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Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen.

Welcome to the health committee. It is 3:30. We should get started.

I am very pleased to have here the Canadian Centre on Substance Abuse. You each have 10 minutes for your presentations, Mr. Perron and Ms. Robeson. Go ahead. If you need translation, it's there for you.

Mr. Perron, you're going to speak for 10 minutes. Go ahead, sir.

Mr. Michel Perron (Chief Executive Officer, Canadian Centre on Substance Abuse): Thank you. Good afternoon, Mr. Chair and members of the committee.

My name is Michel Perron and I'm the chief executive officer of the Canadian Centre on Substance Abuse, or CCSA as I'll refer to it in my remarks.

I'll extend my congratulations to you, Mr. Lobb, on your appointment as chair of the committee. Thank you for having us here.

I am joined today by Paula Robeson, one of CCSA's knowledge brokers and the lead on the prescription drug abuse file.

For those of you who are not so familiar with CCSA, we were created by Parliament to bring government, the not-for-profits, and the private sector into alignment on substance abuse issues. As a result, we have a federally legislated mandate to provide national leadership in reducing alcohol and other drug-related harms, and we have been doing so since our creation 25 years ago in 1988.

We are largely funded by Health Canada to perform the role of bringing together these entities. I think we have demonstrated our capacity to do so in areas such as alcohol treatment, youth drug prevention, and many of the issues that are important to you individually, to your ridings, and to this committee. It is therefore appropriate and relevant that CCSA initiated the process that brings many of us here today.

[*Translation*]

I want to tell you about the strategy titled First Do No Harm: Responding to Canada's Prescription Drug Crisis, which the centre launched last March in collaboration with many partners, including Health Canada. This strategy represents a unique approach in Canada to respond to the country's prescription drug crisis, which is an understandable source of concern for the government, as evidenced by the latest Speech from the Throne and this committee meeting.

[*English*]

Why develop a strategy? I know it has been circulated. I suspect the committee has heard some facts about the magnitude of the prescription drug crisis in Canada. Allow me to add to that, if I might.

Canada is now the world's second-largest per capita consumer of prescription opioids behind the United States. In Ontario alone, the deaths related to prescription opioids doubled from 1991 to 2004, and the mortality rate is now more than double that of HIV.

More recent data show that of the 2,300 drug-related deaths in Ontario between 2006 and 2008, 60% were opioid-related. The number of drug-related deaths goes as high as 74% in Nova Scotia. These are smaller numbers but nonetheless a very significant proportion.

Prescription drug use is a growing problem among young Canadians. A 2001 survey of Ontario students in grades 7 to 12 revealed that 14% reported the non-medical use of pain relievers. Among these, 72% said they got it from home and 6% got it from their friends. The abuse of prescription drugs by young Ontario students ranks third behind binge drinking and cannabis use.

It's clear that prescription drug abuse touches us all and requires a comprehensive pan-Canadian approach to deal with the issue.

“First Do No Harm”, the strategy we will refer to today, was launched in March 2013 by the CCSA, along with then Minister of Health Leona Aglukkaq and over 20 partners who were participating in the development of this strategy. This 10-year pan-Canadian strategy lays out 58 recommendations to address the devastating harm associated with prescription opioids, stimulants, and sedatives, in the interest of improving the health and safety of Canadian communities across the country.

[*Translation*]

This strategy is the result of over a year of work by the National Advisory Council on Prescription Drug Misuse, which included health professionals, patients, families, members of first nations, law enforcement representatives, regulatory bodies, the pharmaceutical industry and researchers. The council was co-chaired by Alberta's Coalition on Prescription Drug Misuse.

[*English*]

whom I know you will be meeting with in the weeks to come.

[*Translation*]

Also involved were the Nova Scotia Department of Health and Wellness and the Canadian Centre on Substance Abuse.

[*English*]

The federal government was represented throughout that process by a number of departments, namely Health Canada, Public Safety Canada, the Department of National Defence, and Justice Canada.

CCSA brought together those with a clear stake in the problem to help develop the solution. It was apparent to all of us when we initiated this process a year and a bit ago that the status quo could not carry on and that we needed to find a new path forward.

Following the first meeting we convened, all stakeholders called upon CCSA to take the lead in developing the strategy, as we have in other areas.

● (1535)

In answer to the question being considered by this committee, that is, the role of the federal government, there is a very clear one in addressing this national problem, but I wish to underscore as well that this goes well beyond any one level of government and well beyond government alone. We have, however, taken the liberty of drawing out all of the recommendations from the First Do No Harm strategy that recommend the involvement of the federal government, for your particular attention. I'd note as well that Health Canada was identified as a co-lead, alongside the Canadian Centre on Substance Abuse, and other parties, whether regulatory, professional, or the like. A copy of this has been handed to the clerk of the committee.

[*Translation*]

The following are the main areas in need of the federal government's involvement: preventing the harms associated with prescription drugs for individuals, families and communities; ensuring that the system can provide the affected individuals with effective and timely treatment; controlling and monitoring prescription dispensing, as well as the associated consumption, abuse and harms, at provincial, territorial and national levels.

[*English*]

Other aspects include ensuring that law enforcement has the tools it needs to prevent diversion and trafficking in prescription drugs and related criminal sanctions; reviewing federal and provincial and territorial legislation and regulations that govern all areas of our current prescription drug system; and finally, leading and contributing to enhanced research and knowledge exchange about the nature and extent of the prescription drug abuse problem in Canada.

On a separate but related note, I was very happy—delighted would be a better word, and perhaps even more—that the federal-provincial-territorial ministers of health recently turned their attention to this very piece of work, the First Do No Harm strategy, and committed to working in the areas of prescription monitoring programs and surveillance and prescriber education—again key recommendations that found their way into the strategy. That's to say that, along with the intentions and the actions of the federal, provincial, and territorial governments, there are many other activities already under way that are responding to the recommendations identified. We underscore that it's vital as we move forward that all of these efforts be coordinated in a strategic and comprehensive manner to avoid any duplication and to maximize the investments being made.

[*Translation*]

By the way, since the launch, eight months ago, of the strategy titled First Do No Harm: Responding to Canada's Prescription Drug Crisis, the centre has created two implementation teams whose mandate is to ensure that each of the 58 recommendations is carried out.

[*English*]

To put it bluntly, if I may, we are moving forward and we have a plan. We have a plan for Canada, and we have the right people at the table to realize the vision laid out in First Do No Harm and we are now working together to obtain the resources to make it happen.

Mr. Chair, while the committee should rightfully consider the role of the federal government in addressing prescription drug abuse, I would argue that the committee should also consider the role of CCSA, an agency created by an act of Parliament and responsible to Parliament, as part of that response.

To provide greater clarity to the members of the committee, I have brought copies of the relevant sections of the CCSA Act to show the purpose and scope of our intent and how that might be helpful in this regard. By definition, we have a legislated responsibility not only to have initiated the process of First Do No Harm, but also to see it through to completion.

Beyond this, it's imperative that the hard work and dedication of the great number of organizations that participated in the development of the strategy and committed to staying with it toward its implementation not be squandered. The fact that we have 58 consensus recommendations means that we have at the table—and prepared to engage in the process—all of the key organizations responsible for not only identifying the problems but also resolving them. That is more than only talk and goodwill; it's about putting real dollars, real investments, real professional practice, as well as their commitment, on the table for us, in a truly pan-Canadian approach to dealing with the issue.

[*Translation*]

Distinguished members of the committee, the strategy First Do No Harm: Responding to Canada's Prescription Drug Crisis is putting forward a strong call for action. It is proposing detailed solutions that encourage all of us to find a remedy to the problem of prescription drug abuse in Canada.

[*English*]

I am very happy that you'll be hearing from others who collaborated on the development of First Do No Harm, including Ada Giudice-Tompson, whose son died of an unintended drug overdose, and Dr. Susan Ulan of the Coalition on Prescription Drug Misuse, among others, who participated in First Do No Harm. I am sure you will hear a consistent message from them about what needs to happen now. Indeed, part of our role is to attenuate the noise on this issue and help you focus, as decision-makers, on the signal, and First Do No Harm is the signal.

To conclude, Mr. Chair, we urge special attention by this committee to three areas. The first is to prioritize the key functions that the federal government can engage in to address prescription drug abuse, consistent with the recommendations laid out in First Do No Harm. I would add CCSA to that as well.

The second is to underscore your committee's support for the structure and process going forward under First Do No Harm, which, again, is a true pan-Canadian strategy to address this issue.

