National Framework

for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

First Edition
Fall 2005

Answering the Call

National Framework

for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

First Edition
Fall 2005

Answering the Call

Drug Strategy and Controlled Substances Programme

Health Canada

123 Slater Street

Ottawa, Ontario

K1A 0K9

Government of Canada Gouvernement du Canada

Canadian Centre on Substance Abuse

Suite 300

75 Albert Street

Ottawa, Ontario

K1P 5E7

CCSA - CCLAT

Answering the Call

The issues around problematic substance use in Canada are complex and multi-dimensional. Their effects are social and personal, their dimensions legal, economic and health-related, span the life cycle, and have a direct and/or indirect effect on virtually everyone.

This document responds to a call issued by Canadians, their governments, non-governmental organizations and other key stakeholders for a more coordinated approach to meeting the challenges posed by the harms associated with alcohol and other drugs and substances. Answering the call requires concerted effort, collaboration and commitment – from the national level to Canada's smallest communities.

At the core of this document is a collective conviction that a national framework for action to reduce the harms associated with alcohol and other drugs and substances is necessary, practical and – most of all – achievable. These goals can be attained through dedication and the sharing of expertise, experience, ideas and perspectives.

Table of Contents

For a country of Canada's size and diversity, there is considerable convergence in findings across provinces regarding the prevalence of alcohol and illegal drug use and related harms. There are also important differences in terms of levels and patterns of use, and risk of harms that are of significance not only to researchers, but to decision-makers and ultimately to all Canadians.[1]

Substance Use and Related Problems in Canada: A Snapshot

Problematic substance use[2] affects every nation in the world and Canada is no exception. Substance use and its related harms affect individuals, families and communities. While the situation is evolving constantly, it is important to have a snapshot of the Canadian environment on alcohol, and other drugs and substances in order to provide some context for action.

While the Canadian Addiction Survey 2004 (CAS) has made a major contribution to providing more recent data, significant information gaps remain. For example, street youth, the homeless and injection drug users, are typically not well represented in general population surveys. There is also much to be learned about concurrent disorders (e.g., co-occurring addiction and mental health issues) and the factors affecting substance use and related problems in Canada. These knowledge gaps underscore the need for additional targeted research and monitoring activities.

In the last decade, there has been significant growth in the prevalence of alcohol and other drug use in Canada. From 1994 to 2004, rates of current use went from 72% in 1994 to 79% in 2004 for alcohol; from 7% to 14% for cannabis; from less than 1% to almost 2% for cocaine/crack use; and from 1.1% to 1.3% for LSD/speed/heroin (Adlaf, Begin and Sawka, 2005).[3] Additionally, about 25% of Canadians – occasionally to frequently – use alcohol in a manner that increases risk of acute or chronic complications.

Decisions made by youth to consume alcohol and other drugs merits particular attention. Reports of substance use among young people reveal that there has been a general increase in rates of use since the 1990s, including increases in the reporting of multiple substance use.

The CAS indicated that the prevalence of current alcohol consumption by Canadian youth in the 15 to 24 year old group is at 83%, which is slightly higher than the general population rate of 79%. However, the proportion of Canadian youth who reported binge drinking[4] was much higher at 37%; those who reported doing so at least once weekly was 12%. Similarly, current use of other drugs among youth aged 15 to 24 tended to be higher – approximately 37% for cannabis; 6% for cocaine/crack; 4% for speed

Prevalence among general and key populations

1. Canadian Addiction Survey: A national survey of Canadians' use of alcohol and other drugs, November 2004.
2. Planning for further discussions on terminology is underway. In this document *problematic substance use* is used. Its meaning should be considered as general and as encompassing as possible.
3. Prevalence of use within 12 months preceding each survey.
4. Defined as consumption of five or more drinks on a single occasion at least once monthly.

(amphetamines); 4% for ecstasy (MDMA) or other similar drugs; 4% for hallucinogens (PCP, LSD, etc.) and in contrast, 0.1% for heroin.

Health Behaviours in School Aged Children Survey 2000/01 show that 34% of grade 10 boys and 23% of grade 10 girls reported that they had an alcoholic drink at least once a week. This rate increased steadily from 6% and 3% respectively at grade 6, to 16% and 11% at grade 8, to 27% and 18% at grade 9. Beer was the most popular alcoholic beverage consumed by young people in this survey. In addition, excessive drinking seemed to be a problem, considering that 46% of grade 10 boys and 42% of grade 10 girls said they had been drunk at least twice in the past.

While many people drink without a negative effect, the more heavily alcohol is consumed, the more likely they are to report harm to themselves, as well as harm done to them by others who drink. High risk drinking can also be harmful to others in a variety of ways. According to the CAS, 18% of Canadians had exceeded the drinking guidelines[5] in the past year and 14% of Canadians had engaged in hazardous alcohol use[6] and were thus considered high-risk drinkers. High-risk drinkers included 9% of female drinkers and 25% of male drinkers. Males aged 18 to 24 and single persons were the most likely to exceed the drinking guidelines. More than 30% of those under the age of 25 were identified as high-risk drinkers.

Nearly a quarter of former and current drinkers reported that their drinking had caused, themselves or others, harm at some time in their lives. The younger the respondent, the more vulnerable he or she was to alcohol-related harm from their own drinking and the drinking of others. Additionally, approximately 5% of Canadians who used cannabis in the last year reported cannabis-related concerns, such as failing to control their use. Among those who have used other illegal drugs during the past year, 42% report *risk indicator symptoms* indicative of the need for intervention, according to the World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test.

No sector of Canadian society is untouched by the harms that can result from the problematic use of alcohol, and other drugs and substances. Individuals, families and communities may all bear often negative health, safety and economic consequences. Research and experience demonstrates that these harms can be effectively addressed through a broad and integrated multi-sectoral approach. This would include individual action and collaborative action to help ensure appropriate social conditions, policies and programs that contribute to the creation of healthy environments.

The impact of problematic substance use varies across segments of the population. Aboriginal peoples have been disproportionately affected by the harm associated with problematic substance use and are over-represented in some inner-city populations, the sex-trade, and the prison system. The use of inhalants has been identified by Aboriginal populations as a serious problem that often begins in children as young as four years of age. The national Environmental Scan of First Nations and Inuit Mental Health Services (2002) reported that addictions appear to be increasing (Health Canada).

Canada's incarcerated population is divided between federal offenders – those serving sentences of two years or more in federal penitentiaries – and those under provincial/territorial jurisdiction, who serve sentences of less than two years. Approximately 80% of federal offenders have a history of alcohol or other drug problems, and more than half were under the influence of alcohol or other drugs when they committed the offence that led to their incarceration (Brochu, *et al.*, 2001). Research also indicates that offenders consume large amounts of psychoactive substances, at rates higher than the general population. Like the

5. CAMH Established Drinking Guidelines (two standard drinks on a single day – a maximum of 14 for men a week and nine for women who are not pregnant).
6. WHO Alcohol Use Disorders Identification Test (WHO AUDIT).

general population, alcohol is the most commonly used substance by offenders before incarceration (Brochu, *et al*., 2001.) A number of studies have shown a clear relationship between substance abuse, past criminal behaviour, and the risk of future criminal behaviour. (Blanchette, K. 1997; Bonta, J., Law, M., and Hanson, K. 1998; Loucks, A.D., Ph.D. and Zamble, E., Ph.D. 2001)

According to an end-of-2000 review (Motiuk, 2001), 26% of the prison population comprised drug offenders. More specifically, 18% were serving sentences for drug trafficking, 3% for importation, 1% for cultivation, and 10% for possession of illegal drugs.

