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● (0940)

[*English*]

The Chair (Ms. Paddy Torsney (Burlington, Lib.)): I will call this meeting to order.

We are the Special Committee on the Non-Medical Use of Drugs. We were struck, pursuant to an order of reference adopted by the House of Commons on Thursday, May 17, 2001, to consider the factors underlying or relating to the non-medical use of drugs. After April 2002 we were referred the subject matter of a private member's bill, an act to amend the Contraventions Act and the Controlled Drugs and Substances Act related to marijuana.

We are very pleased to have with us this morning representatives from the Department of Health. Dann Michols is the Assistant Deputy Minister, healthy environments and consumer safety branch. Mr. Michols, I'll let you introduce the rest of your team. We are very pleased to have you talk to us about Canada's drug strategy and what your department is doing.

Mr. Dann Michols (Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Department of Health): Thank you very much, Madam Chair, for the invitation to appear today. We particularly appreciate the opportunity to speak with you at the end of your process, as well as at the outset.

On my left is Dr. Gillian Lynch, the director general of the drug strategy and controlled substances program. On her left is Beth Pieterson, the associate director general. On my right is Carole Bouchard, the director of the office of controlled substances. Among us, we should be able to answer any questions you might have on the drug strategy, but most particularly on Health Canada's activities within it.

We have prepared a brief, which I believe has been handed out and which I will speak to as quickly as I can. We thought the purpose of this appearance might be twofold. Certainly, we are here to answer any questions you might have about Health Canada's role in the development and implementation of a comprehensive drug strategy for Canada, now that you have been immersed in the subject for a number of months. We also thought it might be useful to share with you some of our thinking on the development of a comprehensive strategy and on the challenges, particularly the challenges facing federal public policy-makers as you pull together your ideas, your recommendations, and your report.

You have heard a lot of evidence from many presenters and many points of view. You now have considerable knowledge on the breadth of the substance abuse problem in Canada, on the depth of that problem, and certainly on the complexity of the interventions in this area. Slide 3 provides a scant overview of the breadth of drug and substance abuse in Canada. Drug and substance abuse is increasing in Canada. It is not only substances that are normally considered to be narcotics, as you found out from a number of presenters yesterday. Misuse of therapeutic products is a continuing concern for governments and professional associations. We have learned that regulations and interventions must be flexible and constantly vigilant, as man's ingenuity in abusing some of these substances is truly amazing. I use the example of OxyContin. Alcohol remains the most commonly abused substance.

There is one ray of good news. The one substance for which we do see a significant reduction in use is tobacco. There are some lessons to be learned from that situation. It reflects the advantages of a comprehensive national strategy with a commitment to significant funding in support of coordinated activities across governments, NGOs, and other stakeholders. This is what we would like to see reinforced with regard to the abuse of other substances.

Slide 4 perhaps demonstrates the depth of the problem we face, and it is but one example, the use of different substances by grade 10 students in 1994 and 1998, drawn from a study by the World Health Organization. In general, use was higher in boys than girls. Between these years the use of all substances that are listed increased. Similar increases in use were demonstrated by grade 8 children as well.

One thing that is not represented here is the use of steroids. Steroids were not included in this survey, but are of concern because use is most often found in otherwise healthy athletic youth. In addition, our data show that 20% of all injection-drug users are steroid users. The likelihood of contracting a communicable disease due to needle sharing is a major concern in an otherwise healthy population.

You know the impacts of substance abuse on individuals, families, and society are broad and far-reaching. Fetal alcohol syndrome is estimated to affect 3 in 1,000 births. This causes a combination of mental and physical defects by affecting the growth and proper formation of the fetus' body and brain. At least one child in Canada is born each day with full fetal alcohol syndrome.

Over one-third of the new HIV cases in 1999 were attributable to intravenous drug use. It has been estimated that there are 4,500 new hepatitis C infections per year in Canada, of which 63% are related to injection-drug use.

Alcohol is a continuing factor in road accidents, leading to significant health care costs.

You have been exposed to much more evidence than this of the need for society to place a priority on addressing this issue. We now have to come to terms with how all this information and data can be organized to make decisions on objectives to be set, on partnerships to be formed, on resources to be allocated, and on interventions to be made. Slide 6 presents a very busy model that attempts to visually demonstrate some of the players and their relationships.

A vision is needed of what is to be accomplished. Historically, in Canada that has involved a combination of activities to reduce supply and to reduce demand. It has always included a long-term goal of seeking to reduce the harm caused by abuse of these products. It has involved many partners, including 11 federal departments and agencies, all provinces and territories, municipalities, and a range of non-governmental organizations, with a special contribution being made by the Canadian Centre for Substance Abuse. The strategy has been composed of four broad categories of activities, on which I will give more detail in a moment.

I would like to say that knowledge development and management must be seen as a foundation for any decision-making activity to be undertaken. There are many stakeholders, and the beneficiaries include all Canadians. Communication is the key activity without which the whole strategy will not succeed.

Canada's first drug strategy was approved in 1987 with funding of $210 million over five years. The focus was on prevention, education, and research. The strategy was renewed in 1992 for a further five years. During that time approximately $104 million was spent in support of the strategy. The last renewal was in 1998 and resulted in approval of the strategy, but the funding level was severely reduced. We now have the opportunity to develop the next generation of a national effort to combat drug abuse, but a sustained effort with adequate resources allocated is essential. Your findings, those of other committees, the research and experiences of those who have appeared before you, and international experience can now be combined for the consideration of the government.

While the Minister of Health and Health Canada have a particular role to play as lead for the development and management of a national drug strategy, we also have a particular responsibility to deal with the health impacts caused by the abuse of these substances. Slide 7 uses the same model as the previous slide to depict Health Canada's roles and activities in the current drug strategy. Many, if not all, of Health Canada's branches are involved in this struggle, but especially, my branch, which is the lead, acts as the regulator of controlled substances, provides services to various law enforcement agencies, and supports a number of health partners in a number of projects. The population and public health branch monitors and develops strategies to combat communicable diseases and the first nations and Inuit health branch is responsible for the health programming for these populations.

Slide 8 shows the current expenditures of Health Canada in working towards the goals of the drug strategy, with $34 million per year going to support the activities of the drug strategy and controlled substances program, which is in direct support of the drug strategy. The first nations and Inuit health branch expends approximately $70 million a year in support of the national native alcohol and drug abuse program, which provides prevention, treatment, and rehabilitation services to first nations on reserve. There is some additional contributory funding provided by the population and public health branch toward activities in the area of FAS/FAE and communicable diseases.

In describing Health Canada's role, activities, and our view of the challenges ahead, I would like to use the model on slide 9 as a means to structure the development of a national strategy and to consider possible components.

Coordination, consultation, and communication are key activities that support the management of the process. Research and other methods of knowledge development must form the foundation of policy and program development. Analysis of this information and data leads to consideration of policy alternatives and goals, the determination of appropriate programming interventions, the setting of performance measures, and the allocation of resources. These interventions are designed, consulted upon, and implemented, and the results measured. The evaluation of these interventions, their outcomes, and their impacts then feeds back into the research and knowledge development. I would now like to outline some of our current initiatives under each one of these areas and present you with some thoughts on what challenges we think lie ahead.

The first component is research and knowledge development. To develop and maintain any strategy, we need accurate, current data and information. At present the available data is fragmented, inconsistent, and not coherent with the strategy goals. The Auditor General noted this in a recent report, and we agree. Analysis and use of the available data, as well as identification of gaps, need improvement. We need to understand what data are required, from whom they are required, and how they can be collected and used. Having listened to a range of experts, the committee's views in this area would be most appreciated.

● (0945)

Research and knowledge management was a priority of the first cycle of the drug strategy. At that time the Canadian Centre on Substance Abuse was set up. In 1989 and again in 1994 the Canadian alcohol and drug survey was conducted, providing the beginning of national trend information. Resources have not been available since 1994 to support the repeating of this survey.

Health Canada is attempting to explore a number of improvements. We're exploring options within existing funding of an ongoing survey similar to CTUMS, the Canadian tobacco use monitoring survey, produced by Statistics Canada for our tobacco control program.

We need an updated study on the costs to society of substance abuse. The last study was undertaken in 1996 using 1992 data, and we're exploring opportunities to renew that work in 2003. Currently, Health Canada receives a lot of data that are not systematically mined for information. Examples would be the seizures data we receive from police forces across the country, or even the data our own drug analysis labs have on what is coming into the labs for analysis, which could tell stories about trends and emerging issues. We are improving our analytical capacity to make better use of existing data and to help identify the gaps in the new data that are required.

There are, however, a number of challenges we face in this area. We need to create an accurate inventory of what data relative to the drug strategy are being collected across Canada and, from that inventory, identify gaps in knowledge. These data should be drawn from the activities of our partners and stakeholders. We need to develop and establish national indicators against which all partners and stakeholders can agree to collect data annually, and we need to maintain these activities in the long term to determine trends.

We need the capacity to collect and analyse the data on a national basis, which requires an ongoing commitment of funding to maintain the databases, to perform regular high-quality analysis, to participate in required research studies, to collaborate nationally and internationally, and to create reports on such things as best practices and new and innovative initiatives across all parts of the drug strategy and of the country.

The second component is policy development. Policy development is a process that enables us to identify what needs to be done, by whom, and the best mechanisms to do it. It enables us to set priorities for what will always be limited resources in comparison to the need. Currently, Health Canada has an active policy agenda on issues involving both the reduction of supply and the reduction of demand.

