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Chair

Mr. Ben Lobb

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● (1535)

[*English*]

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

We have another busy meeting here. This afternoon we have four different groups and organizations presenting. We'll do what seemed to work well the last number of meetings. We'll have the individuals and groups here via video conferencing go first, and then we'll have the people who are here in person go next.

Just to get a little bit of housekeeping out of the way before we start this afternoon, this is our second-last meeting for 2013. In the spirit of Christmas or anything else you celebrate at this time of the year, we have a bit of wine from the good riding of Huron—Bruce. After the meeting, if anyone would like to have a test run, there's some wine back there. It will be available until the votes. We will have to go and vote, and then anybody who's left here can finish it off, I guess, if they want to.

Without further ado, let's start with Mr. Buckley from McMaster University.

Go ahead, sir.

Dr. Norman Buckley (Professor and Chair, National Pain Centre, McMaster University): Thanks very much. Are we all set?

The Chair: Yes. Go ahead, sir.

Dr. Norman Buckley: Thanks very much for the opportunity to appear today.

My name is Norm Buckley. I'm a professor and chair of the Department of Anesthesia at the Michael G. DeGroote School of Medicine at McMaster University. I also serve as director of the National Pain Centre at McMaster University, an endowed centre with the mission and vision to support best-practice pain management through the dissemination and creation of guidelines for care.

We currently hold the copyright for, and have agreed to disseminate and update, the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*, affectionately called “the Canadian opioid guideline”.

I'm also chair of the Canadian Pain Society's special interest group on education. I co-lead, with Professor David Mock of the University of Toronto's school of dentistry, the Canadian Centre on Substance Abuse implementation group for education as part of the First Do No Harm strategy on the issue of misuse and abuse of prescription medications. During the development of the CCSA strategy, I chaired the expert advisory committee on education.

These affiliations notwithstanding, my appearance here today is not as the representative of any of these organizations. I'm appearing at your request. The leaders of these groups are aware that I will be appearing, but they are not in any way responsible for my opinions or my responses. My dean has some mild anxiety about my appearance here, but he's a very brave individual.

My disclosure statement follows in two parts: fiscal and belief.

From the fiscal standpoint, I'm a physician who derives the largest part of his income from fee-for-service clinical earnings. I receive an administrative stipend as chair of the Department of Anesthesia and earnings for academic activities supported by the Hamilton Academic Health Sciences Organization alternate funding plan. I provide some medical legal opinions and I also engage in consulting through a consulting organization, as well as consulting for two provincial health committees.

I carry out research that is funded by a number of sources, including pharmaceutical companies, although funding from peer review sources, such as the Canadian Institutes of Health Research and the Heart and Stroke Foundation of Ontario, exceeds industry funding substantially. Research funding is on a cost recovery basis, and I do not receive income for carrying out research except through the alternate funding plan. In particular, I do not receive income for research from industry.

I have received speakers' fees from a variety of organizations, including industry, medical, legal, and other professional societies.

Since the problem of finding a solution for prescription drug misuse is complicated by issues to do with belief, clinical perspective, and a variety of other issues, it is probably of greater interest to know my beliefs and my clinical perspective. I come from the position of a clinical practitioner in pain management. My patient population is the patient with acute pain or chronic pain, a problem that continues to be poorly understood and a topic that is very poorly taught and treated in our health care professional training programs. Some of these patients also present with mental health disorders, including mood disorders and addiction.

Given the proportion of Canadian population that suffers now and is likely to suffer in the future with pain, and the impact of that suffering on the health care, social, and economic systems, it is my belief that there must be a dramatic change in the function of the Canadian health care system to provide rapid access to appropriate treatment, including early assessment and treatment, with active intervention and physical rehabilitation and psychological treatment as the situation dictates.

The problem of prescription drug abuse seems to be several different things, perhaps depending upon perspective. Selling of prescription medications or diversion of prescription medications into the recreational or abusive sphere for money strikes me as being theft or fraud, and should be treated as such.

The epidemiology of crime is outside my purview today, so I will not comment upon the magnitude of this element, except to say that law enforcement is the appropriate source of information in this regard. Part of the solution may be found in improving communication between health care providers and law enforcement and improving understanding of each other's goals while recognizing that health care professionals are not the police and law enforcement is not health care. There does need to be collaboration.

