

Rising Incidence of Hospital-reported Drug-facilitated Sexual Assault in a Large Urban Community in Canada

Retrospective Population-based Study

Margaret J. McGregor, MD, MHS¹
Janet Ericksen, RN, MA²
Lisa A. Ronald, MSc³

Patricia A. Janssen, PhD⁴
Anneke Van Vliet⁵
Michael Schulzer, MD, PhD⁶

ABSTRACT

Background: Drug-facilitated sexual assault (DFSA) occurs when an individual has been sexually assaulted due to the surreptitious administration of drug(s) thereby rendering her/him unable to give consent. Our study aim was to calculate the age- and sex-specific annual incidence of hospital-reported DFSA and to determine whether a one-year increase in DFSA observed in 1999 in a pilot study on the same population was a significant and sustained trend.

Methods: We identified cases of DFSA by reviewing the sexual assault examination records of all the individuals who presented to a hospital-based sexual assault care referral service in Vancouver, British Columbia during the study time period (January 1, 1993 to May 31, 2002). The annual sex- and age-specific incidence and temporal trends of drug-facilitated sexual assault were examined using population data from the British Columbia Ministry of Health.

Results: The mean annual incidence of female DFSA increased from 3.4 per 100,000 (years 1993-1998) to 10.7 per 100,000 (years 1999-2002). Age-adjusted relative risks for female DFSAs were significantly higher in 1999 (2.77, 95% CI 1.85-4.15), 2000 (3.01, 95% CI 1.97-4.57), 2001 (3.14, 95% CI 2.07-4.78) and 2002 (4.88, 95% CI 2.84-8.37) compared to 1993-1998. Women aged 15-19 years had the highest DFSA incidence, with a year-adjusted relative risk of 3.89 (95% CI 2.75-5.50) compared to all other age groups.

Conclusion: This study demonstrates that the incidence of hospital-reported DFSA has shown a marked and sustained increase since 1999. Young women in their teens are particularly vulnerable to this form of sexual assault and further efforts are needed to develop and evaluate prevention programs for this group.

La traduction du résumé se trouve à la fin de l'article.

1. Clinical Assistant Professor, Department of Family Practice, University of British Columbia, Vancouver, BC; Sexual Assault Service, BC Women's Hospital and Health Centre; Centre for Clinical Epidemiology and Evaluation, Vancouver Hospital and Health Sciences Centre
2. Sexual Assault Nurse, Sexual Assault Service, BC Women's Hospital and Health Centre; Assistant Professor Emeritus, School of Nursing, University of British Columbia
3. Project Researcher, Sexual Assault Service, BC Women's Hospital and Health Centre
4. Assistant Professor, Department of Health Care and Epidemiology, University of British Columbia
5. Sexual Assault Service Coordinator, Sexual Assault Service, BC Women's Hospital and Health Centre
6. Statistician, Centre for Clinical Epidemiology and Evaluation, Vancouver Hospital and Health Sciences Centre

Correspondence and reprint requests: Dr. Margaret McGregor, Mid-Main Community Health Centre, 3998 Main St., Vancouver, BC V5V 3P2, Fax: 604-875-8790, E-mail: mrgret@interchange.ubc.ca This study was funded by the Vancouver General Hospital, Interdisciplinary Grant Funding FY 2002.

Acknowledgements: We thank: Susan Scarrow, who assisted with manuscript preparation; Dr. Sue Comay, Dr. Sevena Khun Khun, Lianne Ritch, and Helen Griffiths (Sexual Assault Service coordinators), who assisted with data access, provided physical space, and gave many useful suggestions; Dr. Stuart Huckin, Provincial Toxicology Centre, Riverview Hospital and Dr. Morris Pudek, Vancouver Hospital and Health Centre, who assisted us with understanding the complexities of toxicology testing; Inspector Barbara Morris from the Vancouver Sexual Offences Squad of the Vancouver Police Department, who advised us with regard to police issues; and Dr. Sam Sheps, Department of Health Care and Epidemiology, University of BC, who reviewed the manuscript.

