FALL 2005

NB COALITION ON PRESCRIPTION DRUG USE & CCENDU FREDERICTON SITE COMMITTEE

NEW BRUNSWICK COALITION ON PRESCRIPTION DRUG USE

CCENDU

AIDS SIDA

AWARE!

A Look at Drug & Alcohol Issues in N.B.

INSIDE THIS ISSUE:

FUNDING PROVIDED BY:

PURDUE

WELCOME READERS!

Members of the New Brunswick Coalition on Prescription Drug Use and the Fredericton Site Committee for the Canadian Community Epidemiology Network on Drug Use want to welcome you to the 2nd issue of AWARE! This newsletter is coordinated by AIDS New Brunswick and funded by Purdue Pharma.

The goal of this newsletter is to enhance knowledge, awareness and understanding of substance/ medication use, misuse, and addiction issues and resources throughout New Brunswick. AWARE! is available in electronic and paper format and in both official languages. While the first two newsletters are free, a $10 annual membership fee will be implemented for future editions. More information will be provided in the upcoming months.

New to AWARE! is a set of values which form the foundation for all article content:

- Non-judgmental
- Everyone has value
- Celebrate diversity and value differences
- Everyone has the right to appropriate help
- Social justice for all
- Client focused

We welcome article submissions of between 250-500 words that uphold these values.

Contact Haley Flaro at 506/459-7518 or sidaids@nbnet.nb.ca.

FEATURE: PAIN & ADDICTION - NOT AN 'EITHER OR' PROPOSITION

Dr. Gourlay (MD, FRCPC, FASAM) is a medical consultant with the Centre for Addiction and Mental Health and the Wasser Pain Management Centre at Mount Sinai Hospital.

The notion that pain and addiction can exist in the same patient is a relatively new concept. The prevailing thought was that if a person had a legitimate pain problem, the likelihood of there being a substance use disorder was so small that it did not merit looking for. Similarly, those who had been identified as having a substance use disorder were often deemed unsuitable for chronic pain management with anything more than non-opioid analgesics. This 'either-or' approach to pain and addiction has left many clinicians confused about how best to approach the treatment of chronic non-cancer

FEATURE CONTINUED...

"Although addiction and dependence are often used interchangeably, they do not mean the same thing."

"Unfortunately, by taking an 'either-or' approach to pain and addiction, two potentially manageable conditions may go untreated."

pain. Some clearly adopted a 'don't ask – don't tell' approach preferring to leave the issues of drug and alcohol use out of the clinical inquiry entirely. As a result, patients suffering from chronic pain and addiction may be inadequately or inappropriately treated.

As we currently understand it, addiction is a multifactorial, biopsychosocial disease which occurs in the context of a reinforcing substance used by an 'at risk' individual in the proper setting. The true prevalence of addiction within the chronic pain population is, at present, unknown but in the general population is between 3-16% with 10% being a commonly quoted number. It is difficult to imagine that this rate is lower for the chronic pain population.

Although addiction and dependence are often used interchangeably, they do not mean the same thing. Addiction is typically diagnosed using the criteria in the Diagnostic and Statistical Manual version IV (DSM-IV). Since virtually all patients treated with opioids develop some degree of physical dependence and tolerance, two thirds of these criteria are met in most chronic pain patients treated with opioid analgesics. Clearly, the majority of these patients are not addicted to these drugs.

Application of the DSM-IV is particularly challenging in settings where the drug in question may be both the problem and the solution at the same time. The diagnosis of a cocaine addiction may be relatively easy to make in the context of chronic pain since there is no legitimate medical indication for cocaine in pain management however opioids do have a legitimate role in the management of pain. In some cases, pain and addiction may be better viewed in the context of a continuum, rather than as co-morbid conditions, with either being potentially dominant at any given time. Failure to identify where on this continuum such patients may be at any given time can lead to inappropriate treatment.

In diagnosing opioid addiction in the context of chronic pain, the utility of the DSM-IV is severely tested. Of the criteria present in the DSM-IV to diagnose addiction, 'continued use despite harm' is likely the most useful. When a drug is clearly "doing more to the patient than for them, yet they continue to use" a substance use disorder should be included in the differential diagnosis.

Addiction is often diagnosed prospectively, over time. Although risk can often be estimated early on with a careful clinical history, those patients who will ultimately become problematic users of prescription medications can not be identified with any degree of certainty at the first visit. By carefully setting reasonable and clearly understood limits, the patient who continues to step out of bounds may self-identify as having a substance use disorder.

