HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 009 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Wednesday, December 4, 2013

Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. Welcome to the health committee meeting. It's 3:30 so we'll get things started.

We have four witnesses here or by video conference this afternoon, so we'll get right to them. If it's okay with the committee, we'll have the individuals by video conference go first, and then we'll hear from our guests who are here in person.

First up we're going to have from British Columbia, Donald MacPherson from the Canadian Drug Policy Coalition. Go ahead, sir.

Mr. Donald MacPherson (Executive Director, Simon Fraser University, Canadian Drug Policy Coalition): Thank you very much.

I'm the executive director of the Canadian Drug Policy Coalition based at Simon Fraser University in Vancouver.

Thank you for inviting me to speak to the committee today on such a critical issue for Canadians.

Our organization has membership of about 70 organizations and 3,000 individuals working to improve the state of Canada's approach to substance use and drug policy.

It's clear that there's a problem with the use of prescription drugs and opioid dependence, overdose, and other related problems in Canada, and we're delighted that this committee may be taking a serious look at the issue in the near future. Canada is clearly lagging behind in developing a national strategy, and the urgency to do so is clearly laid out in numerous publications. In the coming weeks, the coalition will be presenting to the committee a comprehensive brief on overdose prevention and awareness, which will chart a way forward for levels of government and communities in Canada to maximize efforts to save lives and prevent what are, most often, preventable overdose deaths.

I will not go into great detail about regulatory fixes for the growing phenomenon of prescription drug use dependence and non-medical use of prescription drugs. Others who will be presenting to the panel have more expertise in this area than we do. I will, however, caution the committee that regulatory fixes may be a small part of the solution if a serious study is to be undertaken, which we think is clearly justified by the current situation, and that the committee should consider broadening the scope of its work to include an attempt to get at the underlying causes of this growth in non-medical use of opioids as well as immediate actions to stem the increasing number of lives lost to opioid overdose.

The challenge before us, with regard to prescription opioid use is, as one researcher in the U.S. states, “finding the optimal balance between the risks of over-prescribing which may lead to addiction, overdose, and diversion, and under-prescribing which may lead to underdeveloped treatment of pain.” Even in the U.S. where there is much better data on this phenomena, he says, “there is little evidence to guide good decision-making on finding this balance”. Suffice it to say we all know this is a complex problem.

Opioid use, dependence, and deaths from overdose have been with us for a long time. I'm a veteran of efforts in the Downtown Eastside of Vancouver to stem the rate of lives lost resulting from opioid use throughout the 1990s and into this century. Thousands of individuals lost their lives during this period in Vancouver and in British Columbia, and many others suffered serious health consequences as a result of opioid use.

The response to the Vancouver situation was slow, inadequate to meet the scale of the problems, and 20 years after the first epidemic of opioid overdose deaths in 1993, still very much a work in progress; hence my other warning about regulatory fixes to this problem. The complexity of the issue and the jurisdictional divides mean it will take significant time to come up with a solution that balances regulatory control with access to medicine for those suffering severe pain.

Our presentation will focus more on what we can do in the meantime to prevent people from suffering opioid overdose deaths while we work towards a multi-level and multi-sectoral approach to reducing the harm from this phenomena. The CCSA, Canadian Centre on Substance Abuse, document, “First Do No Harm: Responding to Canada’s Prescription Drug Crisis” is a good start and lays out a road map for the high-level, multi-sectoral, and interjurisdictional work that needs to take place in order to get a grip on this phenomenon.

Opioid overdose prevention and response, interventions that work at the community level, exist today and are becoming commonplace in some jurisdictions, most notably the U.S. Policy changes and concrete interventions that can be implemented in short order at all levels will improve safety and prevent loss of life from opioid use. I emphasize this again to stress the fact that regulatory fixes and more upstream efforts, by definition, will take time to discover and implement. In the meantime much can be done to minimize harm.

Our challenge with this issue is exacerbated by a significant lack of data at the national level, which is a problem identified by numerous studies, including the CCSA report. This past May we released a report called, "Getting To Tomorrow: A Report on Canadian Drug Policy". After a year of working on this report, it was apparent that Canada is suffering from a lack of data on a number of issues related to this issue as well as to other drug policy-related issues.

● (1535)

Non-medical use of prescribed opioids is now the fourth most prevalent form of substance use in Canada, and there is evidence that prescribed opioids are the third-leading cause of harm behind alcohol and tobacco.

Canada and the U.S. lead all nations in prescription opioid consumption. This has resulted in an increase in problem opioid use and overdoses. Let me be clear, though, that before the increase in prescribing, opioid overdoses were a problem of epidemic proportions in the early 1990s in British Columbia.

In fact, drug overdose is associated with both the medical and non-medical use of prescription drugs. Overdoses specifically associated with prescription opioids have increased. On October 12, 2012, the B.C.-based Interior Health Authority released a warning that overdoses in the region from legally prescribed non-methadone opioid use were about twice the B.C. provincial rate. These overdoses were associated with the use of prescription opioids as prescribed, though most of these overdoses occurred among people who were prescribed other medications as well.

U.S. longitudinal studies have also noted the high risk of overdose when prescribed opioids are used with benzodiazepines and/or alcohol.

These events speak to the need for two interrelated opportunities for federal policy development: one, provision of leadership on the matter of prescribing practices; and two, taking a risk reduction or harm reduction approach to overdoses.

With respect to prescribing practices, given that Canada has one of the highest levels of prescribed opioid use in the world, it is important to acknowledge the role that prescribing practices have had in opioid use and accidental overdoses in Canada, especially in the last 10 to 15 years. In many communities, opioid-related deaths appear to be concentrated in areas where physicians prescribe opioids more frequently.

As a recent strategy on prescription drugs released by the CCSA notes, efforts need to be made to make physicians more aware of the risks of opioid use.

Physicians who prescribe opioids must ensure that patients and their families receive up-to-date information about the potential effects of these drugs, including the risks of overdose and dependency. As a routine part of their practice, physicians should help patients to identify and respond to overdose symptoms.

In several jurisdictions in the U.S., medical boards have recommended that naloxone be co-prescribed with opioids to anyone at risk of overdose. We urge provincial governments and appropriate professional colleges and associations to consider making similar recommendations to prescribers in their jurisdictions.

In adopting a risk reduction approach to opioid overdoses, it's important to recognize that the relationship between using opioids and overdose is not necessarily simple or causal. Many people use opioids without suffering ill effects. Use in and of itself does not lead to dependence or overdose.

Being clear on what increases the risk of overdose is critical. People are at a particularly higher risk of overdose under the following conditions: if they use opioids in combination with alcohol or other drugs; if they are initiating or tapering off opioid therapy; if they are coming off a period of low or non-use, such as being incarcerated; if they have difficulty accessing primary care; or if a prescription drug is delisted or suddenly made unavailable and they are forced by circumstance to seek out other resources for mitigating pain.

These risks apply to both medical and non-medical use of opioids. Overdose is also more common among people who are homeless, because of the health problems and lack of access to health care that can stem from the lack of safe and stable housing.

When the number of overdoses increases, often the first response is to attempt to control and contain the supply. Typically, these strategies call for prescription monitoring programs, drug take-back events, and limiting the doses of prescribed opioids, but none of these measures have been shown to be effective at reducing accidental overdose deaths.

There may be cases where limiting the supply of prescription opioids is an important component of a prevention strategy, but it is equally important to ensure that strategies to contain the negative effects of opioid use do not result in misdiagnosis of illness or ignoring the physical causes of pain.

In addition, strategies to address overdose sometimes fail to acknowledge the gender differences that characterize overdose events. Though men are more likely to experience overdose, overdose deaths due to prescription opioids among women have in recent years been increasing at a greater rate than among men, in part because of the increased prescribing of pain medications to women, often in conjunction with drugs like benzodiazepines.

● (1540)

Limiting supply results in displacement of the problem to an illicit market. In response to concerns about the non-medical use of prescription opioids, seven provinces removed OxyContin from provincial drug formularies in 2012. These changes were meant to suppress a widespread use of these drugs by limiting their supply, but as referenced in the United Nations Office on Drugs and Crime reports, if the use of one drug is controlled by reducing supply, suppliers and users may move on to another drug with similar psychoactive effects but of greater potency and purity.

As oxy products have been removed from many of the provincial and federal formularies, some people have switched to equally strong prescribed drugs or are seeking other illegal alternatives. Data and anecdotal evidence suggest that the non-medical use of prescription opioids has become more prevalent than heroin use. With the recent removal of OxyContin from many provincial drug formularies and the federal drug plan, illegal substitutes, such as heroin and fentanyl analogues, could be making a resurgence as cheap available alternatives to OxyContin.

An example of displacement can be found in B.C. In 2013 the B. C. Provincial Health Officer released an alert based on the B.C. Coroners Service's finding that there had been 23 deaths related to fentanyl.

The Chair: Excuse me, Mr. MacPherson. We're just a little over time here and I'm just wondering if you're close to concluding your opening remarks. How much longer do you think you need?

Mr. Donald MacPherson: Yes, I need about a minute.

The Chair: Okay. Go ahead, sir. Thank you.

Mr. Donald MacPherson: On the issue of displacement in the U. S., using the combined data from the 2002, 2004, 2008 to 2010 national survey on drug use and health, a recent study has shown that 77% of those reporting both non-medical prescription pain relievers and heroin use in the past year were found to have initiated non-medical use of pain relievers prior to initiating heroin use. Although the discontinuation of one drug cannot account for all transition from non-medical pain relief to heroin use, it may be a significant role.

I'll close by saying what we believe. We will submit a more comprehensive brief in the coming months. It is being translated at the moment.