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term that includes Fetal Alcohol Syndrome (FAS) and related disabilities. Alcohol use during pregnancy is one of the leading causes of preventable birth defects and developmental delays in children. In Canada, at least one child is born with FASD each day. FASD has an estimated incidence rate of 9.1 per 1000 live births in industrialized countries. In Canada, the FASD-related lifetime costs per individual in extra health care, education and social service are estimated to be $1.4M (U.S.) (Binkeley, 1989). A recent Canadian study suggests that costs of $855,000 are associated with FASD up to age 21 years (excluding justice-associated costs) (Stade, 2003). It has been estimated that, in the United States, the cost of providing effective pre-pregnancy prevention programs for a mother who has already given birth to an FAS child would be 30 times less than the costs of raising another child with FAS (Nanson, *et al*., 1995). Although data about alcohol during pregnancy are scarce, it is possible to estimate that approximately one-seventh of Canadian women drink during pregnancy, albeit infrequently. What is important to note about this observation, is that many of these women may have only had an occasional drink before they even knew they were pregnant.

Injection drug use is a serious public health and social problem in Canada. According to the Canadian Addiction Survey, approximately 269,000 Canadians have used a drug by injection at some point in their life, most commonly heroin, cocaine and steroids (Adlaf, Begin and Sawka, 2005). This is an increase from 175,000 in 1994. Injection drug use is linked to overdose, infections such as HIV, hepatitis B and C, abscesses, and endocarditis, other communicable pathogens, suicide, and poor nutrition, (Health Canada, 2001). One study estimated that, if trend continues, the direct and indirect costs of HIV/AIDS attributed to injection drug use would be $8.7 billion over a six-year period. (Albert and Williams, 1998). Because the prevalence of hepatitis C is much higher than HIV infection, the medical costs to treat injection drug induced hepatitis C are expected to be substantial.

Despite the increase in the prevalence of drinking by Canadians, the incidence of fatally injured drivers who tested positive for presence of alcohol has declined from 53% in 1987 to 33% in 1999. It then increased to 38% in 2001. The number of drivers who exceeded the criminal threshold for alcohol use decreased from 43% in 1987 to 32% in 2001. Based on the data available from multiple sources about drinking and driving, it is estimated that the number of people killed in alcohol related motor vehicle collisions went from over 2,200 in 1987 to approximately 1,100 in 2001. During this same period, the number of people charged with impaired driving offences decreased from approximately 128,000 in 1987 to approximately 70,000 in 2001. These overall decreases in drinking and driving in Canada can be attributed to an integrated multi sector approach involving the implementation and enforcement of strict laws and penalties, public education, and targeted interventions in settings such as schools, workplaces and alcohol drinking establishments.

Substance use related impacts

Recent Canadian studies have also associated alcohol consumption rates with traffic-related deaths, homicides, suicides, liver cirrhosis mortality, alcohol-related mortality and total mortality (Mann, *et al*; Norstrom; Ramstedt; Rossow; Skog; Xie, *et al*.)

Alcohol remains the primary criminal cause of motor vehicle deaths on Canadian roads; however, other drugs are increasingly being recognized as a significant problem. Studies on the presence of drugs in toxicological samples of fatally injured drivers vary from 20% to 26% (Beirness, 2005). Cannabis, benzodiazepines and cocaine are the substances most frequently detected.

The total health, social, and economic costs of alcohol and illegal drugs, to Canadian society in 1992, was estimated to be $8.9 billion (Single, *et al*., 1996[7]). These costs are attributable to direct losses associated with the workforce and administrative costs for transfer payments, prevention and research, law enforcement, and health care. The largest cost was lost productivity due to illness and premature death. Since this estimate was calculated, alcohol and illegal drug use in Canada, during the 1990s, has increased and some serious issues have emerged. These include increases in injection drug use and in the rate of infectious disease transmission through the sharing of injection equipment. More recently, there are reports of increasing use of crystal methamphetamine and diversion of prescription painkillers such as oxycodone. Hence, it is to be expected that the current costs to Canadian society are substantially higher.

The federal, provincial, territorial and municipal governments, non-governmental organizations and the private sector in Canada have contributed to various aspects of the continuum of prevention, treatment, and enforcement interventions over the last several decades. Despite these investments, desired reductions in the harms associated with alcohol and other drugs and substances have not been achieved. While progress is evident in areas such as drinking and driving, effective integrated strategies have not been adequately translated or applied in addressing other aspects of the problematic use of alcohol, other drugs and substances. In addition, best practice strategies, tools and processes from other health issues such as cardiovascular disease prevention have not been fully applied or utilized.

Sharing a collective vision, in a broad and integrated way, is an effective approach to reducing the harms associated with problematic use of alcohol, and other drugs and substances. Approaches that build on lessons learned from the work underway in Canada and elsewhere, including current prevalence and patterns of use, are instructive. Action closely linked to research and monitoring activities help ensure effective progress. Shared ownership and accountability by all key stakeholders also helps ensure success.

7. Work is underway to repeat the Canadian cost study and results are expected later this year.

The Genesis of this Framework

This Framework is the product of extensive consultation. As a first step, in 2004, a series of ten cross-country roundtables dealing with the prevalent and growing issue of problematic substance use in Canada were convened. Priority issues, recurring consistently throughout these consultations, were followed up by focused thematic workshops where they were explored in greater depth. The work accomplished during these workshops will continue and additional thematic workshops will be held in order to examine other priority areas.

Language, for example, is an issue of particular concern. Words and phrases such as: *use, addict, abuse, dependence, user, misuse, addictions, problematic use* and many others are used to describe the broad range of issues in the *substance use* field. There is a need for furthering discussions on terminology to clarify meanings and develop common understanding. A separate consensus building exercise is planned for the near future to address this important issue. However, in the absence of consensus and for the purpose of this Framework document, the term *problematic substance use* is used. This terminology should be considered to be as general and encompassing as possible. Other words such as *use* and *abuse* may also be used in some instances when considered more appropriate.

This Framework reflects the contributions of all those who have shared their expertise, practical experience, academic training, policy and programming perspectives, knowledge of research issues and frontline experience from a wide range of professions and occupations, including:

- addiction and mental health specialists;
- epidemiologists and social scientists;
- physicians and health practitioners;
- lawyers and legal experts;
- frontline counselors and caregivers;
- organizations representing people who use drugs;
- researchers and policy officers;
- non-governmental organizations;
- Aboriginal service providers;
- policing and enforcement representatives;
- youth; and
- government officials in education, health, and justice.

All of the above contributed to the success of the Framework: a commitment to preventing and ameliorating the adverse health, social and economic impacts of problematic substance use.

This framework actively fosters collaboration by bringing key stakeholders together in an effort to achieve the most beneficial results for the greatest number of people.

A Framework for All

In Canada, valuable efforts are underway to address problematic substance use. There are currently a myriad of interventions and initiatives aimed at reducing the harm associated with alcohol, other drugs and substances. Non-governmental organizations, the private sector, federal, provincial, territorial and municipal departments as well as law enforcement agencies are developing strategies to address harms associated with alcohol and other drugs and substances. Once implemented, this Framework will leverage a wealth of Canadian expertise from these stakeholders – propelling a comprehensive and coordinated effort that enables, enhances and values individual initiatives across Canada.

This Framework is intended to reflect a national perspective on problematic substance use. It outlines, in no particular order, goals, principles and priorities that have been identified collectively and shown to be of common interest to all stakeholders. In this sense, the Framework should complement and facilitate other efforts already underway as well as guide collaborative partnerships in planning for national responses. More than simply encouraging collaboration, the Framework actively fosters it by bringing key stakeholders together in an effort to achieve the most beneficial results for the greatest number of people.

What the Framework Achieves

The benefits of a national framework for action are many. It increases the possibilities for support at all levels and across all sectors; enables better planning and utilization of resources for enhanced effectiveness; and establishes a common frame of reference.