On the other hand, some maladaptive behaviour is driven by the inadequate

treatment of chronic pain (pseudoaddiction). In this context, the diagnosis is made retrospectively, with normalization of behaviour occurring through optimized pain management.

So given the fact that pain and addiction can coexist and that the at-risk individual can not easily be identified, what is the best approach to take? By taking a careful drug and alcohol history including current and past personal and family use in all patients, and by setting reasonable limits on the prescription of appropriately chosen agents, risk can be reduced and care optimized. Having a chronic pain problem does not eliminate the risk of a substance use disorder, it simply complicates it. Unfortunately, by taking an 'either-or' approach to pain and addiction, two

PARTY PROGRAM IN NEW BRUNSWICK

Article submitted by Claire Gibson of the RCMP Drug Awareness Service. For more information contact her at claire.gibson@rcmp-grc.gc.ca.

The Prevention of Alcohol and Risk Related Trauma in Youth (PARTY) program has been active in NB since the initial pilot in 2005. The program promotes injury prevention through reality education, enabling youth to recognize risk and make informed choices about activities and behaviours. The program was initially developed in 1986 by a nurse at Sunnybrook Women's Hospital in Toronto, Ontario. There are now more than 50 PARTY programs throughout Canada.

The PARTY program in NB operates under the HEP (Health, Education and Enforcement in Partnership) initiative. This initiative promotes support and collaboration between health social agencies and the police/justice system. It was through the HEP partnership between River Valley Health Addictions Services and the RCMP Drug Awareness Service that the PARTY program was first established and coordinated.

New Brunswick now boasts six active PARTY sites (Harvey, Perth-Andover, Woodstock, Doaktown, Chipman and Grand Falls) which provide the program on an annual basis for grade nine students in fifteen communities. The students start off the day by witnessing a dramatic scene of an incident caused by risky behaviour. These scenes most commonly depict a motor vehicle crash wherein one or more of the passengers are intoxicated. The students witness how various community agencies including the fire department, police departments, ambulance workers, among others, work together to help victims. Directly after the scenario the workers explain their roles and explain the effects that such incidents have on themselves, the victims and the community as a whole. Once students have witnessed this scenario they are introduced to an injury survivor who discusses their injuries and the lasting effects of those injuries.

In the afternoon, students rotate between six sessions where they explore in more depth the possible

New Brunswick now boasts six active PARTY sites which provide the program on an annual basis for grade nine students in fifteen communities.

PARTY CONTINUED...

consequences of incidents caused by risky behaviour. These sessions explore issues such as mobility, eating, communication, medical nursing, alcohol poisoning and social relationships. During these sessions the students are in smaller groups and provided with the opportunity to ask questions, try equipment and interact with the various professionals delivering the sessions.

Many communities support the PARTY program because they feel it provides young people with information that will help them make healthy choices and avoid risky

An estimated 240,000 people are living with hepatitis C in Canada

References

1. Canadian AIDS Society. *HIV and HCV Transmission: Guidelines for Assessing Risk.* 2004.
2. Wiebe, Jamie & Bette Reimer. *Profile of Injection Drug Use and Hepatitis C in Canada.* 2000.
3. Government of New Brunswick. Communicable Disease Reports. 1996-2004.

HEPATITIS C AND INJECTION DRUG USE

Written by Amber Nicol, AIDS New Brunswick Hepatitis C Project Coordinator.

The Growing Epidemic

Communities in New Brunswick and throughout Canada are facing a growing hepatitis C epidemic among people who inject drugs. Between 1996 and 2004, 1746 hepatitis C cases were reported in the province (reporting started in 1996). Currently an estimated 240,000 people are living with hepatitis C in the country – many of whom are not aware of it.

A history of injection drug use and sharing needles is linked to approximately 70% of all hepatitis C infections in Canada. Studies show that in many Canadian cities over half of all people who inject drugs are infected with the virus.

Access to harm reduction programs such as needle exchanges and methadone maintenance therapy and to drug treatment/rehabilitation programs is an important public health measure to help reduce the transmission of hepatitis C.

Hepatitis C - Get the Facts!