Use of prescription medications by the addicted patient to meet the demands of their addiction represents addictive behaviour, which is a medical condition. Again, I'm not an expert in this field, and I will limit my comments on this topic, but medical conditions should be identified as such, and treated appropriately. According to Health Canada, behaviours that represent addiction are present in approximately 10% of the population. Since pain is present in approximately 12% to 20% of the population, depending on the study you look at, one would expect a certain amount of crossover amongst these groups. This creates a complicated clinical situation if an abused medication is otherwise appropriate for a pain condition.

The patient who buys medication on the street or borrows medication from a family member or friend because he or she has an untreated pain problem or an undertreated pain problem seems to represent a failure of appropriate medical care, and it should be treated as such.

● (1540)

Prescribing of medications by physicians is a professional practice issue. When this occurs for inappropriate indications, in inappropriate doses, or in an incautious fashion, which may tacitly permit diversion or abuse, this should be amenable to educational and administrative interventions if the appropriate data-gathering tools are in place and directed interventions are undertaken.

When a physician fails to prescribe when appropriate or fails to offer treatment because he or she does not have the knowledge to treat, this should be addressed by directed educational activity. When patients die because they have combined the prescription medication with other intoxicants, intentionally or by accident, this is a tragedy. When it is the result of inability to gain access to appropriate treatment for mood disorders, addiction, or pain, it is a failure of the health care system, and should be treated as such.

There are several models of successful community interventions to address local cultures of prescription drug abuse and diversion. These have been reported elsewhere, but include Project Lazarus from the United States and a community action in Inverness, Nova Scotia.

Lazarus is a broad-based community intervention, which includes physician practice education, community education about pain and addiction, distribution of narcotic antagonists to make emergency treatment of overdoses in their early state possible, law enforcement involvement to address diversion issues, and availability of pain and addiction treatment programs. This program resulted in a dramatic reduction in unintentional death due to overdose and a reduction in diversion and abuse of prescription medications, while not reducing the prescribing of opioid pain medications for patients requiring these. It is noted in passing that the diversion behaviour seems to have translated itself to neighbouring communities, but this does not in any way negate the demonstration of the effective program.

In Inverness a small medical community undertook to implement a pain-management practice guided by the Canadian opioid guideline and to engage the entire community, including pharmacy, law enforcement, and other health care professionals. The result was a dramatic change in prescribing practice; no loss of capacity to treat patients with pain problems, within the context of the guidelines; and a significant reduction in diversion-related health care interactions and criminal activity.

My own observation, from attending several years of meetings having to do with prescription drug misuse and hearing of interventions that have been undertaken, is that one of the common characteristics of communities facing problems having to do with drug misuse is the disruption of the social fabric of that community, or disruption of the social structures in which the drug-abusing individuals function. Returning communities to a functional state seems to be a necessary element of successfully addressing the problem.

Earlier today I forwarded three editorials by Dr. Mary Lynch, past president of the Canadian Pain Society and co-leader of the Canadian Pain Society's national strategy on pain. My goal is to make the case that improving pain education and establishing an understanding of the appropriate response to patients with pain problems can, to a large extent, address problems of prescription drug misuse by providing care that can limit the inappropriate prescribing of medications that may become diverted and/or abused. If pain is appropriately treated, then the patient who seeks out analgesics because his or her pain is not being treated will no longer need to do so. Addiction is a separate medical problem, which also needs to be addressed through appropriate diagnosis and treatment.

Acute pain typically occurs as a result of the reaction to an injury or a metabolic or inflammatory process. This can occur from a variety of sources, including trauma, surgery, arthritis, metabolic disorders such as diabetes, infections such as shingles, the direct effect of cancer or an effect of surgery, radiotherapy or chemotherapy to treat cancer, peripheral nerve injuries due to trauma, central nervous system injuries due to spinal cord injury or stroke, and a variety of other causes.

A great deal is known about the treatment of acute pain, and effective treatments exist that can significantly reduce pain and support recovery. Some pain resolves spontaneously as the underlying disorder is treated, but some does not. Despite knowledge of the physiology and treatment of pain, it is still the case that within our acute care health systems, patients often experience moderate to severe pain. That is pain that can delay recovery or contribute to additional morbidities such as cardiac events, sleep disturbance, and delayed activation and discharge. This can occur up to 75% of the time following surgery for the first few days. In some patients, up to 30% of them, this can persist for as long as three months or more after surgery.