On all aspects of problematic substance use, the Framework serves to generate dialogue across jurisdictions, sectors and functions and to promote understanding of these issues by:

- articulating a vision, principles and goals for national action;
- setting out strategic priorities and directions that allow coherent planning, delivery and evaluation of activities;
- providing the umbrella under which strategies and policies to address specific issues can be developed;
- defining and clarifying the roles, responsibilities and accountabilities of the different jurisdictions and stakeholders;
- providing mechanisms to ensure coordination and facilitate collaboration and partnerships among jurisdictions and sectors; and
- creating an environment within which funding can be leveraged.

With the right tools, attitudes, support and commitment, the vision is transformed into reality across communities, municipalities, provinces and territories.

Vision

All people in Canada live in a society free of the harms associated with alcohol and other drugs and substances.

Seeing Clearly and With Hope

The vision statement is positive and inclusive. It is a forward-thinking, succinct and inspiring statement that describes what all partners, working together, hope to achieve. It acknowledges that the harms associated with problematic substance use affect, both directly and indirectly, individuals, families and communities. It also implicitly invites partnerships to deal with those harms and their causes. The vision remains open to the full range of necessary interventions, from health promotion through prevention, treatment, enforcement and harm reduction activities.

Substances defined: The substances covered in this Framework include alcohol, pharmaceuticals (both over-the-counter and prescription), illegal drugs, inhalants and solvents.

Principles

Guiding the Way

These key principles transcend all efforts undertaken in support of this Framework to address the harms associated with alcohol and other drugs and substances. They are statements reflecting the fundamental values and beliefs that guide the collaborative efforts of individuals, governments, organizations and communities in working toward the Framework's vision.

Principle 1: Problematic substance use is a health issue

Problematic substance use is a health issue that needs to be given a high profile within the health system.

Principle 2: Problematic substance use is shaped by social and other factors

Addressing problematic substance use requires a population health approach that:

- considers and addresses the potential risk and protective influence of socio-economic status, culture, gender, housing, education, geography, family, law and policies, and other factors;
- recognizes how stigma, trauma, discrimination, violence and cultural dislocation may contribute to problematic substance use;
- understands that problematic substance use often co-occurs with other conditions such as mental illness or addictions such as gambling or tobacco; and
- recognizes and addresses not only the harm to the individual who uses drugs, but also the adverse impact on families, communities, society and the economy.

Principle 3: Successful responses to reduce the harms associated with alcohol and other drugs and substances address the full range of health promotion, prevention, treatment, enforcement, and harm reduction approaches

Preventing and reducing the harms associated with alcohol and other drugs and substances require integrated, culturally appropriate, comprehensive, and balanced responses to ensure a range of appropriate activities, programs, and policies that include a combination of population-based and targeted intervention.

Principle 4: Action is knowledge-based, evidence-informed and evaluated for results

Health promotion, prevention and treatment, law enforcement as well as harm reduction approaches aimed at reducing the harms associated with alcohol and other drugs and substances, should be based on evidence from research and evaluation. In addition, traditional interventions such as those drawn from Aboriginal history and culture and knowledge from exploratory qualitative and quantitative research, evaluation and international experience should be shared. This will strengthen the decision-making capability, including that of discontinuing whatever measures are not working. Actions should be motivated by knowledge and evidence that take into consideration the distinct issues related to gender, sexual orientation, age, culture and other determinants of health.

Principle 5: Human rights are respected

Efforts to reduce the harms associated with alcohol and other drugs and substances must respect the *Charter of Rights and Freedoms*. Equitable access to a full range of

programs and services must be provided regardless of whether an individual uses alcohol, other drugs or substances.

Principle 6: Strong partnerships are the foundation for success

Given the complex nature of the underlying causes of problematic substance use and the links to other social issues and sectors, there is a need to facilitate and establish partnerships. Partnerships build knowledge, capacity and networks and also enhance access to services. Partnerships also take many forms including those with or between governments, with First Nations, Inuit and Métis organizations or with academia. They can also include agencies within the criminal justice system, mental health system or social and health services, other regulatory bodies, people who use drugs, educators or the private and voluntary sectors.

Principle 7: Responsibility, ownership and accountability are understood and agreed upon by all

Common goals are better identified and achieved when all levels of government take ownership of issues and work together to address them – along with communities; NGOs; industry; First Nations; Inuit and Métis People (regardless of status or geography) and their organizations; professionals and their agencies; and people who use drugs. Domestic and international issues, desired outcomes, and roles need to be defined, understood and agreed upon so that stakeholder accountability is clear.

Principle 8: Those most affected are meaningfully involved

Voices of those most affected by the development and implementation of policies, research and programs must be heard and their participation facilitated and meaningfully sought.

Principle 9: Reducing the harms associated with alcohol and other drugs and substances creates healthier, safer communities

People have a right to live in fair and safe communities free from the harmful impacts of alcohol, other drugs and substances. It is recognized that the goal of safer communities is most effectively achieved through social development.

Framework Principles at a Glance

- Problematic substance use is a health issue
- Problematic substance use is shaped by social and other factors
- Successful responses to reduce the harms associated with alcohol and other drugs and substances address the full range of health promotion, prevention, treatment, enforcement and harm reduction approaches
- Action is knowledge-based, evidence-informed and evaluated for results
- Human rights are respected
- Strong partnerships are the foundation for success
- Responsibility, ownership and accountability are understood and agreed upon by all
- Those most affected are meaningfully involved
- Reducing the harms associated with alcohol and other drugs and substances creates healthier, safer communities

Goals

Translating Vision into Action

Goals provide clarity for developing strategic plans that address specific issues. They help focus attention on priorities and sustain ongoing discussion and action over time. Concerted and coordinated action by many under the umbrella of this Framework empowers all to bring about positive change in the lives of people who use drugs, their families and communities. This change focuses on action to:

- Create supportive environments that promote the health and resiliency of individuals, families and communities in order to prevent problematic use of alcohol, other drugs and substances; and
- Reduce the harms associated with alcohol and other drugs and substances to individuals, families, and communities across Canada.

Priorities

Focusing Efforts

Shared ownership of the Framework enables leaders, within any sector, to emerge as defenders of a given priority or priority area or to advocate a particular focus for action. Priorities identified for action to date are grouped together by key focus areas and are outlined below.

The Framework's nine principles transcend all priorities and guide the manner in which each priority is to be addressed. Actions taken to address these priorities will facilitate the achievement of the Framework's goals and, ultimately, its vision.

While priorities are addressed regionally or locally, coming together under the umbrella of a national framework helps leverage experience and expertise for joint action, resulting in an increased number of positive outcomes.

Under the principles of this Framework, actions have a particular focus on populations with distinct circumstances. Research, policy and programming development and community initiatives are inclusive and responsive to the needs of First Nations, Inuit and Métis people, offenders, women, ethno-cultural groups and seniors, among others.

Taking action on any priority and determining roles and responsibilities is a key outcome and a gauge of the Framework's success. Roles and responsibilities related to a specific priority will vary depending on the issue. Domestic and international jurisdictional obligations and powers (often entrenched in law), fiscal capacity and human resources, to name but a few, may also have a bearing on how roles and responsibilities are assumed. All sectors will bring different strengths and levers to provide the needed impetus for best results.

The field of addictions must not be burdened with language that acts as a barrier to thinking positively about the issue… Terms such as "addiction" and "abuse" hold negative connotations that affect how resource allocation, research, training and basic policy issues are approached.

Priority Area 1: Priorities to Address Specific Issues

Increasing Awareness and Understanding of Problematic Substance Use

Although problematic substance use directly or indirectly affects many Canadians, the issue does not receive the same profile as that accorded to other health and social problems. It has been suggested that language and attitudes relative to problematic substance use may act as a barrier to understanding and responding effectively to the issue and contribute to stigmatization and discrimination. This not only affects the individual who uses drugs, but his or her family as well. It is also suggested that the stigma associated with problematic substance use is partly responsible for how policy issues are approached and how resources are allocated.