We feel it's a component of a comprehensive overdose strategy around both illegal opioids and prescription opioids. This is an overlapping public health problem that we have and people move back and forth between both of those markets, and then there are accidental overdose deaths when people are attempting to take medication as prescribed.

We recommend that the federal government adopt a comprehensive approach to overdose prevention and response that includes six key components.

One would be to make naloxone more readily available and cost effective by including it in provincial drug plans and making it available over the counter.

Two would be to scale up community-based and institutional overdose programs training on how to prevent, recognize, and respond to overdose. I just took one of those at the Canadian Students for Sensible Drug Policy conference. It takes about an hour.

Three, would be to scale up overdose training programs for first responders.

Four would be to reduce the barriers to calling 911 during a drug overdose event so that people do not fear police arriving and arresting them for some other drug charge during an overdose event. The Vancouver Police Department has a policy of not routinely responding to overdose calls unless they're asked to by ambulance attendants. This could be expanded to other departments.

Five would be to implement appropriate guidelines for opioid prescription that do not limit access to needed pain medication or result in further discrimination against people who use drugs.

Six would be to increase the timely collection, analysis, and dissemination of data on drug overdose events.

This is probably one of the more important recommendations, because in the literature that I've read, Canada really does need to get much better at monitoring and collecting data so that we can come up with some sound policy decisions based on some sound evidence.

Thank you very much .

● (1545)

The Chair: Thank you, Mr. MacPherson.

Up now from the Centre For Addiction and Mental Health, we have Dr. Selby and Dr. Sproule.

Go ahead, for 10 minutes or less, please.

Dr. Peter Selby (Chief, Addictions Program , Centre for Addiction and Mental Health): Thank you. I'm Dr. Peter Selby, and this is Dr. Sproule on my left. I'm the division chief of the addictions program at CAMH.

CAMH, as you may or may not know, is the largest mental health and addiction treatment and research centre in Canada, affiliated with the University of Toronto. We have about 600 beds at the hospital, and about 48 of them are for patients with addictive disorders. We do have a large program to treat opioids addiction. We have a special program to treat people who have both pain and addictions, whether they've got the pain and addiction through recreational use or through the use of prescribed medication. We also have a specific program for injured workers.

We've been bringing out that perspective from the treatment side. We also have a large research program, as well as a large educational program. We are the providers for comprehensive education in Ontario for prescribers and other health care practitioners in the appropriate use of opioids, both for the treatment of addiction as well as for pain.

Having said that, and in working with CCSA on the report, in terms of looking at prescription opioid overdose as well as prescription opioids and the recreational use of prescriptions, there are roughly three things I'd like to say. There are three ways we can think about it.

First, we need to have the appropriate products on the market that have the least amount of risk to manage pain. We also need to have better use of the products that are lower risk on the market for managing pain as well as appropriate use of those medications for the treatment of addiction.

Second, we need to make sure the manufacturers have a monitoring program, that when they bring a product onto the market, the products is monitored. This is to make sure they follow the precautionary principle and no harm is brought to society, which is then borne by society and not by the manufacturer. Things can be done to make sure we have that level of safety when the product is coming into the market and to show what a promoter of that product needs to do.

Third, we heard a little bit about the prescribing practices. Education practices and regulatory practices need to go with those practices, to allow or to not allow prescribers to bring and use opioids for the treatment of pain, as well as for the treatment of addiction. Within practices, you do need to make sure we have a strong evidence-based and comprehensive management of pain disorders. The absence of good management of pain doesn't mean medication. It means other ancillary services required by Canadians to get back into the workforce are very necessary to make sure that people can manage.

We need to make sure there isn't a geographical divide in the access to these services. This is so that people even in remote areas don't have to resort to pills or anything like that for managing their pain, but can have things like physiotherapy, appropriate pain management to be functional again without the need for pain medications, or if pain medications are used, they're used sparingly.

Last, I would say we need to have in place policies that clearly bring in some of the regulatory aspects that have to do with how formularies are constructed and what medications are out there, that will promote the use of the least harmful but the most beneficial form of opioids for the management of pain. As well as promoting that, when these reforms are taking place, appropriate treatment for people who get addicted needs to also be in place. This will ensure there is an adequate number of providers for the treatment of addictions to help mitigate some of the effects.

In terms of policies, many were talked about, from reducing the risk of overdose by having, for example, naloxone either built into the medication or being available at pharmacies at no cost to patients who are at a high risk.

I'm now going to hand it over to my colleague, Dr. Sproule, on what role monitoring programs can play in shaping practice.

● (1550)

Dr. Beth Sproule (Clinician Scientist, Pharmacy, Centre for Addiction and Mental Health): I'm Beth Sproule, and I'm a clinician scientist in the pharmacy department at CAMH, and also with the University of Toronto.

I want to follow up on the remarks, specifically around the monitoring and surveillance piece and recommendations, again, supporting and echoing the recommendations in the CCSA document, “First Do No Harm”.

As Mr. MacPherson said, and I want to repeat, Canada at the moment does not have a comprehensive surveillance system for knowing where we are on the extent of the problem, the numbers and the impact of the problem. We have bits of information from different sources and different parts of the country, but not a systematic view, and certainly not the routine surveillance mechanisms that they have in the U.S., for example.

I think that's quite important, not only for knowing where we are, but also for any of the interventions we're now striving to implement. We need to be able to monitor the impact, and the only way to do that is to know where we're starting from and then look at change.

Again, as mentioned here, we want to prevent the problems of prescription drug abuse, but we also want to keep the drugs available for their therapeutic use. Any intervention could impact either way, and we need the surveillance system to keep track, so that whatever interventions we're doing are in fact reducing the harms but not reducing the availability and benefits of the drugs as well.

One of the key types of surveillance activities is prescription monitoring programs, which have been mentioned. These are thought to be quite important. I think that in Canada we have a few good programs in different provinces. We need to come together to look at the best practice evidence, what features of these programs are the most effective, and how well they do at monitoring the issue.

They also serve as an intervention. It's by identifying patients or prescribers that prescription monitoring programs serve a kind of dual role, of monitoring and also by having interventions in a prevention role.

Knowing what we do now, I think there are some documents about best practices, but also there's a lot of research that's needed to evaluate what these best practices are, and again, evaluate their impact.

Those were the main points I wanted to make.

Thank you.

Dr. Peter Selby: Thank you.

The Chair: Very good.

Now, we're live here, or at least in person. We have two more groups to go, and then we're on to the questions.

We'll start off with the Coalition on Prescription Drug Misuse.

Mr. Harris or Dr. Ulan, go ahead, for 10 minutes, please.

Det Collin Harris (Member, Coalition on Prescription Drug Misuse): Thank you, Mr. Chair and committee members, for inviting the Coalition on Prescription Drug Misuse to present today and be part of this important parliamentary study.

My name is Collin Harris. I'm a detective with the Calgary Police Service. I work in the drug unit, and I am a subject matter expert on drug files that come through the Calgary Police Service.

Dr. Susan Ulan (Co-Chair, Coalition on Prescription Drug Misuse): I'm Susan Ulan. I'm a family physician by training, and I work with the College of Physicians and Surgeons of Alberta. We're the regulatory body that oversees the practice of medicine in Alberta. As part of my portfolio, I'm involved with physician prescribing practices, and I'm co-chair of the Coalition on Prescription Drug Misuse.

We're delighted to be here today.

Thank you.

Det Collin Harris: I'd like to start by telling you a story about an individual known to us as Jodie Bruketa.

Jodie Bruketa was a 28-year-old Calgarian and a recent university graduate who was establishing her career in the communications field and living on her own in Calgary. Jodie developed headaches as a result of a motor vehicle accident, and as a result, was prescribed Percocet in April 2003. By the fall of that year, her Percocet use had escalated. In January 2004, Jodie died as a result of an overdose of Percocet and a sedative. She was found by her brother in her kitchen. At the time of her death, she was making soup.

I wish I could tell you that Jodie's death is uncommon, but it's not. Jodie's story is all too common. That is why it is important that we are here today.

The Coalition on Prescription Drug Misuse, or as we refer to ourselves, CoOPDM, was formed in May 2008 to address the issue of prescription drug misuse in Alberta. What makes our organization unique is who we are.

CoOPDM is composed of organizations and individuals that have voluntarily and collaboratively come together with a common vision to address and reduce the misuse of prescription drugs in Alberta. Around our table, we have pharmacists, treatment providers, police officers, physicians, and government representation, many of the stakeholder groups that see first-hand the impact of prescription drug misuse.

Since 2008 we've been actively and collaboratively addressing the issue of prescription drug misuse. We have undertaken a number of research and consultation initiatives to better understand the scope and complexity of the problem within Alberta. We began by commissioning a study to look at the scope of the problem in 2008. As we've heard here today, there are very limited data and information available for us to work on.

We conducted a series of focus groups on reserves in first nations, in inner-city neighbourhoods with high-risk populations, and with key professional groups, such as physicians, pharmacists, police officers, and treatment professionals. We held a symposium of professional, government, and community leaders to begin to engage some of the most senior leaders in our province on the issue.

We've undertaken a number of research projects to better understand how to improve the collection of data on prescription drug misuse, which would help us to better understand the problem and determine what is required to more comprehensively address this issue at the provincial and national levels.

We've been active participants with the Canadian Centre on Substance Abuse in the development of the “First Do No Harm” strategy. In fact, Dr. Susan Ulan, who is our co-chair of CoOPDM, was also a co-chair with the National Advisory Council on Prescription Drug Misuse, which authored the report.

We are also currently working closely with Alberta's chief medical officer of health to determine the right path to ensure this issue gets priority attention in our province's public health agenda.

I'd like to turn it over to my counterpart, Dr. Susan Ulan.