● (1545)

It is possible to do considerably better than this with appropriate education and implementation of treatment systems. Since poorly treated acute pain is one of the predictors of the development of chronic pain, improved treatment is a necessary goal.

Chronic pain states are in some ways analogous to mental health problems, because they are frequently subjective and not immediately apparent to the external observer. They are even less well understood and treated than acute pain states. Its simplest definition is that it occurs when pain has persisted for more than three months, or after the expected resolution of the triggering injury or illness.

Chronic pain interacts with the underlying psychological makeup of the patient and their social situation, to have a behavioural impact that extends beyond the sphere of physical or biological injury. This relationship is well described by a conceptual model referred to as the biopsychosocial model of pain.

The Chair: Excuse me, Mr. Buckley.

We're over 10 minutes here. How much more do you have before you conclude?

Dr. Norman Buckley: My apologies. I think the simplest thing to do would be to conclude by saying that a variety of issues have to do with chronic pain treatment.

A lot of the issues have to do with the ability to provide appropriate care, which is currently possible in some situations and in some areas, but not in others. A great deal has to do with providing appropriate pain care, which will go a long way towards addressing many of the problems of prescription drug misuse.

I think that's the simplest and most concise statement.

The Chair: Very good. Thank you very much.

As the meeting continues, I'm sure many of the colleagues around the table will ask you questions that maybe you didn't have time to address in your opening remarks.

Dr. Norman Buckley: You mean I get a chance to use the rest of the brilliant speech?

Voices: Oh, oh!

The Chair: Well, you could hand it over to Ms. Cooper, if you like, and she could finish it off, but....

Ms. Cooper, you have 10 minutes, please.

Ms. Lynn Cooper (President, Canadian Pain Coalition): Good afternoon, Mr. Chair, and esteemed committee members.

This is the third time I have presented before this committee on pain issues, representing the Canadian Pain Coalition. The CPC is a partnership of people living with pain, pain organizations, health organizations, health professionals treating people in pain, and scientists looking for better ways of managing pain.

Our primary goal is to promote the sustained improvement in the understanding, treatment, management, and prevention of all types of pain in Canada, and we do this through our national awareness initiatives. We provide education for individuals living with pain, and we advocate for improved pain management.

The Canadian Pain Coalition commends the Standing Committee on Health for undertaking its study into the extremely serious issue of prescription medication abuse in Canada. The CPC is confident that in its recommendations this committee will strongly balance providing appropriate pain management for Canadians with reducing risks and devastating harm from prescription drug abuse and deliberate misuse. CPC's role in this discussion is to provide the person-with-pain perspective, and highlight for your consideration who is affected by pain, the burden of pain, and what Canadians need for effective pain management, which often includes the use of prescription pain medication.

The CPC is committed to working towards determining and implementing solutions to these problems. Canadian research reveals that under-managed pain is in epidemic proportion in Canada. Those affected include one in five, or almost seven million Canadian adults, including our veterans. One in five Canadian children have weekly or more frequent chronic pain like headaches or stomach aches. There are 5% to 8% of our children and teenagers who suffer from chronic pain severe enough that it interferes with school work, social development, and physical activity. All people associated with the individual living with pain are impacted, with the greatest devastation most common in families. Among these populations are individuals who may develop or who are currently living with the disease of addiction.

The burden of pain is staggering. Pain costs Canada an estimated $56 billion to $60 billion annually in lost productivity and health care costs. Costs for individuals like me are approximately $17,000 each year in lost income and out-of-pocket expenses for treatment modalities that are not covered.

The stigma of being labelled as malingerers, drug seekers, druggies, and pushers is denigrating and disempowering. The backlash continues to grow, creating fear of taking medications that could reduce pain and improve functioning as part of a well-rounded pain management plan. Misunderstandings about pain, like the difference between addiction and physical dependence on a medication, fuel fear of becoming addicted to pain medications. This negatively impacts compliance in taking prescriptions, or accepting prescriptions that could reduce pain.