Raising awareness and understanding of problematic substance use, which would in turn minimize the stigma associated with it, is recognized as a necessary first step that will help facilitate the achievement of other priorities. To accomplish this, sustained, comprehensive and coordinated approaches, initiated early and supported by public policy, are required and should include:

- public education at the national, provincial/territorial and regional levels aimed at de-stigmatizing problematic substance use, without minimizing the negative behaviours and consequences that may be associated with this use;
- conveying the message that problematic substance use is often linked to other illnesses such as mental illness and other determinants of health ;
- building consensus around common definitions and terminology such as *misuse, abuse, dependence, addiction* and *drug related harms*; and
- involving those most affected in the formulation of the messages and terminology.

Reducing Alcohol-Related Harms

Without exception, after tobacco, alcohol is consistently recognized across the country as the substance that causes the greatest harm. As such, the problematic use of alcohol has become the number one priority to address because it significantly contributes to the burden of disease.

Alcohol consumption can result in fatalities and serious injury through motor vehicle collisions, suicide, violence, health effects, mental illness and FASD. The significant social and economic costs of the problematic use of alcohol include lost productivity and increased law enforcement efforts. Reducing alcohol related harms is of particular concern in Aboriginal communities, as well as among youth, seniors, and pregnant women. Its effect in the workplace is also of concern.

There are many stakeholders in Canada who intervene in various ways to prevent, reduce and address the harms caused by alcohol. Responsibilities are largely dispersed among levels of government, non-government organizations, academia and the industry itself.

Some responsibilities are, however, shared among partners. These include prevention, research, taxation, regulation, and responsible advertising. Nevertheless, there is a need to identify specific areas of focus where partners can use their respective influence toward national action.

In certain limited circumstances, evidence strongly supports the need to address problematic alcohol use while recognizing the documented positive health and social effects associated with moderate alcohol consumption. Steps to be taken involve a combination of population-based policies and targeted interventions including:

- comprehensive and coordinated action to promote the use of routine screening and brief interventions by health care professionals for hazardous drinkers or those at risk;
- developing and promoting policies to reduce chronic disease, including FASD;
- addressing the drinking context (e.g., in bars, at sporting events etc.) and promoting the use of targeted interventions (e.g., server and door staff training);
- structuring alcohol taxes and prices in a purposeful manner; and
- developing a culture of low risk drinking rather than one of binge drinking (excessive drinking) for both youth and adults.

Addressing Fetal Alcohol Spectrum Disorder (FASD)

The use of alcohol during pregnancy has been shown to affect a developing fetus, causing a range of permanent neurological disabilities and behavioural disorders known as Fetal Alcohol Spectrum Disorder (FASD). The leading form of preventable birth defects and developmental delays in North America, FASD is a complex, life-long disability and a public health and social issue affecting individuals, communities, families and society as a whole.

Without proper supports and interventions, individuals who suffer from FASD are at greater risk of disrupted school experiences, recurring employment problems, encounters with the criminal justice system and suicide attempts. FASD not only affects an individual's quality of life but also has significant repercussions for their families, caregivers and communities. Some individuals with FASD may require substantial community and family support to live independently.

Preventing FASD requires concerted action at all levels to address the underlying risk factors. Current thinking suggests that this might best be achieved by:

- addressing the root causes of alcohol use in pregnancy;
- improving awareness of the effects of alcohol consumption during pregnancy;
- enabling women to make informed decisions about their health and the health of their family;
- providing women-centered and culturally appropriate services;
- building an integrated system of supports and resources characterized by leadership, direction, partnership and collaboration to prevent FASD and to meet the needs of people living with FASD and their families; and
- enabling individuals with FASD, their families and communities to improve their lives using screening tools and interventions that are both gender and culture appropriate.

Preventing the Problematic Use of Pharmaceuticals

The problematic use of pharmaceutical products is an issue of concern across Canada. The issue is defined as a deliberate, excessive or illegal use and abuse of pharmaceutical drugs, which has product-specific regional differences. A key challenge is to balance the need to make pharmaceutical products available for therapeutic use, while minimizing the risk of diversion for non-medical use, as well as problematic use

within a therapeutic context. There is a need for a better understanding of the issue through surveys and research on the prevalence, as well as the nature and causes of the problematic use of pharmaceuticals.

Preventing the problematic use of pharmaceuticals requires coordinated action between governments, health care professionals, stakeholders, the criminal justice system, industry and provincial licensing authorities. Current thinking suggests that this might best be achieved by:

- educating health care professionals and the public about the potential harms associated with the problematic use of pharmaceuticals and at the same time, encouraging safer use of psychoactive medications in order to maximize benefits while minimizing harms;
- developing a framework for systematically reporting the prevalence and nature of the problematic use of prescription drugs in Canada;
- monitoring prescription records to detect potentially problematic patterns of prescribing;
- developing product formulation strategies to reduce the risk of problematic use, (for example, developing drug delivery systems that are resistant to tampering like crushing or chewing); and
- improving research related specifically to treatment of the problematic use of pharmaceuticals.

Addressing Enforcement Issues

Many communities, rural and urban, are adversely affected by drugs. Organized crime groups are extensively involved in the production and distribution of illegal drugs in communities. This contributes to an increase in violence, crime rates and a disproportionate amount of law enforcement resources dedicated to the investigation of drug related crime. Marijuana grow operations and clandestine laboratories that produce synthetic drugs continue to be a growing concern. Implementing enforcement strategies that involve broad-based partnerships and community responses to support the development of safer, healthier communities is vital.

Police across Canada are strategically focusing efforts to address drug production and distribution operations and the organized crime groups behind them. Advances in technology and managing interagency intelligence at the domestic and international levels are increasing the complexity of law enforcement drug efforts. To help police address emerging and growing risks in the area of supply reduction, there is a need to focus efforts on joint operations and partnerships between federal, provincial, territorial and municipal law enforcement agencies and enhanced information sharing and intelligence.

Comprehensive national data must be collected and shared to provide a better picture of drug production operations, and the associated public safety and health risks. Other activities to support current enforcement efforts include: research into the effectiveness of law enforcement efforts; improved training and capacity for police officers to implement new legislation and methodologies; strengthening the coordination among partners; and creating new partnerships across sectors.

Priority Area 2: Priorities to Build Supportive Infrastructure

Sustaining Workforce Development

Frontline workers in the field of prevention and treatment have particularly difficult and stressful jobs. In territorial and northern communities, where “burnout” rates are highest, this factor increases considerably. Hence, a significant influx of resources is needed to deal with outreach, treatment and aftercare to cover expenses related to the remoteness of northern communities. The need to recruit and retain care workers – and to support their professional

development – is crucial, especially if holistic and culturally relevant programs are to be designed and delivered effectively.

Across Canada the need for collaborative action by key stakeholders in the field – including government, academia, regional addiction organizations, non-profit, and private sectors – is required to help ensure ongoing availability of appropriately trained workers at all levels. Necessary actions identified to date include: establishing national standards and competencies to enhance knowledge and skills; developing education and training curricula which promote effective practices; promoting professionalism of the workforce through a range of mechanisms such as websites, national conferences and advanced learning institutes; taking measures that ensure as diverse a workforce as possible; and, conducting research on the workforce to support knowledge transfer.

Implementing a National Research Agenda and Facilitating Knowledge Transfer

Canada's capacity to make informed policy decisions and to develop and implement the appropriate prevention, treatment, enforcement and harm reduction programs to address alcohol and drug issues depends in great part on our collective knowledge and understanding of the nature and scope of substance use issues. Implementing a national research agenda that influences policy and practice is a key priority.

The Framework contributes to conditions that facilitate increased collaboration and information sharing among stakeholders, researchers, experts and jurisdictions. It embraces the development and implementation of a National Research Agenda that will enable collective identification of issues of common concern, as well as research needs and priorities of national interest.

