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Chair

Mr. Ben Lobb

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. Welcome to the health committee. We have a quorum so we are going to get under way here.

We have another large contingent here to provide information and their expert experience for our study addressing prescription drug abuse.

We ask that you do a 10-minute presentation, or shorter, to the committee. There is translation if you need it. Then there will be several rounds of questions to follow.

We have five different groups. We'll start with the Royal College of Dental Surgeons of Ontario. Please go ahead.

Dr. Peter Trainor (President, Royal College of Dental Surgeons of Ontario): Thank you, Mr. Chairman, and members of the committee.

I am Dr. Peter Trainor, president of the Royal College of Dental Surgeons of Ontario. I am also president of the Canadian Dental Regulatory Authorities Federation.

The college is the regulatory body for the dental profession in Ontario. We regulate the practice of over 9,000 dentists. These dentists work in both general practice as well as specialty practices. To put that into a different perspective, we regulate about half the dentists in Canada. Our legislative mandate as a provincial health care regulator is very clear: it is public safety and protection. Everything that we do is seen through the single lens of public protection, and we have been doing that for a long time. RCDSO has been regulating the dental profession since 1868. Dentists have a long history of safely and effectively using and prescribing medications to their patients in the treatment of oral health disease. It is an essential component of the modern practice of dentistry, and this is why our college is very pleased to have the opportunity to be before this committee today.

Joining me today is Irwin Fefergrad. Mr. Fefergrad is a lawyer by profession. He is the registrar and chief executive officer of the college. He is certified by the Law Society of Upper Canada as a dual specialist in civil litigation and health law. He is also the executive director of the Canadian Dental Regulatory Authorities Federation.

Also with me is Dr. David Mock, a dentist as well as a specialist in oral pathology and oral medicine. Dr. Mock is an expert in pain management and as such is the associate director of the Wasser Pain Management Centre at Mount Sinai Hospital in Toronto. He is the former dean of the faculty of dentistry at the University of Toronto, the largest dental school in the country. Dr. Mock is also a member of our governing council.

Our college, due to concern about the management of chronic pain, has held a one-day symposium strictly dedicated to this very important topic. As an outcome of that symposium, a working group was established to study acute and chronic pain. Dr. Mock is the chair of that working group.

Dr. Mock, as well as Dr. David Segal, an oral surgeon on the RCDSO council, are also members on the working group of the Canadian Centre of Substance Abuse. Dr. Mock co-chairs that working group, and they have produced a statement on the national document *First Do No Harm*. The working group is composed of both professional as well as lay people developing competencies for health care providers.

With that brief introduction, I would like to turn the presentation over to Mr. Fefergrad.

Mr. Irwin Fefergrad (Registrar, Chief Executive Officer, Royal College of Dental Surgeons of Ontario): Thank you very much for having us. Good afternoon.

As the registrar of the college, I have responsibilities under the statute to protect the public, the public interest, and the health and safety of the public of Ontario. Our mandate does not include advocacy for the profession; it does not include anything involving protection for the profession. As a regulatory body, we are governed by statute, as Dr. Trainor has said, and that is our mantra.

The issue of drug prescription, particularly with opioids, has been in the forefront not only of the college, as Dr. Trainor has outlined and as Dr. Mock will explain in a minute, but it has also been at the forefront of the thinking of the government of Ontario. It produced a document through the Health Professions Regulatory Advisory Council, which is the Minister of Health and Ontario's key statutory advisory committee.

I have copies of it here and will make brief reference to it. I apologize that it is in English only—

● (1535)

[*Translation*]

but it is not my document. It comes from the Ontario government.

[*English*]

I have not translated it. It is an Ontario document and I've just given you what the Ontario government has produced. I hope that for this session you will look at it. I think it has an impact on what you might be doing, analyzing, and discussing.

I understand there is a procedure that you have. Again, I apologize. This is not a document that the college produces. If you see our magazine, you will see that features of it are bilingual. If you looked at our website, you will see that features of it bilingual. But this is from the Government of Ontario.

I've given it to the clerk, Mr. Chair.

The Chair: Thank you.

Does that conclude your presentation or is there more to that?

Mr. Irwin Fefergrad: No, I want to refer to the document.

The Chair: Okay, carry on.

What we'll do, just for your information, is to have it translated and then distributed to the committee. Okay?

Mr. Irwin Fefergrad: Thank you very much.

I won't take a lot of time, but the conclusions of the Ontario report were, at page 231, that dentists prescribe medication, particularly prescribe opioids, safely.

At page 214, the government's counsel reviews the professional misconduct regulation on prescribing, and says:

> Dentists...have a detailed professional misconduct regulation. It includes "prescribing, dispensing or selling a drug for an improper purpose, or otherwise using improperly the authority to prescribe, dispense or sell drugs" as grounds for disciplinary action.

I would also urge the committee to look at pages 215, 216, 217, and 218 of the report. It outlines the education in the pharmacological area at the universities, and concludes:

> Dental programs have extensive general pharmacology courses at levels comparable to medical students. All programs offer courses in general medicine relating to how common illnesses impact dental care.

It goes on to analyze what the programs are about and then it compliments the college for its ongoing education in drug education.

Finally, at page 218 of the report, it concludes that we are responsible as a regulatory body looking at the public interest in regulating the profession. There's a comment on online adverse drug interaction programs providing timely and reliable information on drugs, and the minister's counsel feels that this is a very important availability for each and every dentist at chair-side to avoid contraindicated medication prescriptions.

I will tell you, in conclusion, as the registrar, that we are very proud of the way the dentists in Ontario have used their prescription privileges. That's not to say that every dentist is perfect. That's why we have a regulatory body. But it's to say that, overwhelmingly, dentists are very responsible with the current knowledge and its use for prescription medication.

We don't rest on our laurels. I'll turn matters over to Dr. David Mock, former dean of the University of Toronto dental school, who's now on our council. He will tell you about some of the initiatives we are making collaboratively with our friends and colleagues at the College of Physicians and Surgeons of Ontario, who are here, and others on a national and provincial basis.

Dr. David Mock (Professor, Royal College of Dental Surgeons of Ontario): Thank you. To begin, I have a slight correction to make on the credentialing.

Dr. David Segal and I were on the larger federal body for the CCSA that produced the *First Do No Harm* document, which I'm sure you've seen. But that was a large national body and the two of us were just members of the committee. I'm now co-chairing with Dr. Norman Buckley from McMaster a working group subcommittee to develop competencies, guidelines, and educational material for health professionals, patients, students, and the general public with respect to the whole issue of substance abuse.

As an outcome of the meeting that was just described at the RCDSO, I'm chairing a committee there looking at producing guidelines for dental surgeons in Ontario on chronic and acute pain, concentrating primarily on establishing guidelines for the prescription of drugs in general and, more specifically, opioids. In turn, that committee is going to make recommendations on additional educational programs for dentists in practice to make sure they're up to date on the whole issue of prescribing, and in particular prescribing opioids. The program at the university has been described to you. I was actually the one who described it when we met with HPRAC.

I'd certainly be glad to answer any questions. I will say that dentists across Canada are very well educated on the issue. In fact, as the general public has become more and more aware of the potential for substance abuse and the problems with that, particularly with prescription drugs, the educational programs are being augmented to ensure that our students and graduates are also aware of the issues and how to deal with them.

● (1540)

The Chair: Thank you very much. You're pretty close to being right on time, so that's very good.

Next up is the Canadian Pharmacists Association.

Mr. Phil Emberley (Director, Pharmacy Innovation, Canadian Pharmacists Association): Good afternoon.

I'm Dr. Phil Emberley. I'm the director of pharmacy innovation at the Canadian Pharmacists Association and also a practising pharmacist. CPhA represents over 35,000 Canadian pharmacists from coast to coast, practising in community and hospital pharmacies, family practice clinics, industry, and other settings.

I'm joined today by my colleague and peer, Mr. Mark Barnes, who is a pharmacist, owner, and VP of business development and public relations of a pharmacy in Ottawa that provides treatment to patients addicted to opiates. In a couple of minutes, Mark will share with you the services he provides, as well as the impact he has on his clients.

As front-line health professionals, pharmacists see first-hand the devastating impact of prescription drug abuse—in particular, opioid painkillers—as it shatters careers, relationships, and indeed lives. Many patients who become addicted to opioids start them as prescribed therapy for an actual ailment.

Ensuring access to pain medications for patients who have legitimate needs while working to prevent misuse, abuse, and diversion of opioids is a complex balancing act for prescribers and pharmacists. There are no easy answers to mitigating the prescription drug abuse problem in Canada. However, pharmacists can play an important role in helping patients to avoid the pitfalls of prescription drug abuse and in providing treatment for those who are addicted to opiate medications.

But there also remain areas where further work and efforts must be addressed. First and foremost, pharmacists want to do what is best for the health of their patients, and their goal is to steer patients away from harmful situations such as prescription drug abuse. As drug experts, pharmacists fully understand how drugs work and how addictions occur, including the factors that lead to medication abuse and misuse.

In recent years, provincial governments have expanded the professional scope of pharmacists. In most jurisdictions, pharmacists can now provide medication reviews to their patients. A medication review allows pharmacists to become more familiar with a patient's diagnoses, the indication for treatment, and their response to medication.

This service can also be used to flag potentially problematic medication use, as well as to provide an opportunity to better educate patients on how to take their medication safely. For example, stopping some narcotics abruptly can cause harm to patients and even lead to emergency room visits in some cases. Medication reviews are an ideal setting for pharmacists to educate patients on how to safely stop a medication.

The CPhA recommends that all jurisdictions, including the federal government, as a provider of health services, support pharmacist medication review programs.

The Canadian Pharmacists Association is also an accredited provider of continuing education. While there is medical, nursing, and pharmacy training that educates to optimize the prescribing of psychoactive drugs, there is an opportunity to do much more. Health providers need better education in order to weigh the risks and benefits of opioid treatment and in order to educate patients on the safe use of these medications.

Health professionals also need to be able to recognize evidence of and potential for the misuse of these medications. National and inter-professional education programs need to be developed that ensure all health care providers are fully up to date on the current treatment regiments for chronic pain and mental health disorders.

I'll now pass the floor over to Mark, who will describe some of his experiences with patients who have problems with prescription drugs.