According to the World Health Organization, sexual violence has generally been a neglected area of research, yet the evidence suggests it is a public health problem of substantial proportions. There is a need for further research on all aspects of sexual violence.¹

Within the past five years, the medical literature and lay media have reported incidents of "date rape drugging" in which an individual was given a drug(s), thereby rendering her/him unable to give consent, and was sexually assaulted.^{2,3} A typical history is of a woman consuming one or two alcoholic beverages and, upon waking, having no recall of what happened – often in circumstances which lead her to suspect that she was sexually assaulted.

While alcohol is still the most common 'drug' implicated in sexual assault,^{4,6} there are increasing reports of assailants using a range of prescription and non-prescription drugs to induce disinhibition or sedation and amnesia of the victim to facilitate sexual assault.^{7,8} The media have frequently implicated flunitrazepam (Rohypnol) and gamma hydroxybutyrate (GHB), but there are other less publicized, easily available and potent sedative-hypnotics, such as lorazepam, clonazepam, zopiclone, and chloral hydrate. Many are rapidly absorbed with only trace amounts excreted in the urine for a brief time after ingestion. Most medical literature on this topic has focussed on a description of the drug effects,^{7,9-13} forensic toxicology methods,^{14,15} management of suspected cases,⁸ toxicology screening results,^{16,17} and case reports.^{2,18-20} There is virtually no literature on the magnitude or epidemiology of this phenomenon.

Located in the emergency department of a large urban hospital in Vancouver, British Columbia (BC), the BC Women's Sexual Assault Service (SAS) is the referral centre for all hospital- and police-reported sexual assaults for the city of Vancouver and surrounding communities of Richmond, the North Shore and Howe Sound (SAS catchment area). The service sees approximately 250 sexual assault victims annually, with about two thirds of these reporting to the police. As the SAS is the primary referral centre for the SAS catchment area, it provides a good measure of the total number of hospital- and police-reported sexual assaults in this community. A pilot study found that the fre-

quency of DFSAs presenting to the SAS had increased substantially in 1999 compared to the previous five years.²¹ Anecdotal clinician evidence suggested that female DFSAs were occurring more frequently among teens. The objectives of this study were to: calculate the age- and sex-specific annual incidence of hospital-reported DFSA for the SAS population catchment area from 1993 to 2002; determine if the increased rate observed in 1999 was a significant and sustained trend; and test the hypothesis that young women were at particular risk.

METHODS

Study population

The study population consisted of all sexual assault victims presenting to the SAS between January 1, 1993 and May 31, 2002 and whose residence was within the SAS catchment area. Residence was identified using addresses provided during the sexual assault examination. Sexual assaults that had occurred over thirty days prior to reporting to the SAS (n=12) were excluded, as it is not the usual mandate of the SAS to provide care in such circumstances.

When an individual presents to the SAS, the examiner completes a standardized sexual assault examination record. Demographic information, assault details and medical examination results are later entered into a database. In assaults that may involve the police, a typewritten narrative account of the assault history and examination findings (the medical-legal report) is also dictated by the examiner shortly after the examination.

TABLE I

Summary of Hospital-reported Sexual Assault and Drug-facilitated Sexual Assault (DFSAs) for Vancouver and Surrounding Communities, January 1993-May 2002*

Year of Assault	Total # of Sexual Assaults	# of DFSAs	Proportion of DFSAs (%) Among Total Sexual Assaults
1993	186	17	9.1
1994	147	12	8.2
1995	130	8	6.2
1996	164	14	8.5
1997	165	17	10.3
1998	162	16	9.9
1999	208	45	21.6
2000	156	40	25.6
2001	180	51	28.3
2002 (Jan-May)†	96	26	27.1

* Excludes individuals presenting to the SAS who resided outside the SAS catchment area (Vancouver, Richmond, North Shore, Howe Sound)
 † Data only available to May 31, 2002

One of the study investigators with extensive nursing experience in sexual assault care and a trained research assistant reviewed the SAS examination records and the medical-legal reports (when available) to identify individuals meeting the case inclusion criteria. A DFSA case was defined as a sexual assault victim reporting a suspicion of having been drugged and sexually assaulted, unexplained anterograde amnesia, and/or other symptoms suggesting deliberate drugging in relation to sexual assault. Victims reporting alcohol overuse and memory loss judged to be consistent with the volume of alcohol consumed and those who were forcibly injected with a drug were excluded. This study did not require toxicology laboratory confirmation for case identification because the investigators felt that using such a criteria would result in the exclusion of a large number of "false negatives".

