September 2013

Message from the Prime Minister

It gives me great pleasure to extend my warmest greetings to everyone marking the 25th anniversary of the Canadian Centre on Substance Abuse (CCSA).

Established by an act of parliament in 1988, the CCSA has played an invaluable role in increasing awareness of the ills of drugs and alcohol and reducing the harm inflicted by substance abuse on Canadian society. Working in partnership with organizations across the country, the CCSA has provided national leadership on Canada’s drug strategy.

As you celebrate this significant milestone, you may take pride in the decades of research, collaboration and effective public education that have advanced your laudable mission. Looking ahead, I have no doubt that your commitment to the health of Canadians will continue to inform your efforts.

On behalf of my colleagues in the Government of Canada, please accept my congratulations as the CCSA celebrates this special anniversary.

Sincerely,

Prime Minister of Canada
Collective action is not just a concept. It’s a process for finding solutions when problems are too complex, too significant and too deeply rooted to be solved by any one group or approach.

Substance abuse is that kind of problem. It affects our communities, compromises our health and our social systems, and undermines our economy.

In 2012–2013, the Canadian Centre on Substance Abuse continued to drive and enable collective action—with meaningful, tangible, replicable results.

“Large-scale social change requires broad cross-sector coordination.... Our research shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.”

LOOKING BACK
In August 1988, Brian Mulroney was Prime Minister of Canada, Wayne Gretzky was traded by the Edmonton Oilers (reigning Stanley Cup champions) to the Los Angeles Kings, and the Canadian Centre on Substance Abuse was born. For the first time, Canada had a national body to lead substance abuse prevention and treatment efforts. Since then, CCSA has helped build the evidence base, networks and collective spirit needed for partners at all levels to reduce the harms to Canadians from substance abuse.
CCSA celebrates its 25th anniversary in 2013. Here’s a look at its history of collective action.

1987
Health minister Jake Epp asks Dr. David Archibald to develop a national focus for efforts to address substance abuse

1988
August–CCSA is created by an Act of Parliament with all-party support

1990
July–CCSA publishes its first report, An Overview of Youth-Oriented Prevention Programmes in European Countries

1991
April–CCSA convenes first meeting of a National Working Group on Drug Addictions Awareness Week in Ottawa

1993–1995
CCSA participates in the development of international guidelines for estimating the health, social and economic costs of substance abuse

1994
March–CCSA launches Canada’s first national information service on fetal alcohol syndrome and its effects

1996
June–CCSA publishes The Costs of Substance Abuse in Canada

1998
June–CCSA enters a partnership with the United Nations International Drug Control Programme and the Alberta Alcohol and Drug Abuse Commission to host the Youth Vision Jeunesse forum in Alberta, with 24 participating countries

2000
September–CCSA co-hosts the first Symposium on the Social and Economic Impact of Gambling with the B.C. Ministry for Children and Families in Whistler, B.C.

2001
CCSA launches the Canadian Problem Gambling Index on behalf of a consortium of provinces

2002
April–CCSA helps launch the Canadian Executive Council on Addictions

2006
April–CCSA partners with the Correctional Service of Canada to publish a landmark study called Proportions of Crimes Associated with Alcohol and Other Drugs in Canada, the first report of its type and scope in Canada

2007
September–CCSA helps organize the first World Forum on Drugs and Dependencies in Montreal

2013
CCSA celebrates its 25th anniversary in 2013. Here’s a look at its history of collective action.
From pilot implementations of the Canadian Standards for Youth Substance Abuse Prevention to the ongoing uptake of the national Low-Risk Drinking Guidelines, tools, resources and initiatives from CCSA continued to roll out across the country in 2012–2013.

Legend

- Focus groups for Technical Competencies for Substance Abuse Workforce
- Adoption and implementation of Competencies for Substance Abuse Workforce
- Provinces and territories in which the Low-Risk Drinking Guidelines are being distributed
- Pilot projects for Standards for Youth Substance Abuse Prevention
- Provinces in which the Systems Approach Workbook is being applied or adapted
- Provinces and territories providing data for the National Treatment Indicators report

Adoption and implementation of Competencies for Substance Abuse Workforce
- Regional:
  - Thompson Rivers University, Kamloops, BC
  - Hamilton Addiction Services Collaborative, Ontario
- Provincial:
  - BC Mental Health and Addiction Services
  - Alberta Health Services
  - Addictions Foundation of Manitoba
  - Addictions and Mental Health Ontario
  - Nova Scotia Health
  - Newfoundland Health
- National:
  - Veterans Affairs Canada

Focus groups for Technical Competencies for Substance Abuse Workforce
- Regional:
  - Vancouver
  - Winnipeg
  - Hamilton
  - Toronto
  - Ottawa
  - Montreal
  - Halifax
  - St. John’s
  - Yellowknife
  - Iqaluit
- Provincial:
  - Alberta
  - Saskatchewan
  - Manitoba
  - Ontario
  - Quebec
  - Newfoundland and Labrador
  - Prince Edward Island
  - Yukon
  - Northwest Territories