● (1545)

Mr. Mark Barnes (Pharmacy Manager and Owner, Westboro Pharmasave, Respect Rx Pharmasave, Canadian Pharmacists Association): I want to describe to you situations—just two, unfortunately, due to time constraints—that will give you a better understanding of the type of person or patient we can see on a daily basis at the pharmacy. That way you guys can understand exactly how a pharmacist can make a difference in identifying but also treating or preventing addiction to opioids especially.

I'll describe one patient. We'll call him Adam. He was a successful person, well-adjusted, from university, and a successful accountant living in Ottawa, doing quite well, with two children. He had a sports injury, went into treatment, and was prescribed short-acting narcotics. This led to overuse of the narcotic, then misuse of the narcotic, and eventually seeking the drug on the street.

He came to me at the pharmacy at a very young age, with two small children and a wife he was hiding his addiction from. He started into a methadone program that was unsuccessful at the pharmacy level.

I approached Adam and asked him why he was not continuing to take his methadone on a regular basis: what was going wrong? He said he was hiding his problem from his wife and trying to maintain a job. He was busy, dropping his kids off at day care at 8 a.m. and couldn't get to the pharmacy on time.

I simply provided him the option of coming 15 minutes earlier to the pharmacy. After a connection we made, he got compliant, he got better, and he finished using methadone.

Five months later, he called me from Disney World and said, “Thank you for making a difference to me. This is the first vacation I have had in five years with my family.”

This was not a person who you would normally think would have a problem with addiction. This was a person who was successful, well-adjusted, with no financial problems and no other comorbidities. He was simply prescribed medication post-injury.

The second patient I'll describe to you is probably the type of patient you're more familiar with, a product of the system. At five years old he was abused physically—as a child he was woken up in the morning by his parents dunning his forehead with a cigarette—which led to his being in and out of child care services. Obviously he then became addicted to drugs and alcohol, became HIV-positive and hepatitis C-positive. He presented to me at the pharmacy and we got to know each other well. He described the situation to me and said, “Listen, I never had a chance from the start.”

I simply asked him what he was doing now, and he told me that he was on a treatment program and doing quite well. He taught me how addiction can work. He's now reaching out to children. He's teaching them how to be safe from HIV. He's teaching them about proper needle exchanges. He's teaching kids how not to do drugs, to stay away from drugs. He volunteers at local churches. He tries to educate where possible. He's successful.

Will he ever stop using methadone? Maybe not. But it's important that you guys realize that addiction itself does not have any boundaries. It can affect many different classes of people in society, from the homeless to the well-adjusted.

It's important that everyone here today understands that pharmacists see these patients on a daily basis and can make a difference every day to keep them in the treatment and see them progress through treatment.

Mr. Phil Emberley: Thank you, Mark.

It's important that we address problematic drugs and that we take steps to prevent their misuse and diversion. This includes public policy that prevents the marketing of drugs known to be problematic.

For example, last year OxyContin lost its patent and was approved for generic manufacture despite its known notoriety as a drug of abuse. We need a regulatory mechanism that prohibits generic drugs with high risk of harms, such as OxyContin, from easily gaining approval and entering the market.

Potential for abuse of new brand and generic drugs must be an important determinant for whether such drugs are authorized for sale in Canada. The fact that crushable forms of generic OxyContin still exist in Canada poses a major risk to the public and leaves pharmacies more vulnerable to robberies.

Many jurisdictions across Canada have implemented controls that reduce the diversion of narcotic and controlled substances. One example is Ontario's narcotics monitoring system, or ONMS, which acts as a centralized database for storing the history of monitored drug prescribing and dispensing activities across the province. ONMS is capable of reviewing previous history of monitored drug use, and can provide real-time alerts to pharmacies if drug abuse is suspected.

Several other provinces have triplicate prescription programs. While these controls are important, the most effective would be implementation of electronic health records—in particular, drug information systems and electronic prescribing in all jurisdictions. Pharmacists, physicians, and other prescribers would be able to see records of all narcotic and controlled drugs prescribed and dispensed for patients. Knowing a patient's controlled drug history and behaviours would support both pharmacists and prescribers in monitoring use and applying their professional judgment.

Ultimately, as gatekeepers, pharmacists make the final decision on whether or not to dispense a narcotic or controlled substance, based on their careful assessment of the patient, the prescription, and the prescribed medication. With the proper tools and policies in place, we can better enable pharmacists to do their job in this respect.

Thank you. We would be happy to entertain questions later.

● (1550)

The Chair: Thank you very much.

Next up is the Federation of Medical Regulatory Authorities of Canada.

You have 10 minutes. Go ahead, please.

Dr. Rocco Gerace (President, Federation of Medical Regulatory Authorities of Canada): Thank you very much.

I'm Rocco Gerace, and I'm pleased to be here as the chair of the Federation of Medical Regulatory Authorities of Canada.

With me is Louise Marcus, who is the director of professional affairs.

FMRAC is the voice, both nationally and internationally, of the provincial and territorial medical regulatory authorities.

My background is in the practice of emergency medicine and clinical toxicology. I practised for many years using opioids on an acute-care basis, and currently I'm the registrar of the College of Physicians and Surgeons of Ontario.

In describing the problem, we know that opioids are critical in the treatment of pain, whether that's acute pain, chronic pain, or terminal pain. There's no doubt that health professionals are very keen, along with their patients, to ensure that pain is treated. But treatment of pain is fraught with uncertainty, especially when it comes to opioids. The use of opioids ranges from underuse to overuse, and the dosing can be difficult. So we need to create a balance. We have to encourage the judicious use of these agents without creating an atmosphere of fear. There's no doubt that if we approach this too aggressively there will be fear among the prescribers.

We know there is overuse of these drugs in Canada. We are amongst the largest users in the world, second only to the United States. The problem is multifactorial, involving prescribers, dispensers, and, in some cases, the public by way of diversion. Misuse has terrible effects on the individual, sometimes creating addiction, which is occasionally fatal, but I'm sure I don't have to talk about the societal impact of overuse of these agents.

Just to describe what we see in the case of doctors, I'm pleased to say that the majority of doctors prescribe these drugs appropriately. But having said that, we are seeing increasing numbers of reports related to inappropriate prescribing at the regulatory level. These have a number of outcomes. We see some doctors, who want to treat appropriately, who deviate slightly from standards. These doctors really need an educational approach to help them do the job better. Occasionally we see pervasive inappropriate prescribing. The only outcome for these doctors is a regulatory approach, ultimately removing their ability to prescribe these agents. Rarely we see intentional overprescribing for the purposes of diversion. We look at this as criminal behaviour and feel that these individuals should be prosecuted to the full extent of the law. But I think it's important to remember that doctors want to do a good job in prescribing these drugs and in treating their patients' pain.

I'll describe briefly what has been done around the regulatory community. We've provided links to this activity in the material we've circulated.

First of all, at the national level, the regulatory authorities brought together experts to develop standards for opioid use. We have provided this reference. The document has been internationally validated. What these Canadian guidelines do is give evidence-based guidance for the appropriate use of opioids. Flowing from the document have been things like an opioid manager, a tool that helps doctors in the appropriate use of opioids. It also provides the regulators and others with a measure of the standard of care so that when we look at individual doctors prescribing, we know the sorts of outcomes we might have.

The second area is activity in Ontario, which I'm just going to allude to. This was a multi-stakeholder task force to consider what we might do as a community to deal with what we've described as a public health crisis. In this stakeholder consultation, we brought together multiple health professionals, patients, educators, law enforcement officials, and members of the provincial government. I'm just going to highlight a couple of the areas, and we will leave with you a copy of our report.

● (1555)

The recommendations we made are equally valid today. We've suggested that we create a coordinated and accessible system for the treatment of pain and addiction. We do know that in the community there is not adequate access to either treatment of pain or treatment of addiction.

You've heard about the importance of technology. We felt it was important to move forward with greater use of technology so that all providers have real-time access to the drugs their patients are receiving.

Key in our recommendations is the ongoing education of health care providers, individual patients, and the public at large. We feel it is important that all of these stakeholders are aware of the benefits and risks of opioids.

Finally, we felt that there needed to be a mechanism to empower all of the stakeholders to reduce diversion by facilitating an exchange of information, whether it be with regulatory bodies or law enforcement. Certainly, criminal activity has to be stopped.

In closing, I want to say that this is a very complex problem. I'm fond of quoting H.L. Mencken, a journalist in the U.S. from early last century. He said, “For every complex human problem there is a solution which is simple, straightforward and wrong.” This issue of opioid use is complicated. We all have to work together to find solutions that will be applicable across the country.

On behalf of the federation, I appreciate the interest of the committee and the federal government. It's only with the involvement of all of the stakeholders that we're going to come up with meaningful solutions to this difficult problem. I assure you that the medical regulatory community across the country would be pleased to help in any way it can.

Those are my comments. Thank you.

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

I think the Toronto Maple Leafs have been using that slogan for a few years, and that could be the problem. Maybe we've uncovered the problem.

Dr. Rocco Gerace: I hope I can disavow myself of the Toronto Maple Leafs.

Thank you.

The Chair: Okay.

Next up we have the Canadian Generic Pharmaceutical Association.

For 10 minutes, please.

Mr. Jim Keon (President, Canadian Generic Pharmaceutical Association): Thank you.

Good afternoon.

On behalf of the Canadian Generic Pharmaceutical Association, I would like to thank the Chair and the honourable members for this opportunity to participate in your study of addressing prescription drug abuse.

I am the president of the CGPA, and I am joined today by Dr. Colin D'Cunha, director of global medical affairs with Apotex Inc. Dr. D'Cunha is also a former chief medical officer for the Province of Ontario and an adjunct professor at the University of Toronto medical school.

I will begin with a little bit about our industy.

The generic pharmaceutical industry operates the largest life sciences companies in Ontario, Quebec, and Manitoba. We are Canada's primary pharmaceutical manufacturers and exporters, and are among the top research and development spenders across all industrial sectors.

Generic pharmaceutical companies directly employ more than 12,000 Canadians in highly skilled research, development, manufacturing, and other scientific positions. Our industry's most important role is in controlling health care costs in Canada. Generic drugs are dispensed to fill 65% of all prescriptions; approximately two out of three prescriptions in Canada are now filled with generics. However, we account for less than one quarter of the $22 billion spent in Canada on prescription medicines—two thirds of prescriptions by volume, less than a quarter by cost.