Chronic pain happens to average, honest people, to someone you know, to someone you love, to someone who looks like me. This disease negatively impacts every aspect of a person's family, work, social, school, personal, and spiritual life. It dramatically reduces our quality of life and well-being. At the very least, living with under-managed pain is devastating and demoralizing. At its worst it is depressing, disabling, and dehumanizing. It can turn deadly, as research tells us that people with pain have double the risk of suicide compared to those without chronic pain.

● (1550)

The burden of pain is overwhelming and likewise is the need for effective, best-practice, multidisciplinary pain management, which is not provided by Canadian health systems. We have the knowledge and we have the technology, but we cannot get it to the patient within the current structures. For instance, physician visits are covered, while access to other pain-relieving modalities, such as physiotherapy, occupational therapy, and psychology are dependent upon having extended health benefits or the ability to pay. Many Canadians with chronic pain have neither. As a result, there is a heavy reliance on prescribed medication as treatment for chronic pain, while research has revealed that pain relief may be as little as 30%.

When their pain is not managed, individuals return to their doctors, such as Dr. Buckley, who may decide to provide other or stronger medication. Again, the relief provided is not enough.

Many Canadians believe that pain medication is their only option. A CPC 2010 survey revealed that 45% of people suffering moderate to severe chronic pain believed that there was nothing that could help them with their pain. Out of desperation, the person may use more medication than prescribed, or they may combine over-the-counter medications with their prescription. A dangerous vicious cycle can develop. People can encounter that slippery slope, which no one intends to happen, unless awareness and accessibility of other management options are made available. Sadly, some individuals take their own lives with the very medication that they expected would relieve their pain. This happening to one person is one too many. Sadly, I know of many.

Experience shows us that effective pain management occurs when a personalized combination of health care modalities are working in concert with learned coping strategies, the person's knowledge of their chronic pain condition, an attitude shift, and lifestyle adaptation. People will experience an increase in their quality of life, their productivity, and their functioning when all the pieces of a pain plan are working together.

Of key importance to this inquiry is the fact that, based on each person's success, pain medication dosages are often used more effectively or may be reduced. Length of reliance on medications may also be reduced or even eliminated as other pain strategies are successfully integrated into one's lifestyle.

Canadians living in pain require timely and best practice delivery of acute pain and chronic pain treatment within our health systems. We need health professionals who receive standardized training in effective pain management and who are supported to subscribe and monitor appropriate medications for individuals with and without the disease of addiction. We need them to be using best practice guidelines.

Individuals with pain require the widest variety of prescription medications for their pain, because a medication that provides relief for one individual may not work for another. As well, combining medications with different mechanisms has been shown to dramatically reduce pain.

People with pain require improved pain education opportunities so that we can make informed decisions, take responsibility for becoming actively involved in our pain management, and feel equipped to create a pain plan and to work our pain plan every day. This education would include the benefits, risks, and realities of taking prescription medications for pain, as well as prescription safety to prevent harm to others. We can get involved in that. The public education and working group of the national faculty associated with the DeGroote National Pain Centre and the Canadian Pain Coalition have created just such materials for people living with pain.

● (1555)

Medications play a key role in chronic pain management for Canadians. A balance must be struck to provide access to medications within a well-rounded pain plan while ensuring protection against potential harm for the patient and others. This is not a simple task, but one that is necessary for the well-being of all Canadians.

The 2012 national pain strategy for Canada, a document that CPC helped to create and launch, and best practice guidelines—

The Chair: I'm sorry to interrupt you, Ms. Cooper. Are you close to concluding your opening remarks?

Ms. Lynn Cooper: Yes, I am.

The Chair: Okay. Briefly, please.

Ms. Lynn Cooper: What I would like to finish with is that we need to utilize awareness programs and best practice guidelines, and consult with pain experts and addiction experts. We need a federal government-led initiative that would ensure uptake of these valuable resources and set the tone for responsible, respectful treatment of chronic pain while protecting Canadians.

I would like to tell you that the Canadian Pain Coalition is committed to working with you to establish solutions.

Thank you.

● (1600)

The Chair: Thank you very much.

The next witness we will hear from this afternoon is Ms. DeGroote of the Wellbeing Pain Management and Dependency Clinic.

Ms. DeGroote, you have 10 minutes, please.

Mrs. Peggi DeGroote (Founder and President, Wellbeings Pain Management & Dependency Clinic Inc.): Thank you, Mr. Lobb, and congratulations on your appointment as chair.