- Hepatitis C (Hep C or HCV) is an infectious virus that is transmitted through direct blood-to-blood contact. It affects the liver.
- Even if you have no symptoms of the virus you are still able to pass it on — 70% of Canadians with hepatitis C do not know that they are infected.
- ***High risk activities*** for hepatitis C include sharing needles and other drug equipment (syringes, cookers, filters, straws for snorting, water for injection). Cleaning equipment with bleach does not kill the hepatitis C virus.
- ***Low risk activities*** for hepatitis C include sharing tattooing ink wells and needles, sexual transmission, mother-to-child transmission, transfusion of blood or blood products (blood screened for hepatitis C since 1990), and sharing personal care items such as toothbrushes, razors, and nail clippers.

STREET WORKERS AND ADDICTION

Excerpts from conversations with Kelly Steeves of PEERS Moncton and Dr. Gayle MacDonald of St. Thomas Univ., by Rachel Watters, summer student at the Advisory Council on the Status of Women. For more information contact Rosella Melanson at Rosella.Melandson@gnb.ca

Do sex workers start using drugs / alcohol before or after becoming street workers?

Kelly**:** In some cases, women are not involved in the drugs/alcohol (before starting sex work). Once in the trade and as a result of many traumas (from pimps, purchasers, adolescent/child abuse) women begin to use to cope in their environment. For those already involved with drugs/alcohol before entering the trade, it's used to suppress the pain of past issues. The street trade makes up only about 40% of the sex industry. It's my educated guess that about 85% of the street workers are wholly addicted and about 98% use to cope and escape. They think they're social users, much like mainstream society who go out for a drink after a stressful day.

Gayle: Many become addicted to prescription drugs, which can lead to needing large amounts of cash, which then may lead to the sex trade.

What kind of drug /alcohol program would be most effective for street workers?

Kelly: The most effective is the 12-step program that addresses each individual's addiction. Sex work and addiction are strongly linked but are completely different addictions. Healing from a life of prostitution requires dealing directly with what maintains it, such as low self-esteem and self-identity awareness, self-destructive behaviour. When one addresses sex work and addiction simultaneously, it's very effective and empowering. 12-step programs are available across Canada, but in most cases of recovery it takes long-term treatment to begin the healing. There are waiting lists everywhere for women in need of a bed. When the moment of realizing comes, it's a "live or die today" choice, something that CANNOT be put on a waiting list.

Do street workers face discrimination when they seek help?

Kelly: There are cases of women who have been asked by their addictions counsellor how much they charge. I went to a medical doctor for counselling as a youth because of waiting lists (for treatment) and was sexually assaulted in his office. I didn't report it for fear of being blamed because of my work. Women must be able to obtain services in a safe place. Women in sex work go years without contact with mainstream society. Fear of losing their children if they admit they sell sex and of having to repeatedly admit it after leaving the life. Most women, when they get out, want to forget it.

"When one addresses sex work and addiction simultaneously, it's very effective and empowering."

"Women must be able to obtain services in a safe place."

"I had always maintained that an alcoholic need only be 'insane' long enough to reach the closet liquor establishment."

"The price of sobriety is eternal vigilance"

TESTIMONIAL: THE PRICE OF SOBRIETY

Excerpts from an article written by a client at the Fredericton Community Health Clinic.

It was in my 22nd year of unbroken, continuous sobriety – total abstinence – that I stepped out one hot Sunday afternoon and trembled my way to the nearest liquor store. I had always maintained that an alcoholic need only be "insane" long enough to reach the closest liquor establishment and, unfortunately, mine was only a three-minute walk away. Upon arrival, I rushed and grabbed a pint of vodka and walked up to the counter pondering the great increase in price since my last purchase. Then I promptly turned back around, restored the bottle to the shelf, returned home and sat down wondering what that was all about. Yikes! What a close call! Not ten minutes later I repeated the whole process, except this time – disaster – I followed through and bought the pint. With some trepidation accompanied with the haste of just wanting to "get it over with" I opened the bottle, started drinking and forever changed my life.

... If someone had told me on Saturday that I was going to drink the following Sunday, I would have laughed in their face. Such was the extent of my ignorance of the precarious position I was in.... I had ceased being vigilant for quite some time and since "the price of sobriety is eternal vigilance" it was inevitable ... I had slowly but surely let my guard down and suffered accordingly.

... I lost my job, my home, my wife, some of the respect of my children ... and my own dignity and self respect. I at the age of 46 ended up destitute living here at the Fredericton Shelter.