● (1540)

Finally, the third is to commit to examining adequate resourcing for the strategy to move forward, including the role CCSA is expected to play in it now and in the future.

[*Translation*]

I want to thank the committee for its interest in this issue, which is of vital importance for the health and safety of Canadians.

[*English*]

I am very happy to take your questions at this time.

Thank you.

The Chair: Thank you very much, Mr. Perron.

We're going to begin our first round. To begin the first round, Ms. Davies, for seven minutes, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson.

Thank you, Mr. Perron, and Ms. Robeson, for coming today. You've provided a lot of information.

The first question I'd like to ask—well, it's maybe not appropriate to you—is that I do find it a bit curious that we have this First Do No Harm strategy. I guess it was rolled out just in March of this year, so it's very new. It does beg the question why we're actually studying it, because it does appear that we actually do have a strategy.

Now, you've laid out some areas where we can maybe assist, but it begs the question why we're actually studying this. Nevertheless, I do have some questions.

I noticed that Nova Scotia is one of the provinces. In fact, it's the only province that's involved. I'm curious about that because I don't know if you remember, Mr. Perron, but when the Special Committee on the Non-Medical Use of Drugs did its report in 2001 or 2002, what I remember from that study across Canada was that in Atlantic Canada in particular, there was much higher misuse of and addiction to prescription drugs than elsewhere in Canada. I just wondered if you could give us any sense of this across the country. I know that in B.C. it was more around so-called illegal drugs, whereas in Atlantic Canada it was legal prescription drugs. Is that still the case? Is there a great variation across the country? That's one question.

The second question I have is this. I'm very interested to know if you will be investigating something, and I've been looking through the strategy here very quickly as you were speaking, to see where it is, if anywhere, and I haven't found it yet. I thought maybe it would be under monitoring and surveillance—that we would actually set up some sort of national system regarding the way pharmacies and dispensaries are operating to prevent people shopping around and getting double, triple, whatever, prescriptions. Is that part of the plan too? And if so, where would that happen?

And thirdly, I noticed that Health Canada is the lead on a lot of these things, which of course would naturally be so. I wonder if you could tell us if Health Canada has committed any funds to actually implementing this strategy at this point.

Mr. Michel Perron: Thank you. I'll try to treat these, and if I miss one, please move back to me.

First of all, I am delighted that you remember the committee of 2001, and it's important that we have that continuity at the table here.

Ms. Libby Davies: Oh yes.

Mr. Michel Perron: The first thing is that Nova Scotia took the lead in being co-chair of this process on behalf of the federal-provincial-territorial problematic substance use committee. They were our door into the PT process. The other co-chair was the College of Physicians and Surgeons of Alberta. So we tried to get the right elements participating at that level.

Second, I guess the question is, why are we here? Perhaps I think it was a bit rhetorical. But nonetheless, on the purpose of the CCSA, our role is to develop—and I go back to that signal-noise thing—and to try to provide for you a very clear understanding of where, collectively, those who are charged with accountability and responsibility for the system from all levels of government, the not-for-profit and private sector, think we should be spending most of our time. First Do No Harm does that. It is not a federal strategy, any more than it is a PT strategy, any more than it is a College of Physicians and Surgeons' strategy. I think everybody would associate it as being the vision of how we need to deal with this issue across Canada, and there is an understanding that to address this deeply complex and diverse problem we need to have a collaborative approach to dealing with the solution. First Do No Harm is really an articulation of the what and the how we wish to deal with that problem.

In terms of the variations of harm across the country—and I'll ask my colleague Paula to jump in at any point afterwards—there are two things I would say. One is that I don't think any jurisdiction is unaffected by the issue of prescription drugs, whether opiates, which have received a lot of the attention in the media these days.... Here I want to underscore that this deals with three categories: stimulants, depressants, and opiates. So while we have seen scores of reports pointing to the need to address this issue, the actual granularity of the data is varied across the jurisdictions. But it's safe to say that no jurisdiction has escaped the issue and that they're all committed to dealing with it.

In your province there are very good triplicate programs for how to manage these. That isn't necessarily the case across the country. Part of First Do No Harm is to try to equalize, I guess, the level of rigour that is present in the system.

● (1545)

Ms. Libby Davies: Can you tell me where that is in your strategy. What section does that come under?

Mr. Michel Perron: The prescription monitoring programs would be under the monitoring and surveillance section. You'll see that there are three elements there.

Ms. Libby Davies: You talk about a coroner's report, poison—

Mr. Michel Perron: Right. The initial challenge in this whole strategy was trying to figure out who should be at the table. The whole notion of having a prescription monitoring program—which gets to your other point about how dispensing and the whole supply chain is monitored and who is intervening at which point, whether it be for physicians who are perhaps prescribing it in a manner inconsistent with others to allow for a flag to be raised for the college to go in and ask why they are prescribing in this manner, to monitoring the actual transaction of the prescriptions, and on from there so to speak—is captured under monitoring and surveillance.

I'll go back to the point of not necessarily having the right data. Monitoring is about the prescription monitoring programs and the variability among the jurisdictions. Surveillance is about the broad prevalence data and some of the harm data that I was referring to earlier, which we frankly are still lacking in many of the jurisdictions.

The other point I would make, and then perhaps Paula can jump in, is that the pharmacies and dispensaries I think are well covered off. In fact, we had the National Association of Pharmacy Regulatory Authorities there. Again, we had them all at the table and they all indicated that this is something they want to engage in and be a part of.

In terms of Health Canada's role, I think our responsibility was to create a context in which the government could see where its actions should be focused. I think First Do No Harm gives that concentration of activities. As you pointed out, Health Canada is listed in a number of them along with other jurisdictions.

The good news for me is that we saw that it has now been included in the Speech from the Throne, which we thought was a significant accomplishment.

Ms. Libby Davies: But do you have a budget at this point to actually implement the strategy from Health Canada?

Mr. Michel Perron: Not that I'm aware of from Health Canada. Health Canada can respond about what they're prepared to put on the table for that, but I know they are very much engaged—and certainly on the first nations side they are very present. The fact that they are having these discussions with FPT ministers of health and that it's in the throne speech and has expanded the reach of the national anti-drug strategy to allow for the inclusion of prescription drugs, I think, bodes well.

So what all of that amounts to I can't speak to specifically.

The Chair: Very good.

Thank you, Ms. Davies.

Next up for seven minutes is Ms. Adams.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you very much for coming today and sharing your experiences with us.

I'm particularly interested in the First Do No Harm report that you have issued. Can you share with our committee some of the recommendations from that report, especially focused on knowledge gaps and our ability to strengthen the surveillance of prescription drug abuse.

Mr. Michel Perron: Among the knowledge gaps I think there are three areas in particular that we can focus on. This again was a subject of the discussion with the FPT ministers of health. One is on prescription monitoring programs and the understanding of what exactly is occurring across the country in that regard. The next is the surveillance and understanding of the extent, effect, and impact of prescription drug use and abuse. Third is around the area of prescriber education.

Not to focus singularly and solely on prescribers, that nonetheless certainly surfaced as part of the discussion in First Do No Harm as a significant component to this issue. That was one of the first challenges we had to wrestle with as a committee: what is prescription drug abuse? We clearly it as being on dual tracks. One is a purely therapeutic track, a medical track if you wish. The other is outside of that in illicit drug use—in other words using these drugs for purely illicit purposes.

Within the therapeutic track we determined very clearly that greater understanding and attention to prescriber education was necessary for all forms of physicians, in general practice and the other. This is from the physicians themselves. Also, there is the ability to understand, particularly around opiates, when opiate prescription is appropriate and when it is not appropriate and how best they can serve individuals with short-term acute pain in particular.

● (1550)

Ms. Eve Adams: We're very early in our study at this point, but what seems to be quite consistent is the fact that there is a general lack of awareness of the extent of this problem and shortage of metrics quantifying how widespread this problem is.

Are you aware of anyone taking up that information, or where we might look to find this type of information?

Ms. Paula Robeson (Knowledge Broker, Canadian Centre on Substance Abuse): One of the six teams that have been put together for the implementation of the strategy is the monitoring and surveillance team, and there is a group working on bringing together the key data holders on this issue. They vary by province, and it's difficult to compare across provinces right now, but the lead of the committee to bring all the data holders together to talk about common metrics, similar data sources, and data collection methodologies is Dr. Beth Sproule of CAMH.