While we await the recommendations of your committee, we are maintaining the networks of federal and national partners needed to come to agreement on the possible content of a renewed drug strategy. The consultative process undertaken by the work of your committee will be an important input into the development of any renewed strategy.

Again, there are challenges. Substance abuse does not happen in isolation. A 1997 study conducted by Health Canada found that 30.9% of the street youth interviewed had experienced identifiable verbal, physical, or sexual abuse, or some combination of all three. We need to better understand these dynamics. We need to understand and manage the many different determinants of behaviour in relation to drug abuse. We need to understand the relationships between existing systems, such as the health care system and those dealing with education, employment, housing, policing, corrections, etc. We need to establish and maintain consultation and collaboration across a broad base of stakeholders, government and non-governmental, with differing agendas and differing needs.

The third component involves the actions that need to be undertaken. Legislation and legislative change provide one possible outcome of policy development. Legislation and its subsequent regulations provide the legal framework within which we can act. We have relatively recent legislation. The Controlled Drugs and Substances Act was passed in 1996 and came into force in 1997. It is administered by Health Canada and lays out the processes by which substances are controlled and by which they can be obtained for legitimate purposes, while minimizing the opportunities for diversion and misuse.

Canada is a signatory to three UN drug control conventions, and Health Canada is the national competent authority for administration of these conventions. Before now, we and other federal departments have come before you, laying out the provisions of these conventions and the consequences of working outside them.

● (0950)

Health Canada has been active over the last several years in developing and implementing new regulations, industrial hemp regulations in 1998, marijuana medical access regulations last year, and precursor control regulations this year. We know the narcotic control regulations are out of date and need to be overhauled.

What else do we need to do? We need to achieve the right balance between, on the one hand, providing effective controls to minimize diversion and, on the other hand, not impeding legitimate access to controlled substances.

International drug control conventions bring together a variety of different national approaches to deal with the problem of abuse. While the conventions stipulate that measures taken to enact a convention are subject to a country's constitutional limitations, international expectations may not always be in synch with the requirements of our Charter of Human Rights and Freedoms. Developing or changing legislation or regulations is a lengthy process. We need flexible legal mechanisms that will provide a quick response when a problem is identified.

Developing an intelligent regulatory framework is only part of the battle. We also need to see that resources and mechanisms are put into place to ensure compliance with the regulations and to enforce them when there is no compliance. Health Canada shares compliance and enforcement responsibilities with several federal and provincial law enforcement agencies and with the CCRA. We monitor compliance with the regulations and investigate potential cases of diversion or misuse by regulated clients. We provide periodic inspections of regulated clients such as licensed dealers. Serious cases of non-compliance with the regulations are generally dealt with using administrative sanctions such as the non-renewal or revocation of licences, but is this adequate?

Health Canada's drug analysis service, with four laboratories across Canada, serves the police forces by providing analysis of seized products and by assisting in the dismantling of clandestine labs. Currently, Health Canada is reviewing its compliance and enforcement strategies and programs and will be increasing the number of inspectors over the next couple of years.

There are challenges. There is a need to undertake ongoing risk assessments to ensure a cost-effective balance between adequate monitoring and available resources. It is not feasible, and probably not necessary, to inspect regularly all persons or companies involved in the legitimate distribution and use of controlled substances, which is to say, licensed dealers, pharmacies, hospitals, and physicians. Resources must be targeted where they will do the most good to prevent and correct abuse and misuse.

We need a better capacity to gather and analyse data to be able to target resources more effectively. Data gathering, compliance programs, and enforcement actions need to be coordinated with different jurisdictions, and this is a challenge. For example, regulation of health professionals such as pharmacists and physicians is a provincial responsibility. When these professionals are identified as parties in cases of diversion or abuse of controlled drugs through inappropriate prescribing or dispensing, it is not always clear who has or should have the primary responsibility to take action.

Over and above legislation and regulation, there are a number of other components to the interventions we need to put into place. Our ultimate objective must be that Canadians do not misuse or abuse substances. Prevention is important, but not 100% possible. At the moment, despite our best initiatives and programs, some people will never be able to be drug-free. Therefore, a range of services is required to encourage people, especially the young, to never take up the use of such substances, to provide treatment for those ready to quit their use, and to reduce the harm to individuals and society for those who cannot quit their use. Prevention promotes the health of the population, reduces the number of people who misuse substances, and is probably the most preferable and humane approach. Prevention was a priority in the first years of the drug strategy. However, during times of fiscal restraint, the focus shifts to people already in need of treatment.

Currently, there are many ongoing innovative prevention activities within Canada, provided by provinces, municipalities, and communities. One of these is the Vancouver agreement, a five-year tripartite urban development agreement to address problems in Vancouver's downtown east side. Health Canada contributed $1 million to the Vancouver agreement in 1997 and will continue to be a strong proponent for a comprehensive and collaborative approach to tackling the serious and highly complex situation found in the downtown east side. In 2000-2001 Health Canada contributed more than $2 million for various initiatives in the downtown east side in areas such as HIV/AIDS, hepatitis C, prenatal nutrition, children at risk, and aboriginal health.

● (0955)

Although prevention has not been funded as a specific activity under the current drug strategy, there are a number of initiatives within the department that support prevention activities across the country. For example, early childhood programs such as the community action program for children, Canada prenatal nutrition program, and aboriginal headstart are oriented toward developing healthy children who are able to make healthy choices. They are examples of programs for high-risk groups that build on protective factors, including parental capacity and developing learning skills, and reduce risk factors, such as the lack of proper stimulation.

Besides these primary prevention activities, Health Canada has been active with provincial and territorial partners in developing best practice documents for use by professionals. One is “Preventing Substance Use Problems Among Young People: A Compendium of Best Practices”. This document speaks to prevention issues, principles, and programs pertaining to all youth and considers a variety of settings, such as schools and the streets. These documents have been well received by addiction workers and professionals across the country, but again there are challenges still facing us.

Prevention funds are often most difficult to justify. They tend to be provided to avoid a certain outcome and not to deal with specific individuals of communities in current difficulties. Therefore, it is a continuing challenge to ensure that sufficient and sustained moneys are provided to support prevention activities.

We need to find ways to coordinate all partners to build on strengths and to ensure that the outcomes are synergistic, especially if funding is short. It is difficult in times of fiscal restraint to have sufficient incentives to encourage partners to maintain participation over long periods.

We need to identify innovative cost-effective interventions. This again is difficult, because many of the initiatives only show results in the long term. Sustaining support and commitment for the right intervention is a major challenge.

Treatment and rehabilitation programs are operated through provincial health and social systems. Health Canada contributes to the provincial and territorial programs through the alcohol and drug treatment and rehabilitation program, which is a matching funds program. We provide $14 million a year to provinces and territories to support treatment and rehabilitation, with the main focus being on treatment for youth and women. Best practice documents again are produced by Health Canada in consultation with the provinces. According to the provinces, these documents have proven to be very successful for frontline service providers. Approximately 54,000 copies have been disseminated to date.

The national native alcohol and drug abuse program provides treatment and rehabilitation services on reserves through 61 treatment centres across the country, including eight dedicated solvent abuse centres that provide services to all first nations.

Health Canada created special regulations to support methadone treatment programs. These programs are operated under provincial jurisdiction, but Health Canada authorizes its physicians to use the product. In Canada and internationally methadone maintenance treatment remains the most widely used form of treatment for people who are dependent on opioids, but we are reviewing the mechanisms to distribute and control newer products.

Drug courts are emerging as appropriate options for managing drug addiction offences, but are often resisted, as they are seen to be putting an additional burden on an already stretched health care system. Health Canada has financially supported the Toronto drug court.

Challenges remain. Treatment and rehabilitation programs are challenging to operate and manage. Treatment is rarely easy and quickly achieved. Recidivism is common. Addicts are often unable to secure help when they are ready to take advantage of these services. The timeliness of the response is often essential to the success of the intervention. A continuum of care that can manage the patient through the treatment cycle is not well established. This affects success for both the individual and the treatment program. As well, there is not equal access in all Canadian communities, and treatment needs of individuals are often diverse, increasing the difficulty of achieving success. This is especially true for youth.

The concept of harm reduction accepts that there will always be people who abuse substances. The aim is to ensure that the harm wreaked upon the individual and society by substance abuse is reduced as much as possible. Reducing the spread of communicable disease, the deaths due to overdose, the exposure to crime, and the exposure of non-addicts to addictive behaviour and improving access to social and health services by addicts are all objectives of health reduction programs. There are a number of harm reduction programs across the country, needle exchanges being one of the best known.

● (1000)

Health Canada works with the provinces and territories to identify new and more effective initiatives. The work of the federal-provincial-territorial committee on injection-drug use is one example. A report was presented to the federal and provincial ministers of health, and if you haven't seen it, I would recommend it to you. Over 40 comprehensive recommendations were tabled by this committee. One of the more innovative suggestions is the exploration of pilot research on safe injection sites. Health Canada is currently working to identify a legal framework that would support such research projects if the provinces and municipalities responsible wish to undertake them.

Again there are challenges. Harm reduction as a concept is not acceptable to all, and more work needs to be done to explain its value to society. For harm reduction initiatives to be successful, all stakeholders in a community need to be willing to fully support the activity. An example would be the support of the police on the street, which would be critical to the success of any safe injection site project. Developing innovative, successful approaches that also respect our international obligations under the UN conventions is challenging.