Ethics approval for this study was obtained from the relevant institutional ethics review boards.

Data analysis

Descriptive statistics included the proportion of suspected DFSAs to all sexual assaults during the study period and the frequency of DFSAs among different age and sex strata. Incidence rates (number of hospital-reported assaults/100,000 population/year) were calculated using age- and sex-specific population estimates of the SAS catchment area (obtained from the BC Ministry of Health)²² as the denominator.

Poisson regression was used to estimate and compare the sex- and age-specific annual rates of DFSA based on counts of rare events over time (MLn software, University of London, 1998). To account fully for the excess empirical variance in the data ("overdispersion"), the extra-Poisson adjustment was applied.²³ Age-adjusted relative risks and 95% confidence intervals of DFSA were calculated for the years 1999, 2000, 2001 and the first five months of 2002, using the time period from 1993-1998 as the reference. A similar

TABLE II

Age-specific Annual Incidence of Female Hospital-reported Drug-facilitated Sexual Assault (DFSAs) for Vancouver and Surrounding Communities*

Year	Age Group (in years)															
	10-14		15-19		20-24		25-29		30-39		40+		All ages§			
	#†	Rate‡	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate		
1993	3	14.0	4	17.0	3	9.0	2	5.0	1	1.3	3	1.6	16	4.2		
1994	0	0	2	8.2	2	6.0	4	10.0	3	3.7	0	0	12	3.1		
1995	0	0	2	8.1	2	6.0	2	4.9	2	2.4	0	0	8	2.0		
1996	0	0	5	19.2	5	14.4	2	4.7	1	1.2	1	0.5	14	3.4		
1997	1	4.3	5	18.7	2	5.6	4	9.0	3	3.5	2	1.0	17	4.0		
1998	0	0	5	18.7	4	11.1	2	4.5	2	2.3	2	0.9	15	3.5		
1999	2	8.6	11	41.3	8	22.1	6	13.6	11	12.6	4	1.8	42	9.7		
2000	3	13.0	14	52.7	7	19.3	8	18.1	5	5.7	0	0	37	8.4		
2001	0	0	11	42.0	10	27.5	14	31.9	10	11.3	2	0.9	48	10.8		
2002	3	31.8	11	101.1	3	19.9	2	11.1	3	8.2	3	3.1	26	14.0		

* Note: Excludes individuals presenting to the SAS who resided outside the SAS catchment area (Vancouver, Richmond, North Shore, Howe Sound)
 † Number of DFSA cases presenting to SAS
 ‡ Number of cases per 100,000 population at risk
 § All ages category includes 3 additional individuals with suspected DFSA whose ages were unknown (one in each of 1994, 2001 and 2002)
 || Rates of suspected DFSA cases for 2002 estimated from # of cases presenting to SAS to end of May 2002.

TABLE III
Relative Risks of Female Hospital-reported Drug-facilitated Sexual Assault (DFSA) and Other Sexual Assaults for Vancouver and Surrounding Communities by Year*†

Years	RR (95% CI)
DFSA Cases	
1993-1998‡	1.0
1999	2.77 (1.85, 4.15)
2000	3.01 (1.97, 4.57)
2001	3.14 (2.07, 4.78)
2002 (to May 31)	4.88 (2.84, 8.37)
Other Sexual Assaults (non-DFSA)	
1993-1998‡	1.0
1999	1.06 (0.73, 1.53)
2000	0.79 (0.52, 1.22)
2001	0.83 (0.54, 1.23)
2002 (to May 31)	1.25 (0.74, 2.13)

* All relative risks from Poisson regression models were adjusted for age group. Due to data over-dispersion, the "extra-Poisson" adjustment was applied.
 † Excludes individuals presenting to the SAS who resided outside the SAS catchment area (Vancouver, Richmond, North Shore, Howe Sound)
 ‡ Reference category (January 1, 1993-December 31, 1998)

