescribe methadone in the province. One of the immediate changes was that there were no longer limits imposed on physicians with respect to the number of patients that they could treat at any given time. This led to more accessibility to methadone treatment for clients who had been on long waiting lists.

As of July 31, 2004, there were 10,497 individuals in active methadone treatment in Ontario. This number compares to just 975 individuals who were receiving treatment prior to the 1996 reorganization, an increase of more than 1000%.

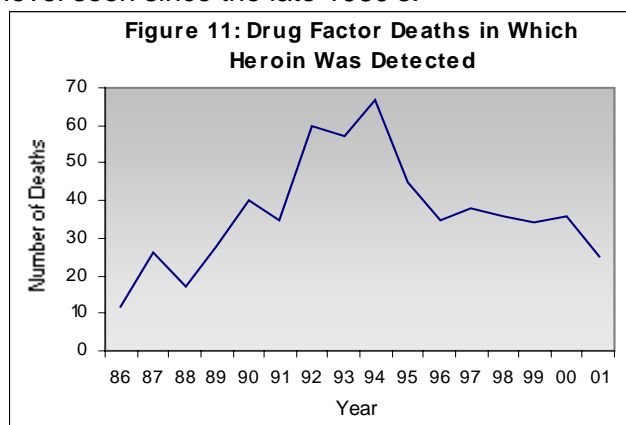
According to officials at the College of Physicians and Surgeons, there is better access to a range of methadone treatment programs in the Toronto area than outside the city. Of the total 257 physicians who provide methadone maintenance treatment in Ontario, 87 (34%) practice in the city of Toronto.

Officials at the CPSO also report that the number of pharmacies dispensing methadone has continued to increase and that there is reasonable availability of methadone in pharmacies throughout the province.

In 1999, correctional facilities in Ontario adopted a policy of maintaining methadone clients who become incarcerated. While physicians associated with the correctional system are being encouraged to obtain methadone licenses, it is not yet possible for a newly incarcerated individual to request methadone treatment if not previously prescribed.

Drug-Related Deaths

As noted in the previous edition of Drug Use in Toronto, an increase in heroin-related deaths during the period 1988-1994 was followed by a decline from 1995-1998. From the high of 67 heroin-related deaths in 1994, subsequent results from the Office of the Chief Coroner showed a decline to 45 such deaths in 1995, 38 deaths in 1996, and 36 deaths in both 1997 and 1998. The additional data included in the current report reflect a continuation of this downward trend. This new information indicates 34 heroin-related deaths in 1999, a slight increase to 36 in 2000 and a decline to 25 deaths in 2001. The latest figures indicate a decrease to the lowest level seen since the late 1980's.



The age range of the decedents covered more than 5 decades; the youngest was a teenager while the eldest was over 70 years of age. The median age was consistent, at 39 years in 1999, 40 years in 2000 and 39 years in 2001. The

percentage of male decedents in each of the three years was also consistent, at 79%, 83% and 80% respectively.

In terms of death types, 18 heroin-related deaths (53%) were ruled as accidental for 1999, with 23 (64%) in 2000 and 19 (76%) in 2001. The corresponding figures for suicides are 2 (6%), 4 (11%) and 1 (4%), while those of undetermined origin were 14 (41%), 9 (25%) and 5 (20%) respectively.

The lethality analysis indicates that heroin is frequently lethal alone; the corresponding annual figures are 20 (59%) in 1999, 12 (33%) in 2000, and 13 (52%) in 2001. The numbers of deaths due to heroin combined with other drugs were 12 (35%), 21 (58%) and 11 (44%), while the corresponding totals for non-lethal doses of heroin were 2 (5%), 3 (8%) and 1 (4%), respectively. Alcohol contributed to death in 8 (22%) of these combination cases. Twenty-nine, or 30% of the heroin-related deaths, also involved cocaine.

For more information on Heroin and other opiates in this report, see:

- **Emerging Issues in Mainstream Drug Use and**
- **Marginalized Users and Injection Drug Use**

From the 1994 “Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia,” Office of the Chief Coroner.

“And what of the circumstances leading up to and surrounding these deaths? These are not so readily measurable. In fact, they are damned complex and confounding: human behaviour, human failings, social issues, and political issues. Various opinions were expressed, ranging from “What’s the worry; they’re dead aren’t they?” to “We have a social conscience which ought to drive us to assist those who cannot help themselves...”

Unless there is a greater understanding on the part of the general public of who these people are, where they come from, and where they are going – all the elements that have gone into their present state – then I am afraid our collective social conscience will not drive us to assist them.”

J.V. Cain, (then) Chief Coroner, British Columbia