... None of this [personal problems] would have caused me to drink had I been attending AA meetings on a regular basis as I had in the past. The 12 steps of AA include the crucial, absolutely essential "maintenance steps" 10, 11, and 12. These last three steps are designed specifically to assure that you retain everything that you learned, acquired, and achieved in the previous nine steps. It was my failure to be more attentive to these steps that led to my downfall.

...It was only the kind intervention and treatment at the Community Health Clinic, the hospital and Detox that saved my life from the downward spiral ...

... Understand that alcohol is just another drug...even if you are <u>just a social drinker</u> (whatever that is…) Please be careful.

PROFILE: A NEW HOME FOR ADDICTION SERVICES CAMPBELLTON

By Amber Nicol based on an e-mail interview with Michael Levesque, Manager Region 5 Addiction Services.

A New Home

Addiction Services has provided services and treatment to people in the Campbellton region and beyond since 1974. Currently located in Campbellton on Prince William and Stanley Street, the main facility will be re-locating to Gallant Drive this year. Satellite offices in Dalhousie and Jacquet River will be maintained at their current locations. This new facility will provide increased accessibility and enhanced opportunities for staff collaboration. Its strategic design will help ensure services are delivered confidentially, consistently, and effectively.

Programs and Services

The centre's programs and services focus on education, prevention and treatment. The centre deals with many addictions including alcohol, cocaine, opiate and gambling. Last year inpatient programs served 380 clients while outpatient programs served 617 clients. All services are provided in French and English and staff can be reached by phone 24 hours a day. Programs and services include:

- 6-bed Detox unit
- 12 bed, 21-day short-term residential program
- Adult outpatient program focused on individual and family counselling, skill building, relapse prevention and other group sessions
- Counselling and support to youth through local schools and learning centers
- Community program to provide information on the use, misuse and abuse of alcohol, other drugs and gambling
- Training and workshops
- Partnership work to address issues relevant to the region

Moving Forward

The prevalence of people who present with concurrent mental health and substance use disorders is high and offers some unique challenges. Traditionally Mental Health and Addiction Services have worked in isolation. The centre has developed protocols with the community Mental Health Center to work together in the best interest of clients.

The world of substance abuse treatment is changing and it is essential that services are based on sound research and begin where the client is in life. It is important to have the skills, knowledge and values to effectively work with people who have been negatively impacted by substance use or gambling. Treatment modalities such as social skills training, brief motivational counselling and the community reinforcement approach are fundamental to the centre's work with clients. The much needed new facility will undoubtedly serve an important purpose, but it is people who ultimately make the real difference.

"This new facility will provide increased accessibility and enhanced opportunities for staff collaboration."

"Methamphetamine is highly addictive– both physiologically and psychologically."

Q&A: METHAMPHETAMINE

What is Methamphetamine?

Methamphetamine (MA) is an illegal synthetic drug belonging to a group of drugs known as amphetamines. When ingested, it speeds up the central nervous system (stimulant). MA is a white odorless bitter tasting powder that is easily dissolved in water. In its smokeable form, it appears as transparent sheet like crystals. In addition to smoking, MA can be taken orally, snorted, or injected. Street names include Speed, Meth, Crystal Meth, Chalk, Crank, Fire, Ice, Crystal, Glass, Tina, Gak, Jib, and Yaba (CCSA, 2005: CAMH, 2001). MA is relatively inexpensive (Myers, 2005).

How is Methamphetamine Produced?

MA is produced in clandestine labs using ingredients available at local pharmacies and hardware stores: ephedrine (from over-the-counter cold medicine), ether, battery acid, insecticides, solvents, and lye (CAS). The chemicals are toxic, corrosive, flammable and explosive, and approximately six pounds of chemical waste are created for every pound of MA (CCSA). The quality of MA produced depends on the supplier. Users often have no way of knowing exactly what is in the drug they purchase.

What are the effects of taking Methamphetamine?

The use of MA leads to an intense euphoria, called a "rush" or "flash". The effects of MA can last up to 12 or more hours. MA "makes people feel alert and energetic, confident and talkative" (CAMH). Undesirable effects include, "racing of the heart, chest pain, dryness of the mouth, nausea, vomiting and diarrhea, and physical tension" (CAMH). Some users report "an anxious 'wired' feeling of restlessness and irritability" (CAMH). MA use can also lead to "paranoid delusions, hallucinations, aggressive behaviour and impulsive violence" (CAMH).