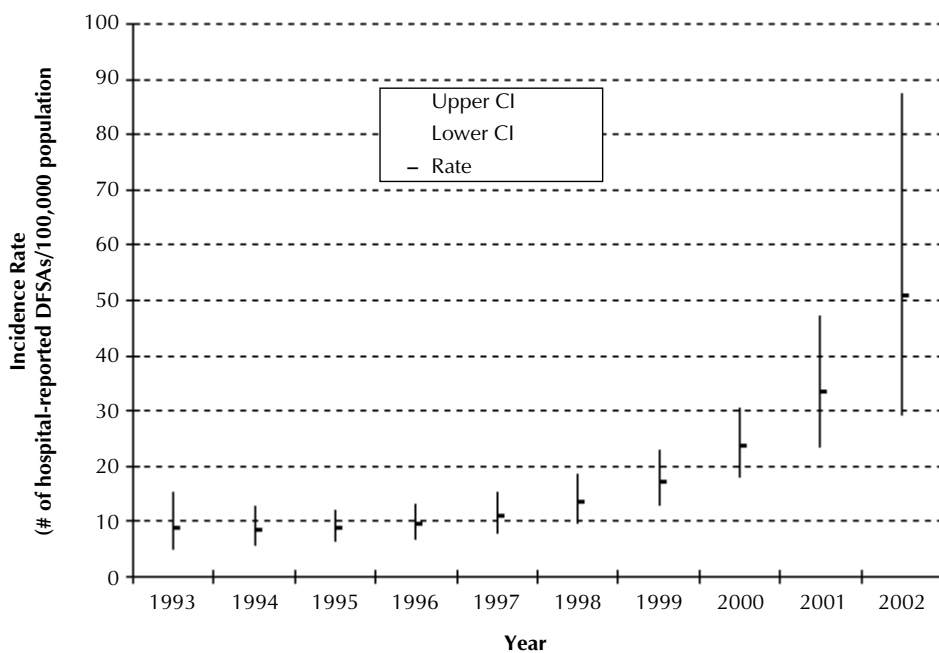


Figure 1. Annual age-adjusted incidence of female hospital-reported drug-facilitated sexual assault (DFSA) for Vancouver and surrounding communities by year*

* Excludes individuals presenting to the SAS who resided outside the SAS catchment area (Vancouver, Richmond, North Shore, Howe Sound)

regression model was also run to determine age-adjusted relative risks of non-DFSA assaults (to assess for possible observer bias). Finally, the slopes of the incidence curves for the age-adjusted rates of DFSA pre-1999 and 1999+ were compared to determine if the trend was significantly increased after 1998.

To test the hypothesis that teenage girls were at particular risk, we also calculated the year-adjusted relative risk of female DFSA for ages 15-19 years, using all other age groups as the reference in a Poisson

regression model. Reporting of results among male victims was limited to a description of incidence rates.

RESULTS

Among the 1,594 sexual assaults in the study population, there were 246 (15.4%) incidents meeting our DFSA case definition. Two hundred and thirty-five (95.5%) of these incidents involved females.

The proportion of DFSAs (female and male) as a total of all hospital-reported sex-

ual assaults presenting to the SAS showed a clear increase since 1999 (Table I). The mean annual incidence of female DFSA increased after 1998, with mean rates of 3.4 (range 2.0-4.2) per 100,000 from 1993-1998 and 10.7 (range 8.4-14.0) per 100,000 from 1999-May 2002 (Table II). Teens aged 15-19 had a higher mean baseline incidence before 1999 (15.0 per 100,000). This rose to a mean of 59.3 per 100,000 after that time.

Using 1993-1998 as the reference, the age-adjusted relative risks for hospital-reported DFSA were significantly increased in 1999, 2000, 2001 and 2002 (Table III). In contrast, the age-adjusted relative risks for other hospital-reported sexual assaults (non-DFSA) in 1999, 2000, 2001 and 2002 compared to 1993-1998 were not significantly different. The year-adjusted relative risk for hospital-reported DFSA during the study period among women aged 15-19 compared to other ages was 3.89 (95% CI 2.75-5.50).