Evaluation of the initiatives of any strategy is essential to ensure the most appropriate use and most effective targeting of dollars and the identification of best practices. Reporting on individual projects, such as the injection drug use project, or the review of regulations would aid all parties in selecting effective mechanisms. The challenge here is that it is difficult to attribute cause and effect in well-integrated programs. This has been well documented in successful strategies, such as our tobacco control strategy. By definition, the initiatives work better when linked to other initiatives, and differentiating their value to the end result has not been possible. Having well-defined and agreed performance measures and indicators is a requirement. This links to the research component. Developing simple, consistent measures must be a priority for any renewed strategy. Once more we have the spectre of resources. Evaluation is costly and in times of fiscal restraint tends to be a lower priority.

We believe drug and substance abuse is first and foremost a health issue for the individual and for the population at large. For this reason, Health Canada has been given the lead role in developing and managing Canada's drug strategy. Leadership requires strong coordination, consultation, and communication skills and activities. It is largely about bringing people and information together at the local, national, and international levels to build collective understanding and agreement on policy and action to be taken in areas of common concern. A current example might be the misuse of prescription drugs or emerging trends such as the increase in substance abuse among youth in recent years, particularly the use of ecstasy. It is acknowledging that we need each other's expertise and that the development of a national substance abuse strategy needs to involve all stakeholders, including users. It is about recognizing and developing partnerships. Slide 20 visually represents the many coordinating activities led by Health Canada, including federal, national, and international partners.

Finally, we are looking forward to the recommendations of your committee and to those of the Senate special committee to inform and direct our work. Following the tabling of your recommendations, we expect to be working with our partners to create a renewed vision for a national substance abuse strategy and to identify renewed approaches to achieving measurable and challenging goals and objectives to which all partners can contribute.

Creating a truly integrated, yet comprehensive network of services and initiatives will be challenging. Understanding how the pieces fit together and the relative priorities will be difficult. For example, how do these initiatives and activities link to any health system renewal process that will take place over the next few years, so that gaps do not occur?

Identifying how to implement activities such that the network supports and moves individuals and society seamlessly down a pathway of reduced drug use and improved health will not be easy and will take commitment and resources. Strong partnerships and coherent approaches across jurisdictions will be needed to ensure consistency and progress. The progress will need to consider all aspects of the supply and demand sides of the equation. Historically, this has been difficult to sustain, largely because of resources.

● (1005)

The base for developing and maintaining an effective drug strategy will be comprehensive, sustained, accurate, relevant information gathering and knowledge management with all partners, federal, provincial, municipal, and non-governmental organizations. We look forward to your recommendations and would stress that the success of any renewed strategy will depend upon the allocation of resources balanced across the components of the cycle and adequate to meet the expectations of the strategy.

Thank you.

The Chair: Thank you, Mr. Michols.

Before I turn to Mr. White for questions, I have one question, and that's on the current expenditure slide. The healthy environment and consumer safety branch is $34 million. The first nations and Inuit health branch is $70 million. Is that because you're basically replacing the provinces in that particular case?

Mr. Dann Michols: We are the direct health service provider to first nations on reserve and Inuit in the north.

The Chair: Okay. So that's why that number seems so large relative to the other one.

And to clarify, from 1987 to 1992 you had $210 million, or $42 million a year, in the next five years you had $20.8 million a year, and since then it's been reduced. How would that break out?

● (1010)

Mr. Dann Michols: I'm sorry?

The Chair: You said you had—

Mr. Dann Michols: A sum of $210 million over five years for all departments involved in the strategy.

The Chair: So that works out at about $42 million a year.

Mr. Dann Michols: Yes.

The Chair: And then the next five years you had $104 million, and that works out at $20.8 million per year.

Mr. Dann Michols: Right.

The Chair: And then, you said, it's been—

Mr. Dann Michols: It's been reduced significantly now to not too much more, I think, than the ADTR program, which is the $14 million a year.

The Chair: Okay. Thank you.

Mr. White.

Mr. Randy White (Langley—Abbotsford, Canadian Alliance): Thank you, Mr. Michols, for coming today. We've heard previously from Health Canada, and I, quite frankly, wasn't very impressed the first time we met with Health Canada. Your department has been more or less coordinating this effort since 1988. That's 14 years. Just let me give you an idea of some of the things I have seen in this country.

A lot of departments in the federal government are involved in the drug program, many of them not knowing where they're spending their money, not having goals or objectives, measurable outcomes, year after year just plain spending money. Substance abuse is increasing. There are many places in Canada with no treatment. You happen to mention the $2 million or so you put into Vancouver, but I live about an hour's drive from Vancouver, with very little, if any, money put in there. There's been no national survey since 1997—you said 1996, but I believe it was 1997. I've seen overlapping research studies in this country, municipal, provincial, and federal, mostly uncoordinated. I see a minister of health making some kind of political announcement in Vancouver some time ago on safe injection sites, and I'm not sure he had a clue what he was talking about at the time he made the announcement. I see a justice minister recently talking about some kind of political announcement, I take it, on the legalization of marijuana or the decriminalization, based in part upon his own personal expertise, not necessarily on fact.

I haven't seen anybody define harm reduction in this country yet consistently. In fact, in some cases, I would say harm reduction could be better described as harm extension. I see two successive drug strategy documents I've taken across the country to many places where the documents themselves just plain don't relate to the people on the street. Conversations I had about those documents with people on the street working hard to try to help some people addicted showed they really didn't mean very much to them.

I've seen a lot of money dribbled away on this exercise, rehabilitation facilities closing, not opening, many barely hanging on. And to top it all off, I see Canada Corrections developing their own research centre in P.E.I. to look at drugs in prison, when the same kind of research could and should have been done elsewhere.

I'd like you to tell me how you gauge your success over 14 years in the Department of Health as to the current scene of drugs in this country.

Mr. Dann Michols: I think the outline you have just given is not inconsistent with the challenges I have laid out within my comments now. The task of addressing the problem of substance abuse across the country involves many different levels of government, many different partners. The resourcing for those activities, by any calculation, is not equal to the task that has to be developed.

That said, there have been a number of successes, and I have laid out a number that Health Canada have been responsible for. They have been primarily along the lines of coordinating activities among the various parties involved, disseminating information to those across the country, and trying to support the development of the information data and research required to determine which are effective. But by any stretch, it is not an effective counterbalance to the problem which exists.

● (1015)

Mr. Randy White: But is Health Canada is the right place to coordinate this activity? I'm seriously thinking that perhaps the coordination of this should not necessarily be within the bureaucracy of a department. How other departments see your department, I think, is, well, we'll do our thing, they can do theirs. I'm wondering if there shouldn't be a central Canadian agency that coordinates and manages this drug problem, both nationally and internationally. It's a question to you.

Mr. Dann Michols: I suspect the government would be prepared to examine any possible alternative that might prove to be an effective way of addressing this problem. The reason that the lead is with Health Canada now, I have explained, is because drug abuse is looked upon primariy as a health problem and we are the federal department responsible for that. But it does require a considerable amount of coordination of other departments. All departments have their objectives and goals. Most of them are under-resourced to accomplish them. There may very well be other alternatives to the effective coordination. That is something we would look forward to analysing.

Mr. Randy White: How does a coordinating department like yours cooperate with a place like Corrections Canada, which seems to have one of the largest budgets in this drug thing, but in my opinion, does the worst job. Who coordinates? Who goes to Corrections Canada and says, you know, you've got a really serious problem in those prisons with drugs, and you get a lot of money—exactly what are you doing with it? Who does that?

Mr. Dann Michols: We have on a number of occasions been giving advice to Corrections and to other departments on how they might include initiatives for substance abuse in their programming. They are ultimately responsible for delivering those services to their inmates, but we have provided advice on that.

Mr. Randy White: If I seem frustrated to you, you're right. I am extremely unhappy with the progress and the coordination on the problem of drugs in this country, and I am not pleased with your department, nor am I pleased with any of the departments, quite frankly. So I'm asking these questions directly because of my own frustration in trying to deal with various drug issues in this country.

On the issue of rehabilitation, I had an experience with Health Canada over help with a pilot project in my own riding. The minister at the time, Allan Rock, did refer me to Health Canada, and things worked fairly well on the discussion level in Ottawa. But when I got to British Columbia in the regional office, it was just, no way, go away, we don't have any money here, we are not basically responsible for what those bureaucrats say in Ottawa. It deteriorated very quickly. I'm wondering, even within your own department, how well coordinated this exercise is. I really do see an autonomous organization out there in the field that says, well, it's nice what Ottawa says, but here we kind of have our own thing and do it that way. Are you satisfied that your branches are really with you on the projects you're doing?

Mr. Dann Michols: As you may know, Health Canada went through a major restructuring about two years ago. At that time my branch was created, it didn't exist before that. The restructuring was done in large measure to try to bring together activities that were of a health protection nature, regulatory, and activities that were of a health promotion nature. My branch has responsibility in both of those areas. As well, that restructuring brought to me the responsibility of pulling together various pieces of the drug strategy that had been in other aspects of Health Canada. Furthermore, it has given us the opportunity to strengthen the regional operation for activities for which I am responsible and to build better relationships between the directors general of my various programs and the staff who support those programs in the regions. So I would like to think that if you undertook the same approach today, you would receive a far more informed and better reaction right across the country.

● (1020)

Mr. Randy White: Thank you.

The Chair: Thank you, Mr. White.

Monsieur Ménard.