Prescription medications are generally safe, but only when they are taken as prescribed and for the intended purpose. When they are abused, they can cause an array of adverse health effects. Prescription and over-the-counter drugs may be abused by taking a drug for a purpose other than prescribed, taking a drug in a higher quantity or in a manner other than prescribed, and taking a medication prescribed for somebody else.

This committee has heard disturbing statistics from earlier witnesses with respect to the prevalence of prescription drug abuse in Canada. This is a cause for concern for all pharmaceutical stakeholders, and for all Canadians. We commend the Government of Canada and the committee for its efforts to review the appropriate roles throughout the supply chain of all stakeholders in addressing prescription drug abuse.

We hope our testimony today will help you in this regard.

On the role of the pharmaceutical industry, this afternoon I want to highlight three ways in which the generic pharmaceutical industry is supporting efforts to address prescription drug abuse. First, it provides essential information about the safety profile, proper prescribing, and use of prescription medicines; second, it operates a safe and secure supply chain for our medicines that prevents opportunities for diversion; and third, it supports the safe disposal of unused or expired prescription medications.

The first item is information. To give you a little background, the brand-name companies that develop new medicines generally promote their products to doctors during the period of patent exclusivity. Generics typically enter the market 12 to 15 years after the original-brand product has been introduced. By that time, after 12 to 15 years of use, the characteristics of the medication, including its therapeutic benefits as well as side effects, are well known and understood by doctors and pharmacists, who have been prescribing and dispensing the product to their patients for many years. As a result, generic companies do not promote or detail their medicines to doctors. There are, however, several ways in which generic pharmaceutical companies support enhanced knowledge about the products we sell.

First of all, the drug labels and packaging of our products give health care professionals the information they need to prescribe and dispense drugs appropriately. Health Canada is currently undertaking an important initiative to make drug labels and packaging information easier for the general public to read and understand—and we're participating in that exercise.

Second, we have our product monographs. A product monograph is a factual, scientific document on the drug product that describes the properties, claims, indications, and conditions of use for the drug, and contains any other information that may be required for the optimal, safe, and effective use of the drug. It includes appropriate information respecting the name of the drug, its therapeutic or pharmacological classification, its actions or clinical pharmacology, and its indications and clinical uses. A product monograph also includes many other important pieces of safety information, including contraindications, warnings, precautions, and adverse reactions. In accordance with Health Canada requirements, the generic company must follow the information in the product monograph of the equivalent brand-name product. We are not able to have different information in our product monographs.

● (1600)

The third area where the generics engage in active efforts for patient information is risk management plans. Companies develop risk management plans, or RMPs, for particular medicines in consultation with Health Canada. These plans include information about a medicine's safety profile, how its risks will be prevented or minimized in patients, plans for studies, and other activities to gain more knowledge about the safety and efficacy of the medicine, risk factors for developing side effects, and measuring the effectiveness of these risk minimization efforts.

Monitoring the use and effect of medicines is an essential focus for any pharmaceutical company. All pharmaceutical companies in Canada are required to monitor the use and effect of a given medication and to detect, assess, understand, and prevent any adverse reactions or any other medicine-related problems that arise. These activities and the science behind it are known as pharmacovigilance in the pharmaceutical industry. Our member companies prepare safety reports to meet regulatory obligations. We'd be happy to discuss this whole area of adverse drug reaction more with the committee. We also conduct ongoing monitoring and literature reviews on a global basis to identify any adverse drug reaction case reports.

The second area identified where generic companies operate to help prevent prescription drug abuse is in the supply chain. Having a safe and secure supply chain is a high priority for generic pharmaceutical companies. Generic pharmaceutical companies supply Health Canada with approved medicines to meet the demands of the Canadian market. The standards are the same for both imported and domestically manufactured products, and for both brand and generic products. Almost all generic medicines in Canada today are distributed through sale to wholesale distributors, who are licensed by Health Canada. These wholesalers must meet stringent standards for the safe and secure distribution of the medicines across Canada. It is the wholesalers who distribute the medicines to pharmacies in Canada.

There are four primary aspects of the pharmaceutical supply chain. They are the regulatory review approval process, the manufacturing process, procurement and delivery, and front-line delivery. I will not go through those, but Dr. D'Cunha and I would be pleased to answer any questions you may have with respect to the pharmaceutical supply chain this afternoon.

The final area I'm going to cover is the safe disposal of prescription medications. Unused portions of medications provide opportunities for abuse. Those that are left at home or are tossed in the garbage can make their way into the wrong hands and be abused. Improper storage at home may also provide opportunities for abuse. For this reason, as well as environmental concerns, the generic pharmaceutical industry educates consumers about the proper disposal of medication.

All CGPA member companies participate in the Health Products Stewardship Association. The HPSA program objective is to divert expired and/or unused health products from landfills and sewers, as well as to ensure safe and effective collection and disposal. There is no charge for the public to return medications. All costs for the collection and proper disposal of pharmaceutical products are paid by HPSA members from the pharmaceuticals and health products industries. In addition, the Government of Canada initiated the first National Pharmaceutical Take-Back Day in May 2013, where the public was encouraged to take unused medications to police and RCMP stations for safe and proper disposal. We commend the government for this initiative and we're pleased to participate in a stakeholder round table.

I will stop there, and I thank you again for the opportunity for the generic pharmaceutical industry to participate in your study. Dr. D'Cunha and I would be pleased to answer any questions

● (1605)

The Chair: Great, thank you very much.

Our last witness to testify here today is from the National Association of Pharmacy Regulatory Authorities.

Ms. Bouchard, go ahead.

Ms. Carole Bouchard (Executive Director, National Association of Pharmacy Regulatory Authorities): Thank you, Mr. Chair.

Good afternoon, honourable members, ladies and gentlemen.

It is a great pleasure for the National Association of Pharmacy Regulatory Authorities to appear today before your committee.

Our association understands that the committee has recently begun a study on the government's role in addressing prescription drug abuse, and wishes to dedicate today's meeting to best practices and federal barriers regarding practice and training of health care professionals.

We thank you for the opportunity to come to present our view on this important topic.

Let me first explain who we are. NAPRA is the National Association of Pharmacy Regulatory Authorities. It is a not-for-profit organization that represents all provincial and territorial pharmacy regulatory authorities whose mandate is the protection of the public. Our membership also includes the Canadian Forces' pharmacy services.

Our members play a key role to ensure that optimal regulatory practices are in place for a safe practice environment for the benefit of all Canadians. Over 36,000 pharmacists are licensed by our members to practise pharmacy across the country, and operate within specific regulatory practices and requirements. Our members have also started to license another group, pharmacy technicians, in certain jurisdictions in Canada, as this group is now becoming regulated.

In my presentation today I will be sharing information on four key areas with the committee: a general perspective of prescription drug abuse; our association's contribution so far to the matter; the role of health care practitioners and their regulatory authorities; and to conclude, the most urgent area for improvement by the federal government from a regulatory lens.

First of all, I would like to share our perspective on prescription drug abuse. When we refer to prescription drug abuse in our presentation we have in mind the drugs that, generally speaking, have abuse liability potential such as analgesics, stimulants, tranquilizers, and hypnotics.

Prescription drugs approved by Health Canada have been reviewed for their safety, efficacy, and quality and are made available to health care practitioners to help patients cope with their medical conditions and associated symptoms. They have a place in the therapeutic drug arsenal. However, these drugs have abuse liability potential and when taken or used inappropriately can cause problems.

The issue of prescription drug abuse is not new, but it seems to have been forgotten or underestimated during the development of what is currently the national anti-drug strategy, led by the Department of Justice. That needs to change. I am confident that the committee has already heard details from previous witnesses on the overall situation in Canada and worldwide regarding this matter. Canada is not unique in dealing with this issue. It is a topic of interest to the United Nations Commission on Narcotic Drugs.

I'm sure each of us has seen at least once the harm experienced by a person as a result of prescription drug abuse. This is a sad situation for the person and his or her family, which could have been avoided.

This leads to the second point in my presentation regarding our association's contribution on the matter to date. Over the past few years NAPRA has participated in a series of meetings and workshops held by the Department of Public Safety and the Canadian Centre on Substance Abuse. We understood that all of this work was to serve as a foundation for the launch of the development of a renewed anti-drug strategy for Canada. We accepted being a part of the National Advisory Council on Prescription Drug Misuse. This undertaking was important to NAPRA and its members, in order to examine the problem a bit more closely and to elaborate a strategy to improve the situation in Canada.

We are pleased to have contributed to this work that led to the release of the report entitled *First Do No Harm: Responding to Canada's Prescription Drug Crisis*, which contained several recommendations, as you know. The report established a vision and outlined a road map for action.

NAPRA, through its president, continues its work with the National Advisory Council on Prescription Drug Misuse.

This leads naturally to the third key area of my presentation, which is the role of health care practitioners and the regulatory authorities in prescription drug abuse. Health care practitioners are regulated professionals who abide by a code of ethics and follow standards of practice developed by their regulatory authorities, and that is to ensure consistency across Canada in the practice of public protection.

Pharmacists are no different. They comply with the standard of practice that involves providing drug therapy management services. They are the medication management experts and their goal is to ensure optimal drug therapy for patients. They work collaboratively with the patient and other health care providers in defining the health-related needs and drug therapy problems to be resolved. They prepare care plans. They undertake implementation, monitoring, and follow-up. Pharmacies are able to identify issues, provide education or other information, and refer patients to other care providers when appropriate.

● (1610)

Drugs that have abuse liability potential are no different from the other drugs. When it comes to the job or work of the pharmacist, we look for the most appropriate drug therapy for the medical condition symptoms the patient is being treated for, and we monitor the patient's use of drug therapy to identify any issues such as side effects or misuse.

When needed, regulatory authorities take action to correct any problems that may come with the practice of their members. They also provide a series of guidelines and standards to support best practices in the every day work of pharmacists. They collaborate with other stakeholders on initiatives that aim to improve patient safety and public protection. Although regulatory authorities and pharmacists do their best to curtail prescription drug abuse by many interventions and means, they lack tools and authority when it pertains to drugs that have abuse liability potential. These drugs are, for the most part, found in Canada in the Controlled Drugs and Substances Act, which is federal legislation.