The National Research Agenda focuses on: basic and applied research; surveillance and monitoring, including surveys and ongoing data collection; evaluation, including policy and program evaluation on prevention, treatment, enforcement, and harm reduction interventions; and infrastructure (i.e., the entirety of supportive mechanisms needed to ensure viable, dynamic, high quality and comprehensive research in the substance use and abuse field). Building or augmenting existing infrastructure or mechanisms to support the development of a research agenda is pivotal for ongoing identification of priorities for action under the Framework. It is also essential that immediate action be taken on priorities already identified.

Creating the pre-requisite conditions for collaboration among stakeholders, researchers, experts, and jurisdictions is a first step in implementing a National Research Agenda. To this end, working groups linked to a National Research Substance Use and Abuse Advisory Committee are needed to implement the proposed National Research Agenda and to plan how to: approach the development of an evaluation work plan; continue research planning, including the study of determinants of problematic substance use; develop a national surveillance strategy, including building consensus around a common set of indicators; and, develop effective knowledge transfer mechanisms.

Improving the quality, accessibility, and range of options to treat harmful substance use including substance use disorders

Research has demonstrated that providing a range of options to treat harmful substance use, including substance use disorders, is cost-effective in reducing morbidity, mortality and health care utilization. Hence, the allocation of resources sufficient to ensure an appropriate level of care is a pre-requisite. If these services and programs could be better integrated within the health care, mental health, education, social service and criminal justice systems, then a healthier Canada would result.

With integration, many more Canadians would be able to access suitable treatment options, such as brief counseling interventions by health care and social service workers.

Moreover, screening and identification rates in health care facilities would improve, trainees and clinicians would be better educated in substance abuse and concurrent disorders, and health care facilities with existing rudimentary treatment programs also would provide better service.

Currently, many Canadians do not have access to the full range of services and programs of the treatment continuum. These include: brief interventions, more intensive outpatient and day treatment, pharmacotherapy as well as short and longer-term residential treatment. Treatment for those with concurrent disorders may currently be inadequate or non-existent, even in large urban centers. Individuals with serious substance use disorders have unequal access to medical treatments and social supports that are essential for long-term recovery; and in-patient, residential treatment and withdrawal management services for youth could be significantly upgraded – right across the country.

It is a widely held belief that Canada needs to increase funding for pharmacological supports for the comprehensive treatment of substance use disorders. For example, naltrexone and disulfiram are under-prescribed and are often not covered under provincial drug plans; not all communities throughout Canada have equal access to methadone treatment; and acamprosate and buprenorphine are not yet widely available in Canada.

Planners, clinicians and researchers in the substance abuse field need to work together to ensure that all Canadians have access to a range of high-quality and effective services and programs along the treatment continuum. Through advocacy, the government and the public need to understand that substance use treatment should be given the priority it deserves. There needs to be increased collaboration with others in the health care, education, social service and criminal justice systems to ensure that effective treatment services/programs are available to those who use substances in a harmful way and/or to those who have a substance use disorder, when and where they need them.

Modernizing Legislative, Regulatory and Policy Frameworks

The relationship between legislative, regulatory, and policy frameworks and the provision of effective responses to prevent or reduce the harms associated with alcohol and other drugs and substances cannot be underestimated. Canadian and international law can have both positive and negative impacts on the provision of effective responses to the harms associated with problematic substance use. The extent to which current policies or legal frameworks are reflective of and adequately address existing and emerging alcohol, other drug and substance issues and concerns is critical. Systematic, ongoing review of the benefits and potential adverse consequences associated with Canadian and international policies and frameworks is needed to strengthen Canada's ability to both establish its own effective responses and influence the modernization of international policies and legal frameworks.

Priority Area 3: Priorities to Address the Needs of Key Populations

Focusing on Children and Youth

It is important to reach the broad diversity of children and youth, including urban, suburban, First Nations, Inuit and Métis, gay and lesbian youth, street and rural youth of all ages, socio-economic background and interests. Comprehensive policies and programs that begin at an early age are more effective in delaying first use of substances and reducing problems associated with substance use in the future. Programs that recognize the reality of adolescent substance use and focus on reducing the potential for related harm are more likely to be successful than programs that focus on abstinence alone. It is also important to deliver messages that are factual, age-appropriate, accessible and meaningful to them. For example, the Internet and popular media and culture are key vehicles to reach children and youth. Because of how pervasive the popular culture is in the lives of young people, there is a need for

prevention and health promotion messages to provide a more balanced approach to counter the "glamorization" of alcohol and other drugs often depicted in popular media.

Problematic substance use by adults is a strong influential factor on future choices that children and youth make. At times, problematic substance use by others such as parents and neighbours, directly impacts the safety of children and youth (e.g., hazardous materials in homes where marijuana or synthetic drugs are illegally being produced). Research has continued to demonstrate that substance use and addiction issues need to be handled within the context of a young person's family and community. Without parental and family involvement, the impact of an intervention is diminished. Therefore, additional efforts are required to promote and facilitate the use of both prevention and treatment that include parents and family environments. These types of interventions may often have a lasting influence in the lives of children and youth and in the decisions they make.

Meaningful youth engagement, at the onset and throughout, is necessary for the development of successful strategies. Investments should include: long-term, sustained programming for school curricula; comprehensive prevention and health programs including appropriate messaging about the harms associated with substance use, including during pregnancy; approaches aimed at improving resiliency and promoting protective factors; improved access to and availability of youth-specific treatment programs; and implementation of public policies, such as restricting access to alcohol.

Reaching Out to Canada's North

Northern communities face many unique challenges. Issues of culture, language, social and geographic isolation, poverty, housing and education contribute to an increasing risk for problematic substance use in these communities. Infrastructure disparities and hard to reach areas add to the complexity of addressing problematic substance use in Canada's territorial and northern communities. Research has shown that the use and abuse of substances, particularly alcohol and solvents, is more common in northern and remote communities where social and economic infrastructure may not be as strong or as developed. The use of alcohol is linked with higher rates of suicide, violence and poor performance in schools.

The complex and often interwoven conditions faced by Canada's territorial and northern communities set the stage for an increased vulnerability to problematic substance use. Addressing the underlying issues of this serious problem and providing access to appropriate prevention, health promotion, treatment and aftercare programs, using holistic approaches, are needed. A concerted effort is required to support northern communities in developing an infrastructure that is culturally appropriate and based on an understanding of the nature, prevalence and causes of problematic substance use in these communities.

Supporting First Nations, Inuit and Métis Communities in Addressing Their Needs

Problematic substance use poses serious harms to Aboriginal peoples both on and off reserve and in rural and urban settings. The problematic use of alcohol by Aboriginal peoples is four times the national average and is associated with low employment, family violence and suicide. FASD and solvent abuse are also particular challenges for Aboriginal children and youth. Like Canada's northern communities, some Aboriginal communities also face issues of isolation, both social and geographic. Barriers such as language, geography and lack of culturally sensitive services pose significant challenges to accessing health care and treatment.

There has been an abundance of research on how to best address the unique needs of First Nations, Inuit and Métis people. Addressing the root causes of problematic substance use in Aboriginal communities is considered critical. There is also a need to

provide access to treatment using a holistic approach, recognizing the involvement of the individual and the whole community. Training and capacity building within First Nations, Inuit and Métis communities and empowering Aboriginal peoples to develop and implement their own culturally sensitive strategies are important to achieving long-term sustainable progress. In working towards this goal, Federal, Provincial, Territorial Ministers of Health and Aboriginal Affairs and the Leaders of the five National Aboriginal Organizations are developing a Blueprint on Aboriginal Health. Each of the five major national Aboriginal organizations is developing a strategic plan within the context of the Blueprint.

Approaches for Aboriginal peoples living on and off reserve also need to be coordinated. As well, the high level of mobility among Aboriginal peoples, particularly youth, between rural and urban centres is a factor in the ability to provide and access programs and services.

Responding to Offender-Related Issues

The majority (70% to 80%) of people entering Canada's correctional systems are identified as having problems with substance use (alcohol, other drugs, or both). In addition, approximately 50% report using drugs or alcohol prior to the commission of their last offence. Research has established a strong link between problematic substance use and both past and future criminal behaviour. Treating problematic substance use reduces the rate of re-offence of offenders after release from prison and provides for more effective re-integration into communities.