[*Translation*]

Mr. Réal Ménard (Hochelaga—Maisonneuve, BQ): I have a series of eight questions for you. I'll go through them quickly, trusting that I will receive brief, concise answers from you. First off, I'm delighted to see you again.

In the background material that you forwarded to our clerk — I can't recall when exactly — you provided us with a considerable amount of information. There are approximately thirty responses on file to questions raised by committee members. I reviewed them last night to draw a clear parallel between your presentation today and the information that you supplied to us.

Would it be possible for you to submit to the committee, similar to what happens in the case of CAPC, the Community Action Program for Children, external evaluations of the strategy employed by your department?

Generally speaking, I think committee members are wondering how to assess phases one and two of Canada's Drug Strategy. In your submission, you point to eight positive signs.

That's all well and good, but I'm curious as to whether any external evaluations were done and if so, what they revealed. Among the positive signs noted, you point to the fact that drug use has declined in general, particularly among youths. On what do you base your assessment? That's my first question.

[*English*]

Mr. Dann Michols: The drop I referred to was in the area of tobacco. Unfortunately, the data we have show an increase in all the other substances prone to abuse.

[*Translation*]

Mr. Réal Ménard: I was referring to the document which mentioned a decline in drug use. However, we need to understand that in the case of young people, boys and girls behave differently where tobacco is concerned.

As far as external evaluations are concerned, since these are conducted in the case of other Health Canada programs, can you tell me if any have been done of Canada's Drug Strategy and if so, whether the committee can be apprised of the findings?

[*English*]

Mr. Dann Michols: The most recent evaluation, if you like, was the Auditor General's report, which I think you have access to, but we can certainly table. I do not know what other evaluations we have available.

Gillian?

Dr. Gillian Lynch (Director General, Drug Strategy and Controlled Substances Programme, Healthy Environments and Consumer Safety Branch, Department of Health): As far as I am aware, there was not an outside evaluation of phase one and phase two. There was a process evaluation of phase one. There may be evaluations of individual projects at times, but we don't have an overall evaluation since we started phase three.

[*Translation*]

Mr. Réal Ménard: I trust you realize how much of an aberration this is, because when our local community agencies receive either $18,000, $20,000 or even $25,000, they must contend with a considerable amount of red tape in order to have evaluations done. Obviously, in the case of CAPC, the experience is a positive one because some training is provided. However, in a department such as your own, which has primary responsibility for coordinating the strategy, as Randy White noted, I feel certain practices need to be called into question.

This brings me to another question. In looking specifically at how the strategy's budget breaks down, excluding expenditures for first nations which account for half of your available resources, there is also the matter of the Office of Controlled Substances.

I'd like to talk a little about the Office of Controlled Substances. If I understand correctly, the Office is conducting the latest research into the legalization of marijuana and is likely to have the broadest possible information about whether or not this substance poses a health hazard.

Do you have any useful information to share with us that might broaden our understanding of the issues surrounding the legalization of marijuana?

● (1025)

[*English*]

Mr. Dann Michols: I'll ask Gillian to speak to that as well.

First, it's not the office of controlled substances that deals with medical marijuana; it is within the program, but it's another office within the program. We have collected and compiled as much information as we can possibly find on the subject of the therapeutic value and the risks provided by medical marijuana. The reason we have a research program in that particular area is that our conclusion is that there has been a lot of anecdotal information, there has not been any scientific information or evidence of the therapeutic benefit, the kind of evidence we would expect of other products being used as medicines.

[*Translation*]

Mr. Réal Ménard: I'm sorry, Madam Chair, but I was mistaken. The witness's document is very clear. I read the wrong line. The research is in fact conducted by the Office of Cannabis Medical Access. I was reading the incorrect line. I apologize.

Could you let us in on the type of research that you have conducted? How does your research differ, if at all, from that done by the Addiction Research Foundation? For example, did you know that some witnesses have called for the creation of a specific addiction research institute. Some have even pointed to the fact that the US government spends ten times as much money as its Canadian counterpart on addiction research.

Therefore, I'm curious as to whether a brief summary has been drawn up of the overall research carried out by the Office of Medical Access. If so, do these research findings differ from those arrived at by the Canadian institute for addiction and mental health research?

[*English*]

Dr. Gillian Lynch: Yes, I think I can help. We have a research plan, which was tabled, I think, in 1999. It put about $7.5 million against the plan for research into medical marijuana. We are moving forward with that research plan. We have two pilot projects that have been approved through the CIHR process or through a separate process. One is the Community Research Institute in Toronto, and the other is McGill. The one in Toronto is dealing with appetite enhancement for people who are living with HIV-AIDS. The one in McGill is dealing with neuropathic pain. These two studies are ready to go. We are currently negotiating with NIDA, and we have just heard that NIDA has given approval for the Toronto project to go ahead. We heard verbally from the Toronto program on Monday, I think, that they would be ready to go ahead probably in late September or sometime in October. So those two are going ahead.

[*Translation*]

Mr. Réal Ménard: Basically then, you're referring to studies carried out by the institutes. Correct?

[*English*]

Dr. Gillian Lynch: We have a budget for research. We may use the Canadian Institutes of Health Research to assist us in managing that research. We may do it outside the Institutes of Health. One of those studies, the study from McGill, is being done through the Canadian Institutes of Health Research, but it's from funding we provide for that program. We are also working with the Canadian Institutes of Health Research for additional research into other controlled studies and into broader-based studies that will involve more people. That is working through now, and we are looking forward to doing those in the near future. That's the status of our research program at this point in time.

[*Translation*]

Mr. Réal Ménard: Three different studies have been brought to our attention. I happen to have a copy of one of them with me, namely the study done by Zoccolillo, Vitaro and Tremblay.

Could we possibly get a summary of the studies that have been carried out? The committee received a document on several studies which was also tabled in the Senate. Given that an office has been established to focus specifically on the therapeutic use of cannabis, it seems appropriate, to my mind, that we receive an update on the work that has been done to date.

With the chair's permission, I would like to put a third question to the witness.

The Chair: You have ninety seconds.

Mr. Réal Ménard: Really, Madam Chair!

The Chair: You have ninety seconds.

Mr. Réal Ménard: However, knowing you, there will be a second round of questions.

What is your assessment of the federal-provincial-territorial committee in charge of the harm reduction strategy? Do you think it could be a viable vehicle for implementing certain components of the strategy?

I'm aware of the existence of a federal-provincial-territorial committee on street prostitution, as well as a committee on harm reduction. What can you tell us about the efforts of the federal-provincial-territorial committee in the area of harm reduction and drug use?

● (1030)

[*English*]

Mr. Dann Michols: The federal-provincial-territorial committee is made up of representatives of all the provincial and federal ministries that are involved in this subject. It was a working group set up under the auspices of the deputy ministers of health conference. They produced this report with a number of recommendations having to do with injection drug use. That report was tabled with the deputies and accepted and tabled with the ministers. It is now a case of each one of the jurisdictions going through and determining what next steps they want to take with these recommendations. It was a very collaborative effort. The organizations worked quite well together, and we would hope it continues to deal with the subject.

[*Translation*]

Mr. Réal Ménard: Summing up, I...

The Chair: There will be a second round.

Mr. Réal Ménard: I'd like us to visit the Office of Access...

The Chair: As I said, there will be a second round.

Mr. Lee.

[*English*]

Mr. Derek Lee (Scarborough—Rouge River, Lib.): Thank you for your fairly precise overview of what Health Canada is doing.

As the committee has gone about its work, we have taken the premise that all is not as it should be in the envelope. We have a sense more could be done. Both in Canada and in other countries we see money being thrown at the problem. Perhaps the good news is that we don't seem to throw as much money as some of the other countries do. Our neighbours to the south, of course, throw billions at it. At the end of the day, Canadians still have a sense that we haven't made a lot of progress. The problem is there, and perhaps we are never going to get rid of the problem with the challenges to manage and get the best results and the least harm.

I have some sympathy for the position of your department. You really do not have a lot of resources. Maybe it was poor strategy in the beginning, or maybe it was the program review that reduced all the departmental budgets to get rid of the national deficit, but in any event, we don't see a lot happening, and as a legislator, I can't blame the department, because you really haven't got that much money.

You have properly described our concept of the drug problem in Canada as primarily a health issue. The primary deliverers of health in Canada are the provincial governments. How do you manage to deal with that problem, if this is really a health problem? By the way, I see how much money we spend relative to the other moneys in the aboriginal health envelope, where the federal government does have a significant responsibility. But with the rest of the country, how do you deal with that problem? If it is primarily a health problem and if the provinces deliver health care, how does the federal government manage to be a player in developing solutions?

Mr. Dann Michols: That's an excellent question, and I think it goes to the root, to some extent, of the role the federal government plays as a national coordinator, not necessarily having its hands directly on all the levers. My colleagues may have some additional comments, but I would say there are three prerequisites, if you like, for working successfully with the provinces. The first is to have the data and the knowledge as to what the problem is, where exactly it is, and what might be done to address it. The second is education of the various parties involved in it. That includes provincial ministries of health on occasion and, for some of the various areas, access to the data and interpretation of the data. The third is a capacity to integrate the action that might be taken in the area of substance abuse with the other actions being undertaken by the province in the health care system, so that we are able to put a “harm reduction because of substance abuse” spin to some of the expenditures that are already being invested in the health care system because of the tremendous concern across the country over the overall lack of resources in that area. Additional new resources would be useful, but targeting some of the current resources to also address harm reduction activities is helpful as well. .