● (1555)

Dr. Susan Ulan: What have we learned in the last five years of being part of CoOPDM? We have learned that prescription drug misuse affects everyone, every community, every demographic. It is not about marginalized populations. Jodie Bruketa could be the daughter of anyone here, so this is an issue that requires urgent attention. It is having an impact on our public health and safety and our health care systems.

It's a very complicated issue, as the other speakers have mentioned. These are medications that have therapeutic purposes, and so we need to have access to those medications for legitimate purposes. Fixing this problem is not a simple, one-sided solution. If that were the case, it would have been done a very long time ago. It's a lot more complicated than that.

The tendency is to focus on opioids, but really, there are many medications that have abuse potential. We need to factor in opioids, sedatives, and tranquilizers, as well as stimulants. Canada happens to be one of the highest per capita users of Ritalin, so I think that focusing only on opioids is missing other issues as well.

Discontinuing access to one medication is not going to solve the problem, because what we have seen in Alberta is that communities or patients individually will rotate to other medications, other illicit substances. Alcohol becomes more common, and that itself has unintended consequences. Any efforts we make need to be deliberate, and they need to be comprehensive. We need to look at a very encompassing strategy to improve things.

As mentioned previously, the CCSA document “First Do No Harm”, really did look at a very comprehensive approach. It looked at five different streams of implementation addressing education, prevention, monitoring and surveillance, treatment, as well as law enforcement issues. Really, to be effective you need to address all of those collectively, not pick out a few of them, because the repercussions and the complexity of issues make that really the only viable way we're going to improve things.

The other issue we've learned about is data. Data collection and getting data from multiple sources is critical. As Dr. Sproule alluded, that allows us to quantify the problem and to look at the response to interventions. It also allows us to develop a surveillance system so that we can look at identifying new issues rather than waiting for them to become part of the media, and to look at how to identify things in a much more proactive way.

We need better access to treatment, such as treatment for chronic pain, addictions, and mental health issues, because, as Dr. Selby has indicated, as prescribing practices change, there are more patients with legitimate and sometimes self-induced problems who need access to treatment. If we don't have access to treatment, we are diverting health care situations to the law enforcement system, so access to treatment is a critical part of the solution.

We cannot address this without the leadership of government. This point really can't be stressed enough. In order to change organizations, we need leadership at both provincial and territorial levels, but really that has to come from the federal government to begin with. It's the way we can incite, encourage, and require organizations to make meaningful change. Collaboration is a part of it—it's a big part of it—but with collaboration you still need to have leadership.

In conclusion, the Coalition on Prescription Drug Misuse has accomplished a lot in the last five years. We're a volunteer organization with limited funding and limited influence, and we've brought it to the level of our Alberta chief medical officer of health. It's on their radar, and we're working with them to look at how a governance structure might look in Alberta. I would recommend that this is something we all should be doing across the country.

We are, and have been, a very active partner and supporter of “First Do No Harm”. The strategy is comprehensive. We've got a road map. We've got all the right people at the table, all the right organizations. We're starting to implement all the different streams, and what we need is support and some financial funding. We're asking that you consider that part of your recommendations.

This committee has an important opportunity to do the right thing and to make some meaningful recommendations that can, in a dramatic way, influence the risk of harm so that families such as the Bruketas and people such as Ada, who will speak about her own experiences, will not have to experience the real harms that come from inappropriate medications.

Thank you for your time and interest.

● (1600)

The Chair: Thank you very much.

Our final presenter this afternoon from the Advocates for the Reform of Prescription Opioids is Ms. Giudice-Tompson.

Go ahead for 10 minutes, please.

Mrs. Ada Giudice-Tompson (Vice-President, Advocates for the Reform of Prescription Opioids): Mr. Chairman, and members of the committee, good afternoon and thank you for the opportunity to provide testimony.

My name is Ada Giudice-Tompson. I am vice-president of Advocates for the Reform of Prescription Opioids, and I serve as a member of CCSA's National Advisory Council on Prescription Drug Misuse that developed Canada's strategy “First Do No Harm”.

However, I am also here as a bereaved mother of a wonderful young man, my son Michael, who died in 2004 from an opioid prescribed by his physician. I speak both as an advocate and as a person who has lived the personal pain of seeing someone die from the effects of prescription opioids, drugs that are too often deemed "safe as prescribed", but which are, in my view, anything but.

Indeed, if I had been provided with accurate information about Percocet, I would not have filled my son's first prescription, and I would not be here today. My son Michael died within two years of that initial prescription.

Like many other Canadians, I had no idea legally prescribed drugs, those coming from a physician, dispensed by a pharmacist, and approved by Health Canada are as dangerous as such illicit drugs as cocaine, heroin, or crystal meth. In fact I believe they are more dangerous, because when a drug receives approval from Health Canada, Canadians accept the premise that the drug is safe, or at the very least, safe as prescribed. My story could be anybody's story; thousands of Canadians have been prescribed into addiction and overdose death.

The current scope and risk associated with prescription opioid drugs is significantly underestimated. The Centers for Disease Control and Prevention has stated that the epidemic of addiction and overdose death has increased in parallel with the prescribing of opioids. The CDC has acknowledged they have an epidemic, the worst in U.S. history. Yet Canada and the U.S. continue to be the top per capita consumers of opioids worldwide, and Canada's consumption has increased faster than that of the U.S.

At risk is any Canadian who is exposed to opioids, with or without a prescription. Additionally, with each passing year we are presented with more and more evidence of safety issues, and that opioid misuse is becoming increasingly common among chronic pain patients. Indeed, this should come as no surprise, given the lack of clinical trials for the use of opioids long term.

Advocates for the Reform of Prescription Opioids is a binational organization in the U.S. and Canada composed of people whose lives have been destroyed by the massive over-prescribing of opioids. ARPO represents what happens in the real world, and our mission is to end the epidemic of death and addiction caused by prescription opioid drugs by ensuring opioids are regulated, prescribed, and used in an evidence-based manner.

ARPO has studied this problem alongside Physicians for Responsible Opioid Prescribing, PROP. We believe prevention of prescription drug misuse cannot be studied in isolation from the systems that sanction drugs of abuse. In addition our understanding must come from science not misinformation. By looking at both the process and content we are able to find gaps starting with the regulatory approval of drugs right through to prescriber practices and patient use of legally sanctioned drugs that act on the body in very much the same way heroin does.

History reveals the truth. If we look at the successful court actions against drug companies, the misleading marketing of morphine, heroin, oxycodone slow release tablets, abuse deterrent formulations, and the ongoing United States Senate finance committee investigation into the financial ties between the pharmaceutical makers and groups that advocated broader use of opioids, we begin to see a clearer picture. What we see is a picture of misrepresentation of the drugs' safety and efficacy, as well as conflict of interest and influence.

● (1605)

The message for broader use of opioids was not based on scientific evidence so much as it was on the desire to maximize sales. Many well-meaning physicians have advocated for broader use of opioids because they wish to relieve pain, yet the sad reality is that the drugs don't work nearly as well as physicians have been told. In fact, pain sensitivity is often increased when patients are on opioids in the long term.

Misinformation has framed our laws, regulations, policies, and the practice of medicine. Pharmaceutical manufacturers, health care providers, and others have told us many myths about opioids, but unfortunately, our main regulatory agency, Health Canada, accepts as gospel the clinical trial information provided by drug companies, without any further checks and balances.

This in turn has implications for marketing, product monographs, labelling, prescribing, and, ultimately, patients and their families. Health Canada must acknowledge that the regulatory role impacts on clinical practice, and they should be required to review how they are arriving at the approval of opioid drugs, or frankly, any drug in Canada that has a high abuse potential and/or can lead to abuse, misuse, or dependence.

Many Canadians say that we have an epidemic of prescription drug abuse. This is not quite the right way to describe the problem. Yes, abuse is part of the problem, but typically this behaviour is not how an individual starts down this road.

The focus is always on abuse because it is to the advantage of many if we neatly categorize people into being either legitimate patients or abusers. This is a false dichotomy. It also perpetuates the stigma of people who develop addictions. Indeed, the product monograph for oxycodone states that drug abuse is usually “not a problem in patients with pain in whom oxycodone is appropriately indicated”. This claim continues to reinforce the fallacy that addiction is rare in pain patients and speaks to the extent of industry rhetoric and influence.

Presently, the Food and Drugs Act does not permit approval of a drug to be withheld on the basis of misuse. This is extremely worrisome, given the non-transparent manner of the drug approval process and the fact that use can lead to misuse. This is so important that it bears repeating. Many people start using prescription opioids as prescribed and then later begin to misuse or abuse their prescriptions. After all, opioids are highly addictive narcotics, so perhaps we should not be all that surprised by this. The Minister of Health should be empowered to reject the approval of a new drug if there is high potential for it to be misused or abused.

Further, in September 2013, the FDA requested that opioid manufacturers update the language on product monographs, labelling, and patient counseling information to improve warnings and precautions. One example was provided by the FDA, “Even if you take your dose correctly as prescribed you are at risk for opioid addiction, abuse. and misuse that can lead to death.” Health Canada should request similar warnings.

Prescribers need accurate information on which to base patient care decisions. Emphasis on prevention should occur before drugs are approved, not after patients have been harmed by their use. A committee of experts on drug and patient safety should be established at the federal level, independent of industry, to assist Health Canada with drug approval and/or recall. Prevention must begin with the regulatory agency, and it must have the authority to fully recognize its mandate of patient safety.

Regulators need to stop listening to people who have a vested interest in the sale of opioids and start listening to patients, families, health care providers, and Canadians nationwide who want to see a full scale change in how drugs are being brought to market. Your role as legislators can do much more than mitigate harm. It can prevent it in the first place.