Pilot projects for Standards for Youth Substance Abuse Prevention
- Campbell River Alcohol and Drug Action Committee, Seeds of Resilience, Campbell River, BC
- SACY (School Age Children and Youth), Substance Use Prevention Initiative, Vancouver, BC
- Richmond Addiction Services Society, Richmond, BC
- Yellowknife Committee for the Prevention of Youth Substance Abuse, Yellowknife, NT
- The Drug Class Program and TV Series, Saskatchewan
- Wellington-Guelph Drug Strategy, Strengthening Families Program, Guelph and Wellington County, Ontario
- Addiction Services, Pictou County Health Authority, Nova Scotia

Provinces and territories in which the Low-Risk Drinking Guidelines are being distributed
- British Columbia
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- Newfoundland and Labrador
- Prince Edward Island
- Yukon
- Northwest Territories

Provinces in which the Systems Approach Workbook is being applied or adapted
- Alberta
- Saskatchewan
- Manitoba
- Ontario

Provinces and territories providing data for the National Treatment Indicators report
- Yukon
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- New Brunswick
- Prince Edward Island
- Newfoundland and Labrador
- Nova Scotia
Our Vision
All people in Canada live in a healthy society free of alcohol- and other drug-related harm.

Our Mission
Provide national leadership and advance solutions to address alcohol- and other drug-related harm.

Our Values
Respect for others
Excellence
Cultivating knowledge and striving for objectivity
Integrity
Partnerships
Innovation and transformation

Strategic Directions
A. Create and sustain partnerships to mobilize individual and collective efforts.
B. Foster a knowledge exchange environment where evidence and research guides policy and practice.
C. Develop evidence-informed actions to enhance effectiveness in the field
D. Foster organizational excellence and innovation.

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Message from the CEO

The Canadian Centre on Substance Abuse celebrates its 25th anniversary in August 2013. This milestone marks a quarter-century of bringing diverse individuals and groups together to find common ground and take collective action to reduce the harms of substance abuse.

What does “collective action” mean, exactly? In the field of substance abuse, it means recognizing the complexity of the issue and the need for structured collaboration across sectors and disciplines to address it. It means aligning commitments, policies and funding so they can produce the greatest good. And achieving collective impact requires a backbone organization to coordinate these efforts and keep track of the bigger picture.

CCSA is that organization in Canada. The results we have achieved with our partners include a National Treatment Strategy, a National Alcohol Strategy, Standards for Youth Substance Abuse Prevention and Competencies for Canada’s Substance Abuse Workforce. We continued to roll these out across Canada in 2012–2013.

CCSA and its partners added to this impressive body of shared achievements by launching a national strategy to deal with prescription drug abuse. Leaders from many fields came together to develop a strategy to address this problem, which has a tremendous impact on Canadians from all parts of the country.

Substance abuse touches us all. But creating the space for collective action is challenging when there are so many voices, priorities and perspectives. At CCSA we work to bring these voices together.

As an example, in 2012–2013 we launched SystemAction, an innovative online knowledge-sharing network that will create a better treatment system for Canadians. SystemAction provides a forum for organizations to exchange knowledge and best practices instead of duplicating their efforts.

Best practices are based on sound evidence, rigorously applied and evaluated for results. CCSA continues to produce evidence-based tools to support those who set policies, run prevention programs or deliver treatment. This past year, we researched the impact of pricing on alcohol consumption, supported pilot implementations of the Canadian Standards and distributed a workbook on bringing about change in our treatment systems.

We’ve seen the impact of taking an evidence-based approach with diseases like cancer. One of our former Board Chairs used to say that in the 1930s cancer was seen as a visitation of the devil. Even 25 years ago, a cancer diagnosis was seen as a death sentence. Today, people talk about being cancer survivors. Evidence-based prevention and treatment, and stringent expectations of quality care got us there. It is time for us to expect and do the same for those touched by substance abuse.

Over my 13 years with CCSA, I have come to appreciate that enabling collective action demands hard work from a dedicated team. And so once again, I thank CCSA’s staff for their dedication in pursuing our goals. I also thank CCSA’s Board members for giving so freely of their time, expertise and energy to support us. We were all thrilled to welcome a new Board Chair with the appointment of Leanne Lewis, who succeeds our very accomplished Interim Chair, Beverley Clarke. CCSA continues to benefit greatly from the wisdom and passion for our cause of all our Board members and alumni.