● (1035)

Dr. Gillian Lynch: You also have the capacity to bring people together and to build consensus around what it is you really want to do. You need the data and the rest to begin with, but once you have them, if you really want to move forward in a partnership, getting people to agree to follow and try to achieve the same objectives is crucial. That's difficult, because people have different agendas at different points in time, and that's part of the challenge we have to deal with. That would just be a build-on point to what Mr. Michols said.

Mr. Derek Lee: If I had to ask you to remind us all what the problem is with drugs, what is it? What is the perceived problem with drugs? If I take an aspirin, that's not a problem, right? What is the drug problem? Does your department know what the drug problem is? Is it the taking of the drug or the harm associated with the taking of the drug? Tell me what the drug problem in Canada is.

Mr. Dann Michols: The drug problem in Canada is a combination of a number of things, but primarily, it is the use of substances that should not be used and the abuse of substances that should be used for other purposes. The harm caused by that activity is to the individual, and then to society overall. As that harm permeates through, it loads on institutions or society or families directly. It is a misuse and abuse problem of various substances. The substances are very broad, as you've undoubtedly learned over the experience of this committee: alcohol, prescription drugs, non-prescription drugs, as well as narcotics and controlled substances. It is a very wide range of substances that have to be addressed in various ways.

Mr. Derek Lee: Surely, from the point of view of the health department, illegality is a non-issue. Wouldn't it be a non-issue? Isn't the issue the harm brought to the individual and the other harms? What are the harms? Tell us what the big harm is without saying that somebody has broken a rule somewhere.

Mr. Dann Michols: Sorry, I would not say the harm is caused by breaking the rules, but the making of the rules, if you like, as I tried to indicate, is a mechanism by which you attempt to address some of the problem. The problem is the use and abuse of substances. It isn't the fact that some are illegal; many of them are legal, but are being diverted or not used in ways they should be used.

The particular harms stretch from the incapacity of the individual to be productive and healthy right through to the impact of the resources that are being diverted from other uses in society in order to cope with that individual and the problems thereof.

Mr. Derek Lee: That's a very broad target. That includes people who take too much caffeine through coffee, doesn't it? Caffeine is a substance. People can abuse it. They can get too much caffeine. There can be health impacts there.

Mr. Dann Michols: There are undoubtedly health impacts from that. As to whether they are of the same nature as abusing some of these other substances, I suspect not.

Mr. Derek Lee: If I were to say that caffeine should be on the chart at Health Canada—it's not, is it? It's a substance.

Mr. Dann Michols: It's not a controlled substance.

Mr. Derek Lee: It fits within what you described. I suppose the point I'm getting at is that the problem is so huge. You've given a verbal description of what the problem is, but when you get down to nailing the thing to the mast, you leave out some substances that are abused and concentrate on others.

Mr. Dann Michols: Yes.

Mr. Derek Lee: Sometimes we don't even focus that much on the substance, but on the harms associated. For example, with marijuana, I'm still looking around for the harms. I can see that it's illegal, but we have a bigger problem with nicotine and tobacco than we do with whatever is in marijuana. I'm just looking for help in determining what your focus is in dealing with the most significant of the harms associated with taking substances. Someone who is smoking two packs of cigarettes a day is a bigger health problem than someone who is smoking one joint of marijuana a day. I'm sure your department accepts that as a reasonable statement.

● (1040)

Mr. Dann Michols: I think one of the challenges that faces you, and subsequently faces us, is describing or defining the breadth and the depth of the overall problem that has to be addressed. There are substances that cause much more harm when abused or used than others, and how you go about determining the varying priorities and the resources to be allocated to them is the challenge public policy-makers have.

Mr. Derek Lee: And drunk people in Canada cause more harm quantitatively than do heroin addicts. That's true, isn't it?

Mr. Dann Michols: And that's why alcohol is considered to be one of the substances that can be abused and dealing with the subsequent harm to the individual and society is included in the strategy.

Mr. Derek Lee: Okay. I was just trying to record the fact that there is a certain inability for all of us, as a society, to focus on what's worse, what we should be targeting, putting at the top of the list and the bottom of the list. Our committee, of course, is looking at the non-medical use of drugs, which is a piece of the envelope. I'm still looking for that focus.

Thank you.

The Chair: Thank you.

Mr. Sorenson.

Mr. Kevin Sorenson (Crowfoot, Canadian Alliance): Yes. Thank you for coming.

It's good to go through this, although I'm looking forward more to going through your statement after it's printed out, because I think there was probably a lot more information there than we were able to grasp. It seemed as if we were on auctioneer mode there when we were going through it.

Mr. Dann Michols: I know the feeling.

Mr. Kevin Sorenson: Mr. Lee suggests that we have more concern with the person who is drunk here in Canada. He is costing us more than the heroin addict, the guy smoking two packs a day is surely doing more damage than the guy having one little joint of marijuana, but I think it's not relative to what we are trying to discuss here. We are looking at overall substance abuse, whether it's nicotine to the vast extent we're seeing it being used in Canada or marijuana to a lesser degree. We can't go to a shop or a store and pick up marijuana, and I think, if we had that ability, we would find out that perhaps the marijuana would be causing many more problems for our country than the guy who is on a couple of packs of cigarettes or a pack of cigarettes a day. Both of them cause a great many problems for this country in productivity and health and welfare of each citizen.

I want to go to the slide “Health Canada current expenditures on substance abuse, setting the context”. We have talked a lot about evaluation. We haven't had enough evaluation of the drug policy, we haven't had enough evaluation of how Health Canada is managing or how they are being held accountable. Are they successful? Are they a dismal failure? Perhaps you can help me out here. We look at the direct expenditures on substance abuse and we go down and see administration of regulations $5 million, medical marijuana program $5 million. We know with the medical marijuana program we started growing our own marijuana. We know it was a dismal failure, it didn't pan out—the Flin Flon experience, anyway, didn't pan out, it was a failure. But we have spent $5 million on continuing. Is this yearly or what?

● (1045)

Mr. Dann Michols: This is an annual expenditure.

Mr. Kevin Sorenson: So this is last year's annual expenditure?

Dr. Gillian Lynch: It's the budget for this year.

Mr. Kevin Sorenson: All right.

Then we have drug analytical services. We have $34 million that is broken down into the $5 million, $5 million, $4.5 million side of the ledger; policy research and international affairs; alcohol and drug treatment rehabilitation $14 million. But when we come to the first nations and Inuit health branch, we see $70 million. I want to know what evaluations have been done on that $70 million. There is nothing broken down there, all we know is it's alcohol and solvents. We've got twice the budget the aforementioned have received. We see the previous expenditures all broke down into six or seven different categories, but here there's no other information available, no other breakdown, no other evaluation of success or failure rates. Can you break down this $70 million?

Mr. Dann Michols: Yes, we can break down the $70 million, but you must be very careful not to compare apples and oranges. The reason the funds are broken down for my branch is that they directly pertain to the coordination, development, and management of the drug strategy. The dollars that are being expended in first nations and Inuit health provide health services to a particular population of Canada and would have to be compared to expenditures by the provinces for other aspects of the population for which they are responsible. There ought not, I think, to be any relationship of the $70 million being greater than the $34 million. It really ought to be the $34 million against the need to coordinate and manage the drug strategy and the $70 million against the need to provide health services to a substantial population.

Mr. Kevin Sorenson: Well, you put them in the same category. You've put them together and combined them at $104 million and you've broken it out into two groups. It's all under direct costs.

Mr. Dann Michols: What we have attempted to do with this is indicate Health Canada's expenditures dealing with the harm caused by substance abuse. Some of that is in the management of the strategy, some is in delivering services to particular populations for which we are responsible. So it's not an attempt to compare the operations of the two branches. They are quite different. It is an attempt to give you a feeling for Health Canada's activity in the particular area of substance abuse.

Mr. Kevin Sorenson: You aren't suggesting that the $70 million includes all the aboriginal, first nations and Inuit direct costs of the abuser coming in and receiving health service?

Mr. Dann Michols: That for which Health Canada is responsible, first nations on reserve and Inuit north of 60.

Dr. Gillian Lynch: I used to work in that area a few years ago. The $70 million refers to the funding for the national native alcohol and drug addiction program, which is a specific program on reserve that provides prevention, treatment, and rehabilitation services on reserve for first nations peoples.

Mr. Kevin Sorenson: On reserves.

Dr. Gillian Lynch: On reserve only.

Mr. Kevin Sorenson: What about the aboriginal or the first nation abuser who comes into a downtown Edmonton hospital? Is that eventuality included?

Dr. Gillian Lynch: No. That would normally be done through the provincial services. If that person were referred back to the reserve for treatment, then they would fall into the NNADAP program, but if they're off reserve, that would fall within the provincial program.

Mr. Kevin Sorenson: So these are only on reserve.

Dr. Gillian Lynch: Yes

● (1050)

Mr. Kevin Sorenson: Individuals who are receiving treatment for abuse.

Dr. Gillian Lynch: And prevention and education for children. It's a broad spectrum program similar to what would be provided by a province in a community.

Mr. Kevin Sorenson: But the $34 million does not include treatment of other Canadians.

Dr. Gillian Lynch: It includes a portion. The $14 million that is shown for alcohol and drug treatment and rehabilitation is a contribution program through which we provide funding to provinces to assist them in the treatment and rehabilitation services they provide to their citizens. It is intended to support them for innovative new programs. It's targeted at women and children and it's a contribution that's a 50-50 match. In other words, we will provide an amount to a province so long as they are providing at least that amount in that kind of programming. So there is a contribution in the $34 million towards provincial treatment and rehabilitation.