Ms. Eve Adams: How far along are they at this point?

Ms. Paula Robeson: The strategy is in its fairly early stages in being put together, but we have a template for a meeting. We're waiting on some funds to bring that group together, but there are a number of key data sources and data stakeholders, including coroners across the country, various treatment databases, and poison control centre information. Lots of different sources need to be brought together.

We have identified those key players, and it's now a matter of bringing them to the table.

Ms. Eve Adams: It clearly seems that critical work needs to be done.

Ms. Paula Robeson: Yes.

Ms. Eve Adams: Do you anticipate that they will meet within the next six months, or what's the timeframe at this point?

Mr. Michel Perron: I can speak to the broader point of where we are at CCSA in terms of the implementation of First Do No Harm. As I mentioned in my remarks in French, we've developed action implementation teams composed of the same individuals and organizations that helped create the recommendation, and who are at the table helping with implementation.

The implementation teams are composed of the key custodians of these areas of expertise. In the area of monitoring and surveillance, we have Health Canada at the table and the FPTs. The process now is to help those entities determine what role they would like to play as part of the overarching implementation around monitoring and surveillance.

We have the signal from the FPT health ministers that they want to do something in that area. We look forward to seeing what it is in particular, but we're confident that as they look at that, they can contextualize their work as part of the broader whole, part of the first Do No Harm activities, respecting fully the role that governments want to play in that particular area.

At the same time, there are other data points that are non-governmentally related that will be coming to the fore so we can have a truly comprehensive picture of what is happening over time.

This is clearly an initiative that's going to take a significant amount of effort, number one, but it's time to move forward. The intent of first Do No Harm is again to minimize any duplication of effort or spun cycles that don't need to be spun that are being undertaken by others.

Ms. Eve Adams: No, exactly. Nobody wants to do that.

Health Canada, Public Safety Canada, and Justice Canada all spoke to the fact that there really is a lack of awareness of how serious prescription drug abuse is. Could you offer any advice to us as to how we might practically raise awareness on this issue?

Mr. Michel Perron: Certainly. The notion of awareness of the issue crosses a number of populations. The first area is around the prescribers, for them to understand the impact and the extent of this issue, and second is around the patients themselves and the general population to understand how they can be more educated around the issue of prescription drugs.

The last thing we want to do is to create a phobia: “I can't take any prescription drugs.” There is a very real purpose for prescription drugs, whether they be opiates, stimulants, or sedatives, but it is appropriate for Canadians to be informed in a proper manner and to ask the right questions as they go into these kinds of treatments and to have that discussion with either their primary care physician or the pharmacist.

A variety of specific recommendations have been identified around this issue, including an awareness campaign that could be provided nationally to provide greater attention to the issue and where we would want to go on it.

I'll let Paula colour in the details on that one.

● (1555)

Ms. Paula Robeson: A number of the prevention-focused recommendations—there are 12 of these in the 58—include informing consumers, families, and communities of the nature of the issue, the extent of the issue, mechanisms for mitigation, tools to build community capacity and individual capacity to understand the issue and help protect themselves from it, including, as Michel said, an awareness campaign.

The basis of a lot of that information, however, is a clear understanding of the nature and prevalence of the issue itself, which comes back to data collection and being able to compare across jurisdictions and communities.

The Chair: Thank you very much, Ms. Adams.

Next up is Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much.

I first want to ask the chair if it's possible for everyone to get a copy of the report of the Special Committee on the Non-Medical Use of Drugs, tabled in Parliament in December 2002. I think it answers a lot of the questions that I hear people asking here, and a lot of it is detailed. For instance, what does it look like when you are overusing opiates? What are the symptoms? What are the signs?

It's all detailed in this report. I think it would be interesting for people to read it so that they can be starting off at a jumping-off point with a lot more information than is written in here.

Now I just want to change the channel a little and congratulate you on your recommendations as written in here. I like the idea you propose that the responsible level of government lets you take the lead. I think that's good.

But I want to note that everyone talks about opiates and opioids, and no one really talks about things like benzodiazepines. If any of you are as old as I am, you can remember the book *I'm Dancing As Fast As I Can*, which talked seriously about the use of Valium, etc. These things go on. They have been subsumed by opiates, which take all the media headlines, but they are continuing.

So I think we can talk about that. We can talk about the use of a fair number of prescription drugs that we know young people—in this report, there is some of that—take out of their parents' cabinets because the drugs give them a buzz and do all kinds of things.

Could give just a quick rundown—I have two more questions to ask, and I only have seven minutes—on what you know currently about the data available on the misuse of benzodiazepines?

Mr. Michel Perron: I would direct your attention to the fact that we'll be leaving behind with the clerk some short summary documents.

Essentially, for 2010-11 approximately 1.5% of Canadian students from grades 6 to 12 reported past-year use of tranquilizers to get high or for non-medical purposes.

Hon. Hedy Fry: Sorry, that was grade 6 to grade...?

Mr. Michel Perron: Grades 6 to 12, and it's about 1.5%; that's for non-medical use by young students.

What we are hearing, however, around the issue of benzodiazepines is primarily around the prescribing for women.

Hon. Hedy Fry: Housewives.

Mr. Michel Perron: In particular, we are hearing that this is a population that we need to be looking at in addition to seniors. So it's not limited to any age group, per se.

I would again underscore, picking up on Madam Adam's question, that the data here is as good as we have but by no means sufficiently robust to say that we all have to charge this way. I think we have to do more investigation in that area.

Hon. Hedy Fry: That leads me to my second question, that the data is there but it's at provincial levels, some better than others.

Do you see there being a role for the federal government in acting as a clearing house, a place where they can collect all of the data that's coming through from provincial governments, and making some sort of national database out of it? It would be the same thing for best practices. If some provinces are doing some really great things about tracking physician prescriptions, about tracking misuse of drugs in terms of inappropriate prescribing, etc., then could we not pull that together into a database?

I think that's a real role for the federal government. We can get a scan, an environmental scan, of what's going on across the country, which helps us, as federal politicians, to understand the nature of the problem.

Do you see that as being of valid use?

● (1600)

Mr. Michel Perron: I would certainly agree.

Perhaps I'll direct the attention of the clerk to flag for the members afterwards in the report, under the monitoring and surveillance recommendations, point one in particular. It's really to standardize the key elements of the prescription drug surveillance system in Canada.

That's really for the federal government; professional associations; the Institute for Safe Medication Practices, which was identified as well; and the provinces and territories. I think there is absolutely a need for consistent national data collection. That means talking to the data holders, which are often the provinces, and looking at the different data streams that would come from that. It could be coroner reports and poison centre reports, as was mentioned earlier.

The bane of existence in these matters is common terminology. This includes a definition of how we're quantifying, what is the effect and impact of these, and the collection methods and the reporting.

As to the actual specific federal role, I think we could look to roles that the federal government plays in other national data collection mechanisms. Certainly the ability to have one understanding of what's going on in the country, as fed into by the provinces, would be useful.

Hon. Hedy Fry: Thank you.

How am I doing, Chair?

The Chair: You're doing quite well. You have two minutes to go.

Hon. Hedy Fry: Thank you.

My next question has to do with something you say in *First Do No Harm: Responding to Canada's Prescription Drug Crisis*. You state, in your second paragraph, "Develop and promote risk-reduction programs for individuals...". Can you elaborate on that? As you said, the lead is Health Canada, the Public Health Agency of Canada. So perhaps you can elaborate on it.

I also want to thank you for your last answer, because I think all of us who have been involved in looking at this issue know that if you're going to set up, you're going to evaluate, you're going to monitor, and you're going to look at indicators, then you're going to need data first. You're going to need data that has been broken down by particular groups and demographics, and other data that tells us who's more prone, etc.

Thanks, Mr. Perron.

Mr. Michel Perron: Thank you, Dr. Fry.

The issue of risk reduction is a key principle throughout this entire document, the first point being that we should not immediately turn to a pharmacological response to pain or to some ill that someone is facing.

There's a variety of other interventions, whether they be chiropractic, massage, or a variety of other ones. Simply put, I think, in a very blunt form, there was a general sentiment that we are overly reliant on a pharmacological response to dealing with issues that are facing Canadians. That's at the base of this strategy. Second is that if in fact a pharmacological or therapeutic drug is required, that it be an informed manner of prescribing and how that goes into it.