Formularies at the federal and provincial level should provide coverage for non-opioid drugs and other forms of therapy to assist with pain management.

● (1610)

Just to be perfectly clear, I am not suggesting that opioids should never be used. There is no question there is a need for opioids in appropriate clinical situations. When we have all the facts, we may better determine the clinical situations in which we are willing to put patients at risk with an opioid.

This epidemic has resulted in countless deaths and destruction to patients, families, and communities. The status quo cannot continue. We need those who have moral, legal, and regulatory accountability to accept their responsibilities and bring about change.

Thank you.

The Chair: Thank you very much for your heartfelt presentation. Just for the benefit of the rest of the members of Parliament, it's Giudice-Tompson?

Mrs. Ada Giudice-Tompson: It's Giudice, like a girl's first name.

The Chair: You've heard me say it wrong three times, so hopefully the other members can get it right once or twice.

First up with our round of seven minutes is Ms. Davies.

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

Thank you to all the witnesses for being here today, especially to you, Ms. Giudice-Tompson, for reminding us how personal this issue is. You spoke about your son, and I'm sure that's not easy to do in a formal parliamentary committee and so on, so thank you for sharing your story.

There are a couple of things I want to try to tackle here. It is becoming clear at least to me that the line of what's deemed legal or illegal is very blurry. Clearly we're dealing with substances here that are addictive. Many of you have mentioned opioids, whether they're obtained through “legal means” or illegal means.

I find it ironic that when a substance is deemed illegal, a common response has been to say that we should just ban it, yet when there's a medical purpose, we can understand that even though there are a lot of risks with that particular drug, whether it's OxyContin or something similar to that, there are legitimate medical uses. It requires us to think of a response that is thoughtful and comprehensive and not just a blanket prohibition through which we think we're solving the problem.

I'd like to tackle the idea that somehow outright banning is going to work. I wonder what kind of approach we should be taking. We used to have what we called the four pillar approach for addiction issues when it came to drugs. Those were prevention, treatment, enforcement—enforcement was an element—and harm reduction. Those have now been narrowed down to exclude harm reduction. It seems to me that this sort of approach based on a public health understanding of what we're facing is what we need.

I wonder, Mr. MacPherson and Dr. Selby, if you could respond to that. As a committee, when we're looking at how the government should approach this, do we need to be taking a public health approach in terms of reducing risk and reducing harm as opposed to saying that an outright ban on whatever it is will somehow work? I think we're hearing that if we go down that line, something else will pop up. It really does make us think about what approach will work and what approach won't work. I wonder if you could respond to that.

Mr. MacPherson, I'd also like you to explain a little bit more about making naloxone more available. You said there are some barriers or difficulties. This is something that will prevent overdoses, so I just wonder what the problem is in obtaining naloxone and if you could explain that.

● (1615)

The Chair: Just for the benefit of our guests over here, and this isn't cutting into your time Ms. Davies, that was about three minutes and thirty seconds. This is a seven-minute round, so if you could each try to curtail your answers to about one minute or a minute and a half, we could get those in under seven minutes.

Mr. Donald MacPherson: On your first question, Ms. Davies, I think that's why we prefaced our presentation with the notion that this is incredibly complex. The witness talked about so-called big pharma. I think that's important. All you have to do is go to the U.S. and watch TV to see the promotion of pharmaceutical products. We don't have the same level of that advertising in Canada, and I think that's a good thing.

I don't think, in this day and age, that banning any substance really solves that problem. It creates a market for other types of substances, some of which are more harmful, like we're seeing with fentanyl in various places in North America, which is way more powerful than some of the other prescription opioids.

Drug prohibition per se doesn't work. It creates a market for other substances. That's why you need a comprehensive approach. That's why we are arguing that you need to continue this discussion about the complexity of the issues, but in the meantime, let's get to work at the risk reduction or harm reduction level and make naloxone more widely available. In many jurisdictions in the U.S, they are co-prescribing naloxone for people who are clearly at high risk of opioid overdose. We should have it on the provincial formularies. It's not a complex substance. There is no harm that I know of for the misuse of naloxone. It prevents overdose deaths, and it reverses overdose events.

Our national working group of over 25 organizations, which are mostly front-line people working in the trenches, with some academics involved, are helping us with the briefs that will be coming to this committee about making naloxone much more available. In doing so, you educate the public about overdose, the risks of overdose, the risks of using multiple drugs, the importance of having a substance like naloxone available, and the importance of training people to respond to overdose. This would provide a big element of education at the ground level.

● (1620)

The Chair: Dr. Selby and Dr. Sproule.

Dr. Peter Selby: I think this idea of separating treatment from harm reduction is a bit odd. As a physician, I can tell you that western medicine is entirely about harm reduction. We do not cure hypertension. We do not cure diabetes. We do not cure depression. We do not cure heart failure. We simply treat them and reduce the harm that people have from their diseases.

This goes back all the way to St. Thomas More, who's sort of the father of modern medicine in many ways. That's what we've been doing. We haven't been doing curative work. We've been doing harm reduction work. There's effective WHO endorsed treatment for addictions. We have guidelines that don't have anything to do with the manufacture of drugs.

The use of effective, cheap, generic medication that could save thousands of lives as part of a treatment program that even family doctors could prescribe with a little bit of training is not rolling out the way it should in this country. We have more restrictions on physicians in prescribing these medications than we have in prescribing the pain medications.

I think we can do a lot more, even within the existing framework. When we talk about harm reduction, why are we making this false dichotomy? We reduce harm by wearing hockey pads and helmets when we play hockey. We reduce harm when we use unleaded gasoline instead of gasoline. We do this because we believe there are certain things that just have to happen in society. We want the benefits of the drugs, but we reduce the harms from them. That's where the innovation comes from.

The Chair: Thank you very much.

Ms. Adams.

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

I will start my remarks, if I may, by perhaps stating the obvious. I'm sure many of us around this table feel the same way. I am profoundly sorry for your loss, Ada. I can't imagine the terrible pain it would be to lose your son. Thank you for coming here today to share with us your experience and to advocate in his name.

I'd like to turn to some of the experts that we've been hearing from around the table. We've had this recurring issue, and it's interesting that CAMH, that you as an individual on a police team, or the family physicians would all be saying the same thing, which is that we really lack concrete data as to the extent of this problem.

Ada, you also mentioned the same thing, that we don't have a proper surveillance system in place to truly understand and comprehend how widespread this problem is. You're absolutely bang on when you say that we're understating how widespread this issue is. This is why in the Speech from the Throne our government committed to expanding the national anti-drug policy to include prescription drug abuse, which is what brings all of you to the table today.

Over at CAMH, you indicated that in the United States there is a surveillance system where they're actively monitoring. Can you describe that system to us?

Dr. Beth Sproule: [*Inaudible—Editor*]...annual national household surveys that specifically address this issue, targeting prescription drug use and abuse, both on its own and as part of broader surveys.

They have a comprehensive system, one of which is called RADARS, a system that was set up specifically to do surveillance on the harms from prescription drugs. It was originally set up through Purdue, actually the pharmaceutical company that produced OxyContin, and then was branched out to other drug companies by being taken over by the Rocky Mountain Poison and Drug Center.

It looks at a number of different data sources through coroners' data and surveys, and admissions to treatment addiction centres. It is basically funded by contributions by different pharmaceutical industries. Then they have a hands-off approach, and this independent body now collects this information and disseminates it.

That's one model. They also have systematic data collection from emergency room visits, for example.

They have a number of systems that can all be taken together to provide quite comprehensive data on a regular basis.

Did you want to add something?

Dr. Peter Selby: Yes.

I'd like to add that there are some more technological advances that can be done in our data collection systems. They've actually automated the collection of data that can be done through the cloud, off people who are coming and seeking treatment. For example, when they deployed this in the state of California, they showed that you can get really rapid data access.

You can also see what trends are happening. More importantly, that data collection tool is also a treatment tool that helps treatment planning for the practitioners.

It meets the needs of surveillance. It meets the needs of the individual, because it helps give them an assessment. This is really using modern-day techniques of big data and data crunching that helps people end up getting real-time data on what's happening rather than waiting for a data collection tool that you get 10 years later to know what the trends are.

This is real-time stuff. We're trying to bring that into Canada if we can, but again, as you can imagine, it takes money, time, and effort, and convincing people so that we can actually have this here. These are validated instruments that are out there.

It costs $6.20 for each assessment. That's it: $6.20. You could deploy this in a police station. You could deploy it in a family doctor's office. It can be deployed anywhere, but we haven't yet operationalized on some of the big technological investments that have occurred in Canada. Things like high-speed Internet in the north, etc., could be used in a place like Canada.

● (1625)

Ms. Eve Adams: Perhaps I could quickly squeeze in a question to Dr. Ulan before I run out of time.

You raised a very important point about prescription drug abuse pertaining to not simply opioids but also drugs like Ritalin. Could you expand on that?

Dr. Susan Ulan: It's difficult, because currently we don't have a lot of good data so we don't know the full scope of it. If we look at the International Narcotics Control Board data, Canada is one of the highest—I believe it was the highest in 2011—prescriber or consumer per capita of Ritalin.

I think the reason for that is poorly understood. It may be that in Canada we diagnose ADD more commonly. We know that recreational use of it has developed among college and university students who want to enhance their academic performance. We also know that it's misused commonly with other medications of abuse. It can be snorted and give an effect similar to that with cocaine. It can also be used to counteract the side effects of other medications or illicit drugs.

The reality is it hasn't received a lot of attention. We really don't have a lot of good data to know how much of an issue this is in Canada. Once again it speaks to the importance of having a surveillance system so that when we start to see that the use in Canada is rising, we can take proactive measures to evaluate that and develop strategies to improve the situation and reduce the harm.