Mr. Kevin Sorenson: Okay.

How much money have we seen go to research of safe injection sites?

Dr. Gillian Lynch: Most of the work on safe injection sites has been done through the “Reducing the Harm” report. There has not been, to my knowledge, although I can check this for you, any specific funding out in addition to that. So most of our work has been through the federal-provincial committee in coming up with the—

Mr. Kevin Sorenson: Moneys went to Vancouver, though, it was suggested before. How much?

Dr. Gillian Lynch: In the Vancouver agreement? I can get that for you.

Mr. Dann Michols: But that doesn't sponsor a safe injection site.

Dr. Gillian Lynch: No.

Mr. Kevin Sorenson: No, it's research.

Dr. Gillian Lynch: Health Canada in 1997 provided $1 million towards the Vancouver agreement and in September 2000 $5,000, and in total, we will contribute more than $7 million for community health efforts in Vancouver over the next three years. And on top of that, we have the portion of the ADTR program that goes to B.C. on an annual basis

The Chair: That's alcohol, drug treatment, and rehabilitation.

Dr. Gillian Lynch: Yes.

Mr. Kevin Sorenson: I have a penitentiary in my riding, but I am not only speaking about that penitentiary. In fact, there are probably others that are as bad, or maybe worse. I have a responsibility as a critic of the Solicitor General, so I get letters and calls from individuals who talk about prisons and what is happening within them, the access to health services within prisons. We have a drug problem in our prisons. In fact, we have people who come in abusing marijuana and leave using harder drugs. I have a problem with something being tossed under the auspices of Health Canada and another facility under the Solicitor General's responsibility and corrections services. It seems the problems Health Canada is dealing with are being fertilized and are growing in our corrections centres. Is that just lumped in together? Are you using the research facility at all? Does Health Canada have any kind of comprehensive plan as to how it can stop, not drug use within prisons, but the increase in drug-related diseases perhaps? We see hepatitis C and HIV within our corrections services. We are throwing money at medical marijuana programs, drug analytical services, and policy research. Is there any role Health Canada plays in our corrections services, where we see these problems of health sprouting up?

Mr. Dann Michols: I think the problems we see in substance abuse within penitentiaries is a microcosm of the problems we see in other sectors of society, different aspects perhaps, but a similar problem. Health Canada is not responsible for the control of that abuse. It is responsible for coordinating the drug strategy. Corrections Canada is a partner within that strategy, and we would work with Corrections Canada to provide it with the health advice it needs to come to terms with how it should address that problem. But the problem it is facing is not dissimilar to that in many other areas.

The Chair: Thank you.

Can I just clarify these expenditures one more time? We went to the Poundmaker's Lodge in St. Albert. That is something the federal government is supporting because it is for on-reserve people?

● (1055)

Dr. Gillian Lynch: Correct. There may be provincial funding in there too, but this is all something the federal government supports.

The Chair: The Calder Centre in Saskatoon we visited is funded by the provincial government because that is its responsibility and it is for all citizens of the province. There could be additional federal funds in that. If somebody was, for instance, a non-reserve person, that was the place they sent them to.

Dr. Gillian Lynch: If—

The Chair: It's not about the Calder Centre specifically. What I meant to say is that the funding for rehabilitation services for me, as a non-aboriginal person, would be covered by my provincial government. So I need to compare that $70 million to the provincial rehab budget, some of which, across all the provinces, is supported by this $14 million.

Dr. Gillian Lynch: Correct.

The Chair: Okay. Do you have any idea what the provinces are spending on rehabilitation across the board?

Dr. Gillian Lynch: We have some idea, in that we do get an accounting from the provinces of how much they are spending in order for them to access the ADTR funding, because it is a 50-50 split. What I can't tell you is whether the information we are given by them includes everything they do, because all they would have to do is account for a 50-50 split.

The Chair: On the particular projects that they asked to be funded.

Dr. Gillian Lynch: Correct. However, in the accounting we got last year for Ontario, for example, the total would add up to something like $17 million, but in fact, we would only be cost-sharing about $4 million of that. What I couldn't tell you is whether that $17 million represents everything.

The Chair: When we were in Vancouver, they had six youth beds for lower B.C., and we kept thinking, but these are the kids who, without getting help, are definitely going to inflict all kinds of costs on the justice system, the health care system. Why doesn't someone understand and invest in rehab at that level? It's a provincial government responsibility, so we don't necessarily have influence, but if you could inject a lot of money into solving that problem, as opposed to continuing these addictions, we would have smaller costs in policing, in corrections, in health care. So it almost seemed that we needed to get people to realize that there is going to be a cost somewhere.

When the Auditor General did the report on education and health care, health approaches didn't seem to be clear within the balance at the federal level, because, of course, education and the delivery of health is all provincial. We have asked the provincial ministers of health to provide some information, and so far no one has been able to give us stuff. It is a bit hard to compare apples and oranges.

Anyway, that was only a couple of minutes.

I will turn to Carole-Marie Allard.

[*Translation*]

Ms. Carole-Marie Allard (Laval East, Lib.): Thank you, Madam Chair.

Good morning and thank you for coming. First off, I'd like you to clarify something for me. When you refer to $104 million, are the salaries of departmental employees included in this figure?

[*English*]

Mr. Dann Michols: That would include the salaries where salaries are appropriate, yes. So they would be within the $34 million. I suspect the $70 million may have some salary content, but it's mostly grants and contributions.

[*Translation*]

Ms. Carole-Marie Allard: What you're saying then is that this figure of $104 million does in fact include the salaries of all Health Canada employees working in program administration. Correct?

Mr. Dann Michols: Correct.

Ms. Carole-Marie Allard: Can you tell us how many people work in this area? How many employees, or person-years, are we talking about?

[*English*]

Dr. Gillian Lynch: In the $34 million we would have approximately 160 or 170 people, including the people who operate the four drug analysis labs we have across the country.

● (1100)

[*Translation*]

Ms. Carole-Marie Allard: I see. So then, we're talking about 170 people, and $104 million. Is that correct?

[*English*]

Dr. Gillian Lynch: No, sorry, that's the $34 million. The $104 million mentioned earlier was the amount during phase two of the drug strategy, not Health Canada's money, but that of the overall drug strategy. All that remains in Health Canada of the drug strategy money is $14 million. The other money that makes up the $34 million is Health Canada's budget towards the drug strategy. It's not specific drug strategy money that was provided through the drug strategy process in 1987 and 1992.

[*Translation*]

Ms. Carole-Marie Allard: So what you're telling us is that by its own admission, Health Canada cannot do everything. Resources are stretched and you make every effort to intervene in as many problem areas as possible.

However, as we have seen first hand — and I agree with Randy on this — things are in turmoil. People are totally overwhelmed by the situation. Agencies that provide rehabilitation services cannot keep their employees because they cannot pay them decent salaries. Persons undergoing treatment must go back into the community because of the shortage of space in rehabilitation facilities.

We recently returned from Europe and workers involved in drug issues in Frankfurt and Zurich stressed to us that the solutions must lie at the local or municipal level.

Are any funds in your budget earmarked directly for community programs? Do I understand correctly that only $14 million is being allocated to communities across Canada for rehabilitation, and nothing more?

[*English*]

Dr. Gillian Lynch: Correct. There was $14 million of our funding that goes to provinces for the support of communities.

[*Translation*]

Ms. Carole-Marie Allard: Does this money go directly to the provinces?

[*English*]

Dr. Gillian Lynch: To the provinces, yes.

[*Translation*]

Ms. Carole-Marie Allard: And these funds are administered by the provinces.

[*English*]

Dr. Gillian Lynch: Correct.

[*Translation*]

Ms. Carole-Marie Allard: I would imagine that the funds are allocated on the basis of... Do you have the figures for Quebec? Can you tell us what they are? You can? How much is going to Quebec?

[*English*]

Dr. Gillian Lynch: Quebec gets $2,806,790.

Ms. Carole-Marie Allard: Two million dollars.

Dr. Gillian Lynch: It is $2.8 million.

Ms. Carole-Marie Allard: That is for the whole province.

Dr. Gillian Lynch: Yes. It is a 50-50 split. Quebec is expected to put $2.8 million in to match the $2.8 million. It is a way of leveraging money to some degree.

[*Translation*]

Ms. Carole-Marie Allard: This isn't a great deal of money for rehabilitation. Thank you. I have no further questions.

[*English*]

The Chair: Again, just to clarify, that doesn't mean that is all the money the Province of Quebec is spending. That is the money we are using to invest in innovative programs. I would hope that the Province of Quebec is spending a heck of a lot more money than that on rehabilitation—everybody is nodding.

Mr. Ménard.

[*Translation*]

Mr. Réal Ménard: I want us to be clear on this. I was going over some of your responses to the committee and I note that no evaluation was done of the Canadian drug strategy during phase one. However, you indicate in your documents that evaluations were done during phase two and that the findings were rather positive. Is that a fair statement?

If we recommend as a committee that Canada needs a drug strategy, obviously we need an evaluation of some kind on which to base our recommendation.

Earlier, you told me that no evaluation had been done. I reread the documents submitted and learned that evaluations were done during phase two, that these were made public and that the findings were rather positive. To my knowledge, we did not receive these evaluations. Perhaps copies were sent to the researchers, but I haven't seen any.