There's a variety of risk reduction measures also built in throughout the strategy, which you'll see under the treatment element around some of the specifics, in terms of naloxone at home and so on and so forth. There's a variety of initiatives, and again, all of them are soundly evidence-based, sourced, and contextualized within the broader context.

Often in this world, which is fraught with a lot of political attention—and which we welcome—sometimes it's laser-picked as to certain issues. To address the strategy writ large, we really have to look at all streams, and we have to ensure that we're collectively advancing the agenda based on what was put on the table. Again, that brings us back to the CCSA role.

The Chair: Thank you. You were great on time. Very good.

Next up for the last seven-minute questioning is Mr. Hawn.

Hon. Laurie Hawn (Edmonton Centre, CPC): Thank you very much, Mr. Chair.

Thank you to our witnesses for being here.

I want to turn to first nations for a minute. Obviously they are one of the most vulnerable populations, the first nations reserves and so on, in the country. We recently spent about $90 million—or committed that—on addiction prevention, addiction programming, and so on.

Can you comment on the effectiveness of some of those investments. Really, is it enough? Do we need to do more? Do we need to do something different? Are there changing trends on first nations—I'm talking about first nations and Inuit—reserves?

Mr. Michel Perron: The way I would address that is perhaps in the manner that we pull together the strategy.

First of all, the federal government is very present, as you know, on reserves, first nations, and non-insured health benefits and the like; there's a significant investment. I'll let Health Canada speak to their actions.

When we undertook this process, the last thing we really wanted to do was define for first nations people writ large what it is that we need to be doing in the area. We heard very clearly from groups such as the Assembly of First Nations and from National Chief Atleo and others that prescription drugs are one of the very significant factors in their communities and need to be dealt with.

We are very pleased that the Assembly of First Nations participated in this process. In fact, National Chief Atleo formally endorsed the strategy as well, as being consistent with how they wish to be guided in terms of their own decisions vis-à-vis the variety of programs that we've outlined here.

Also, I think that was helpful in connecting the activities of Health Canada. I know that they have a prescription drug abuse coordinating committee that is co-chaired with the Assembly of First Nations, so I think that all of the first nations interests were well represented in the strategy and that the recommendations are consistent with how they would like to see action move forward on this. In terms of the specifics of where it needs to go, clearly there is a massive amount of need in a variety of areas, but again, the strategy allows for that to unfold.

Did you want to speak a bit more to that, Paula?

● (1605)

Ms. Paula Robeson: In the strategy document itself, we have a number of areas where there are strong linkages with first nations. As Michel mentioned, the first nations representatives at the table were an integral part of the development of this strategy and in tailoring some of the recommendations to take into consideration cultural sensitivity and competence, community-driven solutions, and ensuring access to remote and rural communities. Parts of those issues are built into the strategy recommendations themselves.

Hon. Laurie Hawn: Thank you.

This may be a bit of a stretch, but of course there are first nations around the world. I was in Taiwan in April or May. They have I think 12 identifiable first nations communities. The resemblance was striking, not just physically, but in traditions, dance, and music—and in challenges. We've talked to their people a lot about some of the challenges those communities face in Taiwan.

Have we done any kind of comparison—maybe it's apples and oranges, I don't know—or information sharing with other first nations in countries around the world?

Mr. Michel Perron: From a CCSA perspective, we would look to the AFN to be a guide in this. There was no systematic examination of first nation needs in other jurisdictions. I was recently asked to chair the development of a consensus strategy for New Zealand, where the Maori and Pasifika people were very much represented. The need was well defined in a manner not inconsistent with how it is here. I won't speak to scope and size, but there was a need to recognize them as specific populations—acknowledging without stigmatization that they need particular attention. We feel that attention is best placed by the first nations leaders themselves.

Hon. Laurie Hawn: Do you know if they're looking at any of that?

Mr. Michel Perron: Absolutely. The Assembly of First Nations is looking at this matter. I don't know if there has been a systematic look across the country.The only point I would underscore is that the problem we're facing here is a problem of rich countries. If you go to the United Nations tomorrow, you'll be arguing for access to essential medicines. There's a paucity of access to many of these drugs in a lot of the countries. Our problem comes from having a significant amount of supply. How do we manage that supply in the most prudent way, understanding that we need to attenuate needs while mitigating harm?

Hon. Laurie Hawn: Taiwan, Australia, and New Zealand are all pretty rich countries, so they may have similar problems.

Mr. Michel Perron: Exactly.

I also want to underscore the fact that we learned, as we usually do when we sit down with first nations folks, that the construct of pain is very different among first nations people. As they describe it, the intergenerational pain doesn't necessarily have to be a physical pain. It might manifest itself that way, but as we look at how first nations people have been affected by prescription drugs, and we consider mitigating some of those challenges, the legacy of intergenerational trauma is a significant component.

Hon. Laurie Hawn: Sticking with the international theme for a second, all countries, not just first nations, are facing the same kind of health-care challenges writ large that we are. Are we doing any research with other countries to learn from them?

● (1610)

Ms. Paula Robeson: CCSA is involved in a number of collaborations and research initiatives. One example has to do with new psychoactive substances—how to monitor them and share information across jurisdictions, domestically and internationally. We drew on some international data from Australia, the U.S., and other countries to support the work of this strategy.

Mr. Michel Perron: The U.S. is number one in per capita use, and there is Europe and Australia. But in a lot of these countries the problem is not manifesting itself as we have seen here, because the supply availability is very different, or at least it hasn't reached our level yet. This is an opportunity for Canada to lead by saying, "If you're going down the road of expanding accessibility to certain drugs, be mindful of these practices". I think that's an opportunity for Canada.

Hon. Laurie Hawn: Are we doing that at all? Is Health Canada doing that with their international partners?

Mr. Michel Perron: Last year, at the Commission on Narcotic Drugs, Health Canada tabled a resolution on a take-back initiative, encouraging individuals to take the drugs out of their cabinet and bring them back to pharmacies. That resolution was adopted by the Commission on Narcotic Drugs. It provided a toehold, if I can say it that way, for the international community to consider in determining where prescription drugs fit in the realm of abuse.

I think there's ample room, as this strategy and other efforts go forward, for Canada to demonstrate how to deal with the problem. We can offer examples of identification, commitment, investment, follow-through, and best practices.

The Chair: Great. Thank you very much.

That concludes the first round of questioning.

For the benefit of the committee, the clerk reminds me that a couple of weeks ago he sent around the study that Ms. Fry asked about. We all get a lot of e-mails in a day. If anybody would like the clerk to resend it, please contact me or him, and he'll be glad to send it so you can review it.

Okay? Great. I just wanted to get that out there.

Next up we have—this our next round—Ms. Morin.

Go ahead, please.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Thank you very much, Mr. Chair.

I want to thank the witnesses for joining us today.

Mr. Perron, at the end of your presentation, you put forward three recommendations, the last of which had to do with the commitment of the resources you need.

Could you elaborate on those resources? Are you talking about human or financial resources? For the committee's benefit, I would like to understand what your needs in this area are.

Mr. Michel Perron: Thank you for the question.

Ms. Isabelle Morin: Can you please keep your answer brief, as I have other questions for you?

Mr. Michel Perron: Okay.

The CCSA needs resources to support the implementation of the strategy and, more specifically, to coordinate the working groups we listed earlier—the five working groups and the action teams. We have requested financial support from Health Canada to be able to take on that role....

Ms. Isabelle Morin: How much money have you asked for?

● (1615)

Mr. Michel Perron: We have requested $1 million a year for the implementation and coordination of the strategy. With that money, we will be able to encourage not only the participation, but also the investment from other levels of government, other professional organizations and the non-profit sector. That would provide significant benefits, as we have seen in our other strategies.

Ms. Isabelle Morin: Okay. Thank you very much.

During your presentation, you told us about three kinds of medications that require attention—opioids, stimulants and sedatives. I thought that was very interesting because you are the first person to tell us that there are three types of medications. Today, I am most interested in stimulants. I want my colleagues to know that, since I am a bit younger, I was exposed to those drugs at university.

I studied education at the Université de Sherbrooke. So we are talking about a world of educated people. Despite that, one of the problems at the end of semesters was that students would look for Ritalin. This is nothing new. Four years ago, I remember that people were seeking Ritalin because it's a stimulant that helps improve their concentration during exams. That was a very sought-after drug, and I was worried because I knew people who used it without a prescription.