Ms. Eve Adams: Thank you.

Is the quantity that is dispensed provincially shared with you in any way?

Dr. Susan Ulan: It depends on the province. Many provinces do have prescription monitoring programs. In Alberta we have something called the triplicate program. I think we have a very good program in a lot of ways, because we have a provincial health record, which all physicians have the ability to log into. The majority of physicians do have access to that.

If you are directly involved in the circle of care for a patient, you can log in and look at the patient's prescribing data. You can log in and see what the patient has been prescribed and dispensed, from which doctors and which pharmacies. That allows physicians to make timely decisions. I think that is really important.

For the provinces that have prescription monitoring programs, we gather that data and we can use that information on stimulants or opioids and so on to identify potentially high-risk patients and high-risk physicians, and to look at how to interact with their physicians. That's really important. That's the other piece of monitoring, which I think Beth is alluding to. I think it's critical.

Ms. Eve Adams: Thank you.

The Chair: Thank you, Ms. Adams.

For our next round of seven minutes, go ahead, please, Ms. Fry.

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

I want to say that we have that same system in B.C., and it really is a very important tool for the surveillance of patients as well as prescribing habits of physicians.

I want to thank everybody.

I want to say to Ms. Giudice-Tompson that I really am sad to hear about your son. I think you are a very important example of how, when someone is given a drug and dies of an overdose or dies from misuse of the drug, that can happen to anyone. It's not limited to those people, as you said, who we consider to be throwaway people, the people who are marginalized, the people no one seems to care about. It's really important that people understand the nature of how drugs work on the human brain and on the human body, and how they are not respecters of persons. It's important if we're going to deal with this, that we remember that. I want to thank you for pointing that out to us.

I want to thank Dr. Ulan for bringing up drugs other than just opiates and the opioids being prescribed. I want to thank you for bringing up benzodiazepines. I know Don MacPherson brought those up as well. We need to bring in the whole range of drugs: Ritalin, tranquilizers, sedatives, and narcotics of different kinds.

There are so many things we don't know, because we don't have a database. It's clear today—I heard from everybody—that we need a database. I know the provinces have databases and some provinces have good databases and some tracking. I think it's really important, as Dr. Selby said, that we have a federal leadership role in which the federal government coordinates all of this information into one place. This is something that is a federal role, to be a clearing house, to do data gathering, to have some national statistics, pan-Canadian statistics, that will help us to understand the nature of the problem and how it differs in each region, and what other regions are doing that might be helpful.

There's a question I want to ask. It's not a particularly scientific one—or it is a scientific one, actually. Don MacPherson talked about recreational use and prescription use. It is obvious that we have people who use a drug that is prescribed for them because it is necessary for their care, and it's obvious that there are some people who do not have a need for the drug in terms of a physical or mental problem, but they actually have a need for the drug in terms of an addictive problem, so they have a need for the drug per se.

What would you say is the difference between those people who use drugs recreationally and those who use them for prescription reasons and who may or may not become addicted to them, other than the criminal element of it? What are the differences you see in terms of how a federal government or governments should deal with this?

● (1630)

Mr. Donald MacPherson: That's a very tough question, and I wouldn't really use the word “recreational”. Much of the off-label use of opioids could be self-medication. There could be a whole range of reasons that people might be engaged in the non-official market for opioids.

Certainly, if you go from west to east in Canada, and I spend time in Prince Edward Island, almost 100% of prescription opioid use in the east, and in Vancouver, there is still a huge amount of heroin used. As we saw from the data from the U.S., people go back and forth depending on the circumstances. Markets for both illicit use of prescription drugs and illegal drugs use are very active, and there is very much a fluid interchange.

I guess I'm troubled by the term “recreational use”. I think even with the example of Ritalin there is a use; students are using it to sharpen their focus for exams, etc. It's part of the complexity of what we're looking at. It's difficult to come up with one solution. It has to be comprehensive. I do take a little bit of issue with what Dr. Selby said about harm reduction. Many harm reduction programs deal with people who are not in treatment. The Vancouver Police Department overdose response policy of not responding to routine overdose is to try to get people who use drugs to.... It's those sorts of things.

Very few people actually are in a form of addiction treatment. Most people who have addiction problems are not in treatment. There are lots of things we can do for those folks as well as people who are in a pain management who develop addictions as well.

I'm sure that didn't answer your question, but it's a very complicated issue.

Hon. Hedy Fry: Thanks.

No, it's okay, Don. Somebody who was presenting to us had used the term “recreational use”. That's why I used it. I agree with you.

What I hear you saying is that there really is no difference. It is a continuum of use either going back and forth, or whatever, and whatever we do to help is going to have to accept that we can't categorize people into two groups of users. I think that was what I wanted to get out of you, and you did get there. Thank you so much.

On harm reduction, I think that Dr. Selby spoke about harm reduction. I was glad you brought it up. I was a little concerned that you linked it to treatment as Donald MacPherson said, but I wanted to talk a little bit about the whole issue of harm reduction. I noticed that in the “First Do No Harm” document, which uses the word “harm”, treatment is one of the modules, but there is no harm reduction pillar in there. There is just treatment, and harm reduction was missed out. How could you do no harm if you don't reduce harm? I think harm reduction is a key part. Everyone plays politics with this term, and I think it's an important term.

I just wondered what you thought of it being missing from the “First Do No Harm” document. Would you like to expand a little bit on harm reduction?

● (1635)

Dr. Peter Selby: Call it what you will, at the end of the day what we are here for is we want to make sure that Canadians live good, healthy lives, so you want to call it reducing harm while not using the term. The issue is, does the term become divisive, as opposed to integrative. If it is becoming divisive, you'll end up causing more harm by the term itself.

Personally, and I think what we work on is, what the person needs at this point. Whether it's a naloxone overdose or a kit, whether it's a needle exchange, or whether it is actually a reduced risk product or an easier access into treatment, or both, it's exactly, as you said, Ms. Fry, a continuum, and the dichotomy that we've created may inadvertently actually lead to net harm to all of society.

I think we have to use terms and labels appropriately to help further the issue of positive health for people, rather than getting caught up in whether it's harm reduction or not. As we know, these conditions, including addictions, are defined by criteria.

Hon. Hedy Fry: I just think if you leave it out, then you leave it out, and it's going to be left out, period.

The Chair: Okay, good.

Thank you very much.

Mr. Hawn, please, sir.

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

Thank you to all our witnesses for being here.

Dr. Sproule, this one is going to come to you first.

I learned this the other day when I was talking to somebody about the production of tamper-resistant drugs. It's called OxyNEO. It's so hard, apparently, that you can't crush it and snort it. It's not soluble so you can't melt it down and pull it into a syringe and inject it. The pitch was that this would significantly reduce the amount of drugs that are misused, that are gained through legal means but then stolen or somehow mislaid.

Is that technology something we should be looking at, that the pharmaceutical industry should be looking at, and we should be promoting?

Dr. Beth Sproule: In short, yes. I do think that it's one strategy. Again, as we've talked about here, you need to come at this from all the different angles. This doesn't solve the problem because, as has also been said, once you make it either unavailable or less attractive, people may go to something else. But it's the right direction for sure.

There's good evidence from the U.S. For example, the product OxyNEO has been available in the U.S. for several years now; it's still called OxyContin there. There's good evidence through their different monitoring systems that when the formulations switched, there was an overall decline in the attractiveness of the drug and in the abuse rates of the drug. So there is some good evidence to show that it did happen.

I think some people were surprised, though, that the abuse of it didn't go away completely. I think, again, that's where we also need to be thinking that it does reduce one aspect of abuse, which is when people tamper with the drugs and crush them to inject to enhance the high, for example, but a significant proportion of prescription opioid abuse does happen just orally. People take the drug, swallow it, and still get the effects of it.

I think that these tamper-resistant formulations and formulations that put barriers up against the more risky use of crushing them and getting high doses all at once, which increases the risk of overdoses, is good and in the right direction. It's not a whole solution, though.

Hon. Laurie Hawn: I understand, and that wasn't the suggestion. I mean, there is no single measure here that's going to fix this. It's a whole host of things. This is one of them that I don't think we have in Canada at the moment, but it's something we should look at.

● (1640)

Dr. Beth Sproule: Exactly. I agree.

Hon. Laurie Hawn: Thank you.

Detective Harris, you talked about surveillance tools. What surveillance tools are police forces using now in Calgary?

Det Collin Harris: Currently, in regard to drug investigations regarding prescription drug abuse, generally the TPP program, the triplicate prescription program, will usually come on our radar once it's been identified by the College of Physicians and Surgeons.

It all depends on the type of offence that's being conducted. It could be doctor shopping, double doctoring, triplicate pads being stolen from prescribers, or break and enter into residences looking for different types of drugs. It all depends on the type of investigation.

Really, for law enforcement in particular, in regard to coordinating efforts with the College of Physicians and Surgeons and the pharmacists, we're looking at creating a new database in order to share this information. Right now everybody has their own little silos of information, and it's unfortunate that we can't share that information due to privacy laws. If that information were available, we could identify individuals a lot sooner, provide that intervention, and maybe have our law enforcement component act a little bit quicker than before the drugs hit the street. Right now, a lot of times the drugs are already on the street by the time we get to them.

Hon. Laurie Hawn: Thanks for that. I'm pleased to see that Alberta, like British Columbia, has had these programs for a very long time.

Dr. Selby, I think you talked about operationalizing surveillance systems, and that it would be very simple and very cost-effective. What would it take to operationalize those surveillance systems, or did I misunderstand your statement?