CCSA’s 25th anniversary gives us the occasion to look back on what we’ve accomplished as a nimble, lean, innovative organization. More importantly, it gives us the opportunity to look ahead and envision what we want to achieve over the next 25 years. We will continue to guide collective action on substance abuse in Canada. We will do so to ensure that all communities have access to effective tools for prevention and intervention and all Canadians can count on receiving high-quality, evidence-based treatment and support—for the health of our citizens and communities across the country.

Michel Perron
CEO
Message from the Chair

It was an honour to be appointed Chair of CCSA’s Board of Directors in February of this year. With the organization’s 25th anniversary approaching in August, I am especially aware of the legacy that precedes me, reaching back to the first holder of this role, the remarkable David Archibald.

I can say with confidence that the current Board of distinguished volunteers shares the passion and commitment of its predecessors. It also reflects the diversity of the substance abuse field at large, made up of physicians, lawyers, policymakers, enforcement personnel and representatives of the volunteer and not-for-profit sectors who hail from across the country. In many cases, their daily work connects them to the frontlines of substance abuse prevention and treatment.

The CCSA also benefits from the diversity and knowledge of our large Board Alumni group. The brainchild of former Chair Barry King, CCSA values the ongoing opportunity to access the considerable knowledge and expertise of retired directors.

Last year, Board members used their community ties to support CCSA’s Cross-Canada Dialogue, facilitating collective action by coordinating conversations among local leaders and CCSA representatives to identify common priorities and opportunities for partnership.

An overarching priority for organizations today, of course, is to get maximum value from every dollar spent and to spend as little as possible. Ensuring prudent spending was an ongoing focus for our Board in 2012–2013, as was supporting CCSA’s efforts to share knowledge and disseminate tools that help other organizations in the field do the same. For example, recently, the Association des centres de readaptation en dépendance du Québec used our national Competencies as a key ingredient in its work to build comprehensive skill sets for those working in the treatment system in that province.

Those tools have value not only here in Canada, but also internationally. I was pleased to be contacted by an NGO worker from Uganda, who wanted me to know that his and two other African countries were using the Canadian Standards for Youth Substance Abuse Prevention because of their practicality and clarity.

I believe it is testament to the effectiveness of CCSA’s resources—and its ability to foster collective action—that the organization today has a network of more than 1,500 partners. As that network continues to grow, CCSA will continue to punch above its weight: for example, marshalling the full spectrum of vested stakeholders to implement the recommendations of the prescription drug misuse strategy launched last year.

Leveraging connections ensures that the tools developed by CCSA and its partners get into the hands of those who will use them, as was the case with the alcohol Screening, Brief Intervention and Referral tool adopted by the College of Family Physicians of Canada last year.

As so much of what we do involves the dissemination of knowledge, best practices and tools, it is vital that we have a strong, recognizable profile in the country’s substance abuse landscape. To aid the organization on that front, last year CCSA refreshed its brand, adopting a colourful, dynamic graphic identity that symbolizes collaboration and evokes optimism: the sense that, with hard work, collaboration, an evidence-based approach and the flexibility to adapt, we can effect change. To ensure the Board itself functions to its full potential, in 2013–2014 we will be introducing Board assessment tools.

In closing, I want to thank our outgoing Chair, Beverley Clarke, for making my transition into the role smooth and seamless, and also to acknowledge outgoing Board members Rusty Beauchesne and Darryl Plecas for their many contributions during their terms. Finally, I welcome William King and Meredith Porter, who joined our Board last year.

The CCSA has provided impactful leadership in confronting the challenges of the evolving field of substance use and abuse over the past 25 years. I know from all that I have seen of this organization that those are only the very beginnings of what’s to come.

Leanne Lewis
Chair
With Canada the second-greatest consumer of prescription opioids in the world, it’s no exaggeration to call prescription drug misuse a crisis in this country. The problem reaches into every corner of society, disregarding all socioeconomic and demographic boundaries and leading, at its most severe, to overdoses and deaths. If there was ever a challenge that demanded collective action, this is it.

The prescription drug crisis brings home the harms of misuse and addiction to thousands of Canadians.

LOOKING BACK

A problem with deep roots
Back in the 1960s, the Rolling Stones offered a cautionary tale about the potential harms of prescription medications in their song “Mother’s Little Helper.” If anything, over the last 25 years our relationship to such drugs has grown more complex: between 2000 and 2010, Canadian use of prescription opioids rose by 203%.
Physicians cannot, by themselves, prevent the negative consequences of prescription drug misuse. We need to do a better job of assessing and managing patients with chronic pain, but this is only one of the areas where prescription drug misuse is a factor. It’s very obvious from the work of the group that this problem involves several sectors of society.

Dr. Francine Lemire, Canadian College of Physicians

**Those misusing prescription drugs**—specifically sedatives and tranquilizers, stimulants and opioids—are changing the face of addictions. They don’t fit society’s stereotypical “street user” image: they’re moms, dads, children and grandparents, colleagues, neighbours and friends. They access drugs in many ways—from legitimate prescriptions, Internet purchases and family medicine cabinets to fraud, forgery and buying off the street—and risk devastating consequences.