I don't see anything in your recommendations aimed specifically at the university world. Much is said about young people. Individuals who appeared before us at other meetings told us about young people at elementary and high school levels, and about prevention. This issue is a source of concern for me, and the RCMP representatives we heard from last week said that the biggest problem was not in what we knew, but in what we did not know.

So I'm wondering whether you have anything to say about that. What solutions do you have in mind, and what can be done to remedy these kinds of issues? No one has talked about this so far, and I would very much like to know what your solutions are.

Mr. Michel Perron: Thank you.

I would have asked you to talk about the problem because that's exactly what is happening with stimulants. Across the country, we are seeing that the availability and accessibility of those drugs—Ritalin, Adderall and that whole range of drugs prescribed for attention deficit issues—is very high. The consumption of those drugs is abusive, especially among university students during exams for improved concentration. If I may say so, that's an alternative to Red Bull.

Ms. Isabelle Morin: Exactly.

Mr. Michel Perron: Unfortunately, that still has harmful effects and could be dangerous if consumed. The abusive use of stimulants would be part of that strategy of prevention, more specifically when it comes to the recommendation on awareness raising. Ms. Robeson should correct me if I'm wrong, but I believe that we have no specific recommendations for the university demographic in terms of those drugs.

To open another door, I just want to mention that the Canadian Centre on Substance Abuse is co-chairing the National Alcohol Strategy. We held a meeting last week, and representatives from the Acadia University were part of our group. We discussed the prevention messages we would like to communicate to that segment of the population when it comes to not only stimulants, but also alcohol. I would perhaps also like to create links with that strategy.

Ms. Isabelle Morin: I have one last question on stimulants. It concerns the same group of individuals.

So few people have access to a family physician that many of them go to an emergency clinic to obtain a prescription. It's actually very easy to obtain a Ritalin prescription at an emergency clinic. Do you have any suggestions regarding access to family physicians in terms of resolving the prescription problems? People can obtain a prescription for a medication they do not need because they don't have a family physician. Do you have an opinion on the topic or any relevant studies to share?

Mr. Michel Perron: We have mostly been focusing on ways to better educate physicians who are working in emergency clinics. For instance, we talk about what tools those physicians need to have and what questions they should ask those who come to see them. We emphasize the importance of identifying those individuals who could try to commit fraud and those who are there to try to find a physician.

Of course, access to a family doctor is a much broader issue that involves considerations that go beyond this strategy. It would be desirable for everyone to have access to a family physician, but, for the time being, the focus is mostly on better awareness raising among the available physicians.

[*English*]

The Chair: Thank you, Ms. Morin.

Next is Mr. Wilks. You have five minutes, sir.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Mr. Chair.

Thanks to the witnesses for being here today. Mr. Perron, it appears that several recommendations in the First Do No Harm strategy have both CCSA and Health Canada listed. Would you explain further how CCSA's mandate differs from that of Health Canada's? Since we are looking at identifying the federal role, we want to make sure that there is no duplication of effort. Would you talk about that for a while? Then I have one more question after that.

Mr. Michel Perron: Thank you, sir.

Actually, that's a very good question because people often ask about the difference between the two. If we go back to the CCSA Act, which was circulated, our role is really about bringing together all levels of government, and the not-for-profit and private sectors. Our job is ensuring that the efforts and investment that Health Canada wishes to place on the table vis-à-vis on issue can best be leveraged with other levels of government—but also with those other components.

CCSA's role is really about bringing together that national band of organizations and advance it beyond that of one particular department or level of government. It has worked well in other areas and has allowed the federal government and other levels of government to more precisely undertake what they see as their specific role, as opposed to having to take on all aspects of it.

Did you want to comment further on that, Paula?

Ms. Paula Robeson: No.

Mr. David Wilks: I'm curious about this. So CCSA is funded to take on these responsibilities called for in the First Do No Harm strategy. What happens if you don't continue the coordinating efforts you've spoken about?

● (1620)

Mr. Michel Perron: There's always a danger in bringing a lot of people to the table and creating an expectation of collaboration on a go-forward basis. That said, I'm very keen.... Let me put it this way. The fact that everybody has been to the table and remains at the table and is prepared to invest their own resources, time and moneys toward commonly understood and advocated-for recommendations is a very significant addition, value-added, to whether a federal investment would be provided to this equation.

Essentially, federal dollars going to CCSA—because that's largely how we're funded—provide for a maximal national return. In fact, we can demonstrate that in other areas of the strategy. To not fund CCSA at this point in terms of a very specific—and Madam from the NDP asked earlier about what we required—would do two things. One, it would certainly lose the momentum of the partners who are prepared to move this thing forward. Second, it would risk a tremendous amount of duplication, lost connectivity, and the ability to leverage funds that are currently in the system now.

Ultimately, it has taken us a long time to get here and to have the clarity of where to go. It wasn't because there wasn't anything happening; there was a lot happening, but it wasn't connected. Being able to connect it now into a comprehensible whole that everybody can have a reasonable portion of is the role that Parliament created for us to play.

The funds that we would require to move that forward is what our partners have said they want from us. I think if we don't do it, there's a great risk that we'll be coming back to this committee in three or four years and having the same discussions all over again.

Mr. David Wilks: Thank you, Mr. Chair.

The Chair: You still have a minute and a half to go if you'd like.

Mr. David Wilks: Do you want me to?

The Chair: Yes.

Mr. David Wilks: You're such a gracious chair. It's probably because we look a lot alike.

Voices: Oh, oh!

Mr. David Wilks: One of the things you mentioned in the enforcement portion of the document you provided us was to conduct a cost impact assessment related to prescription drugs on law enforcement resources and public safety.

Would you briefly talk about that, because there would be an impact, certainly, on law enforcement from their perspective of resources.

Mr. Michel Perron: Thank you.

There are two sides of the coin. One is that police currently incur significant costs, we would argue, around the illicit use of prescription drugs. They might simply not be aware of it.

The police leaders and the Canadian Association of Chiefs of Police were the lead external partners on the development of recommendations around this, along with Public Safety. They have identified that the police community needs to have a better understanding of what the flow-through impact is on policing.

Public Safety has to date, as they have in the past, invested in the development of that analysis. It has begun. It is under way, which is a significant step forward in articulating where that might go. This would tie in—and I know it's not part of the remit of this committee—to the whole issue of the economics of policing and how the government wants to see where you are going vis-à-vis policing resources.

A cost impact analysis of understanding what is the flow-through, how that fits into efficient policing, and where that goes and where you want to spend your dollars best, is really what's going to come out of it. Public Safety is at the table, and that's part again.... As a committee or as a nation, how do we know all of the different parts that are occurring? That's where First Do No Harm can bring people back to the same table and make sure that the connectivity stays within the group.

The Chair: Thank you, Mr. Wilks.

Next up is Mr. Marston.

Mr. Wayne Marston (Hamilton East—Stoney Creek, NDP): Thank you, Mr. Chair.

I want to follow up a little further on Mr. Wilks' point of view because he was a police officer on the ground, which is where my interest is. From your point of view, the package is very high-level, and the information we've received from various people coming to this committee is quite striking.

The Narcotics Control Board found that Canada had the second-highest per capita misuse of prescription drugs. It says “use” but it's misuse.

Mr. Head, from the prisons, was here yesterday and said that 80% of the new inmates to prison are coming in with addiction problems. Pause for a second, because if that's accurate, this thing is much larger than we thought.

Why do you think that in Canada we seem to be more predisposed to this abuse than in some other countries? Have you come across anything that led you to understand why?

● (1625)

Mr. Michel Perron: I suppose that's the central question of how did we actually get here? I think there is no one answer. You hear that a lot, I'm sure, from your witnesses, and I apologize for repeating the line.

One would argue that the emergence of opiates as a heavily marketed product to deal with a variety of pain elements was done with the confidence of trying to ease the pain of Canadians. There was no malice. This was people trying to help people. But we have gotten to a point where the volume and supply have grown at such a rate that there has been the collateral effect of a doubling in overdose deaths in a matter of 10 years, a doubling of access for treatment, a doubling.... I mentioned earlier that the status quo could not carry on. At this point, we have said, “Okay, we’re not sure how we got here, but we know we can't carry on”. That's the purpose of the strategy.

Mr. Wayne Marston: My generation was among the first—I'm announcing that I'm really old by saying this—that turned to antibiotics. People were surviving illnesses that destroyed people before. As a result, to some extent, we started to think of pharmaceuticals, in general, as some kind of great saviour, and of course we know there are negative ramifications for many.