Dr. Peter Selby: No, you didn't, actually. We've got some models here on primary care whereby we've been able to deploy very rapidly —like a rapid prototype—the program. It would mean getting the program from the U.S. so that it's on a Canadian server. It would mean being able to have it available within the practices where people go. For anyone coming in for a pain prescription, they would have to go through this model that would assess their risk of abuse or misuse. It would detect any misuse, and then provide the practitioner and the patient with opportunities to make decisions jointly as to what treatment happens.

At the back end, this data, if it's done in enough clinics, as has been shown in the U.S.—in fact it was that model that actually showed when the OxyContin shifts were occurring—when you collate that data, you can very quickly get a sense. If you had this across the country in clinics, you would very quickly get a sense of what problems and trends were going on. You'd be actually integrating your clinical treatments with your data collection, with your analysis. There's benefit to the practice, the patient, the administrators, and the funding decision-makers.

It's a new way of thinking about health care delivery. It's difficult to make inroads like that in Canada, but I think we can with the appropriate supports.

Hon. Laurie Hawn: It challenges 13 different jurisdictions, or 14 if you count the feds.

Doctor Ulan, you talked about the ability of physicians in Alberta to log into a prescription monitoring system. Further to what we said before, any drug can be abused, legal, illegal, medically proper or not. It doesn't matter what it is, it can be abused, so we can't ban every drug that can be abused.

What about an obligation to log into that system for physicians in Alberta or anywhere else?

Dr. Susan Ulan: Currently there isn't an obligation to do it because there may not be any reason to be concerned. If somebody is coming in for antibiotics or you've got a very low risk patient who's on a very small amount of medication, we can't require nor would it be recommended to create barriers to appropriate treating.

This is a tool that many physicians use and it's not just related to medications. Physicians can access X-ray reports. You can actually go and look at the actual film. You can access lab data, surgical reports. It's more than just medications, but if you've got a high risk patient or a patient you're concerned about, one you don't know, you've got the ability to look a little bit further and to just minimize the risk of harm.

I think it would be a problem to obligate physicians, but it's certainly a very useful tool, and often it's a way that physicians pick up on patients that they were unaware were multi-doctoring.

● (1645)

Hon. Laurie Hawn: Thank you.

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

Mr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Mr. Chair. That's much appreciated.

Before I ask witnesses questions, I would like to make a comment. I know that this is not common practice in the committee, but I would still like to send a message to the Conservative members opposite. Earlier, Ms. Adams talked about what the Conservative government had announced in the Speech from the Throne regarding the drug policy's renewal. Since we began our study, the government has not seemed to be open to what I have suggested to all the experts regarding harm reduction, which was the fourth pillar of the National Anti-Drug Strategy before the policy change, in 2007. My colleague Libby Davies suggested the same thing to Dr. Selby and Mr. MacPherson.

Since we began studying this issue, I have clearly seen that health experts want the Government of Canada to reintroduce harm reduction into the drug policy. I really hope that the Conservative government will heed the experts' advice.

Dr. Selby and Mr. MacPherson, thank you for once again reminding us how important it is to include harm reduction in our drug policy.

My next question is for Mr. MacPherson.

[*English*]

You spoke to us in your presentation about the guidelines regarding opiate prescriptions. Could you elaborate on that? What kind of guidelines did you have in mind when you talk about opiate prescription guidelines?

Mr. Donald MacPherson: We're referencing one of the recommendations of the "Do No Harm" document. Clearly that is one of the key areas that needs to be looked at, although it's one of several areas that need to be looked at. We're just promoting the notion that we've taken a very hard evidence-based look at what is the evidence around prescription guidelines internationally, in the U. S. where they clearly are ahead of us in the sense that they have some more experience on this.

I would defer to Dr. Selby in terms of the actual detail of what those guidelines would look like.

[*Translation*]

Mr. Dany Morin: So I invite Dr. Selby to continue.

[*English*]

Dr. Peter Selby: The national opioid use guidelines for chronic non-malignant pain are now housed in the national pain centre at McMaster University, and every national college of physicians was part of it. Work is ongoing in trying to help disseminate and implement this.

The real focus there is how to use opioids safely, how to minimize the harm, how to make sure people are monitored appropriately, advised and educated about the risk, and also know when the medication should not be used and when it should be stopped because it is causing harm. It's not a lack of knowing what to do, it's the actual doing, which is where we are in Canada. We are not doing what we know we should be doing.

[*Translation*]

Mr. Dany Morin: Thank you very much.

[*English*]

Do I still have time?

The Chair: You have a minute and a half.

Mr. Dany Morin: I'm going back to Mr. MacPherson.

In your presentation you also spoke about accidental overdose death and other witnesses also raised that issue. This study is about the abuse of prescribed medication. I noted that in some of those overdose deaths, sometimes it is not accidental, but what can the federal government do to protect people from accidental overdose deaths?

● (1650)

Mr. Donald MacPherson: First of all, the federal government needs to be playing a huge leadership role in education. It comes in under the prevention language in the CCSA document. It's finding a way to show the leadership to make responding to accidental overdose deaths common knowledge in communities in Canada, in families in Canada, that people in families that have someone on a pain medication or addicted to an opioid have access to naloxone. They understand what an overdose looks like. These are things we can talk about forever, and they are not complicated things to do, helping find a way to get naloxone on provincial formularies. In other jurisdictions children have reversed overdose deaths. A simple intramuscular injection of naloxone immediately reverses an overdose.

While we look at the complexity that you've heard today, we could be doing things in communities in Canada in the next few weeks and months to at least begin to prevent or stem the loss of life that's occurring across the country from overdose deaths. In the process we can educate the public at the community level that there are things they can do, they can recognize, and they can help their fellow community members who have severe addictions to opioids.

The Chair: Thank you, Mr. MacPherson.

Mr. Wilks, you have five minutes, please.

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

I have two questions, one for Mr. Selby and Mr. MacPherson and the other for Mr. Harris. I'll ask them both and then get you to respond.

I'm interested in naloxone. In my previous life as a police officer, I've seen what I'll refer to as Narcan provided to people, especially to those overdosed on heroin. Reactions, let's say, can be different from person to person. When we talk about having it provided to a person and/or being able to have a variety of people administer naloxone, I'm just curious to understand, should we be determining the dosages that need to be provided? If you give too much you get a different reaction from what you may be expecting. Certainly, I've watched people get quite agitated, shall we say, and you best get out of their way because they're not really happy with what just happened to them. I would like an answer to that.

Mr. Harris, we heard a witness explain that rural and remote areas have higher rates of prescription opioid drug use than urban areas because there is limited access to comprehensive pain management services, such as physiotherapy and pain management specialists, in the regions. I use rural and urban specific to Alberta. Consequently physicians in these areas may be limited to prescribing opioids to acute and chronic patients. How does the use of prescription drugs vary from region to region, both within and among provinces in Canada? What are the differences, if any, in the rates of misuse and abuse of prescription drugs in rural and urban areas?

I'll start with Mr. Selby and Mr. MacPherson on that question, and then I'll lead to Mr. Harris. We can limit to about a minute and a half, Chair.

Dr. Peter Selby: I want to concur with you. As a physician, I actually have seen that happen. When you've given people Narcan, they wake up.

Here's where we have to manage what the risk is. The issue is that I'd rather have somebody a bit agitated, as opposed to dying. From that perspective, in Ontario we are actually looking at the naloxone program so that it's not only Public Health Canada handing it out. We're trying to work out that at the point where opioids are handed out at the pharmacy level, that's the place where the person is. Can we actually educate the family, whoever is picking up the prescription to take the naloxone?

Much like an EpiPen injection, we need to have that innovation in Canada. Right now, you have to fiddle with the syringe and it dries up. It needs to be cheap, and it needs to be like an EpiPen and you just inject it. I think there's some huge opportunities for Canada to show leadership in this innovation piece of developing products that can be used, similar to an EpiPen, for overdose prevention.

● (1655)

Mr. David Wilks: I'll get back to you in a second. I want to hear Mr. Harris's response, and then I'll get back to you, in case I run out of time.

Thank you.

Det Collin Harris: Thank you for posing the question to me.

You were an RCMP member, so you worked federally, and I, unfortunately, am a muni.

Mr. David Wilks: We won't hold that against you.

Det Collin Harris: Our data is specific to the city of Calgary. I wouldn't be in a position to answer your question as accurately and correctly as I possibly could.

However, Dr. Ulan would be able to provide that information.

Mr. David Wilks: Please.

Dr. Susan Ulan: Our prescription monitoring program data in Alberta has been in place since 1986. About four or five years ago, we developed analytic tools to be able to mine our data, so we can actually create geographic mapping for Alberta.

We can look down to population subzones at the rate of prescribing of a particular medication and compare it to the rest of the province. We can identify hotspots in certain communities. Say we were looking at OxyContin. We could identify the highest prescribing communities, and we could look at how to interact with the physicians, or provide that information to the public health officials in that area so they can look at how to address that.

We are just beginning to use that data. It's available publicly on our website. We're sharing it with government officials so we can work collaboratively to develop initiatives.

Mr. David Wilks: Thank you very much.

Mr. MacPherson, back to you with regard to naloxone.

The Chair: Mr. MacPherson, if you could keep it to a minute or less, that would be great. We're running up against the clock on Mr. Wilks' round.

Thank you.

Mr. Donald MacPherson: Absolutely.

I agree totally with Dr. Selby. Having an agitated person in front of you is much better than having a person who is not alive.

It's great that Ontario is doing their work. The BC Centre for Disease Control is doing a pilot program too. These programs seem to be having some success in reversing a significant number of overdose events.