This brings me to the last area of my presentation, which will focus on the most urgent area for action by the federal government.

The Controlled Drugs and Substances Act, CDSA, came into effect in the late nineties. This piece of legislation introduced a series of new provisions that were overdue for Canada at that time. However, since the legislation was enacted, the regulations under the statute have not been improved. As the statute create total prohibition, the regulations are necessary to define the type of activities and control for prescription drugs that have drug abuse liability potential.

The health care environment and the role of health care practitioners have changed significantly since the late sixties, but the regulatory framework for narcotic and controlled drugs, which dictates how these drugs are imported, distributed, sold, prescribed, dispensed, and destroyed, has not changed.

This situation is creating problems for stakeholders, such as health care practitioners, regulatory authorities, and law enforcement, as the outdated framework is not responsive to the current needs and environment. In addition, the ongoing monitoring of these activities for compliance is quasi nonexistent.

Our association is supportive of interventions that will focus, among other things, on education, prevention, treatment, monitoring, surveillance, enforcement, and research. However, above all, we believe that the federal government needs to take leadership, in partnership with affected stakeholders, in redesigning the regulatory framework in Canada so that it can be updated and adapted to the current environment. For instance, current regulations speak about filing paper copies of prescriptions, where it is now possible to maintain proper accountabilities and controls through electronic means while maintaining public protection. Regulatory authorities have been struggling with situations where actions were required to stop or prevent a problem of drug abuse, but were limited in their actions due to the lack of authority pertaining to federal regulation. One aspect of this is the lack of information exchange, authorities, and systems between federal authorities and provincial and territorial regulatory authorities.

In redesigning the regulatory framework, we believe that the government needs to develop the most adequate framework for current and future environments, one that provides the best accountability framework for the management of this category of drug, and eliminates barriers preventing health care practitioners, including pharmacists, from practising to their full scope of practice.

We believe that the government must clarify its intentions regarding the scope of federal involvement with this category of drug. Any regulatory framework requires not only monitoring, in addition to a compliance and enforcement plan, but also must have available the educational resources for carrying out both plans. They also need to ensure that exchange of information is possible between regulators for the purpose of curtailing prescription drug abuse. They need to develop a means of monitoring, nationally, drug prescriptions that could lead to abuse, and implement new technologies or other e-health initiatives across the country.

A good example is the effort being made by the United States with the establishment of a prescription monitoring program that connects state-level programs, entitled InterConnect.

● (1615)

It should also be mentioned that it is necessary for the government to have a role in post-market surveillance. Drug abuse, drug overdose, and inappropriate prescribing are all examples of situations that require monitoring by Health Canada to a much greater and significant extent to what has been done over the past several years.

The government also needs to be quicker in scheduling drugs under the CDSA. By not doing so, the government leaves a series of drugs not scheduled, sometimes for a long period of time. For a drug not scheduled, it often means a lot of confusion among stakeholders and health care professionals regarding the control that applies to the drugs in question. For example, many provincial prescription monitoring programs, which we call triplicate programs, will not add a drug to the list of monitored drugs until Health Canada lists that drug—

The Chair: Excuse me, Ms. Bouchard, is there much left to your presentation?

Ms. Carole Bouchard: I'm almost finished.

The Chair: Okay, thank you very much.

Ms. Carole Bouchard: Therefore, those drugs need to be scheduled very quickly to be able to add them to the monitoring. So a quicker scheduling process should also apply for drugs that may be abused, and it requires urgent review and scheduling in situations where new trends of abuse emerge, for example, over-the-counter health products.

In conclusion, I wish to reiterate that the consequences of prescription drug abuse are important for the health of Canadians and can also create other problems such as drug shortages. When a drug is overused or used inappropriately, it can reduce the supply of the drug to a point that the drug is suddenly not available for legitimate use. We know there is a lot to do in this area and we will contribute to the work of the National Advisory Council on Prescription Drug Misuse.

We believe that primary action needs to start with redesigning the legislative framework.

Thank you again, Mr. Chair, and committee members, for the opportunity for our association to appear before you today.

The Chair: Thank you very much.

We have a great group of individuals here who have provided us with some great opening remarks.

For our members, we do have a large panel here today. We should be able to get through everybody's questions if we keep it to our time. So please don't be offended if I cut you off at seven minutes or five minutes. Also, as discussed previously, because we do have a large panel, if you can direct your questions to those you'd specifically like to answer, that would be very helpful to keep the flow of the meeting going.

For the first seven minutes, we have Ms. Davies.

● (1620)

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

We do have a lot of witnesses today, so thank you for coming.

As we get into this subject more and more, I find myself in a bit of a conundrum. I would certainly agree with Dr. Gerace when he says that it's a complicated issue. It's not necessarily that there's just a black and white answer; there are a number of things that need to be done.

Having now heard from so many witnesses or stakeholders who are involved, whether from a regulatory point of view, a professional point of view, or a practitioner point of view, I'm left wondering where the problem really is. Is it just a leaky vessel that's got so many holes in it that it's sinking? We are hearing from all of you that we have a very serious problem in Canada.

I want to relay an experience that I had a couple of weeks ago at a pharmacy in Vancouver. I went in to get a generic prescription renewed. It wasn't an antidepressant, it wasn't a stimulant, it wasn't an opiate, it was just your run-of-the-mill generic. I was kind of happy when the response was that I couldn't get it renewed, that I had too many days left. They actually counted it out, and I said that I travel a lot and I'm worried about it running out. They said that I had to wait a certain number of days.

The reason I was given did not have anything to do with safety or anything like that—I don't think there were any safety issues—but with insurance coverage. It was the insurance company through our federal plan that wouldn't have reimbursed me unless I met certain timelines. It left me wondering why I got that response when trying to renew a low-level prescription, yet on serious medications where there are serious issues of addiction, you're telling us that there are so many holes—I think that's what you're saying—and that we've got a huge problem.

I'm glad, Ms. Bouchard, that you talked about the monitoring surveillance system and what is going on in the United States. It seems to me that it's something that we have to do in Canada. There has to be some kind of pan-Canadian strategy for a monitoring surveillance system. I wonder if you can tell us a little bit more about how you think that would work.

My second question is for Mr. Barnes. Your front-line experience is very good for us to hear in the two cases that you provided. What struck me about what you said is that you talked about both of them with no judgment. That's good, because I think that for people facing addiction issues there's a stigma, whether they're a street user or whether they're the accountant that you talked about, the guy who was afraid to talk to his wife. From your point of view as a front-line health care professional, how do we deal with the stigma?

You obviously developed a really good relationship with that guy. I don't how rare that is; I would imagine it's somewhat rare. How do we reduce the stigma so that when people run into trouble they can get access to the proper interventions? The system has got to work, but when people do run into trouble, either intentionally or not intentionally, how do we remove the stigma so that we can actually then focus on getting them the proper appropriate interventions without criminalizing or stigmatizing people so they just end up going more and more underground?

Sorry, that's kind of long, but I would just like to get responses on those two things from Ms. Bouchard and Mr. Barnes.

Ms. Carole Bouchard: Thank you for your question.

With regard to a pan-Canadian monitoring system, I may answer that twofold. First, in most of the United States they already have a prescription drug monitoring program, and somehow they've realized, maybe a little bit too late, that they needed to have a mechanism to be able to connect those state prescription monitoring programs together in order to have a better picture for the country. Again, I don't think their system is a good proactive approach. I don't think it gives them everything they would have wished to have because of the differences between each of the states.

For Canada, though, if I look at the second part of the answer to your question, I think we need to have a pan-Canadian monitoring system where we have to really take advantage of what is being implemented in each of the provinces and territories in order to build a national program.

There used to be a time in Canada when a national system existed, but it was much more manual. It was really in the 1980s and 1990s, but with the years that has disappeared. Now electronic technologies are there so it certainly could work, and it would be an advantage because there is a really substantial category of drugs that could fall under that mechanism, but we need to be proactive.

● (1625)

Mr. Mark Barnes: I can definitely understand the drug plan issue. As you're aware, it happens on a daily basis with a day supply, so I can relate to what you're saying. Unfortunately, for addiction it doesn't work, because a patient who is diverting a medication will just pay cash. Unfortunately, the drug plan solution is not there.

You alluded to my approach earlier. It's unique in being a respect-based approach to addiction treatment. I had to evolve that respect myself because, unfortunately, I was a typical health care provider who was a non-believer. My evolution itself, through my patients, taught me that it can work. My respect comes from my experience.

So first, the answer is that respect is from experience, but we can also provide insight. I think there are three answers to your question. The first is about teaching respect at the university level through our students—med students, nursing students, pharmacy students, and dental students. I think that if we make them aware of the problems and teach them a respect-based approach to addiction treatment first...the education is very, very important, I think, as is having educators who have the same approach.

It starts there, but then it also has to continue among our own profession. I also sit on a committee for First Do No Harm, as well as a working committee for treatment teams, and there is no standardized treatment education level among pharmacists, as an example. Every province varies as to what education experience you require to be involved in addiction treatment and prevention, whether it be through the methadone program in Ontario.... I was just in Newfoundland giving a presentation at the university there. We need to have a standardized education system that looks at addiction treatment the same way, with this respect approach. I think that if we work in academia, as well as with our students, it can make a huge difference, and then having standardized or post-schooling training on addiction treatment....

The third thing is that you have to teach people. No matter if it's high blood pressure, when we're treating addiction, it's no different. We've done a phenomenal job with mental health over the last decade in bringing it in from the darkness, from being ashamed and seeing mental health as a character flaw, not really a true illness.

I think we have to use that same approach for addiction treatment. Unfortunately, addiction treatment doesn't go by itself; it's usually a triangle. There's pain, there's addiction, and there's mental health. There's a reason why. As my patients tell me, they didn't wake up in the morning and want to stick a needle in their arm. It's an escape from some reality.

A voice: [*Inaudible—Editor*]

Mr. Mark Barnes: Yes, exactly. It's an escape from some unfortunate event, even in our own military, with post-traumatic stress, so it's very important that we approach those things with an open mind. As well, what we've done with mental health over the last 10 years has been phenomenal. We don't actually need to ask why there's addiction, but why there's pain.