I read a piece today, and I clipped a little bit to put in here. Niagara Falls police today are reporting that since OxyContin was taken off the market, there is a new concoction being used, including by people who can't access heroin. They call it Krokodil. I don't know whether anybody has heard of it. I hadn't heard about it before today, but this is monstrous. It's a blend of iodine, gasoline, industrial cleaning oil, lighter fluid, and paint thinner, mixed with codeine and injected. It's called Krokodil because of what it does to the skin, leading to necrotizing fasciitis or flesh-eating disease. This flowthrough that's happening, ending in this place.

I know we have a philosophical difference with the other side on InSite because of the withdrawal from heroin. If there's anything I've ever heard to say that InSite could protect people from that—and I'm not asking you to comment.... It's just that this thing struck me hard when I read that people are so prepared to inject that kind of concoction. We're in a desperate place.

Mr. Michel Perron: Thank you for the comment.

I have a couple of points. One is that we learned as we entered into this discussion that there's a tremendous amount of mobility among markets, in people who want to use drugs. That's part of the reason for having effective prevention in the first place, of course, but also reaching out to those who are in difficulty when they are dependent.

Here in Ottawa, the issue is not so much OxyContin, but fentanyl. We've seen that if you push down on one drug, another will emerge.

The point is that we need to have a very comprehensive and holistic appreciation for how we wish to deal with this issue, and how we want to have a coherent strategy across the nation that involves all levels of government, the not-for-profit and private sectors, and that involves some of the other elements I referred to.

On Krokodil, I should mention that we are part of a novel psychoactive-substance network, because a lot of these new drugs are emerging, and that will always be the case. There's a new chemist born every year, so that will just carry on.

On novel psychoactive substances, we have an alert system, if you wish, that CCSA works with in the regions. We have asked specifically about the issue of Krokodil. There have not been any known reports of it, just yet, in Canada, if I'm not mistaken. That was the latest information we received.

That said, I will look into this element, because one of our challenges is to have the right kind of quality of information. I think Dr. Fry made the point and that we need to act on it. But at the end of the day, I understand the point you made in terms of—

Mr. Wayne Marston: This is being reported today in *The Hamilton Spectator*, that there were three cases in the Niagara area, just to be specific.

Mr. Michel Perron: Yes, and that would possibly be some transborder stuff going on there—

Mr. Wayne Marston: Well, it's very close, Niagara Falls.

Mr. Michel Perron: —because we haven't seen it in Canada yet.

Exactly.

If I might, Mr. Chair, comment on the other point about the corrections system and 80% of new inmates having addiction problems, one of the strategies that CCSA has long advocated is that we have a coherent offender strategy in this country. Most people don't go to federal jails immediately, they graduate from the provincial ones. Understanding how we can treat and address the needs of incarcerated individuals around alcohol and drug dependence from the very beginning is important. Those 80% would not necessarily have addiction problems with prescription drugs only, of course, but all drugs.

● (1630)

Mr. Wayne Marston: No, I realize that, but just in general terms, when we start talking about the fact that we have access—

The Chair: Excuse me, Mr. Marston. We're over time, but thank you very much.

Mr. Lizon, you're up next.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you, Mr. Chair.

And I thank the witnesses for appearing here.

It's a very interesting discussion, but going to the basics, I truly am trying to understand how we properly define drug abuse or prescription drug abuse. Where do you actually draw the line, and who falls on which side? I'm not talking about the obvious places, where people are addicted and they get drugs that are prescribed for medical purposes and they use them. But if someone, for whatever reason, gets hooked on drugs and doesn't use an excessive amount, let's say a tablet a day, and there's a need, would it fall under "abuse"? How does it show in the statistics?

Now we're talking about prescription drugs. What about drugs you can take off shelves, say, and use every day? I don't know how this is recorded and how this would be different from the prescription drugs. And we're talking about opiates, amphetamines. In many countries there are labs in homes. People are making it left, right, and centre.

How do we, first of all, define it? How do we deal even with non-prescription drugs in this context?

Mr. Michel Perron: Hopefully that was a one-minute round, because that's a long and tough question.

Voices: Oh, oh!

Mr. Michel Perron: Thank you for your question, Mr. Lizon.

We can talk prescription drugs for moment, and you will get a variety of different answers depending on the witness, whether we want to talk about drug addiction, drug dependence, drug abuse, or drug misuse. For the context of our discussion here around prescription drugs, we're seeing either non-therapeutic use, with people using them for non-medical reasons, or secondary negative effects as a result of people using them even for therapeutic reasons. Let me explain, please.

You break your arm, you go to the hospital today, you will likely be prescribed an oral opiate or some sort of analgesic because of the pain in your arm. You might have that prescription for a week to deal with whatever the ailment is. You should not carry on with an opiate beyond that timeframe. Some of the issues that we're seeing concern how many opiates would you provide to Mr. Lizon with a broken arm. Would you ask him to come back at an earlier time? How would you dose it, and so on and so forth.

There are other people who have chronic diseases for which opiates have been indicated as relevant treatment, and these people, by definition, are dependent on the drugs. But that outweighs the conditions of not having access to those drugs for those chronic diseases.

The issue is really about what is the condition, what are we trying to treat for, and is it diverging from what are known to be acceptable practices for therapeutic purposes?

Paula.

Ms. Paula Robeson: If I could add, the strategy focuses on the harms associated with those prescription drugs regardless of whether they are misused, abused, whether it's addiction or dependence. It's really focused on those harms that are associated with them, which include addiction, overdose, death, and other harms.

Mr. Michel Perron: Some would argue that if you use any substance for a non-therapeutic or illegal use, it's immediately called "abuse". Now we're getting into taxonomy, definitional issues. But the point is that you don't necessarily need to be dependent to have immediate harms from the use of a drug. We see that in people who drink too much and kill themselves driving home. There's a variety of ways of looking at it.

I'm sorry if it's less than a full answer, but I think the point made by Paula is really trying to focus on what we know are the issues flowing from non-therapeutic use and therapeutic use that is not consistent with what best practices are called for, either in prescribing for or in terms of treating specific conditions.

The Chair: You have 30 seconds.

Mr. Wladyslaw Lizon: Quickly, the first recommendation here is to encourage provincial regulatory colleges to develop and implement policies to promote appropriate prescribing practices. I would trust my doctor to prescribe the proper medicine for my medical condition, and I don't think the college would know better than my doctor, who knows what my medical condition is. How do you marry the two together?

● (1635)

Mr. Michel Perron: We're assuming that the physician is properly trained in the issues of a particular drug. The medical community who sat at the table with us has indicated that there isn't sufficient education, certainly around the issue.

Second, there's the fact that veterinarians receive far more training around pain management than physicians for humans do. It's not surprising; their patients don't talk back. But I'm not trying to be cheeky here. I'm simply stating that I think part of the problem that Mr. Marston asked about—how we got here—is that there was perhaps an assumption that there is a greater level of understanding and education than is currently being provided. The medical community has said that to us clearly, and has indicated they wish to see additional prescriber education, not only in terms of curriculum when you're going through medical school but also post-graduation. In that regard, a number of post-graduate education programs are largely funded by pharmaceutical industries. There was attention to that matter brought at the discussion as well, to ensure that there is a sufficient distance from any potential conflict of interest in education. Finally, the role of the colleges of physicians is essential to ensuring the uptake of appropriate clinical practice. That is a check and balance that physicians themselves indicate is absolutely critical to knowing if they're prescribing rightly or wrongly. It's our only early warning system, if you wish, and it's one that's managed by their own practice as professionals.

I'd urge you to save or repeat that question for Dr. Susan Ulan, who will be here with the College of Physicians and Surgeons of Alberta. That's precisely their role. You will probably get a better and shorter answer from her.

The Chair: Okay, thank you very much.

Thank you, Mr. Lizon.

Ms. Davies.

Ms. Libby Davies: Thank you very much.

I have just a couple of follow-up questions, Mr. Perron.

Just in terms of the money, I think you said in answer to Ms. Morin that you're requested a million dollars a year for the strategy. Could you tell us whether you have costed out the whole strategy, even in ballpark terms? And are there timelines? Is it five years? Ten years? How does this roll out? And I have one other question after that.

Mr. Michel Perron: I'll start with the easy ones. We haven't costed it out. In terms of what this entire thing would look like, fully costed by all levels of government for all engagement, we haven't done that.

Ms. Libby Davies: Are you going to?