Welcome to the committee members as well.

Thank you very much for inviting me this afternoon to be part of this experience and to share with you my knowledge and my passion for addressing the needs of patients in light of prescription drug use and pain management.

Just over five years ago, I was challenged to become a volunteer in a methadone clinic. I had never given any thought to working with those people before, but it changed my life. I knew that changes needed to be made to the model that existed for methadone treatment for addiction, and my master's was in decision-making modelling, and I came up with a new model just over five years ago. It was a multidisciplinary best practice evidence-based model.

In September 2010 when the CPSO came out with their recommendations in their "Avoiding Abuse, Achieving a Balance" paper, I felt vindicated that in fact what we were doing was of benefit and could be taken to a larger model, not just in my own little community, but to other communities around.

There was a 2007 task force report that was written on methadone that stated that there were four under-serviced areas in Ontario, and Halton, where I lived, was one of them. I couldn't believe that people in Halton, which seemed to be an upscale kind of place, would not be able to get the kind of medical care they needed and deserved.

So I birthed Wellbeings and built it on a *Field of Dreams* kind of vision: build it and they will come, and they did come. It wasn't without a lot of fanfare at the beginning because I was almost publicly lynched in 2008 and 2009 when people said, "You're not bringing those addicts to our area, we don't want those people in our community." Little did they know that they are, as Ms. Cooper says, your mothers, your fathers, your kids, your aunts, and your uncles. They are just regular people we know who have to cope on a daily basis with living in pain and who might suffer from addiction, and as a result they may also have mental health issues.

I have assembled a slide presentation that you can see behind you if you like, and there is also a set of notes there as well. I thank very much Marc-Olivier who helped me to do the French translations for everything. Thank you very much.

If you have any questions afterwards or later on, please feel free to ask me. I'd be happy to answer them.

We have two Wellbeing clinics presently, one in Hamilton and one in Burlington, and we hope to be opening a third very soon in January, because we have over a one-year wait-list now for people who suffer in pain. We're actually on the short end in the Hamilton area for people to get some help within a year as opposed to other funded hospitals where people can wait several years to get help.

In terms of addictions, the physicians who work in Wellbeings clinics see people within 24 to 48 hours. Sometimes we see people who just walk in the door. Our model is not that of a walk-in clinic, but if somebody walks in and there's a doctor available, they will get the help and the attention they need because we do know from the addiction side of the model that when people are in that pre-contemplative mode, when they know today is the day they really need help and they come and ask for it, you can't turn them away. You can't say you'll see them in three weeks' time because it may be too late in three weeks' time.

The physicians who work in our clinic are remunerated by OHIP. The clinic is funded by moneys the doctors pay to me—a percentage to me—and is also funded as part of my philanthropic entrepreneurialism, because the model that exists in Ontario does not fully fund a best practice evidence-based model, unfortunately.

I have been working and trying to bring it to that level. I'm happy to report that last year we helped over 1,100 families, and I think we're actually saving the Ontario government tens of millions or hundreds of millions of dollars. I've asked just for a percentage of that so we can roll this out in lots of other communities, but we know it's really making a significant difference in people's lives.

The analogy I'd like to make to you about addiction and mental health is one where people shouldn't have to let others know why they are going to see their doctor. People should be able to go and see their physician in a private atmosphere, in one of respect, and one where they are well treated, and there's compassion and good clinical management.

● (1605)

As a result of that, I thought to myself that if I were to open an erectile dysfunction clinic, and I hung a big shingle outside that said "Erectile Dysfunction", I don't know how long I would have to wait for people to walk in my door, but I could imagine that it would take an awfully long time. Erectile dysfunction is one of the symptoms we have as part of addiction because when people are addicted, they find they are not able to have sexual relations.

But nobody should know why you go to see your doctor. When people walk into the Wellbeings model, they could have just hurt their shoulder and they're coming in for a pain treatment. It could be that they're coming to see the psychiatrist or the addiction doctor as well. We have people who come on a Thursday when all three areas are covered, as well as having our case manager who is a local RN who was given to us from the ADAPT program. A person could literally spend hours there seeing all the people they need to see. We hope to be able to get people functional again, get them out of pain, first of all, so we can work on titrating their medications to lower what they're taking or get them off everything, and to make sure they have a good outcome in their mental capacities as well.