In Ontario between 2005 and 2011, the number of emergency room visits for narcotic withdrawal, overdose, intoxication, psychosis and harmful use spiked 250 percent. Visits for opioid-related mental and behavioural disorders also climbed. While Canadian data are scarce, the United States estimates prescription opioid misuse on its own carries a price tag of $50 billion a year, mostly owing to lost productivity and crime.

**Accelerating collective action**

In 2012 CCSA’s CEO and co-chairs Dr. Susan Ulan and Carolyn Davison led a group of 40 partners in forming the National Advisory Council (NAC) on Prescription Drug Misuse to tackle the issue head on. Using the highly effective collaborative model CCSA established five years earlier to define Canada’s National Alcohol Strategy, the NAC reached consensus on 58 recommendations in just 14 months, summarized in a ground-breaking strategy called *First Do No Harm: Responding to Canada’s Prescription Drug Crisis*, launched in March 2013. Those recommendations were grouped into action areas to be pursued over the next 10 years: Prevention, Education, Treatment, Monitoring and Surveillance, and Enforcement.

The formation of the NAC marked the first collaboration among the full range of prescription drug stakeholders in Canada: government, industry, First Nations, law enforcement, coroners, physicians and other frontline health professionals, and consumers and their families.

Complementing the strategy, CCSA produced summary reports on the prevalence and harms associated with the use of prescription opioids, stimulants, sedatives and tranquilizers. Going forward, the National Advisory Council will lead implementation of the recommendations, with emphasis first on those achievable within the next 24 months.
Preventing the harms of alcohol starts with changing our culture

Alcohol is the third leading cause of the global burden of disease, but despite its toll on our health and communities it remains deeply woven into our social fabric. Eighty percent of Canadians drink. With risky alcohol use increasing for some segments of the population, particularly women, and a growing variety of alcoholic drinks coming into the market—including highly caffeinated and sweetened beverages—promoting a culture of moderation is critical if we want to prevent alcohol-related harms.

LOOKING BACK
Shifting social attitudes
It was not so long ago that people smoked in restaurants and routinely drove home intoxicated from social events. Awareness-raising campaigns and effective policies successfully shifted public attitudes on tobacco, as well as drinking and driving—and can do the same where problematic drinking is concerned.

9,495 downloads of caffeinated alcoholic beverages documents
The situation in Canada has improved dramatically over the last 20 years, mostly because of the combination of many efforts. While we may still need more targeted interventions, I am immensely proud of CCSA’s dedication to finding the middle ground. Building consensus takes great diplomacy and conviction. What they have achieved over the last four or five years is absolutely astonishing.

Hubert Sacy, Éduc’alcool

The launch of Canada’s Low-Risk Drinking Guidelines (LRDGs) marked an important step in that direction. Released in 2011–2012 after three years of collaborative work by experts, advocates, industry representatives, health authorities and others, the LRDGs set standardized thresholds for “safe” drinking in Canada. The first nationally standardized drinking guidelines, they were supported by every federal, provincial and territorial minister of health in the country.

CCSA built a Screening, Brief Intervention and Referral (SBIR) tool based on the guidelines to help physicians detect and address early signs of alcohol misuse, using a simple three-step process to start the conversation with their patients. The College of Family Physicians of Canada took the lead to connect this resource with physicians across the country, rolling it out to its 40,000 members this past year. Working with partners aligns with CCSA’s sustainability model, which aims to see tools in the hands of organizations that can oversee their implementation more widely and effectively.

A difficult relationship

Part of what makes changing people’s relationship to alcohol so difficult is the fact that the sale of alcohol is profitable and represents a significant source of provincial and territorial revenues. Its social cost, however—which includes healthcare and law enforcement expenses as well as lost productivity—exceeded $14 billion a year when last calculated in 2006.

Beyond launching the SBIR early intervention tool, last year CCSA explored the pricing and taxation of alcoholic drinks and their impact on consumption. Pricing policies are already being used successfully in Europe, Australia and the U.S. as ways to reduce alcohol consumption and related harms. In 2012–2013, CCSA produced three research papers on pricing tactics and held two webinars to spur discussion of its findings and inform policy across Canada consistent with the National Alcohol Strategy.

Understanding the risks of new alcoholic drinks and drinking behaviours is also important to mitigating harms. On this front, CCSA partnered with the Centre for Addictions Research at the University of BC (Victoria) last year to produce a research report and fact sheets about caffeinated alcoholic beverages, raising awareness of the health risks and risky drinking behaviour such drinks can promote.
More potent drugs mean more potent harms for risk-taking youth

Today’s constantly connected, high-speed way of living fuels expectations of instant gratification in virtually every aspect of daily life, including substance use, where youth are seeking drugs that work faster and deliver more powerful highs. Yet as the 2007 edition of Substance Abuse in Canada reported, youth are developmentally vulnerable to the effects of drugs and alcohol, with consequences that can carry far into adulthood. All of this underscores the need for a standardized, evidence-based approach to drug prevention among our youth.