Mr. Michel Perron: No. I say "no" because the answer that we would likely get from a lot of people would be, how long is a piece of string? Rather, as co-chair of the process, I'm interested in knowing who's prepared to put what on the table, now that we know where we need to go.

Ms. Libby Davies: Okay. Do you have a timeline, then, for certain priorities?

Mr. Michel Perron: Correct. There are two things.

Because we are not the government and therefore cannot commit governments at any level, or the others, we have said two things. One is that we will push through toward implementing a process around the action streams, and that's what Madam Robeson referred to earlier. Part of that is forcing people to remain at the table and commit to what they said they were going to do around the recommendations. That work is under way now. That is what we need the financial support for.

Second, we've committed to a public annual report on progress around the strategy, which is currently focused on a 10-year lens.

Ms. Libby Davies: And is the million dollars a year for your agency? Or is it overall that you think it's required for your agency?

Mr. Michel Perron: It would be for our agency to support the implementation of the teams—

Ms. Libby Davies: Okay, I got it.

Mr. Michel Perron: —so that we have the people actually coming to the table, supporting their work. We often don't know what we know in this country. Part of this challenge is ensuring that there is adequate knowledge to practise and a follow-through around the knowledge exchange practices. It's all been costed out in terms of our role and how we'd support the partners.

Ms. Libby Davies: Okay.

I'd just like a quick follow-up of Mr. Marston's question. I think he outlined very well what lengths people will go to, whether a substance is legal or illegal, and so the emphasis on prevention and education and treatment is very important. I just wonder whether the CCSA ascribes to the principle of harm reduction, which is a very important element in dealing with the reality. The idea that just suppression alone is going to work is really not realistic. Drug use exists, whether it's legal or illegal drugs. So the issue of harm reduction and reducing the risks and managing those risks, and then moving people into treatment are very important elements. Does the CCSA subscribe to that?

● (1640)

Mr. Michel Perron: Yes, and it's entirely one of the tenets or principles of the strategy. As you read through it, you will find that the challenge is whether this is a harm reduction strategy or a strategy that reduces harms.

Ms. Libby Davies: But even though the Government of Canada has dropped harm reduction as one of the four pillars, you still have it in your strategy, do you?

Mr. Michel Perron: I'm saying that the strategy has a variety. To ensure that we have everyone at the table and that we can all focus on the common signal, we're talking about how to reduce the harms related to.... And that is a very clear element throughout: you'll see a lot of recommendations in here that are consistent with the term "harm reduction" that you're referring to. But this is focused on specific actions.

Second, these are controlled legal substances. This in fact underscores the challenge of looking at this through a lens of "legal" or "illegal". These are highly controlled, presumably difficult-to-access substances, and yet we have a crisis on our hands.

The reduction of risk is by far maximally advantaged by looking first of all at how these drugs are accessed. It is largely through prescribers and through areas in which we can see that there might be some diversion on the illicit side.

This speaks to a very comprehensive strategy, focusing not only on one particular element, as I mentioned with Dr. Fry, I think, but starting with prevention and education of the prescriber and going straight on through the supply chain. I think that everybody who sees and reads these recommendations will see that concept of reducing harm throughout.

Ms. Libby Davies: Thank you.

The Chair: You still have a little bit of time, if you like, Ms. Davies.

Ms. Libby Davies: No, that's fine.

The Chair: Okay. Thank you very much.

Mr. Michel Perron: I'm sorry; that may have been my fault.

The Chair: No, actually we're under time on that one.

Next up is Mr. Dreeshen.

Mr. Earl Dreeshen (Red Deer, CPC): Thank you very much, Mr. Chair and witnesses.

I also want to thank the CCSA. When I first came on the health committee, I had an opportunity to be briefed by your organization. I got the chance to look at how you fit into the entire health system and how you can help to bring different groups and organizations together. I certainly appreciate it.

One of the things we're looking at now is the national framework for action. You've certainly discussed the First Do No Harm strategy. The national treatment strategy, I think, is also significant here.

But I'd like to focus on the third, which is the Canadian standards for youth drug prevention, and along with those, also on some of the information you've had. You spoke about cannabis use by youth in Canada—that's rather a tongue twister. One point was that youth are at particular risk for experiencing related harms, given their ongoing brain development and the significance associated with it. Also, you have this response in "Clearing the Smoke on Cannabis", the series that is associated with that, in which you talk about chronic use and cognitive functioning and mental health, from the report that was done in that area.

I'd also point to the "Respiratory Effects of Cannabis Smoking".

Then you are also talking about some of the upcoming research on cannabis and the brain.

I'm wondering whether you could put on the table some of the information you have there, so that we can take a look at this particular substance and get some of the real facts on it.

Mr. Michel Perron: Okay.

If I could step back a little bit, I think the point was made—I perhaps introduced the issue earlier—about alcohol and treatment. In Canada we have what's called the national framework for action, which is meant to be a national, pan-Canadian blueprint for how we can deal with alcohol and other drugs. Part of that identified thirteen national priorities, eight of which CCSA is leading on. One of those strategies is around prescription drug misuse. But as we cut into the prescription drug misuse strategy and identify prevention activities that we wish to undertake, the issue for us is what is good prevention.

You can then change the channel to recent work that was funded by the government under its national anti-drug strategy, whereby we have come up with Canada's first national youth drug prevention standards for schools, families, and communities.

In other words, if you are in Estevan, Saskatchewan and want to do a prevention program in your school, the standards allow you to have the confidence that the programs are consistent with what good evidence is telling you is the right kind of prevention, so that it's not only time spent with youth, but time well spent.

The point with CCSA is that we try to knit together a variety of these elements, whether they be alcohol, youth, campus, and stimulants, as was raised earlier, or prevention standards to support the prevention element that we've identified here in terms of the practice with the provinces. This is part of that connecting-the-dot element that we will bring.

The issue of cannabis certainly is one that preoccupies us quite significantly, not only in terms of prevalence of use by young people and the changing components of cannabis with the molecular change between tetrahydocannabinol—the active ingredient that makes you high, if you wish—and CBD, another molecule, which would attenuate some of the psychoactive effects of cannabis.... The point is that cannabis is very present in Canada. We are concerned about its impact on the developing brain.

There are various proof points that we can know much more about, and we plan to bring them forward. The federal government has in fact recently supported CCSA to advance knowledge around this area: around prevention, around the competencies for people who will do prevention, and focusing on cannabis and sport as an element to help with prevention. This is recent funding that we've received from Health Canada, in particular around the national anti-drug strategy.

The last point I'd make is that it will be interesting as this committee goes forward, as a health committee looking at prescription drugs, that one thing we really never discuss in earnest is what happens about medical marijuana and where it fits into this scheme at some point. This is something we will have to look at on a go-forward basis. It's a 10-year strategy. Clearly, as the ground shifts with respect to how that substance is being made available medically, we will have to look at this.

● (1645)

Mr. Earl Dreeshen: I think the other—

The Chair: Thank you, Mr. Dreeshen. You are right on five minutes. That's a perfect job there.

Ms. Adams has the next round.

Ms. Eve Adams: Thanks very much.

I want to follow up on a comment you made early on during the question period, which was about the large increase you're finding in prescription drug abuse among women. Could you speak a little bit to that?

Mr. Michel Perron: I was referring specifically to the prescribing of benzodiazepines for women as one area we are looking at.

All of this is on the basis of less than ideal and fulsome data; however, we are seeing some representation of effect in the fact that women are disproportionately if not much more significantly prescribed benzodiazepine than the male population, the question being whether this is an optimal prescribing rate and what effects would flow through with respect to these women. We're talking typically of adult women. The role of prescription drugs, opiates in particular, is fairly gender-neutral in terms of its application—

Ms. Eve Adams: I know; I noticed that in your report, actually. You noted that prescription opiate use in the world has shown a more than 200% increase since the early 2000s, and that's partially why we're looking at this today. Things have dramatically changed since the early 2000s. That is a very remarkable increase, a more than 200% increase.

Mr. Michel Perron: What we've seen with that, since it is over 10 years, is that we went from being number six in the world in per capita use to number two, and I don't think we want to be number one—that's the U.S.

What we've seen with that 200% increase is a very similar doubling of unintended overdose deaths, a doubling of access for treatment services around opiates in particular, in a treatment system that I would suggest was already very much under duress or under stress to accommodate its existing clients.

We as a government, if I can say that, pay often for this. We pay to dispense it—often it was covered by formulary—and we pay in terms of the treatment modality and some of the lost productivity and mortality. This strategy, while it will require some financial investment, will undoubtedly decrease the entire cost load across the system because of the current situation.