This hasn't come about really quickly, so we need to figure out how to accelerate the dissemination of this information and get this stuff happening in other provinces. Every day that naloxone is not available, or is only available through ambulance attendants or in emergency wards, is a day we risk losing more lives.

The Chair: Thank you very much.

Ms. Morin, for five minutes, please.

[*Translation*]

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

I want to thank the witnesses for participating in our meeting today.

I have three questions, which I will ask right away, so that you can then answer them.

Ms. Giudice-Tompson, thank you very much for your testimony. I have read the recommendations you sent us. However, you did not talk very much about one of them during your testimony. So I would like to give you an opportunity to do so. I am talking about the third recommendation, which consists of the “abolition of specific marketing practices for prescription drugs with potential for abuse”. Could you elaborate on that?

Ms. Ulan, at the end of your testimony, you requested funding. Can you tell us exactly how much money you want and how you intend to use it?

My last question is for Mr. MacPherson.

At the beginning of your testimony, you talked about why opioid consumption is growing. I thought that was very significant. We are told that there is not much data on that issue. When answering a question from our parliamentary secretary, Ms. Ulan talked about Ritalin. She said that all kinds of people use it—young people, students, and so on.

Is any data currently available on that issue? If we were to conduct a study on the causes, where should we begin? How long would the study take and what kind of a sample would be needed?

I will let you answer. Perhaps you could each take one minute.

● (1700)

[*English*]

Mrs. Ada Giudice-Tompson: I believe you said the third recommendation, correct? That's the abolition of specific marketing practices for prescription drugs with potential for abuse.

In the 1990s, Purdue Pharma conducted a massive campaign. They had the brand name OxyContin, but they promoted the use of opioids. Physicians never prescribed opioids for chronic non-cancer pain prior to this mass marketing campaign. The Federation of State Medical Boards in the United States—and I believe ours here in Canada, in Ottawa, is FMRAC—took all of this information from Purdue Pharma on the promotion of opioids, which was to use them because less than 1% of people would become addicted. This information was totally inaccurate, yet some people still use that language today. It was a massive marketing campaign right across the U.S., and Canada as well, with misinformation.

The marketing from industry to prescribers and to the public has to be curtailed. We need to put almost a firewall between industry and the prescribers and patients, because it was promoted as safe: less than 1% would become addicted and you wouldn't become addicted if you took it for pain. That was all untrue. It was a promotional campaign. People don't realize that, because it comes from your doctor so you think it's safe.

Have I answered your question?

[*Translation*]

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

[*English*]

Dr. Susan Ulan: Thank you for your questions.

My understanding is that you had two parts to this. Number one is what would be required from a funding point of view to support the work. Number two is the issue about the Ritalin and the sampling.

I think the most important thing is to first of all get some good data. There are two elements to that. One is prescription monitoring programs. There's a lot of good work being done in each province, but requiring and encouraging each province and territory to have a way of monitoring what is being prescribed, what is being dispensed, and who is being prescribed medications is critical.

Also, I think we need to learn from each other about initiatives being done in various locations, so that we don't redo and replicate work that has already been done. Creating a network of information regarding prescription monitoring programs is key, I think. That will allow us to mine that data so that we can look at national trends as well as identify the prevalence of medications like Ritalin. Until we have some information on concrete data, it's really difficult to look at why it's occurring when we don't even know how much it is occurring across a province and across the country.

Ms. Isabelle Morin: Do you have an idea of how much money it would cost to do this study? Do you have a number?

Dr. Susan Ulan: I think the more important thing is to look at how much it would cost to put together a surveillance system and to standardize some of the prescription monitoring programs. Some of that work is occurring through the national prescription drug abuse strategy. They have an implementation team, of which I am actually a part, because it's something that I feel very passionate about.

I think one of the important things is to do a cost analysis, to make some decisions about what the priorities are, what key indicators we want to look at, and then to look at how we gather that data to be able to establish some dollars to it.

Until we really identify what it is that we need to have a good system, I think it's very difficult to put in a specific request.

The Chair: Thank you very much.

Thank you, Ms. Morin.

Next up is Mr. Lizon, for five minutes, please.

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

My thanks to all the witnesses who are here with us in the committee room and those on by video conference.

Mr. Chair, first I would allow myself to make a comment to my colleague across. The issue was raised in the Speech from the Throne and I don't think the fact that we're engaged in this study can be viewed by anybody, regardless of their political side, as a negative thing. We are trying to address a very important and serious issue that exists in this country.

I'll be very honest. We've had several meetings on prescription drug abuse, and I have to admit that I'm confused. I understand how complex it is; however, I don't think I understand how extensive it is, and what the full scope of it is. So far, everybody who has come, all the witnesses, have focused on opioids.

Dr. Ulan, thank you for bringing up the other medications that people misuse or abuse.

Opioids are not new on the market. Morphine has been around for 200 years. However, I would assume that the fact opioids are very readily available is part of the problem. There are also current treatments that opioids were previously not used for.

Dr. Ulan, you mentioned that on a per capita basis, Canada is one of the countries where opioids are used the most. Why is that? Do other countries have other forms of treatments? Do people have a different tolerance for pain in other countries? Why do we use the most?

● (1705)

Dr. Susan Ulan: It's a very good question. It's an issue affecting first world countries. It does not happen in second or third world countries.

I completely agree with your reflection and comment that it's related to availability. As medications have become more available and physicians have become more comfortable with prescribing medications, specifically opioids, this increased availability has led to some harm. Yes, people with chronic pain have probably benefited, and many other people have, but there have also been some consequences as a result of that increased availability.

As you've seen from the discussion we've had, it's very difficult to draw a line between misuse and abuse. It's difficult to even collect data that might be relevant across the country.

I agree with you. I think the increased availability and access to medications has fuelled some of the trends that we're seeing right now.

Mr. Wladyslaw Lizon: Was there any research done on what percentage of people treated with opioids get addicted? During the First World War or Second World War, that was the only thing doctors had for the terribly wounded soldiers, if they had enough supply.

Percentage-wise, is there such research? What's the risk?

Dr. Susan Ulan: I think that Dr. Selby would be in a very good position to answer that. I'd suggest posing it to him, if that's okay with the chair.

Mr. Wladyslaw Lizon: Thank you.

Dr. Peter Selby: In Ontario, we have a youth survey of drug use. It has been going on for the last 15 or 20 years, and we're beginning to see the recreational use of opioids come in.

To answer your question about what determines whether people get addicted or not, it's not only availability. There's availability and there's the social norm about the use of it. We know that the drug itself, depending on the type of opioid, will have greater or lesser of what we could call abuse liability. The opioids that come into the system quickly, that can be injected and that leave quickly are the ones people will get into trouble with, because of the abuse liability.

If you want to look at the risk of getting addicted, opioids are less addictive than tobacco and more addictive than marijuana. That's where you would find it on the risk continuum, somewhere in there. Taking a look at prevalence, less than half a per cent of Canadians actually end up with illicit drug use problems, if you look at it compared with other substances. So availability does account for some of it, but it doesn't account for all of it.

● (1710)

The Chair: Thank you very much, Mr. Lizon. Your time has come and gone.

Next up is Mr. Marston, please.

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

I want to start off with Detective Harris, and perhaps Dr. Ulan, and Mr. MacPherson, you might want to come in on this.

I've used this several times in this committee since we first heard about it. Mr. Wallace from our prisons group came here and talked about the fact that 80% of new inmates come to the prison system already addicted or in trouble with medications. It just captured me, because I had a meeting with Chief De Caire, our police chief in Hamilton, and he was practically white the day he talked to me about this new drug, desomorphine, the street name of which is krokodil. We've had other people here talking about it.

When I looked at the mixture, the concoction is codeine mixed with gasoline, paint thinner, iodine, or hydrochloric acid. What's really frightening about this is that it's known as the flesh-eating drug, because the area you inject, you can wind up with a very messy situation. It's also called the “zombie drug”, so today with all the young people caught up in this zombie craze.... Now, people with common sense obviously can separate the fiction, but it's less expensive and far more hazardous than any version of heroin. It's more toxic, and the duration or action, the high, is even much shorter.

How did we reach this point? Is oxy to blame, the fact that it was there and then there's a real effort to pull back on it?

I have a couple of other questions, too. Does this desomorphine have a clinical usage? I can't imagine it does. Is it corporately manufactured, or is this something that's being concocted in some chemical lab in somebody's backyard?

Det Collin Harris: Thank you for the question.

The anecdotal evidence that we have that's currently out there is there have been no reported incidents of krokodil use in Canada.

Mr. Wayne Marston: We had three last week in Niagara. They may have crossed the border from the U.S. I'm not sure. They got treated in our health care system.

Det Collin Harris: I think it's great that individuals are bringing awareness of this drug out there but do we have any evidence? Do we have any concrete evidence that drug has been seized? Where is the information coming from? Is it a third party who is stating that the individual has taken krokodil, or is it from a treatment provider who says that the individual said he had taken it? At this point in time, we haven't seen it.

I think we can almost say the same occurred with bath salts in Canada, where individuals have conducted heinous acts...very similar, where information from the media comes out that bath salts were used, but eventually down the road through analysis, none were ever found.

Mr. Wayne Marston: My information came from our chief of police, and then just last week there was a report in our local newspaper that represents the Niagara area.

Just on the background, does anybody know if this has a clinical usage? Is it something that's manufactured by a firm?

Dr. Susan Ulan: No, it's not.

Mr. Wayne Marston: No. Good. Thank goodness, because I couldn't even begin to imagine how we got to that place. There's been all kinds of...well, bathtub gin poisoned a lot of people in the prohibition era. I just won't ever forget the look on our chief's face when he explained this thing to me.

I'm going to take a brave step here, Giudice...I'm not even close. I'm going to call you Ada. That's much easier.