LOOKING BACK
Mixed messages on drugs
The message to youth used to be clear: “Recreational drugs are against the law.” But with the availability of medical marijuana, public debate over legalizing pot and media coverage that often winks at celebrity drug use, young people may no longer see their choices in quite such black-and-white terms. Today in Canada more teens use legal prescription opioids than tobacco—a sharp indication that times have changed.
All young people have to make decisions about substance use. When prevention and early intervention are evidence-based and sustained, they have very real potential to prevent needless harm. We need a comprehensive, wraparound approach to have impact because that’s how people integrate information. The “gumdrop” approach of a lecture now and then won’t do.

Canadian youth today have access to more substances than any previous generation—licit and illicit, natural and synthetic. They are the largest per capita users of cannabis among peers in other G8 countries. Even more concerning is that dangers associated with substance use and abuse have intensified with the introduction of trendy drugs and prescription medications like fentanyl, which has roughly 100 times the potency of morphine and has caused overdose-related deaths.

To advance the prevention agenda, last year seven pilot projects applying the Canadian Standards for Youth Substance Abuse Prevention were held across the country. The Standards, published in 2010–2011, were developed by a wide range of expert stakeholders with CCSA facilitation to help schools, communities and families with prevention efforts. To ensure that knowledge and best practices from the pilots would be shared, CCSA published online case studies that give other jurisdictions real-world examples of how to adapt the tools to their local contexts.

Extending prevention efforts among youth

In 2012–2013, CCSA laid the foundation for ongoing work in youth substance abuse prevention with projects that included surveying youth attitudes on cannabis, exploring sport as a vehicle for substance use prevention, investigating the links between substance abuse and eating disorders, and researching technical competencies for the youth prevention workforce. These projects will provide a stronger evidence base and improve the quality of drug prevention efforts and youth interventions in the future.

To track emerging drug trends, last year CCSA engaged in two new collaborations, linking CCSA’s CCENDU (the Canadian Community Epidemiology Network on Drug Use) with ReDNet (the Recreational Drugs European Network) and the Global Public Health Intelligence Network (GPHIN) of Canada’s Public Health Agency. This expanded knowledge exchange will give Canadian practitioners and researchers earlier insights into drugs, drug trends and drug habits that could cross borders and enter the lives of youth here in Canada.
Bridging gaps and toppling silos to build a stronger treatment system

Canadians depend on our country’s healthcare system to deliver accessible, high-quality, scientifically sound treatments for everything from sprained ankles to cancer. Yet too often those expectations go unmet when it comes to getting help for substance abuse problems. Decades of fragmentation and isolation have led to duplicate efforts, limited options, inconsistent access and variable effectiveness among treatment services. Better use and sharing of evidence-based practices are essential to strengthen and sustain the treatment system and deliver effective, high-quality care to those who need it.

9,147 downloads of components of the Competencies for Canada’s Substance Abuse Workforce

LOOKING BACK
The evolution of treatment
In 1988, harm reduction was a very new part of the treatment continuum, developed mainly in response to HIV/AIDS. Today, harm reduction programs like needle exchanges and methadone maintenance treatment are in place across Canada.
We know depression and anxiety are prevalent, that people self-medicate with substances, and that stigma keeps people from going for care. Integrating mental health and addiction services with primary health care could be a game-changer for normalizing the issues and facilitating early intervention, so we can get out ahead of these things instead of waiting for a crisis to happen.

Terry Gudmundson, Special Advisor to the Deputy Minister
Deputy Minister’s Office, Ministry of Health, Saskatchewan

In 2011–2012, CCSA and its partners established the SystemAction virtual network to facilitate knowledge sharing across what have traditionally been closed-off silos in the treatment field. Last year the network expanded to include a broader range of individuals and organizations, and CCSA worked to cultivate a research-informed culture by co-hosting webinars on evidence-informed decision making and newly released guidelines on trauma-informed care for women. A third-party evaluation found SystemAction helped “reduce duplication of efforts and improve treatment services” by promoting the sharing and re-use of existing practices.

Bringing treatment into focus

Canada’s substance abuse field has long lacked a complete national picture of treatment, treatment use and its costs. CCSA has been working to fill this gap, in 2012 publishing the first-ever National Treatment Indicators Report, which tracks the use of addictions treatment services and supports. A second edition was published in 2013, featuring an expanded set of indicators, more provinces and territories, and data on driving-while-impaired programs. A third round of indicator data collection got underway last year, looking for the first time at the impact and cost of treatment in Canada.