In addition to the impact of effective treatment on criminal behaviour, there are important health benefits to be achieved. Rates of HIV and hepatitis C are higher among offenders than the general population and disease transmission through high-risk behaviours within the closed environment of a correctional facility is a serious concern. After completing their time in prison, offenders return to the community where continued drug use and other high risk behaviours may further spread diseases to the general population. There is a need for effective partnerships between the health and justice sectors to ensure safe community re-integration.

Correctional facilities are required to meet the special needs of Aboriginal and women offenders and individuals affected by FASD. All require tailored programs and services. For example, reliable screening and diagnostic tools to identify and subsequently treat offenders with FASD as well as with mental health problems are needed. In addition, developing strategies that will reduce the harms associated with drug use, while taking account of the realities of prison operations, will require new approaches.

To address these issues more efficiently, the correctional community will need to coordinate their efforts and build effective community partnerships. With 10 provincial, three territorial and one federal agency responsible for adult corrections and similar numbers for youth criminal justice, there is a great deal that can be achieved through effective coordination. Areas identified as requiring greater coordination of effort and development include assessment, intervention and interdiction (keeping drugs out of prisons) and research. Each of these areas requires research to ensure a strong evidence base for decision-making as well as sufficient resources. A priority area for investment is the development of a coordinating body to facilitate sharing of information and resources among the various correctional agencies. This is one of the means by which correctional agencies can work more efficiently within their own jurisdictions and nationally.

Correctional agencies are also responsible for large numbers of offenders serving their sentences in the community; and for this reason, developing community partnerships is vital to addressing the needs of offenders. The transition from institutions to community settings and an effective continuum of care is critical for effective reintegration of offenders. Community partnerships are needed, not only

with agencies that traditionally serve the offender population, but also with those who provide assistance to the general community. Through the development of partnerships, the various agencies can work towards the goals of reducing crime, making communities safer and reducing the negative impact of problematic substance use on families and communities.

Governance of the Framework

Successful implementation of the National Framework, evidenced by collaborative development of strategies to address identified priorities, depends on good governance and sound management.

For the 2005-2006 fiscal year, Health Canada and the Canadian Centre on Substance Abuse are continuing to act as an informal secretariat, managing and assisting Framework partners to:

- seek endorsement of the National Framework from their ministers, boards, or governing bodies;
- identify, lead and/or participate, within available resources, in thematic workshops addressing specific priority issues identified in the Framework; and
- self-identify areas where each organization/ partner wishes to play a more active or leadership role.

A longer-term governance model will emerge following a meeting in 2006.

Those who use alcohol or other drugs and substances, all three levels of government, non-governmental organizations, First Nations, Inuit and Métis organizations, industry/private sector and other communities of interest and concern are all integral to the ongoing development and implementation of the National Framework.

Moving Forward

Forging Partnerships for Action

The Shared ownership of this Framework provides opportunities for leaders to emerge, while at the same time, advocates have increased ability to forge partnerships in developing new strategic action plans or bolster existing ones. It also provides a unique opportunity to create strong, multilateral partnerships that combine individual strengths and experiences that lead toward achievement of the Framework's vision.

This Framework is an inclusive document that recognizes the knowledge and experience of both participants and the community it serves. While the Government of Canada and the Canadian Centre on Substance Abuse have mandated obligations, anyone may use the Framework as an enabling tool to focus attention on priority issues and bring about change in accordance with the Framework's principles and objectives.

The Framework provides the voluntary sector, law enforcement agencies, addictions agencies, the private sector, people who use drugs, communities of interest, education and health sectors, industry, and all levels of government, a unique opportunity to identify national priorities, plan strategically, and shape national process, program and policy.

This document indicates the necessity for a national framework for action to deal effectively with the many aspects of problematic substance use in Canada. It enables greater coordination and integration to address problematic substance use at all levels and across all jurisdictions. It contributes to the development of a collective, national snapshot of the issues and priorities that need to be addressed. Finally, it leads to clarity around roles and responsibilities, encourages the exchange of best practices and – most importantly – enables more informed decision-making for the development of strategic planning that benefits the entire nation.

References

Adlaf, E.M., Begin, P. and Sawka, E. (Eds.). *Canadian Addiction Survey (CAS): A National Survey of Canadian's Use of Alcohol and Other Drugs: Prevalence of Use and Related Harms: Detailed Report.* Canadian Centre on Substance Abuse: Ottawa, Ontario, 2005.

Albert, T. and Williams, G. *The Economic Burden of HIV/AIDS in Canada.* Canadian Policy Research Network: Ottawa, Ontario, 1998

Beirness, D. Drugs and Driving. In Canadian Centre on Substance Abuse (Ed.) *Substance Abuse in Canada: Current Challenges and Choices.* Canadian Centre on Substance Abuse: Ottawa, Ontario, 2005.

Binkeley, Senator. *Report on Fetal Alcohol Syndrome for the Alaska State Legislature, 1989*.

Blanchette, K. Sex offender assessment, treatment and recidivism: A literature review. Correctional Service Canada. Special Issue. September 1997, Volume 9, Number 3

Bonta, J., Law, M. and Hanson, K. The Prediction of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta Analysis, Psychological Bulletin 1998, Vol. 123, No. 2, 123-142.

Brochu, S., Cousineau, M.-M., Michaël Gillet, M., Cournoyer, L.G., Pernanen, K. and Motiuk, L. *Drugs, alcohol, and criminal behaviour: A profile of inmates in Canadian federal institutions.* Forum on Corrections Research: Focusing on Alcohol and Drugs, Vol. 13 (3): 20-24. 2001

CAMH Established Drinking Guidelines (two standard drinks on a single day – a maximum of 14 for men a week and nine for women who are not pregnant)

Environmental Scan of First Nations and Inuit Mental Health Services. John Elias and Deanna Greyeyes, 2002.

Health Canada. *Reducing the Harm Associated with Injection Drug Use in Canada*. Prepared by the F/P/T Advisory Committee on Population Health, the F/P/T Committee on Alcohol and Other Drug Issues, the F/P/T Advisory Committee on AIDS, and the F/P/T Heads of Corrections Working Group on HIV/AIDS for the meeting of Ministers of Health, St. John's, Newfoundland, September 2001. Health Canada: Ottawa, Ontario, 2001.

Loucks, A.D., Ph.D. and Zamble, E., Ph.D. Predictors of Criminal Behavior and Prison Misconduct in Serious Female Offenders, Correctional Service Canada, 2001.

Motiuk, L. and Vuong, B. (2001). *Profiling the drug offender population in Canadian federal corrections*. Forum on Corrections Research: Focusing on Alcohol and Drugs, Volume 13 (3): 25-29, 2001.

Nanson, J.L., Bolaria, R., Snyder, R.E., Morse, B.A. and Weiner, L. *Physician awareness of fetal alcohol syndrome: a survey of pediatricians and general practitioners.* CMAJ, 152 (7): 1071-6, 1995.

WHO Alcohol Use Disorders Identification Test (WHO AUDIT). Saunders and Aasland, 1987; and Babor, *et al.*, 1989.

Single, E., Robson, L., Xie, X. and Rehm, J. *The Costs of substance Abuse in Canada.* Canadian Centre on Substance Abuse: Ottawa, Ontario, 1996.

Stade, B. Proceedings of the Fetal Alcohol Canadian Expertise research roundtable, 2003.

Any omission in acknowledging the contribution of those who participated in developing this National Framework for Action is inadvertent and will be corrected in future editions.