Mrs. Ada Giudice-Tompson: Perfect.

Mr. Wayne Marston: Anyway, thank you again for being here. I certainly appreciate it. There's nothing like the first-hand story.

Currently, Health Canada is still okaying generic oxycodone. Now there are major efforts in the United States to try to get it off their streets. They've recognized that....

Why are we still approving it? In the paper you gave us, you referred to the sales pitch. They get a lot of this out there. Do you suspect that we've been taken into some degree by that? Our medical professionals are going that way, but even Health Canada?

● (1715)

Mrs. Ada Giudice-Tompson: I believe so, I'm sad to say. Health Canada probably doesn't have the staff, but why do we need all this generic oxycodone when Health Canada has pulled from the formulary OxyContin? They've replaced it with OxyNEO, which is more tamper resistant. However, that doesn't mean it's less addictive. My son never snorted or crushed. He took his medication as prescribed, and he was started on Percocet. He died in his bed at home. The doctor had given him hydromorphone, and by the way, Canada is the top consumer worldwide per person of hydromorphone.

Getting back to your question, they've put out oxycodone generic. It doesn't make any sense to me why someone would do that. I think there are laws that protect patents and other business and economic laws that upstage the patient's safety and the drug safety aspect of it. That's what I've seen from my research across Canada and the U.S. There's been a lot of misinformation given to Health Canada. If you followed the lawsuits, they paint a picture for us, for Paxil, for Ritalin, for all of them, especially with Purdue Pharma. They were charged in 2007. They pleaded guilty, and yet we still have their products.

Why do we need so many opioids? We've been talking about monitoring, and databases, and naloxone. These are all great, but these are after the fact. We want to be preventing this harm. Our doctors have to have the information up front. These are life or death decisions. My son didn't have to die. This was just a big marketing scam, and it continues that way.

I'm sorry. I gave you a long-winded answer, but there's a lot of information on that.

The Chair: Thank you.

Mr. Dreeshen, please.

Mr. Earl Dreeshen (Red Deer, CPC): Thank you very much, Mr. Chair, and to our witnesses, thank you for being here today.

To Mrs. Giudice-Tompson, thank you for giving us the testimony that you did today. Your last answer spoke volumes. Thank you very much for that.

I have a couple of other things.

Dr. Selby, you had talked about remote areas and the pain management procedures that would be perhaps taken in those locations. One of the things we heard a few days ago was that it would be more likely that they would use opioids in their prescriptions. I didn't see that as tying into what you had said. I think the reason they gave was that you wouldn't have a lot of these other auxiliary-type health services that would be there.

I'm wondering if you could clear that part up as we move on.

Dr. Peter Selby: Yes. That's exactly right. People end up resorting to using medicines or pain medication like opioids in the belief that this will fix the problem, and they don't have access to covered services like physiotherapy, massages, or relaxation. There are those kinds of issues, and they then resort to opioids because that becomes the easy, magic bullet solution available to them.

There's this whole issue of inequity around health care services availability in general, where people who have private insurance, for example, and are living in urban areas can access those services, whereas if you go further north they become less available. Medications, especially opioids, become the magic bullet that everybody gravitates to for management of their pain. As we've heard before, the chronic use of opioids in some situations can actually worsen the pain. We have to use it judiciously in doses that make sense, and it's not for everybody.

Mr. Earl Dreeshen: Thank you very much.

To Dr. Ulan, I've gone through some of your terms of reference for CoOPDM. This is something that Mr. Harris had spoken about, so I'll just touch on a couple of aspects of that.

I know that you're reviewing and understanding the determinants, the context, and the effect of prescription drug misuse in Alberta. As an Albertan, I was just wondering if you could go through some of those things. Also, part of your mandate was to create a model to demonstrate how the health care community, law enforcement, and the provincial and federal governments should be able to work together. This is what you started back in 2008. I'm just wondering if you could tell us a little bit about the progress that you've had in that scope within your mandate.

● (1720)

Dr. Susan Ulan: Thank you, and I'm happy to answer that.

Initially, our work began as information and data gathering from groups with lived experience in high risk areas and the focus group information from treating professionals and front-line workers. What we recognized at that time was there wasn't a lot of leadership more locally within our province, and so we held a symposium in March 2010. We brought key stakeholders, decision-makers, and leaders together. The Bruketa family was there. They were our first speakers and discussed what happened.

We really got the attention of the chief medical officer of health, who recognized this was an issue that was having a profound impact and it wasn't currently on the radar as a significant public health and safety issue in Alberta. I think that was a key measurement of success.

In order to quantify things, we have since moved forward in looking at what kind of data we have in Alberta. We engaged, first, literature review, looking at different surveillance systems around Canada and in other countries. We also had a group called OKAKI Health Intelligence. We contracted them to interview key stakeholders who had data in Alberta, so the chief medical examiner, the College of Physicians and Surgeons. We looked at the Alberta College of Pharmacists, Alberta Health, Alberta Health Services, and law enforcement.

We looked at what kind of data was being collected, what that data was being used for, and whether or not that data was being shared with other organizations, and we saw large gaps. There is good data, but it's not being utilized effectively. That was another key thing. We're moving forward with that, because we now are engaged in working in Alberta to establish a governance model that will include the groups that are at the table of CoOPDM. We're looking at how front-line workers and how law enforcement, physicians, pharmacists, patient groups, nurses, and service delivery, like addiction treatments, can actually work together more collaboratively to influence and minimize the risk of harm.

The Chair: Thank you very much.

Your time is up, Mr. Dreeshen.

Mr. Aspin, for five minutes, please.

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

Thanks to our guests for coming and helping us with this study.

Particularly you, Mrs. Giudice-Tompson, thank you. You're a brave woman and we're certainly going to gain from your courage.

My first question would be for you. You've listed several recommendations here and I'd like to focus on your second recommendation to establish a multi-disciplinary, expert level, ministerial committee. Maybe you could describe or outline it for us. It's basically to assist Health Canada's regulatory process. Could you talk a bit about that and paint a picture for us of what you envision?

Mrs. Ada Giudice-Tompson: What I was envisioning was that we have a group of experts who assist Health Canada. Right now what happens is there are clinical trials conducted by drug companies, and Health Canada accepts that information as gospel. We really don't get to see the harm or the effects of that medication until it's used by the public. We're really the guinea pigs.

In this recommendation I was hoping that we could get some experts from all the different medical fields and also people with lived experience and family, who could assist before the approval of a drug. We need more scrutiny of these drugs before they go to market. If we talk about prevention, prevention has to start at the beginning. No prescriber with all the tools that they have, all the resources that they have—there's an opioid risk tool, there are the prescribing guidelines across Canada but they reflect a lot of information that came from industry, from drug companies. We need to remove that somewhat. We need to have people at the table who have the expertise, the researchers who can say "No. This is what will happen." We cannot rely solely on someone who makes a product to tell you when and how to use it.

Prescribers don't have the power over addiction. Patients don't have that power. A doctor can't look at you and say, "Fill out this questionnaire. I think this is a good opioid risk tool. You're low risk so I'm going to give you these opioids", or "You're high risk and I'll give you these opioids." All the monitoring in the world isn't going to prevent the addiction. Addiction is a progressive, worsening, sometimes fatal disease. We have to prevent it, not talk about all these issues that are more reactionary.

The monitoring programs are great. Naloxone, sure it's great. I wish I had it; I could have administered the drug to my son. Those are all reactionary. We have to go to the initial preventative, proactive way. Tell a patient what the drug is. But a doctor can't tell me what it is, and they didn't by the way. They prescribed it to my son for pain when we left emergency, because he had renal colic kidney stones, and look what happened to him. It was prescribed legitimately. There's this false dichotomy I speak about as well. They don't have to abuse it.

We need the controls to assist Health Canada with what these drugs actually are. Look at the molecular structure of heroin. Look at oxycodone. They have the same effects on the brain, on the mind, and on the body. We shouldn't be surprised that people are dying, and whether it's one person or 5,000 people, we don't need all these statistics. We should be able to do something now.

● (1725)

Mr. Jay Aspin: Thank you. That seems like a key recommendation to me.

I have a second question, Chair, if I have some time.

The Chair: Just for you, Mr. Aspin, we'll allocate you an extra minute, sir.

Mr. Jay Aspin: Detective Harris and Dr. Ulan, according to your group, to address prescription drug misuse or abuse there is a need to eliminate scientifically unsupported, unethical, marketing business practices of pharmaceutical companies.

In your view do the marketing and business practices of pharmaceutical companies contribute to prescription drug misuse or abuse in Canada?

Dr. Susan Ulan: I actually don't think that's one of our recommendations. I'm wondering if that's more Ada's recommendation from her group.

Mr. Jay Aspin: Maybe to you then...?

Mrs. Ada Giudice-Tompson: I really believe we need a firewall between industry and what prescribers are told. We cannot take at face value what they tell us about the drug.

Mr. Jay Aspin: Would you see this as an advisory group of experts?

Mrs. Ada Giudice-Tompson: Yes.

Mr. Jay Aspin: Thanks, Mr. Chair.

The Chair: Thank you very much. We're right up against the clock again.

I want to thank all of our witnesses who have taken the time today to provide great insight into our study and the report that hopefully will come out of it.

We'll see everybody on Monday.

For the committee, I mentioned that we were going to do a little thing some evening. After the meeting on Monday, we'll have it in the meeting room. We don't want everybody to have to move around. If everybody could make a note of that in their calendar, that would be great. If you can make it, that's great.

We have our Christmas party tonight, so I have to go back quickly and get my hair fixed up for the event.

I hope everybody has a safe and good evening.

The meeting is adjourned.

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