Imagine if you were hurt in a car accident five years ago and you're still suffering and you can no longer go to work and your wife is on your case because you're not bringing in any money and your mortgage is due and your car payments aren't being made. It can be overwhelming for people and they need help in all these areas. Those are the areas we have to help them in.

I saw that Dr. Buckley gave his disclosures, and I'll give one now and another in a few minutes. One is that I receive no remuneration whatsoever from this. My work there is completely voluntary. My staff are amazing because, first of all, they haven't gotten a raise in five years—because my CFO says I can't give them one and she knows what the money situation is—and second, because we have a group of people who care passionately about helping others and want to make the model work. So to that end, I have to give a lot of credit as well to the people who work in this model. We're a kind of Doctors Without Borders, except we're local. This is happening in our community.

I really want to be the Maytag repairman. I want to have no one who suffers from pain. I want no one to have any addiction issues, and I don't want anyone to have to have any mental issues whatsoever. So our model works as a success model when nobody gets to come to us anymore.

One thing I'd like to talk about in terms of a national strategy for pain and addictions is the work of the CCSA and the Canadian Pain Society. They both have national strategies, and I know you've heard from other members before. I've read your minutes, so I'm not going to spend any time on this. I just want to emphasize that you should keep up the good work and ensure that we have national strategies for pain and addiction. You have endorsed national strategies for cancer as well as mental health, and I will tell you that pain and addiction are inextricably interwoven with cancer and mental health. They can't be separated. So please give serious consideration to your continued funding of the CCSA and the Canadian Pain Society in developing a national strategy. We can be world leaders here, and I think it behooves us all to do what we can for people in our community.

The International Association for the Study of Pain came out with a statement in 2011 that said that access to pain management is a fundamental human right, and it is. There are no cookie cutter solutions for people. If you have 100 different people you could have 100 different solutions for their pain management, for their addictions. We see a lot of polysubstance abuse in addictions. So it may be that there is an opioid addiction—which is the reason a person may come to Wellbeings, because we really only focus on opioid addiction—but we also find in urine drug screens things like cocaine and alcohol and THC, and all kinds of other things. There's a whole lot of things that people will do for self-medication because they're in pain in most cases, and whether that's a mental pain or a physical pain—because they all come out in somewhat the same manner lots of times—we need to help them get well.

The most important thing here, I think, is that patients need timely access to care. Imagine that you hurt yourself and your body should heal itself in a month or so but it doesn't and it continues to get worse. Say you were in a car accident and six months or a year down the road, you're still suffering in pain. You can no longer go back to work. You can't do these things.

● (1610)

Are we surprised that people are addicted to the pain medications that their physicians wrote for them and continue to titrate up because the pain medication no longer seems to do the job? The pain got worse. I'm not blaming physicians. We need to work together to make sure that people have timely access to care. Ms. Cooper mentioned that as well.

Government decisions on health funding should be driven by science and reasoning, not by scare tactics and community uproar. Opioids can be effective pain relievers for some period of time for some people who have chronic pain, but there are lots of alternative things that need to be done as well. The other thing that we do at Wellbeing are trigger point injections. A physician receives $8.85 for each trigger point injection and is restricted to doing four as a maximum.

For example, I may have an anaesthesiologist who's doing pain management, and a patient may go in for 20 minutes and get four injections . That's four times $8.85. Physicians should be well remunerated for what they do. If there is a simple and elegant solution to a problem like a trigger point injection, we should use it. We should be looking at the easiest ways to treat things first.

Our first medical director did a study on knee replacements out of Queens University, and 55% of the people, after receiving pain treatments, did not get their knees replaced. The people really only wanted to get rid of the pain. They didn't want new knees. They just wanted to be out of the pain. There are things we can do, but the model that exists right now may not support that. It takes a lot $8.85 injections.

The Chair: Excuse me, Ms. DeGroote. We're up against the clock here again. Is there a chance you could just summarize in 30 seconds or less?

Mrs. Peggi DeGroote: Absolutely. There are solutions that address the issues of misuse and diversion. Dr. Buckley talked about Project Lazarus. We don't necessarily need to decrease the opioid prescriptions to decrease opioid deaths.