Ms. Eve Adams: Changing tracks ever so slightly, could you speak to the effectiveness of National Prescription Drug Drop-Off Day and recommend other similar practical measures that our government could undertake?

Mr. Michel Perron: Certainly.

There are two things. One is that your government is already at the table with First Do No Harm. They were part of the development of the strategy and were able to provide that commentary. Of course you are familiar with the commitment for the ministers of health, so that's important as well.

Drug Drop-Off Day took place in May of this year. It's being led, in part, by the police, and certainly in cooperation with Public Health. As I mentioned earlier, a lot of young people today are accessing medications for non-medical use, which they are getting from their medicine chests. The point being, if you have unused medications please return them.

You can return them any time to a pharmacy. However, there is some concern as to how that return is being managed once they're back in the pharmacy. Take-back day is an opportunity to signal the importance of the issue at a community level, to educate people, and to obtain drugs that would typically be left unattended in a medicine chest and are no longer required.

Last year, in I think about 18 cities, it was coordinated by Public Safety and the Canadian Association of Chiefs of Police. There were over two tonnes of drugs collected, not all opiates. If you can imagine the weight of one pill, you can imagine how many pills that actually was.

There are a variety of resources for any community that wishes to partake in this which have been developed and supported by Public Safety and are available to all jurisdictions. Again, that decreases the cost for the community that wishes to engage in that.

● (1650)

Ms. Paula Robeson: Further to that, one of the pieces that went to Alberta Health for support was the development of an evaluation guide for those who are conducting these take-back initiatives. We can get a better sense of how effective they are in terms of awareness, community mobilization, understanding of the safety precautions and issues that one can take, as well as the types of drugs that are returned.

Ms. Eve Adams: Thank you.

The Chair: Thank you, Ms. Adams.

Ms. Fry.

Hon. Hedy Fry: Thank you very much.

It's all very interesting, and I think the whole idea of how we got there is a very important question. But I want to remind everyone that this is not new, it's simply the global media that makes it new.

Back in the Victorian era, opium—from which “opiate” and “opioid” come—was taken by every good little Victorian lady. She had tincture of opium and she took it all the time. Opium was then a legal drug. Then it became illegal because of trade wars with China. So it isn't new, but what it points to is the fact that it's ongoing.

What we now know today, which we didn't know then, is that addiction is a chronic disease and it comes from lack of dopamine in the brain, which doesn't give you the right triggers to stop you from being addicted. This is why some people drink a lot of alcohol and don't become an alcoholic and others do become alcoholics. We've seen that happen. As teenagers we all went around trying to get drunk because we thought it was cool, then most of us went on to drink responsibly. But some of our friends, we know, never could stop. We now know that it's a chronic brain disease and that we need to deal with that.

You've all made a really good point about prescribing practices. Physicians—on the contrary, Mr. Lizon—don't know very much about addiction. We've only known a lot about addiction in the last 15 years. So you would give something, hoping you could take the person off it. If they happened to be the wrong person with the dopamine problem, they would stay on it and wouldn't be able to get off it.

I will tell you a story, because I think it's important and because I know I'm allowed to make comments as well as ask questions. Recently, a friend of mine had a baby and left the hospital. She had a C-section. She was fine, she got up, she walked out of there, great! For two days she was in the hospital. She was given OxyContin to help her with pain at home. I said to her, “You've been given what? Just tear up the prescription and throw it away”. That was a ridiculous thing to do. If you have pain, take Tylenol Extra Strength. But this is what we see. This is happening over and over, and then we have a problem.

There is a problem I want to bring to your attention. You questioned the problem, which I think is very valid, about the role of advertising. We know a lot of kids who take Ecstasy, etc. After awhile the amount of serotonin in their brain lowers and they become depressed after a good night on Ecstasy. So they go into their parents' medicine cabinet and take out an antidepressant and they get hooked on that, because that antidepressant raises the level of serotonin and they get to behave normally. So here is an illicit drug feeding the abuse of a prescription drug, which is a real problem. Advertising—all these names you see advertised on television about antidepressants—feeds that understanding of what drugs do what for you, for people who need to abuse them.

I do think the role of advertising of drugs, especially narcotics and opiates and barbiturates and antidepressants, all of those, is a really important thing for which this committee should think about making some kind of recommendation. Advertising really opens up this information for a lot of young people about what the drug can do for them. They open their parents' closet, their parents have it in their medicine cabinet, and boom, the young person takes it. I think it's a really important piece.

It's really not only about criminal activity, it's about what you talked about earlier on about education. I think we have to look at the advertising component of this. I think it's completely unnecessary and dangerous.

What do you think?

Some hon. members: Oh, oh!

Hon. Hedy Fry: I did ask a question.

● (1655)

Mr. Michel Perron: I get the 30 seconds now, right?

Voices: Oh, oh!

Mr. Michel Perron: You made a lot of points there, Dr. Fry.

First on the point of advertising, it is a recommendation, but perhaps a bit different from what you might have conceptualized. It's advertising to physicians; it's how in fact the drug companies are advertising and marketing to physicians. Now, practices have changed drastically over the years, but this is an area that we have identified specifically under the prevention rubric:

> Conduct an independent review of the evidence and make recommendations as appropriate on the link between promotion (e.g., advertising, marketing to clinicians) and the harms associated with prescription drugs.

To bring it back to your earlier point, this entire work fits into the broader context of how people may use drugs or not. What we do know is that a significant portion of Canadians got here because they happened to have their teeth extracted, or they happened to break an arm, or what have you. That is not to point a finger at any particular profession, other than to say that people have unwittingly become dependent on a drug, at times very powerful, from which an exit strategy is difficult to attain.

Everybody is agreed that this cannot continue and therefore we need to change the dial on it.

If I may underscore, Mr. Chair and members, in First Do No Harm a lot of the heavy lifting around who should be doing what has been articulated in what we hope is a very clear manner in this report. You can use this by going to the individuals listed and saying, “You sat there, you were part of this process. Have you agreed and will you commit to supporting these, and what will you do?” I say so because there have already been those suspicions.

This is about having a true national approach that will have to evolve over time in the context of broader challenges around youth and cannabis and the like. I don't mean to stump here, but the point is that we think this is worthy of the attention of not only the federal government and this committee, but also of others.

Hon. Hedy Fry: You should have a TV advertisement.

Ms. Paula Robeson: Part of the strategy will be about informing consumers. So some of that will be related to the idea that just because it's prescribed doesn't mean it's safe, and just because you can get it doesn't mean you ought to, and if you're prescribed it, you need to ask a lot of good questions of your physician and care provider.

So that's part of the public education end of that.

The Chair: Very good. Thank you, Ms. Fry.

We just have time for one quick question and then we'll suspend to get into committee business.

Ms. Davies was so judicious with her time in one round we're going to give her a quick question and a quick response.

Ms. Libby Davies: Thank you very much, and first of all, thank you. We've had a very fulsome discussion and your answers have been very forthright. So I really appreciate that.

I just have a general question. I think drug policy overall has changed quite dramatically even over the last decade, notwithstanding whatever our government position might be, and it certainly has globally. I think there is more recognition now that whether a substance is legal or illegal, a regulatory approach may be desirable, as opposed to a suppression approach or a free market approach. A lot more people are discussing that, a regulatory approach. I wonder if CCSA keeps up with that debate. Are you involved in that debate at all in terms of how we look at a regulatory approach to these substances?

Mr. Michel Perron: Thank you. I'll be brief, as per the chair's request.

Of course, we do keep up with this discussion as it evolves. We just had a discussion very recently with another member of Parliament, and I guess the question is what harm are we trying to resolve? What are we trying to fix by regulating something? Some would argue that we already have a regulatory process for these substances and that it hasn't necessarily served us that well, if you look at some of the impacts. So I don't mean to throw it back with a question, but certainly we need to look at what we are trying to fix. What is the problem? What is the evidence pointing us to as the best means by which to do that? We've seen the tremendous damage from legal substances, controlled substances, and in fact illegal substances. So sometimes a regime in and of itself is perhaps not the panacea that some might make it out to be.

● (1700)

The Chair: Thank you very much. It's been a great discussion and dialogue this afternoon, with great questions by our members.

We're going to suspend for a minute to go in camera to discuss committee business for a few minutes and we'll carry on.

[*Proceedings continue in camera*]