Am I making myself clear? Are you familiar with the document to which I am referring? Parliamentarians put a series of questions to which you supplied written responses, specifically the following response:

> In March of 1997, funding of Canada's Drug Strategy was terminated. In June of 1997, a comprehensive evaluation of the strategy was done and the findings were made public. The authors concluded that phase two was conducted in accordance with the broad aims and objectives set out in a Cabinet memorandum, albeit with certain modifications.

Did we receive these particular documents?

Ms. Chantal Collin (Research Officer) This particular committee did not.

Mr. Réal Ménard: It didn't. Could we possibly get some copies?

If we are to recommend whether to have a strategy or not, we need to have some kind of evaluation tool to work with. I think we all agree on that, that this is a fairly basic requirement. If in fact some evaluations have been done, it might be a good idea for the committee to be apprised of them. Wouldn't you agree?

Secondly, since you are all experts in your field, based on your general understanding of phases one and two of the strategy, do you think the committee should recommend an intervention model the focal point of which would be a harm reduction strategy? From a public policy standpoint, do you feel that this is still a positive, effective approach, one that should be the focal point of our recommendations?

● (1105)

[*English*]

Mr. Dann Michols: I will let my colleagues speak for themselves, but from the experience I have had in the management of this area, I would say, yes, the orientation toward the harm reduction is absolutely essential. We have to find the various interventions on the control side, the supply side, and the demand side to lead to that, but I do believe the reduction of harm is essential.

Dr. Gillian Lynch: I agree. The reduction of harm is an essential component. I would also add the reduction of use in general, in other words, trying to prevent people from taking up the abuse of drugs at any point in their lives. I would have that as a balance along with harm reduction.

[*Translation*]

Mr. Réal Ménard: I see. Again, from an evaluation standpoint, of the strategy's four or five components, which one, in your estimation, proved to be the least successful, and why? Conversely, which one are you most proud of, that is to say, which has proved to be the most successful, and again, why?

[*English*]

Mr. Dann Michols: Off the top of my head, I am not sure I am really capable of answering that. That is in large part because I don't think we have sufficient data and knowledge of the impact of a lot of the interventions. As I said in my opening comments, a variety of factors and various impacts would have to be measured. The point is, and I think this is being proven through the tobacco control strategy, that you have to come at the issue from a broad range of interventions in a wide variety of areas. Certainly, prevention is an aspect of it, as is regulatory legislation. We haven't had the sophistication of our evaluations to be able to take a part, and I don't think we have had a sufficient number of interventions to be able to judge that. That is one of the lacks, particularly in the last phase of the strategy.

We must have better data. We must have better information. We must have better evaluation of that which has been done to determine that which is effective.

[*Translation*]

Mr. Réal Ménard: It's been a decade since we've had a drug strategy, 1989 in fact.

The same two comments were made over and over by the witnesses and I would appreciate your views on the matter. We heard that in the case of Canada's Drug Strategy, there was no clear accountability framework at Health Canada. Now we know there's an office, that it receives some funding and that it is staffed by officials. In your opinion, is there a problem in terms of identifying who has decision-making authority?

We also learned that while the strategy may not have achieved the desired results, there were nevertheless some positive findings to report. We were also told about an imbalance between efforts in so far as supply and demand plans were concerned.

How do you respond to these two observations?

[*English*]

Mr. Dann Michols: I would react strongly to the first point. There is an accountability centre within Health Canada for the activities of the drug strategy. It is a program that is set up within my branch. I think the statement probably has more to do with the fact that it is a coordinating mechanism, as in response to a couple of the other questions. There are 11 federal departments and agencies involved in one way or another in activities that implement or address the objectives of Canada's drug strategy. Health Canada doesn't have—

● (1110)

[*Translation*]

Mr. Réal Ménard: The correct number is 14, not 11.

[*English*]

Mr. Dann Michols: It is a case of coordinating those efforts against that. We don't control them, we simply can hope to influence them, hope to work with them, hope to coordinate as we go along. I think the accountability may be federal. It is not necessarily within Health Canada.

I hope also I have not left the impression with the committee that there hasn't been a lot of good work done under the rubric of the drug strategy. There have been best practices documents, meetings have come together, reports have been made federally and provincially, recommendations have been made. The drug analysis service we operate is excellent. There are successes. Whether or not those have been sufficient to have an overall impact on the abuse of substances in Canada is something that needs to be evaluated. The money that has been spent has been spent well, and the people who work in that area work hard.

[*Translation*]

Mr. Réal Ménard: I understand. May I ask one last question?

The Chair: I'm sorry, but we're out of time.

[*English*]

Ms. Hedy Fry (Vancouver Centre, Lib.): I am going to ask you a question you have been asked before. The reason I am asking it is that I think, if we are going to recommend effective strategies for dealing with some of the gaps you have identified, some of the challenges you have identified, we need first and foremost to understand why they exist. I know you have been asked this question both by Randy and by Réal, but I want to ask it again. This strategy has been going on for about 13 or 14 years. You have federal-provincial-territorial working groups. I notice you have about four of them. You have 11 departments working interdepartmentally. Yet you say you have a paucity of data, there are gaps. Of course, as you have heard from the Auditor General, we don't have any data at all. I don't understand why. Is it jurisdictional? Is it that you don't have the resources?

Given that you already speak federally, provincially, territorially, and interdepartmentally, why is it you have no determinants? The great philosopher Yogi Berra once said, if you don't know where you're going, how are you going to know when you get there? You have no indicators. You have not developed any determinants, anything like that, or even measurable goals. How can you set a strategy without those being key and inherent parts of any strategy? They are the building blocks upon which any health strategy must work. The will is there. You have identified the problems. I don't understand why they still exist, given that you have mechanisms for dealing federally, provincially, territorially, given that you have working groups. You have also identified a continuum that you cannot carry through. Under the 11 departments that you have, surely they should be able to provide that continuum for somebody on the street, in prison, or back out again, if those groups are working

My question to you is really one where we cannot resolve the problem unless we get the reason they are not working. What is the reason? Is it jurisdictional? Is it resources? What are the reasons that for over 14 years none of these things has been able to work? I am not saying you are going to solve all the problems, but why haven't you had any of those major components resolved?

Mr. Dann Michols: I think the answer is yes. It is because it is multi-jurisdictional. It is because it is complex. In some cases we have a lot of data. We haven't the capacity to analyse and interpret them in order to determine what they mean. In other cases we haven't necessarily got the data. In some cases we haven't been able to evaluate whether an intervention works or not. You may feel it does, but you don't necessarily know that it does, you can't necessarily prove that it does.

In my opening comments I referred to the complexity and the interrelationship of an effective approach to dealing with the problems of substance abuse. A person is in the Canadian prison system under federal care, leaves, and is then under provincial care. How do you ensure that continuum you speak about? How do you even follow to be sure of what has happened to the individual? It is a complex problem that requires a range of interventions, and we have to be able to track those interventions. It is a function of jurisdictional aspects. It is not necessarily impossible, but it has to be set up and followed. It is a function of the resources to do that.

● (1115)

Ms. Hedy Fry: You are saying it is resources. There are other jurisdictional areas, for instance, when we look at child care. HRDC manages to do a longitudinal survey on the attitudes and behaviour and status of young people in this country. That is jurisdictional. Other departments manage to do certain things that are very complex and jurisdictional. You are saying it is resources mostly, then.

Mr. Dann Michols: Resources are a very large part of it, yes. You have seen over the three phases of the drug strategy that those resources have diminished significantly.

Ms. Hedy Fry: If we were to make a recommendation about improving your resources, given the mechanisms you have for federal-provincial-territorial discussions and for interdepartmental working groups, do you think that would make a difference?

Mr. Dann Michols: It could not help but make a difference, but I don't want it to seem that it is just a function of resources. Those resources have to be applied in the most effective manner. Because it is multi-jurisdictional, it will require a considerable amount of coordination and work with other partners.

Ms. Hedy Fry: Thank you.

The Chair: Thank you.

Before I turn to Mr. White, I noticed that on slide 17, about harm reduction, you mentioned you are working with the provinces and municipalities on some research on safe injection sites. Do we have any timeframe for when something under the current proposal could be implemented?

Mr. Dann Michols: The recommendation in the report is that it is an intervention that ought to be studied in more detail. That would require that the provinces and probably municipalities be involved. The federal role is to determine the legal framework under which it might be done, whether there are legal roadblocks we would then have to deal with, and what other support we might provide to it. So the timeframe to do it would depend on the will of a range of partners to undertake it.

The Chair: In the area of alcohol and drug treatment and rehabilitation, you mentioned that your focus is on the treatment of youth and women. Is there a particular reason you picked those two? Is it the absence of many programs, for instance? Is any work being done on the rehabilitation and treatment of people who suffer from fetal alcohol syndrome or fetal alcohol effects and are also users? I think that's a particularly difficult population that doesn't work well in a regular rehabilitation setting. As we have travelled across the country, it struck us that this is an emerging and very difficult problem.

Dr. Gillian Lynch: I think the reason it was women and youth was that they were seen to be those at risk who were not well served by the general treatment programs that were out there. They tended to be more oriented to men and to alcohol.

I think that your comment about people living with FAS/FAE is very relevant. Certainly, in our discussions with provinces that will be an interesting thing for us to take up with them as a group that could be helped with this kind of funding.

The Chair: Hopefully, it won't be too long until you take it up with them. As I understand it, in some of the youth facilities it's already an issue. They may not be well served by the current programming, and someone is going to have to prod new programs to be developed.