CCSA continued to support the implementation and dissemination of resources related to Canada’s National Treatment Strategy in 2012–2013, publishing a workbook on its Tiered Model and Systems Approach and hosting a webinar to facilitate the uptake of system-improving tools.

Strengthening the system is important if addiction is to be dealt with like other disorders and diseases and to ensure those in vulnerable communities are not overlooked. People whose substance abuse problems are compounded by mental health issues, for example, are more at risk of not getting the support and services they need. This risk is significant given that up to 20 percent of those seeking addiction support also require mental health support, and 50 to 60 percent of those seeking mental health care have substance abuse issues. CCSA continued working with the Mental Health Commission of Canada and the Canadian Executive Council on Addictions to enhance collaboration between mental health and addictions services, and improve overall outcomes of care.
Our Financial Health


To the Directors of the Canadian Centre on Substance Abuse

The accompanying summary financial statements, which comprise the summary statement of financial position as of March 31, 2013, the summary statement of operations and summary statement of cash flows for the year then ended, are derived from the audited financial statements of the Canadian Centre on Substance Abuse (the Centre) for the year ended March 31, 2013. We expressed an unmodified audit opinion on those financial statements in our report dated July 26, 2013.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the Centre.

Management’s Responsibility for the Summary Financial Statements

Management is responsible for the preparation of a summary of the audited financial statements on the basis described in Note 1.

Auditor’s Responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, “Engagements to Report on Summary Financial Statements”.

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of Canadian Centre on Substance Abuse for the year ended March 31, 2013, are a fair summary of those financial statements, in accordance with the basis described in Note 1.

Comparative Information

Without modifying our opinion, we draw attention to the fact that the Canadian Centre on Substance Abuse adopted Canadian accounting standards for not-for-profit organizations on April 1, 2012, with a transition date of April 1, 2011. These standards were applied retrospectively by management to the comparative information in these financial statements, including the statements of financial position as at March 31, 2012, and April 1, 2011, and the statements of operations, changes in fund balances and cash flows for the year ended March 31, 2012. We were not engaged to report on the restated comparative information, and as such, it is unaudited.

Raymond Chabot Grant Thornton LLP

Chartered Accountants,
Licensed Public Accountants

Ottawa, Canada
July 26, 2013

Note 1: The information selected by management for presentation in the Summary Annual Financial Statements has been identified as being the most pertinent and useful financial data for inclusion in the Centre’s annual report.
### SUMMARY STATEMENT OF FINANCIAL POSITION

**As at March 31, 2013**

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<thead>
<tr>
<th>CURRENT ASSETS</th>
<th>31/03/2013</th>
<th>31/03/2012</th>
<th>01/04/2011</th>
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<td>Short-term investments</td>
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<td>$3,254,950</td>
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<td>Trade payables and other operating liabilities</td>
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<td><strong>Total Current Liabilities</strong></td>
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<tr>
<td>FUND BALANCES</td>
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<td><strong>Total Fund Balances</strong></td>
<td>$3,418,764</td>
<td>$3,254,950</td>
<td>$3,591,631</td>
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### SUMMARY STATEMENT OF OPERATIONS

**Year Ended March 31, 2013**

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<tr>
<th>REVENUES</th>
<th>31/03/2013</th>
<th>31/03/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Canada grant</td>
<td>$3,750,000</td>
<td>$3,750,000</td>
</tr>
<tr>
<td>Health Canada contributions</td>
<td>2,705,859</td>
<td>2,846,815</td>
</tr>
<tr>
<td>External contracts</td>
<td>160,439</td>
<td>281,490</td>
</tr>
<tr>
<td>Conference</td>
<td>448,118</td>
<td></td>
</tr>
<tr>
<td>Other income</td>
<td>19,393</td>
<td>39,906</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>6,635,691</td>
<td>7,396,419</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th>31/03/2013</th>
<th>31/03/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and benefit</td>
<td>4,111,090</td>
<td>4,248,197</td>
</tr>
<tr>
<td>Contractors</td>
<td>942,405</td>
<td>1,120,964</td>
</tr>
<tr>
<td>Equipment rental</td>
<td>16,716</td>
<td>71,528</td>
</tr>
<tr>
<td>Cost-shared projects</td>
<td>1,000</td>
<td>8,196</td>
</tr>
<tr>
<td>Professional development</td>
<td>50,957</td>
<td>61,244</td>
</tr>
<tr>
<td>Insurance</td>
<td>11,643</td>
<td>11,635</td>
</tr>
<tr>
<td>Honoraria</td>
<td>18,798</td>
<td>35,554</td>
</tr>
<tr>
<td>Rent</td>
<td>254,108</td>
<td>248,582</td>
</tr>
<tr>
<td>Travel</td>
<td>677,084</td>
<td>827,468</td>
</tr>
<tr>
<td>Evaluation</td>
<td>75,619</td>
<td>55,452</td>
</tr>
<tr>
<td>Office and administration</td>
<td>327,153</td>
<td>375,407</td>
</tr>
<tr>
<td>Membership fees</td>
<td>19,008</td>
<td>19,365</td>
</tr>
<tr>
<td>Professional fees</td>
<td>56,503</td>
<td>33,602</td>
</tr>
<tr>
<td>Printing</td>
<td>32,875</td>
<td>146,350</td>
</tr>
<tr>
<td>Public relations and marketing</td>
<td>35,203</td>
<td>84,472</td>
</tr>
<tr>
<td>Amortization of tangible capital assets</td>
<td>232,524</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>6,819,695</td>
<td>7,550,510</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NET INVESTMENT INCOME</th>
<th>31/03/2013</th>
<th>31/03/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on investments</td>
<td>58,920</td>
<td>60,280</td>
</tr>
<tr>
<td>Dividend income</td>
<td>12,913</td>
<td>9,944</td>
</tr>
<tr>
<td>Changes in fair value of investments</td>
<td>16,950</td>
<td>(49,600)</td>
</tr>
<tr>
<td>Investment management fees</td>
<td>(9,603)</td>
<td>(8,911)</td>
</tr>
<tr>
<td><strong>Total Net Investment Income</strong></td>
<td>79,180</td>
<td>11,713</td>
</tr>
</tbody>
</table>