Methamphetamine is highly addictive (both physiologically and psychologically) and regular users require more of the drug to achieve the desired effect as their tolerance increases. Users who share drug equipment when smoking or injecting MA are at risk for HIV and hepatitis C. The negative health effects of the drug can be permanent.

What is the prevalence of Methamphetamines in N.B.?

While MA is present in a few areas of the province, it is currently not widely available or widely produced (Myers: Breton, 2005). The smokeable form of MA, Crystal Meth, has a strong presence in western Canada and is starting to take hold in Ontario and Quebec. This has created concerns that it is only a matter of time before it is more prevalent in New Brunswick.

References

1. Centre for Addiction and Mental Health. *Methamphetamine.* 2001.
2. Corporal Matt Myers, Fredericton Police Department. Interview. 1 September 2005.
3. Sergeant Luc Breton, RCMP Drug Awareness. Interview. 25 August 2005.
4. Canadian Centre on Substance Abuse. *Fact Sheet – Methamphetamine*. 2005. http://www.ccsa.ca/NR/rdonlyres/A378E355-BB39-45FB-BDB8-FB751EDBAFFD/0/ccsa0111342005.pdf
5. Canadian AIDS Society. *Fact Sheet: Crystal Meth and HIV*. 2004. http://www.cdnaids.ca/web/backgrnd.nsf/cl/cas-bg-0087

STUDY OF SUICIDE CASES IN N.B. BETWEEN APRIL 2002 — MAY 2003

Monique Séguin (Ph.D) is one of the authors of this study. For more information contact Monique at monique.seguin@uqo.ca.

The purpose of this study was to identify the personal and social circumstances that led a number of New Brunswickers to commit suicide so as to propose strategies for improving the services offered to suicidal individuals and their families.

Our research methodology involved 1) charting the development of mental health problems and determining the sequence in which the initial difficulties appeared and tracking their evolution over time; 2) surveying the accumulation of psychosocial risk factors and protective factors; 3) describing help-seeking behaviours and use of health services; and 4) evaluating how well practitioners, programs, and the health and social services system in New Brunswick responded to service needs.

Of the 109 suicide deaths identified by the Coroner at the time of the study, the research team was able to investigate 102 suicide mortality cases that occurred over a 14-month period in the province of New Brunswick.

In the large majority of cases, the suicide victims had a long trajectory of difficulties throughout their lives, i.e. an accumulation of personal, family, relational, psychological, and social problems.

Two-thirds of the suicide victims had long-standing addiction problems, making addiction one of the most prevalent factors. More than 60% of the deceased had an addiction problem at the time of death, and nearly 70% of them had struggled with such problems during their lives, making addiction one of the most prevalent risk factors.

Despite previous contacts with addiction services during their lifetime, only 10% of them were in touch with those services during the year preceding their suicide. As well, nearly 70% of the suicide victims had an affective disorder, at the time of death.

These observations really stress the importance of prevention through early treatment of addiction and mental health problems. While the treatment of depression is an important and indeed inescapable aspect of suicide prevention, it should undoubtedly be multidimensional to address the complexity of co morbid problems especially the importance of concomitant addiction problems. There is a need to enhance treatment efficacy and compliance, and ensure post-treatment follow-up.

"Two-thirds of the suicide victims had long-standing addiction problems."

"Nearly 70% of the suicide victims had an affective disorder, at the time of death.

STUDY ON INJECTION DRUG USE IN FREDERICTON N.B.

As part of a recent Public Health Agency of Canada funded project, AIDS New Brunswick completed a *Community Based Needs Assessment on Injection Drug Use and Related Issues in Fredericton, N.B.* The findings in this report are based on two complementary needs assessments conducted in Fredericton: the first with 47 current and former users of injection drugs, and the second with 48 individuals from 20 different departments/organizations working with this population.

Key findings based on interviews with current/former users of injection drugs included:

- Most started injecting in their late teens or early twenties
- Dilaudid and cocaine are the most commonly injected drugs in this region.
- Almost half had been denied access to a drug treatment program, most often because of limited availability of spaces.
- 35% had shared someone else's needle after it had already been used. The main reason given for sharing was lack of their own equipment (e.g., clean needles) or access to new equipment.
- 47% spent more than $500 per week on drugs; half of these spent more than $1000 per week
- 68% had a criminal record; 30% of those who went to prison, injected while incarcerated

The study also asked both groups of participants what was required to address issue related to injection drug use in the community. Priorities included: reduce wait lists for drug treatment programs, including Methadone Maintenance Treatment Programs; establish operational funding for the Fredericton Needle Exchange Program (NEP), increase program hours and develop a north side location; and address the roots of addiction through treatment and support programs.