There needs to be evidence-based research for alternative, effective, and low-cost treatments for pain. We need to accept that this is a community problem; it's not just a medical problem. We need to get people involved through education. We need strategies to take leftover medications back in drug take-back programs. That's huge. You heard about that in your last meeting. We need better national data in order to plan targeted approaches to medication misuse, and patients need timely access to care in their local communities.

These are the faces of why we do the work we do. A young man passed away from an opioid overdose in Oakville. Two months later, a friend of his passed away from opioid overdose. They had not been doing anything for quite some time, but their tolerance levels changed. They went back one time only to try what they had done before, and they no longer are with us.

We need to help these kids. They're the targets where we can make a difference, just like when we had our seat-belt rules 30 years ago. None of us wore seat belts before. We need to go back and make sure that people keep things safe. Each of you today will get a medication lock-box. It's critical. We lock medications up in a pharmacy. Then we take them home. Our Ontario Student Drug Use and Health Survey, which CAMH will present on Wednesday, indicates that 20% of kids misuse medication drugs that were legally prescribed to their aunt, uncle, grandmother, or father. We need to make sure that those kids don't get addicted. We need to keep things safe.

I hope you'll safely store your things at home. We'll make a change. It'll take us awhile, but we can get there.

The Chair: Thank you.

The last presenter for this afternoon is Dr. Bromley from the Narcotics Advisory Board. You have 10 minutes

Dr. Lisa Bromley (Physician, Ontario Ministry of Health and Long-Term Care, Narcotics Advisory Board): Thank you. I'll strive to stay within that limitation.

● (1615)

[*Translation*]

Ladies and gentlemen, honourable members, it is an honour and a privilege to be invited to speak to you today. Thank you for this opportunity. I also want to thank Marc-Olivier Girard for arranging for me to come here today.

[*English*]

I am a Canadian born in the 1960s. In my lifetime I have been witness to Canada making really huge strides in so many domains in our society in combating and rejecting stigma, discrimination, and hate, and I think this is a defining feature of our country and it makes me really proud to call myself Canadian.

Of course, where I am going with this is that there is still an area where we need improvement. There's a group of people that still need our understanding and compassion. In our society, hospitals, medical clinics, and criminal justice system it is still okay to denigrate and at times excoriate a person who is struggling with prescription opioid abuse. Problematic opioid use encompasses a wide range of behaviours, the extreme of which is injection drug use. Today I'm here to change your minds about what and who someone in trouble with prescription opioids really looks like.

My name is Lisa Bromley. I am a family physician here in Ottawa. I am here as a former member of the narcotics advisory board of the Ontario Ministry of Health and Long-Term Care.

I work in a community health centre less than one kilometre away from this building, the Sandy Hill Community Health Centre at the corner of Rideau and Nelson Street. I have a focused practice in opioid addiction treatment as a prescriber of methodone and buprenorphine/naloxone. I am one of the health care providers on the front lines of the prescription drug abuse epidemic. Let me tell you: these are my people.

We have members of our panel today from the pain world and we still have much progress to make in ensuring access to adequate and comprehensive pain treatments, including but not limited to receiving a prescription for an opioid medication.

Many of my opioid addiction patients once were and continue to be pain patients. The difference is that they developed a relatively uncommon but recognized and devastating complication of prescription opioid use, which is opioid addiction.

It has already been mentioned that when pain and addiction coexist in the same patient, that makes for a very challenging area of medicine. What you are going to hear from me today is squarely from the addiction perspective. Sometimes we view good addiction treatment and good pain treatment as being in conflict for some reason, and I am going to invite you today to consider these two things as synergistic.

Very basically, addiction is a disease of the motivational system in our brain. We all have a motivational system, otherwise none of us would be in this room today, right? It broadly comprises two functions in our brains, the feel good dopamine reward system, which is really responsible for our enjoying our daily comforts, and then the executive planning system, which is our long-term planning and future thinking system. In someone with addiction, that motivational system is malfunctioning. The substance tricks our brain into thinking that the drug is more important than other things in our lives. That is why many people with substance abuse disorders lose their homes, their families, and their jobs.

In medicine every day, we treat patients, we treat people, whose body functions have been impaired and altered by disease. This is the business of being in medical practice. We haven't always connected the dots that a person with an addiction disorder indeed has a brain disease and that the function of an important component of their brains has been impaired and altered by disease.