List of Contributors

Jimmy Akavak, RCMP, Nunavut

Ajah Ambrose, Health and Social Services, Nunavut

Caroline Anawak, National Aboriginal Health Organization

John Anderson, Ministry of Health, British Columbia

Valerie Anderson, Department of Education, Newfoundland and Labrador

Tracy Annett, Canada Border Services Agency

Leslie M. Arnold, Provincial Health Services Authority, British Columbia

Nina Arron, Public Health Agency of Canada

Joyce Aylwood, Qulliit Nunavut Status of Women Council

Diane Bailey, Mainline Needle Exchange Programme, Nova Scotia

Kim A. Baldwin, Health Community Services, Newfoundland and Labrador

Laurent Barbeau, Quebec

Vicki Bas, Canadian Vintners Association

Marilena Bassi, Health Canada

Nicholas Bayliss, Alberta Health and Wellness, Alberta

Marny Beale, Canadian Association of Principals

Barbara R. Beckett, Canadian Institutes of Health Research

Catherine Belanger, Correctional Service Canada

Lynne Belle-Isle, Canadian AIDS Society

Keith Best, Health and Social Services, Baffin Region, Nunavut

Michael Bettman, Correctional Service Canada

Janice Birney, Indian and Northern Affairs Canada

Shaun C. Black, Addiction Prevention and Treatment Services, Nova Scotia

William Blair, Toronto Police Service

Yvonne Block, Manitoba Health

Paul Boase, Transport Canada

Rick Bohachyk, Edmonton Police Service, Alberta

Lisa Ann Bokwa, Public Safety and Emergency Preparedness Canada

Carla Bolen, Government of Saskatchewan

Stephen Bolton, Public Safety and Emergency Preparedness Canada

John Borody, Addictions Foundation of Manitoba

Carole Bouchard, Health Canada

Annette Bourque, Department of Health And Wellness, New Brunswick

Anne Bowlby, Government of Ontario

Mike Boyd, Canadian Centre on Substance Abuse

Susan C. Boyd, University of Victoria, British Columbia

Nancy E. Bradley Usher, Jean Tweed Treatment Centre, Ontario

Michael Bradshaw, Edmonton Police Service

Gary C. Broste, Saskatoon Police Service

Ruby Brown, Alberta Mental Health Board

Jo F. Browne, Royal Newfoundland Constabulary

Chris Buchner, Vancouver Coastal Health Authority

Robert Burley, Foreign Affairs Canada

John Burrett, Federation of Canadian Municipalities

Tracy L. Butler, Health and Community Services, Newfoundland and Labrador

Daniel J. Cable, Department of Justice, Yukon

Allan G. Campbell, Vancouver Island Health Authority, British Columbia

Elizabeth A. Candline, Victoria Faulkner Women's Centre

Michelle Carbino, Public Safety and Emergency Preparedness Canada

Lorri A. Carlson, Regina Qu'Appelle Health Region

Leona Carter, Poundmakers Lodge Treatment Centre, Alberta

Walter Cavalieri, Canadian Harm Reduction Network

Reggie Caverson, Centre for Addiction & Mental Health

Deanne Chafe, Department of National Defence

Eric Chandler, Cool Aid Society, British Columbia

Louise Charach, Alberta Alcohol and Drug Abuse Commission

Geoffrey Chaulk, Canadian Mental Health Association, Newfoundland and Labrador

Claire Checkland, Canadian AIDS Society

Sandra Choquette, Health Canada

Beverley S. Clarke, Health and Community Services, St. John's, Newfoundland and Labrador

Sharon Clarke, National Native Addictions Partnership Foundation

Peter Coleridge, Ministry of Health Services, British Columbia

Howard Collins, Brewers of Canada

Kathy Collins, Alberta Solicitor General and Public Security

Gerald E. Cook, Fredericton Police Force

Trevor Corneil, Three Bridges Community Health Centre, British Columbia

J. Joseph Cox, Montreal Public Health Department

Janis Cramp, Alcohol and Drug Recovery Association of Ontario

Roy Crowe, Association of Substance Abuse Programs of British Columbia

Karen Cumberland, Canadian Centre on Substance Abuse

Margaret Cumming, Health Canada

Halina Cyr, Health Canada

Gail Czukar, Centre for Addiction and Mental Health, Ontario

Linda Dabros, Health Canada

Norma Davignon, Department of Justice, Yukon

Carolyn Davison, Department of Health, Nova Scotia

Caroline H. de Hedervary, Department of Justice Canada

Denis DePape, Toronto Public Health

Louise Déry, Health Canada

Suzanne Desjardins, Health Canada

Annie Di Palma, Health Canada

Wendy Dolan, Government of Nunavut

Tracey Donalson, Health Canada

Jacques Dorge, Education, Citizenship and Youth, Manitoba

Rowland Dunning, Canadian Association of Liquor Jurisdictions

Rachel Dutton-Gowryluk, Health and Social Services, Northwest Territories

Nady El-Guebaly, Foothills Provincial Hospital, Alberta

Richard Elliott, Canadian HIV / AIDS Legal Network

Darryl B. Embury, Health Canada

Robert Eves, Ontario Federation of Community Mental Health and Addiction Programs

Sylvia Fanjoy, Canadian Public Health Association

Bruno Ferrari, Dianova Canada

Murray R. Finnerty, Alberta Alcohol and Drug Abuse Commission

Valerie Flynn, Health Canada

Julie Fontaine, Health Canada

Kathryn Fournier, Indian and Northern Affairs Canada

Patrick C. Francis, Government of New Brunswick

Danielle Gagnon, Health Canada

Melvin Gallant, Native Council of P.E.I.

Linda Gama-Pinto, Health Canada

Lorette Garrick, Alberta Alcohol and Drug Abuse Commission

Robert E. Gérard, Department of Education, New Brunswick

Joel Gervais, Addictions Foundation of Manitoba

Karen Gibbons, Saskatchewan Health

Kathryn J. Gill, McGill University, Quebec

Louis Gliksman, Centre for Addiction and Mental Health

Irene Goldstone, BC Centre for Excellence in HIV/AIDS, Providence Health Care

Jamie H. Graham, Vancouver Police Department

Brian Grant, Correctional Service Canada

Lorraine Greaves, BC Centre of Excellence for Women's Health

Andrea Greig, Health Canada

Barry D. Guy, Regina and Area Drug Strategy

Raju Hajela, Canadian Society of Addiction Medicine, Ontario

Christian Halliday, Nova Scotia

Miki Hansen, AIDS – Vancouver Island

Robert Hanson, Health Canada

Dave Harder, Addiction Services, Northwest Territories

Everett Harris, Guysborough Antigonish Strait Health Authority, Nova Scotia

Enid Harisson, Canadian Centre on Substance Abuse

Heather Hay, HIV/AIDS Service and Aboriginal Health, British Columbia

Paul Henki, Northern Health Authority, British Columbia

Teresa A. Hennebery, Department of Health and Social Services, Prince Edward Island

Ida Hersi, Toronto Public Health

Sharon Hickey, Department of Justice, Yukon

Toby Hinton, Vancouver Police Department

Lindsay Hopkins, Federation of Canadian Municipalities

Shaun Hopkins, Toronto Public Health

Greg Howse, Ontario Federation of Community Mental Health and Addiction Programs

Rachel Huggins, Public Safety and Emergency Preparedness Canada

Beverley A. Huntington, Saskatchewan Learning

Lori Idlout, Embrace Life Council, Nunavut

Alice Isnor, Nunavut

Cheryl Jackson, Health Canada

Laura Jacobson, Health Canada

Darlene James, Government of Alberta

James F. Jameson, Department of National Defence

Elizabeth Janzen, Toronto Public Health

Mary Johnston, Health Canada

Miriam Johnston, Ministry of Health and Long-Term Care

Margaret E. Joyce, Education Department, Nunavut

Catherine R. Kelly, Ministry of Community Safety and Correctional Services, Ontario

David Kelly, Ontario Federation of Community Mental Health and Addiction Programs