| DEFICIENCY OF REVENUES OVER EXPENSES | (104,824) | (172,378) |

### SUMMARY STATEMENT OF CASH FLOWS

**Year Ended March 31, 2013**

<table>
<thead>
<tr>
<th>CASH FLOWS PROVIDED BY (used in)</th>
<th>31/03/2013</th>
<th>31/03/2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating activities</td>
<td>$678,586</td>
<td>$146,485</td>
</tr>
<tr>
<td>Investing activities</td>
<td>6,216</td>
<td>(242,231)</td>
</tr>
<tr>
<td>Net increase (decrease) in cash</td>
<td>684,802</td>
<td>(96,746)</td>
</tr>
<tr>
<td>Cash and cash equivalents, beginning of year</td>
<td>122,070</td>
<td>217,816</td>
</tr>
<tr>
<td>Cash and cash equivalents, end of year</td>
<td>$806,872</td>
<td>$122,070</td>
</tr>
</tbody>
</table>
Our Leadership

CCSA is governed by a Board of Directors consisting of a Chairperson and 12 directors whose backgrounds or experience assist CCSA in the fulfillment of its purpose. The Chairperson and up to four other directors may be appointed by the Governor in Council on the recommendation of the Minister of Health. Up to eight directors may be appointed by the Board.

PATRON
CCSA enjoys the honorary patronage of His Excellency the Right Honourable David Johnston C.C., C.M.M., C.O.M., C.D. Governor General of Canada

BOARD of DIRECTORS

GOVERNOR IN COUNCIL APPOINTEES
Leanne Lewis
Chairperson (appointed February 7, 2013), Chair of the Executive Committee
Community Volunteer

Beverley Clarke
Interim Chairperson (term ended March 18, 2013)
Vice President, Clinical Services, Eastern Health

Sherry H. Stewart
Corporate Secretary; member of the Executive and the Nominations and Governance Committees
Professor, Departments of Psychiatry and Psychology, Dalhousie University

MEMBERS AT LARGE

Dr. Jean-François Boivin
Member of the Finance Committee
Professor, Department of Epidemiology, Biostatistics and Occupational Health, McGill University

Jean T. Fournier
Treasurer; Chair of the Finance Committee, member of the Executive and Nominations and Governance Committees
Retired Senate Ethics Office, Office of the Senate

William King
Member of the Audit Committee
Owner, Sagebrush Communications Inc.

Meredith Porter
Member of the Audit Committee
Lawyer, Porter Law

Michael Prospero
Corporate Secretary; Chair of the Audit Committee and member of Executive and Nominations and Governance Committees
Retired Superintendent of Education, Dufferin-Peel Catholic District School Board

EX-OFFICIO MEMBERS

François Guimont
Deputy Minister; Public Safety Canada

Glenda Yeates
Deputy Minister, Health Canada (retired August 1, 2013)

George Da Pont
Deputy Minister, Health Canada (as of August 12, 2013)

Perron, Michel
Chief Executive Office, Canadian Centre on Substance Abuse

Pierre Sangollo
Member of the Finance Committee
National Investigator, National Board of Investigators and Audits, Correctional Service of Canada

Paula Tyler
Vice Chair; Chair of the Nominations and Governance Committee and member of the Executive Committee
President, Norlien Foundation