The Chair: Thank you, Mr. Barnes.

Those were good questions, Ms. Davies.

Ms. Adams, you have seven minutes.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you.

Mr. Barnes, thank you very much. You've highlighted an excellent point, which is that unfortunately from province to province the clinical guidelines available to pharmacists vary.

Are you familiar with or is somebody at this table familiar with some of the best and leading clinical practice guidelines?

Mr. Mark Barnes: I would like to think of Ontario as one of the leaders. We have extensive training. If you want to be deemed methadone-certified in Ontario to be a dispenser, it requires a significant amount of training.

Being from Newfoundland, I can say that unfortunately in Newfoundland there is no such training; you have to read the guideline and have the guidelines on site. In Ontario, there's significant training. It's an online learning course for months, and then you go to CAMH and do a couple of days down there. It's actually extensive training, so I would say that Ontario is one of the leaders.

● (1630)

Ms. Eve Adams: Thank you. That will help us as we're going forward.

If I could, I'll also put this question to you, Mr. Barnes, and perhaps to anyone around the table who would like to take it. Could you give us some concrete suggestions on how we might actually improve clinical practice guidelines when it comes to over-prescribing and overfilling?

Mr. Mock?

Dr. David Mock: If I may comment, only because of my involvement with CCSA and the RCDSO document on the education committee, and being an educator and member of the University of Toronto Centre for the Study of Pain, I think it was very well summed up by Mr. Barnes.

First of all, there are attempts right now at producing these guidelines. Regarding the documentation that will come forward in the CCSA, Mr. Barnes is working on the therapeutic end and I'm working on the education end. There are already excellent guidelines on opioid prescribing. The Canadian guidelines that were mentioned earlier came out of McMaster.

The committee that I'm on is hoping to produce a list of competencies that clinicians should have and that educational institutions, therefore, will be able to apply. The committee consists of representatives from all health care professions, plus lay people. These competencies are what clinicians, and thus students, should have. As well, other committees are producing guidelines for prescribing, dispensing, and in turn destroying opioids to get them out of the market. I think a lot of this is under way.

As I've already grabbed the microphone—and my colleagues know that I tend to talk too much—there is one further comment I would like to make. One of the areas I think this committee should consider and that has been mentioned is the area of pain. As soon as you consider opioids, you have to consider what they're used for, and that is pain management. One of the problems we have, which I see as a pain clinician, is the uneven availability of pain management across the country or across our own province, therefore leaving clinicians with only one option, the prescription of opioids. There are non-pharmacological or lesser pharmacological processes that should be made more available, which I think would help reduce the problem.

Ms. Eve Adams: I very much look forward to receiving this documentation once it has been created, but are there any other concrete suggestions that anyone at the table would like to make?

Dr. Rocco Gerace: I would just highlight, as Dr. Mock did, the Canadian opioid use guidelines for chronic pain. They have been developed using current literature. They're being kept up-to-date by McMaster and more recently have been validated in an American journal as a comprehensive valid set of guidelines.

That work has been done, they're there—and we've alluded to them in our written submission—and I would urge the committee that they are well worth using going forward.

Ms. Eve Adams: Thank you.

We've been hearing from a number of witnesses over the last couple of weeks and it's becoming abundantly clear that there isn't a great deal of knowledge about prescription drug abuse within the general public. How would you suggest that we approach that issue?

Yes, Dr. Mock.

Dr. David Mock: My working group coming out of the First Do No Harm exercise is actually looking at and will be making recommendations.

You're quite right: it's not just knowledge of the addiction issue and how easy it is to become addicted, but things that have been mentioned like storing of drugs when you get home. You get a prescription and where do you leave it? Do your children have access to it? If you don't finish a prescription, what do you do with the remainder? These are all educational issues for the public.

I know that all of the regulatory bodies and health associations are trying to address it within their jurisdictions. I think that coming out of this CCSA document, there'll be some broader recommendations nationally. You're quite right that it has to be addressed.

I do think it's under way. The process has started.

Ms. Eve Adams: Thank you.

Mr. Emberley, through you, Mr. Chair.

Mr. Phil Emberley: Yes, I just have a comment.

One area that we should really focus on is that our young people are really not educated at a young age about the pitfalls of medication and the role of medication in treating disease. I think we need to catch them early. We need to go into schools and we need to talk to them about medication before they develop mistaken beliefs and ideas about drugs that they get on the street or from other people. We need to education them early.

We actually run some programs at CPhA, putting pharmacists into schools and educating young people on that. But I think it definitely begins with young people.

Then there's also an interprofessional approach to educating patients once they experience pain, about the potential for addiction, and how to perhaps avoid that. I think that's really important.

● (1635)

Ms. Eve Adams: Just very quickly—

The Chair: You have 40 seconds.

Ms. Eve Adams: —we're challenged by the fact that it's difficult to find concrete metrics on how pervasive prescription drug abuse is. To whom would you direct us? Are there other nations that are at the forefront of this? [*Technical difficulty—Editor*]...what were genuine in looking to find the best possible advice?

Dr. David Mock: I think my colleagues would agree that's a very good and difficult question to answer, certainly nationally here, unless somebody knows something that I don't. I don't think we have such a database.

Ms. Eve Adams: This is the challenge.

Thank you very much.

The Chair: You're right on time, Ms. Adams. Very good.

Next up is Ms. Fry.

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

We talk a lot about misuse because that's what we're talking about in this committee, the misuse of prescription drugs, not just of opioids. A lot of prescription drugs have a tendency to be addictive.

The big question I wanted to ask is this, and I want to direct this specifically of Mark Barnes. There's the stigma you talked about earlier on, and we talk about people who take a prescription drug for pain. They injure their backs and they're taking it and then, of course, we talk about the people who are now on the street and are addicted to heroine or to everything. They're all the same drug.

I would like you as a pharmacist to explain the difference between Dilaudid and street heroine and any one of the drugs that we use when we are given them as a prescription for pain. Is there a difference in terms of opiates? Can you just explain this? I think I know the difference, but it might be interesting if I could hear it from you.

Mr. Mark Barnes: Regarding the potential to become addicted to an opiate itself, I would point out, first, that an opiate is a derivative of opium. It's the poppy seed originally and then it was obviously chemically produced, and they have different derivatives, the most famous probably being morphine. They're very efficacious and I hope that this committee doesn't look at opiates themselves as bad because, unfortunately, they're fantastic for pain management and in my own practice I'm an advocate of responsible opiate use, whether it be fentanyl or all of them.

The opiates themselves activate or attach to the opiate receptors, so really whether it be heroine, OxyContin, hydromorphone, or morphine, they all attach to the same receptor.

Certain chemicals have a higher affinity for the receptor than others, and certainly have a little more potential for some of the nasty effects of them, which is what we hear about, the overdoses, and the respiratory suppression, and the bradycardia, and the different things that make me nervous when dispensing them. But certainly from our standpoint, they are essentially opiates and so they all have the same class effects to different extents, and if diverted at the highest dose they certainly are dangerous, equally.

Hon. Hedy Fry: We talked a lot about guidelines for prescription opioid use and on prescribing drugs. We talked about competencies within the profession for doing this. We talked about all of those things. We're talking then about the person who supplies the drug. If these drugs are prescribed, other than by a few bad apples, they're prescribed to help a patient. They're prescribed because they are needed and it's the only drug you can use.

But there are people who are more prone to addiction than others. Can you think of a way in which you can find out which patient is going to be more prone to addiction than others when you are prescribing?

Mr. Mark Barnes: I'm a pharmacist. I don't prescribe.

Hon. Hedy Fry: It's to anyone who wants to answer. Maybe the college might want to answer, maybe the dental—

Go on, David.

Dr. David Mock: There are some tools to evaluate addiction potential. In fact, the CPSO—it's in your document, it's in the guidelines actually—have produced some. There are also some in the Canadian guidelines for opioids, and we're going to have them in our guidelines. They're not great. They're helpful, they're adjunctive. The basic decision still is made by the clinician, as you pointed out, knowing their patients and looking at the way the patient presents, but there are tools. There are a number of tools on the market that are certainly very helpful.

● (1640)

Hon. Hedy Fry: Thank you.

How am I doing?

The Chair: You have two minutes and 45 seconds left.

Hon. Hedy Fry: Thank you.

I just wanted to ask another question, and this is about the generic drugs.

We know that one of the reasons OxyContin is such a drug of use on the streets is that it's easy to take and crush, and do all kinds of things with, inject, etc. It's a drug that can be used in multiple ways, so it gets onto the street very easily.

We are told the company that originally made the brand name has decided it can make a new product that is not as easy to use: OxyNEO. We're also told by all of the provincial health officers, the provincial health ministers, the United States, and the United States Attorney General that we should actually stop making generic OxyContin for that reason.

Do you agree with that, and if so, why are we still making it?

Who wants to take that on?

Mr. Keon.

Mr. Jim Keon: First of all, the product is approved by Health Canada. Health Canada has not determined that it's an unsafe product that should be banned. Our manufacturers produce the product according to all of the Health Canada guidelines.

The abuse of OxyContin did occur. The rapid rise in abuse occurred during what I would call the “exclusivity period”, when Purdue was the only company selling the product. Purdue is now not marketing that product.

As I mentioned earlier, the generics do not market or promote their product to doctors. If a doctor has a patient stabilized on OxyContin and wants to continue to use that, then the generic is there and available at the much lower price, typically, at which generics are sold. It is dispensed and supplied throughout the supply chain in a very safe, effective way.

That is the general answer.

Apotex is one of the companies. I'll let Dr. D'Cunha speak to that as well.

Dr. Colin D'Cunha (Director Global Medical Affairs, Apotex Inc., Canadian Generic Pharmaceutical Association): As Mr. Keon has already stated, the supply is controlled right to the point of pharmacy, at which point the dispensing decision is made.

I will point out that the generic market share of total sales of this compound is less than 5%, based on annual numbers that Mr. Keon showed me at lunchtime.

It seems to me that an element of better prevention, better treatment, and better control is needed.

The Chair: Go ahead briefly, sir. We have a few seconds here.

Dr. Peter Trainor: Thank you.

I like to hear the word “prevention”. As dentists, we always work on a preventative model, and it's been very successful in dentistry.