Estimates of female age-adjusted annual incidence rates showed a sustained increase since 1999 (Figure 1). The slopes of the incidence curves for DFSA before and after 1999 were significantly different (p<0.0001).

Finally, there were a total of 11 reported incidents of male hospital-reported DFSA over the entire study period and 9 of these cases presented after 1998.

DISCUSSION

This study demonstrates a significant increase in the incidence of hospital-reported DFSA since 1999.

One explanation for this finding is that victims are now more aware of DFSA and therefore more likely to seek treatment or report their experiences. By 1999, there was a growing community awareness of DFSA. A search of "Canadian Newstand", an index of 13 Canadian newspapers, including 3 major British Columbia newspapers, found no references to DFSA prior to 1995, 2 in 1995, 13 in 1996, 22 in 1999, and 34 in 2002. A second possibility is that SAS providers, also developing an increased awareness of DFSA, may have begun identifying "drugging" cases that would have previously been considered "usual" assaults. However, the absence of a proportionate decrease in the number of

other sexual assaults during this period suggests that the effect of observer bias, if it exists, is minimal.

Another explanation is that there has been a real increase in DFSAs due to increased awareness among assailants of drugging as a technique for sexual assault. Described as the "Melbourne effect", there has been at least one instance where an offender mimicked a DFSA by another assailant who received widespread media coverage.²⁴ The availability of "date-rape" drugs for purchase over the Internet may also have increased. Recently, a North American police effort resulted in the arrest of a Canada-based internet ring selling approximately 160 GHB-making kits/day.²⁵ At least some of these illegal drugs are likely to have been used to facilitate sexual assault.

Toxicology testing over the time period of this study had marked limitations. In police-reported sexual assaults in this jurisdiction, the police laboratory only runs toxicology studies in incidents they deem likely to proceed to charge-laying. Previous research has demonstrated that a minority of police-reported cases result in charge-laying,²⁶ and thus toxicology results are not available for most police-reported cases. For persons not wishing police involvement, the toxicology testing performed through the hospital laboratory over most of the study period did not routinely screen for some of the newer "date-rape" drugs such as GHB or flunitrazepam. Moreover, the hospital laboratory sensitivity levels were designed to detect drug overdoses rather than trace amounts of drug levels expected in the setting of DFSA.

This is the first study, to our knowledge, to describe the incidence of hospital-reported DFSA over time. As with most retrospective studies, there may be bias due to missing data and case misclassification. As well, because it is estimated that fewer than 10% of all individuals who have been sexually assaulted report to the hospital,²⁷ our results cannot be generalized to the non-hospital-reported sexual assault population. Future population-based surveys examining sexual assault should include specific questions related to DFSA, to assess what proportion of assault survivors actually report to a hospital and/or police, and if reporting patterns differ between

drug-facilitated and other types of sexual assault.

Implications for clinical practice

The BC Women's SAS is now seeing more individuals with a history suggestive of DFSA. DFSA survivors present new challenges for physicians, nurses, counsellors and others providing care to these individuals. The amnesia associated with DFSA, combined with the prolonged delay in presenting for examination, reduces the likelihood of finding toxicology and other forensic laboratory evidence, making this form of sexual assault particularly difficult to treat or study. Case recognition is inevitably going to be "suspected" and usually "unconfirmed." Offering the standard treatments of pregnancy and STD prophylaxis to these women to protect them from something that "may have occurred" is nonetheless appropriate.⁸

Post-assault counselling for DFSA cases is particularly challenging, as it is difficult to counsel for what "may or may not have happened." Victims are often conflicted about reporting to the police due to their lack of recall. The delay in presentation to the hospital²¹ and rapid clearance of many of the implicated drugs^{2,19} suggests that toxicology testing, even when carried out using the most sensitive techniques, is unlikely to be useful as a method of ruling out the occurrence of DFSA. Women need to be counselled about this fact, and police investigating these cases need to be educated about the limitations of toxicology tests.

The greater increase in DFSA among teens and young women suggests the need for educational campaigns and further research directed at this population. Education should also be aimed at individuals who suspect they have been a victim of DFSA, encouraging them to seek medical care.