On your legislation and regulations slide you identified that you need to undertake ongoing risk assessments to ensure a cost-effective balance between adequate monitoring and available resources. I think you said something about it not being feasible to inspect regularly all persons or companies that are involved in the legitimate distribution and use of controlled substances, such as pharmacies. Yet yesterday we heard the pharmacists saying it would really be helpful to have Health Canada run through the actual prescriptions over the last month and say, there's a pattern here, and not force, especially in a small community, a pharmacist to pick out and complain about the doctor who is over-prescribing certain narcotics. They said it was a helpful intervention between the pharmacists and the doctors to make sure there was a check and balance. They expressed some desire to have those services brought back to them. So on the street there was an understanding that it was a valuable service. Is there a possibility that could be re-evaluated?

● (1120)

Mr. Dann Michols: Yes, there is a possibility that it could be re-evaluated, and in fact it is being re-evaluated. I think the point I was trying to make there was on the cost-effectiveness of the application of limited resources. There is no doubt that with unlimited resources, there would be useful interventions made by the federal government. Our problem was that we didn't have those resources. So it was a case of saying where we would most effectively place those limited resources.

We took a look at that a number of years ago and said there are colleges that are responsible for the regulation of pharmacists and physicians. We just don't have the resources to get involved in that sort of interface. It would be a useful intervention, so that the pharmacist doesn't have to finger the physician. If we don't have the resources or that's not the best use of them, then we'd like the colleges to step in and figure out another useful way to deal with that. If we do have the resources or can work out some sort of arrangement, then we will. It obviously came to you, and it has come to us as well, and we're in the process of working with the colleges. We have had consultations with them specifically on this to see what the most effective mechanism would be. It's going to have to be a combination of powers and activities on the part of all parties.

The Chair: It's fair to say there has been a dramatic cut in the annual budget for the drug strategy, from $42 million a year to $14 million a year, and yet the problem is growing in our country. It's one of those areas where if you do a really good job on prevention, people will say there isn't a drug problem, so why continue to invest in this? Frankly, I don't think substance abuse as a national issue was getting the attention it needed. Hopefully, this committee's work will help you in increasing those dollars.

Has your $34 million budget also decreased over that time period or has it remained constant, which is, in effect, a decrease?

Mr. Dann Michols: Our budget has decreased. What it has meant is a diversion of resources from other areas to maintain a certain level of service coordination of the drug strategy. The resources have come from elsewhere within my branch's budget or Health Canada's budget to try to maintain that coordinating and service activity.

One of the comments made earlier was about the overall cost to society of substance abuse. National studies were done in the early nineties in this regard, and one of the comments I made was the necessity to undertake another one now, because I suspect society really does not comprehend the overall cost of this particular problem, over and above the psychological impact in some areas of not acknowledging that there is a problem or that it is not society's problem, it is the individual who needs to be rehabilitated.

The Chair: I just found it remarkable that we have developed a perception that it's a big city problem sometimes. There's a very obvious scene on the Vancouver east side. During breakfast this morning, someone identified that they grew up in a small town, a safe little city in the interior of B.C., and it was boredom. The kids they grew up with did acid all the time, and I'm saying, what! I grew up in an urban environment and that wasn't there, because there were other diversions and other activities to keep us busy. There clearly was substance abuse, whether it was alcohol, tobacco, or marijuana, but there wasn't some of the other stuff I have been shocked to find out occurs in a lot of small and big towns right across the country. It's clearly out there and it's a national issue.

Mr. White.

● (1125)

Mr. Randy White: : Can you tell me how much we spend on substance abuse in all departments?

Mr. Dann Michols: I think the Auditor General had a difficult time determining that. We do not have the data.

Mr. Randy White: Yes, she did—and so did he, by the way. It was exactly 11 months ago that we had your department here and we asked the same question. You come here today and you still don't know the answer. That's one of the reasons in opposition—and I can't speak for my colleague—I certainly would have been one of the strong advocates for more funding, but I'm not. In fact, I'm sitting here thinking there should be less, and I'll tell you why.

We've asked departments how much they spend and some didn't get back to us. Some said they couldn't tell how much. We've asked provinces how much they spend. Some of them didn't even have the courtesy to tell us. Your department is supposed to be the coordinating department, but you really don't coordinate the main resources. I'm not putting your particular office down, I'm just giving you my perception of it. Fourteen departments are involved and none of them can tell us explicitly what they're spending their money on and what the outcomes of their work are. Perhaps you do the best job of that, I don't know.

I've watched and criticized as the Solicitor General built a research facility in Montague, P.E.I., of all places, to study drugs in prison. I was informed by the Solicitor General himself that he built this because, basically, he felt his department needed it. Other departments really didn't buy into it, but he did it anyway. That was $3 million-plus dollars that could have gone to rehabilitation. The research for drugs in prison could have been undertaken anywhere in the country in any facility by you or by any department. Yet in Montague, P.E.I., we have some kind of statue looking like a building or a monument dedicated to the current Solicitor General that does nothing for the rehabilitation of people on drugs.

I'm almost sitting here saying we should withdraw the money from these departments until they get their act together and at least have one coordinating body that takes the money, shares it, and insists on asking for outcomes, rather than each department fending for itself. That is just how I feel about it, and that will be my position in this committee. I'm sorry for that, because I'm a big advocate of trying to help with the drug problem in the country. You said the money was well spent. I say you don't know whether the money was well spent. I also say I have seen situations, as in Montague, P.E.I., where it has not been well spent.

After all that—that's my position—how on earth will we get a drug strategy from this committee to the House of Commons to whoever coordinates it down to the street level where it matters, down to the addict on the street who is looking for help, not a piece of paper in the form of a rhetorical document that says this is your national drug strategy? I've done that. As I have said, I've taken it to needle exchanges, you name it, and they haven't even seen the darned document, never mind knowing what it really represents on the street. How do you get a strategy to where it really means something to John or Jean on the street today who are walking around looking for their next hit or selling themselves? How do you get it there?

● (1130)

Mr. Dann Michols: I would suggest a couple of things. One will not get an intervention or a drug strategy intervention down to the street to the individual who requires it without going through the institutions that are there on the street to serve or deliver that particular service. By and large, those are not federal institutions, so it will require a partnership, as I have mentioned, of the provincial institutions and municipal institutions, the NGOs that are working in the particular area, the law enforcement agencies. It requires a coordinated effort. The way one is going to ensure that all those parties work together is by making the issue and the interventions known to be an important thing to be done for the benefit of society. We don't have the information or the resources to do that.

Health Canada is responsible for the coordination of the drug strategy. We cannot go into a department. We cannot analyse its books. We cannot pull out the information. We coordinate a team, if you like, that has to come together, realizing that the goal is important, and has the resources to do it. It may be a function not of the fact that they don't want to supply that information, but that they may just not have the wherewithal by which to collect it, analyse it, and disseminate it.

Mr. Randy White: That is what is wrong. You are coordinators. We need an organization nationally in this country that gets the money and says, I will give you some money, but you are going to give me some objectives. You are going to tell me what you have done, you are going to give me some outcomes, and I am darn well going to look at your books to see how you have spent the money. Whether or not it is Health Canada—and heaven forbid it be Corrections Canada—we must have a national organization in this country that takes the next step. Your organization doesn't have the clout to find out how much of this is duplicated or whether the money is even being spent in the right place. Is that not a fair statement?

Mr. Dann Michols: I think it is a fair statement of the situation now. Whether or not you could set up an agency that would have the clout would be worth looking into. I think it is more a function of indicating that the objectives are important, that the departments involved are oriented toward them, and resourcing them sufficiently that they work on them.

Mr. Randy White: Whether or not it is Health Canada that coordinates it, it is not just coordination. There has got to be an authoritative organization that gives the money out. No more monuments to the Solicitor General in P.E.I. Put the money on the street in rehabilitation or somewhere that affects young people, or even older people, that are addicted. I wanted to tell you that is where I come from, and that is what I will be very sternly speaking to on this committee. I just don't think the money is going to the right places. In fact, I can't even tell you whether it is, nor can you tell me.

The Chair: To conclude, somewhere in your presentation you mentioned that it was a challenge, that you have been delivering programs, and that maybe some of the money that normally would have been built into evaluation and data collection is not being spent because you are actually delivering programs. So there is something about a certain amount of money. We certainly heard from people across the country, even researchers, who said that if it were a choice between research and service delivery, a rehab program, they would pick a rehab program. This was shocking, because there is so little research that one would have thought a researcher would advocate that, but they knew the need for rehab was even greater.

Somewhere we have to get that right balance, because if we are going to be successful in our rehab and prevention programs, we have to be analysing what we are doing. Whether it is outside Health Canada or an agency, it is going to cost more than what we are currently spending, or we are going to deliver less programming.

● (1135)

Mr. Dann Michols: That is true. I think I offered to you the example of the tobacco control strategy that was recently approved. It was a significant amount of money. There was money specifically set out, not for research into the subject matter, which is necessary as well, but into the evaluation of the interventions to determine, in the longer run, whether that was the best use of the dollars. It is essential, but human nature being what it is, if push comes to shove and there is a choice between short-term rehabilitation expenditure and long-term evaluation expenditure, I suspect the money is going to be put into the service.

The Chair: Thanks to you and your team who came before us today. If there is other information you have for us as we finish up our hearings and work on our report, which is due in November, we would obviously appreciate it. On behalf of all the committee, I hope we can ensure that you continue to do good work and more of it. Thank you very much.

Colleagues, we will adjourn until 2 o'clock.

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