Findings also reflected a need to step up drug awareness and preventative strategies, implement programs "for youth, by youth", increase communication and collaboration among agencies, and reduce stigma and discrimination associated with people who inject drugs.

Note: report is currently available in English only

To request a copy of this report free of charge contact AIDS New Brunswick at

sidaids@nbnet.nb.ca

(506) 459-7518

NEW FUNDING TO ADDRESSS SUBSTANCE ABUSE

On August 30, 2005, the federal government committed $71 million over three years to address substance abuse as part of Canada's Drug Strategy. Health Minister Ujjal Dosanjh commented:

"These contributions represent the Government of Canada's determination to address the detrimental health, social and economic consequences caused by substance abuse in our country… through these funding commitments we are supporting a wide range of exemplary projects that will benefit Canadians dealing with harmful substance use."

The Drug Strategy Community Initiatives Fund will receive $29 million, of which $10 million will be used for national projects and $19 million for provincial, territorial, and community-based initiatives. Projects are funded in 2-key areas: promotion and prevention, and harm reduction. For more information on the Community Initiatives Fund visit http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_93bk1_e.html

The remaining $42 million will go towards the Alcohol and Drug Treatment and Rehabilitation Program (ADTR). This program delivers funding to the provinces and territories in a series of bilateral agreements to increase access to alcohol and drug treatment and rehabilitation programs. Funding is primarily used for programs targeted at women and youth, however, other programs providing specialized services to high-risk populations are also eligible. For more information on ADTR visit http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_93bk2_e.html

Total funding = $71 million

Drug Strategy Community Initiatives Fund = $10 million

Alcohol and Drug Treatment and Rehabilitation Program = $42

NEW HEPATITIS C RESOURCES

Two hepatitis C **information sheets** are now available from AIDS New Brunswick free of charge: *Know your Risks and Get Tested!* and *Living with Hepatitis C!*. Also available is the **interactive game** *Target Hepatitis C* which is perfect for group learning opportunities such as workshops and conferences. Funding for the development of these bilingual resources was provided by the Public Health Agency of Canada. Contact 1-800-561-4009 or sidaids@nbnet.nb.ca.

PROVINCIAL LIQUOR SALES

Provincial liquor sales in 2004/05 totalled $331 million, up nearly 3% from the previous year. Fredericton had the highest sales at $44.2 million, followed by Saint John ($37.6 million) and Moncton ($30.7 million). Beer continues to be the most popular beverage consumed, however sales for spirits and wine were both up about $3 million.

References

1. Hagerman, Shannon. The Capital Toasts the Most. The Daily Gleaner. 8 September 2005.

Thanks to Purdue Pharma for funding the newsletter and to AIDS New Brunswick for its role in coordinating this initiative.

We welcome submissions of 250-500 words articles! (Newsletter Editor reserves the right to edit all submissions)

Contact Us!

Amber Nicol or Haley Flaro
(506) 459-7518 or sidaids@nbnet.nb.ca

ISSUES of SUBSTANCE Canadian Centre on Substance Abuse National Conference 2005 — QUESTIONS de SUBSTANCE Conférence nationale du Centre canadien de lutte contre l'alcoolisme et les toxicomanies 2005

CCSA presents:

Issues of Substance

November 13-16

Markham, ON

Reg. fee = $500

NATIONAL CONFERENCE: ISSUES OF SUBSTANCE

The Canadian Centre on Substance Abuse (CCSA) will be hosting its first national conference *Issues of Substance* in Markham, Ontario November 13-16, 2005. The theme is Innovation and Action with a focus on "Canadian contributions in prevention, treatment, harm reduction and enforcement." The conference is supported by Health Canada, the Canadian Executive Council on Addictions, and the Provincial and Territorial Departments of Health.

Planned plenary sessions cover a variety of topics organized along three lines: Challenges and Opportunities, Action Strategies, and Current Innovative Actions. Included on the diverse speaker list is Fredericton Mayor Brad Woodside, who will be presenting on the Fredericton Strategy for Action.

Registrations will be accepted until November 7, 2005. The cost is $500 +GST and includes all conference meals. For more information on *Issues of Substance* or to register for this conference, visit http://www.issuesofsubstance.ca/IOS/EN/TopNav/Home/