In conclusion, the incidence of hospital-reported DFSA in Vancouver and surrounding communities has shown a marked and sustained increase since 1999. DFSA incidence in Canada and other countries must be examined to determine if the increase observed in our study is international in scope and ongoing.

REFERENCES

1. World Health Organization. World Report on Violence and Health. Geneva, 2002.

2. Ledray LE. Date rape drug alert. *J Emerg Nurs* 1996;22(1):80.
3. Will G. Drugged woman goes public to warn other nightclubbers. *The Vancouver Courier* November 1997.
4. Hindmarch I, ElSohly M, Gambles J, Salamone S. Forensic urinalysis of drug use in cases of alleged sexual assault. *J Clin Forens Med* 2001;8:197-205.
5. Mullins ME. Laboratory confirmation of flunitrazepam in alleged cases of date rape. *Acad Emerg Med* 1999;6(9):966-68.
6. Slaughter L. Involvement of drugs in sexual assault. *J Reprod Med* 2000;45(5):425-30.
7. Anglin D, Spears KL, Hutson HR. Flunitrazepam and its involvement in date or acquaintance rape. *Acad Emerg Med* 1997;4(4):323-26.
8. Jamieson MA. Rohypnol gamma hydroxybutyrate, and drug rape. *J Soc Obstet Gynaecol Can* 2001;23(1):38-42.
9. Schwartz RH, Weaver AB. Rohypnol, the date rape drug. *Clin Pediatr* 1998;37:321-22.
10. Armstrong R. When drugs are used for rape. *J Emerg Nurs* 1997;23(4):378-80.
11. Smith KM. Drugs used in acquaintance rape. *J Am Pharm Assoc (Wash)* 1999;39(4):519-25; quiz 581-83.
12. Schwartz RH, Milteer R, LeBeau MA. Drug-facilitated sexual assault ('date rape'). *South Med J* 2000;93(6):558-61.
13. Pope E, Shouldice M. Drugs and sexual assault - a review. *Trauma, Violence, & Abuse* 2001;2(1):51-55.
14. LeBeau M, Andollo W, Hearn WL, Baselt R, Cone E, Finkle B, et al. Recommendations for toxicological investigations of drug-facilitated sexual assaults. *J Forensic Sci* 1999;44(1):227-30.
15. Nguyen H, Nau DR. Rapid method for the solid-phase extraction and GC-MS analysis of flunitrazepam and its major metabolites in urine. *J Anal Toxicol* 2000;24(1):37-45.
16. Boussairi A, Dupeyron JP, Hernandez B, Delaire D, Beugnet L, Espinoza P, et al. Urine benzodiazepines screening of involuntarily drugged and robbed or raped patients. *J Toxicol Clin Toxicol* 1996;34(6):721-24.
17. ElSohly MA, Salamone SJ. Prevalence of drugs used in cases of alleged sexual assault. *J Anal Toxicol* 1999;23(3):141-46.
18. Kronz CS. A 30-year-old woman with possible unknown ingestion of date rape drugs. *J Emerg Nurs* 2000;26(6):544-48.
19. Marc B, Baudry F, Vaquero P, Zerrouki L, Hassnaoui S, Douceron H. Sexual assault under benzodiazepine submission in a Paris suburb. *Arch Gynecol Obstet* 2000;263(4):193-97.
20. Stark MM, Wells D. Drug-mediated sexual assault. *J Clin Forens Med* 1999;6:53-55.
21. McGregor MJ, Lipowska M, Shah S, Du Mont J, De Sisto C. An exploratory analysis of suspected drug-facilitated sexual assault seen in a hospital emergency department. *Women Health* 2003;37(3):71-80.
22. British Columbia. Ministry of Health Planning; British Columbia Ministry of Health Services. PURRFECT Population Utilization Rates and Referrals for Easy Comparative Tables 8.3 (CD-ROM). Victoria, BC: Ministries of Health Planning and Health Services, 2003.
23. Everitt BS. A Practical Guide: Modern Medical Statistics. London: Arnold, 2003.
24. Sturman P. Drug assisted sexual assault. In: *Study for Home Office Under Police Research Award Scheme*. Metropolitan Police, London, 2000. Available on-line at <http://www.covnet2.org/documents/ACF2A3.pdf>.
25. Mounties help crack 'date rape' internet ring: Sweeping North American police operation nets 115 people in 84 cities. *Vancouver Sun* September 20, 2002.