ALUMNI MEMBERS

Barry V. King, Chair (Ontario)
Dr. André Aubry (Quebec)
Normand (Rusty) Beauchesne (Ontario)
Leonard Blumenthal (Alberta)
Beverley Clarke (Newfoundland)
William Deeks (British Columbia)
Mike DeGagné (Ontario)
Frances Jackson Dover (Alberta)
Dr. Nady el-Guebaly (Alberta)
Ed Fitzpatrick (New Brunswick)
Karen Gervais (Ontario)
Maggie Hodgson (Alberta)
Heather Hodgson Schleich (Ontario)
Dr. Harold Kalant (Ontario)
Roger D. Landry (Quebec)
Anne M. Lavack (British Columbia)
Jacques LeCavalier (Quebec)
A.J. (Bert) Liston (Ontario)
Dr. Christine Loock (British Columbia)
Barry MacKillop (Ontario)
Mark Maloney (Ontario)
Marnie Marley (British Columbia)
R. (Sandy) Morrison (Ontario)
Louise Nadeau (Quebec)
J. David Nicholson (Prince Edward Island)
Darryl Plecas (British Columbia)
Rémi Quirion (Quebec)
Dean W. Salsman (Nova Scotia)
Jan Skirrow (British Columbia)
Margaret Thom (Northwest Territories)

16,532 downloads of Clearing the Smoke on Cannabis series
Our Team
As of August 1, 2013

EXECUTIVE OFFICE
Michel Perron
Chief Executive Officer
Rita Notarandrea
Deputy Chief Executive Officer
Nathalie Amireault
Executive Assistant to the Deputy CEO
Patricia Robb
Senior Executive Assistant and Corporate Secretary
Shannon Smith
Facilities and Executive Office Administrative Assistant

FINANCE
Darwin Ewert
Director, Finance (interim)
Susan Landreville
Accountant
Thushara Ponnampalam
Accounts Payable Coordinator (interim)
Chyloe Sangster
Accounts Payable and Payroll Coordinator

HUMAN RESOURCES
Darlene Pinto
Director, Human Resources
Robert Chon
Human Resources Generalist

INFORMATION SYSTEMS AND PERFORMANCE MEASUREMENT
Rhowena Martin
Director, Information Systems and Performance Measurement
Manon Blouin
Database and Metadata Specialist

HEATHER COLES
Web Manager
Olivera Duka
Project Coordinator
Ben Giroux
Information Technology and Website Support Technician (interim)
David O’Grady
Information Technology Manager
Karen Palmer
Records and Information Specialist
Susan Rosidi
Database Coordinator
Ellen Spencer
Web and Multimedia Specialist

PUBLIC AFFAIRS AND COMMUNICATIONS
Benoit Violette
Director, Public Affairs and Communications
Tina Barton
Communications Advisor
Jody Brian
Communications Manager
Emerita D’Sylva
Administrative Assistant (PAC and ISPM)
Chris Groult
Graphic Designer and Production Coordinator
Suzanne Stoltz
Communications Advisor
John Thurston
Communications Production Manager
Miljana Vacic-Orange
Translator-reviser (interim)

RESEARCH AND POLICY
Cheryl Arratoon
Director, Research and Policy
Alison Ayoub
Administrative Assistant
Heather Clark
Research and Policy Analyst
Chad Dubreau
Information Specialist
Rebecca Jesseman
Research and Policy Analyst
Tyler Pirie
Research and Policy Analyst
Amy Porath-Waller
Sr. Research and Policy Analyst
Matthew Young
Sr. Research and Policy Analyst

STRATEGIC PARTNERSHIPS AND KNOWLEDGE MOBILIZATION
Robert Eves
Director, Strategic Partnerships and Knowledge Mobilization
Karine Diedrich
National Priority Advisor
Carolyn Franklin
National Priority Advisor
Sheena Gereghy
Knowledge Broker
Elva Keip
National Priority Advisor

Rod Olfert
Knowledge Broker
Paula Robeson
Knowledge Broker
Michael Stephens
Knowledge Broker
Heather Wilcox
Administrative Assistant
Tamara Williams
National Priority Advisor

ASSOCIATES
Doug Beirness
Subject Matter Expert: Impaired Driving
Colleen Dell
Expert: Inhalants, Gender and FNIM
Research Chair in Substance Abuse Professor, Department of Sociology and School of Public Health, University of Saskatchewan
Dave Hedlund
Advisor, Drug Treatment Funding Program
Franco Vaccarino
Chair, Scientific Advisory Council Professor of Psychology and Psychiatry, University of Toronto

ON LEAVE
Angela Asquenzai
Accounts Payable Coordinator
Patricia-Anne Croteau
Translator-reviser
Anne Richer
Director, Finance
Lili Yan
Information Technology and Website Support Technician

12.7%
Increase in partners and stakeholders from previous year