Dr. Emberley said that we have to educate young people at an early age. Education, education, education—it's so important to inform families of the harm that can be created by leaving prescription drugs available to children. It needs to be taken into the school systems early, at an early age, so that they understand how the drugs they find in parents' medicine cabinets potentially have very harmful effects.

Coming back to how we can prevent and some of the strategies when dealing with the people who have prescribing rights, it all comes back to having a good, thorough medical history of the patient and an understanding of the patient's problems.

One of the problems we have in dentistry is that people don't think they need to disclose their full medical history to us as dentists. But it is so important, because if there is a history of addiction or something in that patient's history and I prescribe a medication for a painful experience or a surgical procedure I'm going to do, that could absolutely turn that patient right around and cause a catastrophic relapse of their addiction problem. As I say, we need to know so we can prevent these problems.

We all have to work together to develop this multifactorial education process, in all aspects.

● (1645)

The Chair: That's a good point.

We're way over time.

Mr. Hawn.

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

Thank you all for being here.

Dr. Gerace, you were anxious to chime in on that last point. Did you want to do that? Okay.

Dr. Mock, you talked about some of the non-pharmacological solutions to pain. I got the impression that we have an aversion to them or that we're just discovering them. Could you describe some of those?

Dr. David Mock: There are quite a number of things that have been shown to be very useful. Again, chronic pain is more of the concern that I have as opposed to acute pain, where you can get a drug for a short period. And there are things like cognitive behavioural therapy, for example. There's very good evidence that it's effective either on its own or in conjunction with lower dose medication or shorter duration medication, and physiotherapy, things like that, or occupational therapy.

In our clinic we get patients from parts of the province where the local physician has no choice because he doesn't have those modalities available and he has a patient in pain. He has no option but to prescribe a reasonably potent analgesic, very often an opioid. Other things are coming on the market and out into the public now that are just being tested, but the availability is often a problem, particularly in remote areas.

Hon. Laurie Hawn: I guess what I was getting at, and I appreciate—

Dr. David Mock: Biofeedback, acupuncture....

Hon. Laurie Hawn: Yes, there are some of the non-traditional remedies out there that come from the Chinese or whatever, from 5,000 years ago, and nobody knows why they work, but they just work.

Dr. David Mock: Yes, we have that too.

Hon. Laurie Hawn: Is the mainstream medical profession—and I include dental in that—becoming more accepting of those?

Dr. David Mock: Certainly, in my experience, because I work primarily with physicians, yes.

Hon. Laurie Hawn: Dr. Gerace, you talked about creating a better coordinated and accessible system for, I think it was, educating stakeholders, health care providers, and other stakeholders. What would that look like and what can we learn from somebody else who's done this successfully, because we're not the only country facing these kinds of situations?

Dr. Rocco Gerace: Well, I can't speak explicitly for other jurisdictions, but we do know there is a huge need for education. If we look at medical school and the residency curriculum around the management of chronic non-cancer pains, it's woefully lacking. I can't speak for other specialties, but we're simply not doing enough. We've heard about public education, which is critically important, and I would refer you to our report on that issue, which we will leave with you.

In terms of other modalities, I'll just go back for a second. The other problem is that many of these modalities are not insured, and we have a population that is in desperate need of treatment and can't afford it, and the public health system doesn't provide it.

So there is a real need for a comprehensive—and David alluded to that—approach to pain management, and not simply looking at opioids.

Hon. Laurie Hawn: Is one of the challenges the fact we have 13 different jurisdictions—well, 14 if you count the federal government—in Canada? When you say "coordinated", I assume a big part of that is just coordination between those 14 jurisdictions to come up with something common and common sense.

Dr. Rocco Gerace: It won't be a simple solution.

Hon. Laurie Hawn: Simple, straightforward, and wrong.... Maybe it's a little bit complicated, but right. Where does the responsibility lie for that, between the various colleges, the provincial colleges and...? How do you get all those folks together?

Dr. Rocco Gerace: Well, I can tell you from the regulatory perspective that colleges have come together to produce recommendations, or in the case of the guidelines, to produce the guidelines along with the stakeholders. Everyone has a role, and I think one group can't do it alone.

So when we look at having a comprehensive database of narcotics, that's going to take the federal government's implementing changes to the CDSA, as was suggested. Education will involve the medical schools and the other health professions' educational programs. We don't have the resources to educate the public, so we're going to have to work together to produce public education campaigns so that people understand the dangers without scaring them away from the benefits of these important agents.

● (1650)

Hon. Laurie Hawn: Okay, thank you.

Mr. Fefergrad.

Mr. Irwin Fefergrad: I wanted to reiterate what has been said, in that I think the regulators have it right. The regulators are working together collaboratively and cooperatively on this very important subject. I don't know that governments are as good as getting together on it as the regulators are. Perhaps because we focus on our mandate of public interest protection, we're able to come up with some really good solutions that will help public health. We desperately need help legally. We need help through regulation and through legislation.

As Dr. Gerace pointed out, we need help financially—not for us, but for people who can't avail themselves of treatment that is very efficacious but isn't drug-related.

Hon. Laurie Hawn: That's fair comment.

Mr. Barnes, pharmacists are responsible for disposing of unused prescriptions and so on.

How do you actually go about that, and how do you track getting something back from this guy and something else from another guy? Do you do that? Do you track it that way?

Mr. Mark Barnes: As Carole Bouchard alluded to earlier, those are some of the problems in the Food and Drugs Act and the Controlled Drugs and Substances Act as they stand. We take everything back. It's not just controlled substances; it's all prescription drugs, whether they be over the counter or not, depending on what schedule it is. And there's no accountability.

The problem is that if I take back medication from my community, I'm not just taking medications from my patients. I'm taking back medications from others, so there's no access to information with regard to where those prescriptions came from.

Sometimes the simplest solutions are actually in the policy itself, or sometimes controlling the access. At my pharmacy, I started a fentanyl return program about a year ago. Fentanyl is a patch used for chronic pain. I simply use it as an awareness campaign, not necessarily to complicate the treatment of chronic pain or to reduce access to fentanyl.

Fentanyl is a problem in Ottawa in a certain area, and more than heroin to a certain extent. All I said to my patients was, "Well, before you get your next part fill of your fentanyl, can I see those patches back?"

It has worked extremely well. I'm actually educating the patients that this is a dangerous drug and what's left in this patch is still usable and abusable. I'm a target for having it, so I want it out of my possession. I destroy them. In my pharmacy, I put them in a bucket and pour alcohol on them and cut them and get rid of them. But there's no real accountability among pharmacies as to what they're doing with those things.

As cbc.ca said to me online through the blog, I could be using them myself, which is not the case, but certainly it points to the lack of policy on that.

The Chair: Were you done, Mr. Hawn?

Mr. Laurie Hawn: Yes, sir.

The Chair: Now we're into our second round of questions.

Mr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Mr. Chair.

We have been talking a lot about the *First Do No Harm* report over the last hour and a half. The report goes into the government's anti-drug strategy. The abuse of medication works on a continuum. The people who abuse medications, drugs, even if they do it innocently at the outset, get caught on a slippery slope. They always want more of the same drug, or they want a drug that gives them a greater effect. I see a systematic, societal problem there. Since 2010, Canada ranks first or second in the world in per capita opioid consumption. The situation is very critical and I think we have to look at the big picture.

[*English*]

Mr. Barnes, what I liked about your answers was that you really put the emphasis on why the people are abusing those types of drugs. They are essentially in pain, and they just need some relief, physical or mental, from what they're experiencing. We know that in 2007 the Conservative government removed from the anti-drug strategy of Canada the fourth pillar, which was to reduce harm. Nowadays, we do speak a lot about whether this pillar is really important in the overall strategy in Canada to make sure Canadians are living drug-free.

For the past couple of years, this pillar has been removed and the funding across Canada that is tied to reducing harm has been cut.

Do you think that in 2013 we are ready to put it back into the overall anti-drug strategy, or do you feel that we should just leave it aside?

● (1655)

Mr. David Mock: I'm not sure I completely understand because I may not know the history.

The Chair: Mr. Barnes, please, first.

Mr. Mark Barnes: I think it's absolutely necessary.

As practitioners, no matter what profession, it's our responsibility to do no harm and put the patients best interests first. Certainly in Ontario, choosing not to prescribe a medication because you are afraid of misuse or diversion actually is something that we can bill, as pharmacists, as practitioners, now. In Ontario, it's something we actually need to do.

On a national level, it's absolutely necessary. We need to be able to have that time and also the funding and education to be able to do no harm at times. Whether it be to restrict quantity, which I think is probably more reasonable....

Again, as Dr. Emberley alluded to earlier, we cannot just cut someone off from narcotics. That leads to problems. That's not smart. But at that point we can offer two days' supply, have the discussion—multi-disciplinarian—with their physician or dentist at that point, on Monday or Tuesday, or whatever day we can get together and have a conversation. Lots of times in my practice, because I am sensitive to addiction treatment, I'll say, I think we have identified a problem and there are solutions, so let's talk about the solution.

I think that's probably putting the respect first, but "do no harm" is absolutely necessary.

[*Translation*]

Mr. Dany Morin: Thank you.

I am reassured to hear that health professionals like yourself are taking this matter to heart. As I do not have a lot of time available, I will move to another topic.

Ms. Bouchard, you told us earlier that, in the 1980s, Canada had a national drug oversight program with the objective of identifying potential cases of excessive prescriptions and overuse all across the country.

Can you give us more information about that? Can you tell us whether, in your opinion, it would be worthwhile to start another initiative like that in 2013? Could we look at selecting its best features and adapting them to today's reality?

Ms. Carole Bouchard: Yes, indeed, in the 1980s, there was a national oversight program that monitored prescriptions for controlled substances. All the pharmacists in Canada were required to report their sales of certain products that were controlled under federal legislation. The reports of those sales were all sent to Ottawa where the data was put into a system and reviewed.

Specific programs assessed trends by product or by specific region, by appointment or by multiple appointments. Of course, hundreds and thousands of prescriptions were written each year. A program of that kind serves to identify behaviours that might suggest inappropriate prescriptions, multiple appointments or abuses that, in some cases, could implicate health professionals in terms of purchases for use in the office. Under federal legislation, investigations were launched when suspicious behaviours were discovered that required specific action. The program was in existence for several years. It was not abolished until the 1990s. I do not know the exact date.