26. McGregor MJ, Du Mont J, Myhr TL. Sexual assault forensic medical examination: Is evidence related to successful prosecution? *Ann Emerg Med* 2002;39(6):639-47.
27. The violence against women survey: Survey highlights. Ottawa: Statistics Canada, 1993.

Received: January 6, 2004

Accepted: May 28, 2004

RÉSUMÉ

Contexte : On parle d'agression sexuelle facilitée par la drogue (ASFD) lorsqu'une personne est agressée sexuellement après avoir absorbé à son insu une ou plusieurs drogues qui l'ont rendue incapable de donner son consentement. Nous avons calculé l'incidence annuelle des ASFD signalées aux hôpitaux selon l'âge et le sexe de la victime afin de déterminer si une hausse sur un an observée en 1999 dans le cadre d'une étude pilote dans la même population s'inscrit dans une tendance significative et soutenue.

Méthode : Nous avons relevé les cas d'ASFD en examinant les dossiers d'agressions sexuelles de toutes les personnes qui se sont présentées à un service hospitalier d'aiguillage des victimes d'agressions sexuelles situé à Vancouver (Colombie-Britannique) durant la période à l'étude (1^{er} janvier 1993–31 mai 2002). Nous avons examiné les tendances des agressions sexuelles facilitées par la drogue, selon l'âge et le sexe, en fréquence et dans le temps, d'après les données démographiques du ministère de la Santé de la Colombie-Britannique.

Résultats : L'incidence annuelle moyenne des ASFD chez les femmes a augmenté, passant de 3,4 pour 100 000 (1993-1998) à 10,7 pour 100 000 (1999-2002). Le risque relatif d'ASFD rajusté selon l'âge, chez les femmes, était sensiblement plus élevé en 1999 (2,77, IC de 95 % = 1,85-4,15), en 2000 (3,01, IC de 95 % = 1,97-4,57), en 2001 (3,14, IC de 95 % = 2,07-4,78) et en 2002 (4,88, IC de 95 % = 2,84-8,37) que durant la période 1993-1998. Les femmes de 15 à 19 ans présentaient la plus forte incidence d'ASFD, avec un risque relatif ajusté de 3,89 par année (IC de 95 % = 2,75-5,50), par rapport à tous les autres groupes d'âge.

Conclusion : Cette étude montre que l'incidence des ASFD signalées aux hôpitaux présente une hausse marquée et soutenue depuis 1999. Les adolescentes étant particulièrement vulnérables à cette forme d'agression sexuelle, il faudrait faire plus d'efforts pour élaborer et évaluer des programmes de prévention à leur intention.

National Survey on Dissemination Practices

October-December 2004

In the context of the CIHR-funded Canadian Heart Health Dissemination Project, a national survey of all public health organizations across Canada will be conducted over the next few months, to document levels of organizational capacity for chronic disease prevention, current dissemination practices for transferring innovations from one organization to another, and levels of preventive program implementation.

In the next few weeks, a data collection team from McGill University will be contacting senior management within chronic disease prevention organizations across Canada to determine eligibility for inclusion in the survey, to obtain consent, and to identify potential respondents. Thereafter, data will be collected in telephone interviews of nominated respondents (likely project managers or other public health professionals) from October to December 2004.

This survey will provide, for the first time, a systematic look at variation in chronic disease prevention capacity and in dissemination practices across Canada. The data will increase understanding on how to plan effective programs and policy to reduce the burden of chronic disease in Canada, and as such will provide an evidence base for sound investment in the preventive health system in Canada. Pilot work across Canada has demonstrated enthusiastic support for this survey.

For further information, contact the Survey Coordinator, Nancy Hanusaik, by telephone at 514-398-5410 or by e-mail at nancy.hanusaik@mail.mcgill.ca.