Perry Kendall, Ministry of Health Service, British Columbia

Komal Khosla, Canadian Pharmacists Association

Michelle Kinney, Health Labrador Corporation

Christine D. Kitteringham, Association of Substance Use and Abuse Programs, British Columbia

Olaf Koester, Healthy Living and Health Programs, Manitoba

Ainiak Korgak, Department of Health and Social Services, Nunavut

Marja L. Korhonen, National Aboriginal Health Organization

Laura Kozack, The George Spady Centre, Alberta

Michael Kramer, Canadian Community Epidemiology Network on Drug Use

Gerry Kushlyk, Alberta Aboriginal Affairs and Northern Development

Dorren B. Kydd, The Salvation Army, Manitoba

Joy Lang, Ontario Ministry of Health

Kathy Langlois, Health Canada

Melvin Larocque, Hay River Treatment Centre, Northwest Territories

Françoise Lavoie, Health Canada

Janet LeCamp, Blood Ties Four Direction Centre, Yukon

Bridgit Leger, RCMP, Nunavut

Doug LePard, Vancouver Police Department

Sheila Levy, Inuksuk High School, Nunavut

Darren Leyte, Health Canada

Heidi Liepold, Health Canada

Terry Lind, Alberta Alcohol and Drug Abuse Commission

Ann Livingston, Vancouver Area Network of Drug Users

Allan Lockwood, RCMP, Ontario

Carmen Long, Correctional Service Canada

Gillian Lynch, Consultant, Ontario

Cindy MacIsaac, Direction 180 Methadone Clinic, Nova Scotia

Diana L. MacKinnon, Department of Justice, Nova Scotia

Eve MacMillan, Sunrise Native Addictions Services Society, Alberta

Donald MacPherson, City of Vancouver

Doug McCall, Canadian Association for School Health

Michael McCann, Health and Social Services, Yukon

Stoney McCart, The Centre of Excellence for Youth Engagement, Ontario

Maureen McIver, Health Social Services, Prince Edward Island

Ron McCormick, Corrections and Community Justice, Nunavut

Dwayne D. McCowan, Ministry of Education, British Columbia

Doug McGhee, Physician, British Columbia

Noreen McGowan, Department of Justice, Yukon

Bob McKim, Capital Health, Alberta

Christopher J. McNeil, Halifax Regional Police

Marvin McNutt, Department of Justice, Newfoundland and Labrador

Brent McRoberts, Public Safety and Emergency Preparedness Canada

David Marsh, Vancouver Coastal Health Authority

Olga Massicotte, Health Canada

Paul S. Melia, Canadian Centre for Ethics in Sports

Christine Miles, Public Safety and Emergency Preparedness Canada

David Miles, Canadian Association of Principals

Jill Mitchel, Alberta Alcohol and Drug Abuse Commission

Sherry Mumford, Fraser Health Authority, British Columbia

Andrew Murie, Mothers Against Drunk Driving Canada

Erin Murphy, Federation of Canadian Municipalities

James Murray, Ministry of Health and Long Term Care, Ontario

Aideen Nabigon, Health Canada

Gary L. Nelson, Edmonton Community Drug Strategy

Marcia Nelson, Human Resources and Employment, Alberta

Paula Neves, Ontario Public Health Association

Laura Lee Noonan, Department of Education, Prince Edward Island

Warren O'Briain, Ministry of Health Services, British Columbia

David O'Grady, Canadian Centre on Substance Abuse

Derek Ogden, RCMP, Ontario

Ambrose Ojah Jr., Department of Health and Social Services, Nunavut

Eugene Oscapella, Canadian Foundation for Drug Policy

Darlène Palmer, Centre d'action communautaire auprès des toxicomanes utilisateurs de seringues, Quebec

Robert W. Parker, Winnipeg Police

Kim Pate, Canadian Association of Elizabeth Fry Societies

M.J. Patterson, Justice Department, Northwest Territories

Thomas R. Payette, Health Authority, Nova Scotia

Michel Pelletier, RCMP, Ontario

Michael Pennock, Ministry of Health, British Columbia

Nancy Perhoff, Ministry of Health and Long Term Care, Ontario

Michel Perron, Canadian Centre on Substance Abuse

Suzanne Perron, Public Safety and Emergency Preparedness Canada

Beth Pieterson, Health Canada

Roberta Pike, Ministry of Health and Long Term Care, Ontario

George Pine, AIDS Vancouver Island

Nancy Poole, Centre of Excellence for Women's Health, British Columbia

Barry B. Power, Canadian Pharmacists Association

Terry Price, Canadian Teachers' Federation

Jean Pruneau, Health Canada

Gregory A. Purvis, Pictou County Health Authority, Nova Scotia

Jannit Rabinovitch, Health, Education and Enforcement in Partnership, British Columbia

Leslie Reid, Department of Public Safety, New Brunswick

Dan Reist, University of Victoria, British Columbia

Sandi Roberts, Alberta Children and Youth Initiative

Bill Ross, Canadian Vintners Association

Diane A. Rothon, Vancouver Island Health Authority

Mary Rounopoulos, National Parole Board

Sophie Roux, Canadian Professional Police Association

Jacques H. Roy, Canadian Medical Association

Colleen Ryan, Health Canada

Renée Ryan, Government of Newfoundland and Labrador

Sergeant I. C. Sanderson, RCMP

Paul Saint-Denis, Department of Justice Canada

Fred Sanford, Halifax Regional Police

Robert Sarrazin, Conseil de la nation Atikamekw, Quebec

Edward Sawka, Alberta Alcohol and Drug Abuse Commission Research Services

Joanne Seviour, Health Canada

Susan Shepherd, Toronto Public Health

Andy Sibbald, Government of Yukon

Gordon Skead, River Valley Health Region, New Brunswick

Jeannie Smith, Health Canada

Patrick Smith, Centre for Addiction and Mental Health, Ontario

Stephen R.H. Smith, AIDS Vancouver

Thomas A. Smith, Ministry of Health and Long-Term Care, Ontario

Boyd Snook, St-John's Native Friendship Centre, Newfoundland and Labrador

Michele Steele, Capital District Authority, Nova Scotia

John Stinson, Nine Circles Community Health Centre, Manitoba

Tim Stockwell, University of Victoria, British Columbia

Monica Stokl, Vancouver Native Health Society

Shirley Tagalik, Government of Nunavutt

Alain Tellier, Foreign Affairs Canada

Jean-Marie Thériault, Ministry of Educations, New Brunswick

Susan Tolton, Public Health Agency of Canada

Millicent Toombs, Canadian Medical Association

Maureen Tracy, Canada Border Services Agency

Carmen Trottier, Association des Intervenants en toxicomanies du Québec Inc

Don Tully, National Parole Board

Kenneth Tupper, Ministry of Health Services, British Columbia

Peter A. Vamos, The Portage Program for Drug Dependencies Inc., Quebec

Pierre Vaugeois, Comité permanent de la lutte contre la toxicomanie, Quebec

Gerry Verrier, Addiction Treatment Services, Manitoba

Richard Viau, Health Canada

Cecil F. Villard, Provincial Health Services Authority, Prince Edward Island

Matthias Villetorte, Department of Justice Canada

Jennifer Vornbrock, Vancouver Coastal Health Authority

Bruce Walker, Canadian Vintners Association

Patricia Walsh, Public Health Agency of Canada

Marjorie Ward, Health Canada

Lynne Waring, Health Canada

Frances Wdowczyk, The Student Life Education Company Inc., Ontario

Ross R. Wheeler, Health and Social Services Authority, Northwest Territories

Larry Whitfield, Department of Health and Social Services, Yukon

Pam Whiting, Fraser Health Authority, British Columbia

Neil Wiberg, Alberta Justice

Jeffrey Wilbee, Canadian Addiction Counsellors Certification Federation

Brian D.Wilbur, Department of Health, Nova Scotia

Cameron Wild, University of Alberta

Tom Wong, Public Health Agency of Canada

Roslyn Woodcock, Health Canada