Mr. Dany Morin: Do you remember—

[*English*]

The Chair: Thank you very much.

Mr. Wilks, five minutes or thereabouts.

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

To Mr. Barnes and Mr. Emberley, and I guess to the dental society as well, it seems to me that every time the dentist's office calls me—they call me quite frequently to remind me that I have a dental appointment coming—I go, because eventually, I know, if I don't go, they'll continue phoning me. I might as well just go and get it over with.

Voices: Oh, oh!

Mr. David Wilks: It seems to me, from the perspective of returning drugs that have a due date or those that have a "use before" date, that we could go along the same lines and create some form of dialogue with patients to remind them that the drugs will have reached their overdue date by a certain time, if they haven't used them, and that they can return them. There was something along those lines discussed this morning at the CCSA meeting.

I wonder if you could talk about different types of ideas for returning drugs to pharmacies and/or to doctors, or whomever.

● (1700)

Mr. Mark Barnes: I think it's a great idea. It poses some challenges, especially for the "as required" medication. As an example, my father has a chronic back condition that flares up every now and then. He's given a narcotic at times that he can use for travel or what not.

So I think from a return standpoint for medication that's prescribed, it can certainly be problematic in that light; for expiry dates, absolutely, or even after one year.

As I think Dr. Emberley alluded to earlier, on the medication review we could say, "Hey, listen, you're not using this medication anymore. Do you have any left? Can you return it to the pharmacy?" We could have that dialogue and documentation. I think the medication review is probably your best avenue for that.

With regard to how much goes out the door, I think there's a lot we can do with regard to restricting quantity. I understand that every pharmacy is open late, so unfortunately a lot are open on weekends. With this accessibility comes responsibility. That responsibility means we have to be able to restrict access to the medication in larger quantities.

Unfortunately, diversion happens when there's a large quantity. From my experience, patients do have legitimate pain, but they also see it as a revenue stream. They actually take some of the medication and then divert some of it. The larger-quantity reduction could reduce that tremendously.

Mr. David Wilks: Thanks.

My next question is to Mr. Keon, and it's on one of my favourite subjects, which is medical marijuana.

As you know, the Supreme Court of Canada has mandated the federal government to provide medical marijuana to those who can obtain it through their doctor, although I find it somewhat interesting that pharmacies have been bypassed in the whole process.

But there is generic THC, which has been around for quite a while. Can you provide me with some information on generic THC and how popular it has been with regard to chronic pain and other issues?

Mr. Jim Keon: I'd have to get back to you on that. I'm not aware that any of our members are producing that product.

Dr. Rocco Gerace: I was told I wasn't allowed to talk about medical marijuana, but now that you've brought it up, I would like to say something.

I think it's absolutely abominable the way the federal government has dealt with medical marijuana. In fact, it was a divisional court decision that suggested that there was an obligation to provide it, a decision that was overturned by the Court of Appeal. So there is no court decision, and yet this substance is being made available without any of the safeguards that exist for opioids—and we are facing a crisis with opioids.

We are either all going to be getting marijuana legally five years from now or everyone's going to be sitting around the table talking about the public health crisis with marijuana. There is absolutely no control over who should get it or for what indications it should be given, and yet doctors are being asked—and I'll use the term loosely—to prescribe this substance that has no safety profile. I think it's awful.

We've reflected our concerns to Health Canada, and yet we've not seen nearly a response that we think would be in the public interest.

Mr. David Wilks: Mr. Fefergrad, go ahead.

Mr. Irwin Fefergrad: Thank you.

I can't let your comment about the dentists in Kootenay, British Columbia, go without a comment from the registrar in Ontario.

Dentistry is based on a model of prevention. It's based on a model of dentists caring for their patients. It's based on a model of calling you and saying that it's time for a checkup. With the prevention model, dentists are able to deal with prevention so that your oral health condition doesn't become more serious, where you're involved in some substantial treatment requirements.

I know you know that, and I know you love your dentist.

Is that a no or a yes?

Voices: Oh, oh!

● (1705)

Mr. David Wilks: Thank you very much.

The Chair: Thank you, Mr. Wilks.

Next up is Mr. Marston.

You have five minutes, sir.

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

I certainly appreciate this opportunity.

I'm having some problems with my iPad here. I haven't got an eight-year-old grandson here to help me with it.

Voices: Oh, oh.

Mr. Wayne Marston: I'll start with Mr. Keon.

Perhaps I could take you to the recent court decision on generics, relative to Shoppers Drug Mart. What kind of implications does that have for Canadians?

Mr. Jim Keon: Well, as I understand it, the concern was that the generic medicine was interchanged with the brand-name medicine without the patient's being notified.

We talked earlier about the multiple jurisdictions in Canada. The issue of whether a patient should be notified when products are switched is a matter for the provincial college of pharmacy. Certainly, as generic drug manufacturers, we are quite confident and supportive of full information going to the patient. We would be very supportive of a national policy requiring that the patient be notified of any switch from a brand to a generic. That's certainly the situation in a number of provinces, including in Ontario. That's the first point.

The second point is, in terms of adverse drug reactions, they happen. There are no more reactions from either brand-name or generic medicines. In this case, if there has been, we feel bad about that. There is an opportunity for doctors to put on medication "No Substitution". Most drug plans will accept those if it's a medically necessary reason, a valid reason.

Those are my comments on that.

Mr. Wayne Marston: Thank you.

Dr. Rocco Gerace: I would suggest that the changes in Ontario actually save the taxpayer over a billion dollars a year. That's the net effect.

Mr. Wayne Marston: Okay.

Mr. Barnes, you seem to be one of the more popular witnesses today. I have a suspicion it's because your work is more on-the-ground, dealing with those aspects of abuse.

We had a Mr. Head from the prison system here last week. He said that 80% of new inmates come to prison with some kind of addiction problem. We've had this First Do No Harm strategy. Well, someplace along the line, there's been an awful lot of harm done, if we consider the magnitude of that statement. That's haunted me ever since. How many of these people became criminals as a result of their addiction, the natural follow through from that?

Is it realistic for Canadians to expect that pharmacists and owners take a significant role in the tracing of prescriptions and the dispensing of the medication because of the risk of abuse? You have spoken of that to a certain extent already. Is that fair?

Mr. Mark Barnes: It is fair.

The problem with pharmacies over the last decade is that we haven't really sold ourselves well as a profession. But we're certainly more educated—no disrespect to dentists or doctors—in the actual therapeutics and some of the side effects, and seeing diversion at the ground level. We know the problems, we see the acting, the potential for abuse, and we can actually have a big effect and we probably are, already.

I think that education, as I alluded to earlier, has to happen at the pharmacy schools, to make sure that we're ready in how to treat the problem, because if we're going to identify the addiction problem, then we had better be ready to treat it as well, appropriately and respectfully.

I'm so glad you brought up the prison system because a lot of my patients became addicted in prison, which is the first time I'm hearing that. Whether they're incarcerated because of break and enters as children or whatever led them to the criminal system, they actually became addicted in prison, which is traumatic.

I have information, if anyone is interested, on Recovery Kentucky. Rather than putting patients back in jail, they put them in treatment. This is funded through the judicial system, not through the health care system, which is an interesting thing you need to look into.

● (1710)

Mr. Wayne Marston: How much time do I have, Mr. Chair?

The Chair: You have 20 seconds.

Mr. Wayne Marston: Well, that's over.

Thank you, Chair.

The Chair: Thank you very much.

Next up is Mr. Lizon.

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

Thank you, everybody, for coming to the committee this afternoon.

I would like to start with a comment. Since we started this study, we've heard from several witnesses, every single one of whom has mentioned opioids. I assume that this is not the only thing abused by people, but I guess it's maybe the most common.

We talk about unintended consequences, we talk about misuse, abuse, and improper use of a prescription. If we talk about opioids, I'm surprised, because I think we're missing something—at least, I'm missing something. It may be that I don't understand the whole issue—it's hard to understand because it's so complex. Opioids have been around for almost 200 years as a medicine. I think the first time morphine was extracted was probably 200 years ago, more or less. Therefore, this is not a new issue nor should it be surprising. People have been getting addicted to opioids over all these years.

All these frameworks and guidelines we're talking about; those are fine, they deal with consequences. But what is the proactive action that we can take? You, as a doctor, or anybody who has to prescribe medicine to a patient, know this may cause an addiction, a situation that Mr. Barnes described—the fellow who had an injury and that's how he got hooked. People get hooked in different ways. We can do all the education campaigns we want; we do it for drinking and smoking, and to some degree I guess it works. I don't know if the problem exists in Canada, but in some countries, medical professionals get addicted to the very medicine they prescribe because they have access to it.

Can you comment on this? This is something that I think is the base of the problem we should be discussing. What do we do to stop addiction, not treat addiction, but to stop addiction?

I will hear from anybody, Mr. Chair.

Dr. Peter Trainor: I can tell you that within the dental profession in Ontario we are placing renewed and greater amounts of education on the aspects of responsible prescribing. You don't overprescribe in terms of quantities so that diversion becomes a problem or they're available for children to misuse or seek adventure with. As I said, that educative model has to be looked at very seriously. I know we place a great deal of emphasis on that.

Also, as Dr. Mock was saying, we are looking at possible alternatives for analgesics and analgesia, as opposed to some of the things that we used to rely on. It was easy just to rely on the opioids, but you have to look at the alternatives that are available today.

Mr. Wladyslaw Lizon: I was looking more at the situation that, if you have to prescribe opioids to a patient, is there a moment when you, as a doctor, say, "Listen, this may be addictive. You may get addicted and you won't be able to help yourself. If you feel a craving and you think you need more and you don't have more pain, come and see me. You need help right away." I think this kind of preventive action should be in place.

Mr. Phil Emberley: I think one advantage of the recent national opioid guidelines was that they were truly an interprofessional approach to the treatment of pain. For that reason I'm quite optimistic, because, really, it suggests that there's not simply a prescriber and a patient working together, but an entire team that helps to prevent situations in which the patient gets into trouble. It's truly an interprofessional approach in which there's support for the patient, to steer them away, and to do, say, medication reviews at the pharmacy level. But at every touch-point that patient has with the health care system, there's this common knowledge and a common support system so we can prevent patients from falling through the cracks and getting into addictive situations.

● (1715)

Dr. Rocco Gerace: I think you're absolutely right. Opioid addiction has been around for a long, long time. I think in the last decade we have seen prescription opioids overtaking heroin on the street as the opioids of choice for addiction because they are so readily available. Recently we've seen a recurrence of heroin addiction, because we actually are being somewhat successful—although I don't think successful enough—at controlling the prescription drugs. But it's not just about prescription drugs—opioid addiction has been around for a long time.

The Chair: Thank you, Dr. Rocco and Mr. Lizon.

Ms. Morin, go ahead.

[*Translation*]

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

Ms. Bouchard, I would like to go back to the question my colleague raised about the national oversight program. Do you remember why it was abolished?

Ms. Carole Bouchard: That is a good question, Ms. Morin. I have no answer for you. Thinking back, I believe that there may have been a change in practices and policies; perhaps it ended because of budget cuts.

In the program I was talking about a few minutes ago, everything was done on paper. Unfortunately, there was no electronic database. But the transactions were reviewed by the staff, one by one, with a view to detecting problems. But it was abolished.

Ms. Isabelle Morin: Okay, but you do not remember why it was abolished.

My next questions are for Mr. Barnes.

A little earlier, you said something that startled me. You told us, I think, that there is no registry of medications that you have destroyed. I thought pharmacists were required to destroy medications, by which I mean medications that have expired on the shelves of their pharmacies or medications that have been returned to them. If I understood you correctly, there are no checks on that.

[*English*]

Mr. Mark Barnes: There is monitoring of stock we have purchased for sale but no longer use. That's monitored by the federal government, and we write to Health Canada. There's a log of the destruction of the narcotics that we have purchased for sale, but nobody will govern or control what's brought back to a pharmacy. It is a problem. It's been a problem forever, actually. Most pharmacists, because they are diligent in the responsible provision of medications and the destruction of medications, will destroy them on site. I employ a student to do that, to destroy the medications appropriately every night, and the destruction is witnessed. I can't speak for other pharmacies, nor is there a policy in Ontario to monitor that.

[*Translation*]

Ms. Isabelle Morin: Say someone brings back an unidentified medication to you. For example, when my grandmother passed away a few years ago, we were cleaning out her house. We found a lot of medications that were poorly stored. We had no idea what kinds of medications they were. What happens in a case like that? Do they go back to you? Those little white pills could be anything. You can't always identify them. What do pharmacists do then?

[*English*]

Mr. Mark Barnes: The identification, to us, is at that point really no big deal. We just want it out of the public's access. We don't try to identify the medication at all. We just destroy it appropriately. Lots of times there are mislabelled bottles and whatnot. Certainly that's another conversation for another time. But from our standpoint on what's brought back....

As part of the prevention process, especially in a palliative care situation, we will say to people that when the time comes, make sure you get that stuff out of your house, because people will actually look at obituaries in the paper and look at addresses and different things; you're a target for theft, so make sure that's removed right away.

The palliative care team in Ottawa is actually extremely good. In my community the physicians themselves will remove it and bring it to me, which is great.

But you're right, there's absolutely nothing to identify them or anything.

● (1720)

[*Translation*]

Ms. Isabelle Morin: What would you recommend? How can we make sure that it is all recorded in some form? I agree with you, 99.999% of pharmacists will dispose of them in a perfectly appropriate way. But a small percentage will not. How do we get an idea of what is going on?

I recall that people talked to us about National Prescription Drug Drop-Off Day. It was a pilot project in 2012. It happened this year and it will probably happen next year too. Huge amounts were turned in. If that could be done more effectively on a national scale, it could perhaps give us some interesting data. What should Health Canada be doing to make sure that the medications that are turned into you are better managed?

[*English*]

Mr. Mark Barnes: I think probably the best answer would be to provide standardized disposal techniques and processes. Unfortunately, this would have to be controlled at the college of pharmacists level in each province. Whether or not it's federally mandated—which would be great—it would actually be a part of the inspection process such that everything that has to come back has to be handled in a certain way. It has to be destroyed in a certain way. You have to have a certain container to place it in. It has to be removed in a certain amount of time.

The college could also mandate that only so much goes out, and that maybe there should be a follow-up call as part of the annual medication review: "You've had this controlled substance in your possession based on a prescription from six months ago. Are you still using it? Do you need it? If not, it needs to come to us."

For record-keeping, we're looking at a complex situation with maybe no simple answer.

The Chair: Thank you, Mr. Barnes.

Mr. Aspin, five minutes.

Mr. Jay Aspin (Nipissing—Timiskaming, CPC): Thanks, Mr. Chair.

Thanks to our guests for sharing their expertise to help us with our study.

Officials from Health Canada, Public Safety, and Justice Canada have all alluded to a general lack of awareness of the risks associated with prescription drugs. I want to sort this out, and I want a very pragmatic, practical answer today. I'd like to hear you speak to any strategies our government could adopt to raise this level of awareness.

Perhaps I could start off with Dr. Gerace and Mr. Keon, and then have anyone else join in: most practical and pragmatic.

Dr. Rocco Gerace: I'm not sure how much I can help you with that in terms of strategies that have worked. We do know that we need more education of health professionals in the educational environment, and we do know that we need more education of the public, but I'm afraid I can't give you specific strategies.

Mr. Jay Aspin: Thank you.

Mr. Jim Keon: I'll let Dr. D'Cunha jump in here.

Dr. Colin D'Cunha: Essentially, when it comes to the area of chronic medications, one way it potentially could be tackled is by controlling the amount of medication given. However, there are reimbursement consequences. Appropriately, a pharmacy has to be reimbursed every time it fills a prescription.

The challenge is in finding the right balance between the amount of medications dispensed to address the patient's needs, along with the education and counselling by the prescribing practitioner, the dispensing practitioner, and then the creation of a system, which has been indirectly alluded to by Mr. Barnes and others, of having unused prescriptions returned, documented, and destroyed appropriately.

We simply cannot afford to approach this on a one-off basis. A comprehensive "from supply chain to grave" strategy, ensuring that what legitimately needs to get into a patient's system gets in and what's not used comes back into the destruction chain, is the only way one can approach this.

Mr. Jay Aspin: Okay, thank you.

Is there anyone else who wishes to comment?

Ms. Bouchard.

Ms. Carole Bouchard: I agree that education is very important as a strategy. It's hard to really say exactly what it should be, but I think I'd like to emphasize it again. I know I mentioned that a lot in my presentation at the beginning. I think the best thing to do from the beginning is to revisit a framework under the CDSA in order to make sure that the regulations and the types of requirements that are there are really up to the current environment, and also that they can fulfill the needs out there in Canada. I think that is really key to success, starting from the basis of revisiting that framework and clarifying the role of everyone here around the table as well as in the federal legislature.

● (1725)

Mr. Jay Aspin: Thank you.

Mr. Barnes.

Mr. Mark Barnes: I'm wondering if we could add it to the education curriculum at the high school level. That's a simple answer. With regard to your first prescription drug, we all know we have to finish amoxicillin. It's an antibiotic; you have to finish it. It's something you learn when you're a young kid. It's a campaign that worked extremely well about 15 years ago. Certainly another campaign could be talking about mom's and dad's pills or your pills and what not to do with them, and that could be within the education curriculum in middle school or in high school.

Mr. Jay Aspin: Okay.

Gentlemen, Mr. Fefergrad. No?

Is there anybody else? Okay.

How much time is there, Mr. Chair?

The Chair: There's a minute and 20 seconds if you have any other questions.

Mr. Jay Aspin: Previously, we heard from Health Canada officials on the successes of our national anti-drug strategy on illicit substance abuse. Are your organizations aware of the practices used in this strategy? Can any of the same practices be applied to prescription drug abuse?

Ms. Bouchard.

Ms. Carole Bouchard: First of all, I'm not totally sure what kind of practice you're referring to. Is it around the other drugs or the controlled drugs and substances, the drugs of abuse?

Mr. Jay Aspin: It says the national anti-drug strategy on illicit substance abuse.

Ms. Carole Bouchard: Okay.

If I'm not mistaken, the current strategy focuses on only a couple of pillars. I think what was forgotten at the time of the development of that strategy was really prescription drug abuse. That is missing and that's probably where we are here. There is a need to put more emphasis on this area. I think there are actions to be taken.

Mr. Jay Aspin: Okay, thank you very much.

That's fine, Mr. Chair.

The Chair: Thank you.

Our final question—probably just a question—is from Ms. Adams.

Ms. Eve Adams: I might commence, though, with a quick comment.

In fact, the national anti-drug policy does not currently incorporate prescription drugs. We made a commitment during the Speech from the Throne to expand that national anti-drug strategy to incorporate prescription-drug abuse. That is what brings us all around this table to seek your input as we move forward.

I have two very quick questions.

Mr. Barnes, you raised a very important point about the fact that we're now much more knowledgeable about having to consume our antibiotics, for instance, and about why that's important. We're looking for these very practical things we can do to help raise the level of awareness amongst Canadians. For instance, inasmuch as we often hear that you need to consume your antibiotics, I also get a very friendly, annoying, redundant, repeated sticker—

Voices: Oh, oh!

Ms. Eve Adams: —on my antibiotic that tells me I must consume the entire bottle. I do think that repeating information over and over does raise a level of awareness.

Are you aware of any tools such as that to help in combatting prescription drug abuse—any very practical policies?

Mr. Mark Barnes: What you're alluding to is called an auxiliary label. There are certain requirements, again, implemented by colleges, that are expected. As a standard of practice, a pharmacist is expected to apply that label telling people to finish their antibiotics. Certainly we could come up with our own; the Canadian Pharmacists Association would be a perfect organization to actually champion that. There are sometimes simple solutions to larger problems. We can simply add a label saying, “This medication is addictive”. We would not be trying to be offensive, but certainly lots of times being direct and repetitive does work. There are lots of things a pharmacy could do at the point of dispensing to educate and make patients aware.

Ms. Eve Adams: Thank you.

The Chair: I'd like to thank everybody for being here today. I know you're all very successful and busy individuals and that you've taken up either an entire day or half your day, and so our committee certainly does appreciate your time and effort on this worthwhile endeavour we're on.

We'll see everybody back here again Wednesday afternoon.

The meeting is adjourned.