I was asked to address the needs of patients, the scope of the problem, the population most at risk, and to give you ideas for promising strategies to address the issue at the community level. So, here's my shopping list.

Anything you can do to decrease the stigma of the disease of addiction in society will be helpful. I'm going to ask you to be careful here because anti-stigma does not mean embracing the disease. There can be confusion that compassion for someone with a substance abuse disorder is the same as giving them exactly what they're asking for. You have to be careful in being compassionate that you are not facilitating or enabling the disease, but nurturing the patient's spirit.

As for the criminal justice system, the ultimate stigma of addiction is the incarceration of people with a substance abuse disorder. I want to be very clear here: it is absolutely essential that every person with an addiction, no matter who they are or where they are, be held accountable for his or her behaviour. This is actually a fundamental pillar of any good addiction treatment. Having said that, jail is the least therapeutic environment I can think of for recovery from addiction. My request is that we embed more treatment into the criminal justice system so that people whose criminal behaviour is driven by a brain disease, by an illness, can have a chance to get better. And once they get better they will quit hurting other people with their behaviours.

I'd like to comment on abuse-deterrent formulations of prescription opioids. The pharmaceutical industry has developed different types of abuse-deterrent formulations, which I see as an opportunity. It's like adding a seat belt to a car. It is not the only solution to traffic fatalities, but it helps. I believe it can make a difference. I think all of us in the addiction world were disappointed when the decision was made to allow generic long-acting oxycodone. I believe this was a narrow reading of the evidence by Health Canada. In order to make good decisions, you have to have a larger picture.

This brings me to how we know what the larger picture is. What data can we draw on? In Canada, one thing we are lacking is good, comprehensive data collection on substance abuse in the population. What we have, in terms of data collection, is piecemeal. The United States has a comprehensive and excellent system that I believe we should copy completely to the letter, and shamelessly. That is the RADARS System, Researched Abuse, Diversion and Addiction-Related Surveillance System, which is based in Colorado. It's comprehensive. It draws data from many different areas. I'm going to read you something from their website: The RADARS System measures rates of abuse, misuse and diversion throughout the United States, contributing to the understanding of trends and aiding the development of effective interventions.

This system would be inexpensive to implement because in the U. S. the majority, if not all, of their funding actually comes from industry as a requirement for them to fulfill a federal obligation to monitor the safety of their products. So here's a chance to hold industry accountable for the impact of their products on the population.

Regarding first nations and effective treatments for opioid addiction, not all such treatments are funded for all first nations people. Specifically, while methadone is funded and buprenorphine-naloxone is funded for patients living on a reserve, buprenorphine-naloxone is not funded for first nations people not living on a reserve. This is a vexation that I see daily. There's an easy remedy, which is to fund all available treatments for opioid addiction for to all first nations people, no matter where they live.

We've touched on naloxone and overdose reversal kits. I'm going to skip over that to come in under the 10 minutes I have here, but would just mention it as a very inexpensive, safe, and effective way to save people's lives.

On my next point, I expect contention, because what I'm going to talk about is an intervention that will affect relatively few people. For those people, it does have the potential to make a big difference. What I'm talking about is supervised injection sites. We need more of these in Canada.

I made sure to dress nicely to come to the meeting: I put on a skirt and put on some lipstick, but fundamentally my identity is that of an inner-city methadone doctor. The person you have standing in front of you is a soldier on the front lines of this epidemic. I'm faced with this issue every day.

And if you say that people with addictions should get treatment, not injections, I'm going to give you some analogies. The thing is that in medicine we know that treatment does not always work, especially for patients with severe and advanced diseases. Diseases are still smarter than we are. People succumb to diabetes, cancer, and heart disease hourly in our country. And we don't claim that our treatments work in all cases and we accept that there are times when our best treatments fail, despite our best efforts. Does this mean that we send cancer patients to jail if they fail treatment? That thought is horrific, laughable, and humourous. But that's exactly what we do to people who exhibit criminal behaviour because they have a brain disease.

● (1620)

The way I'm inviting you to look at this is that a supervised injection site does not mean the difference between injection or no injection. It's the difference between supervised injection and unsupervised injection. And guess what? Within probably a 500-metre radius of this room, in the Byward Market of Ottawa, there is probably injection drug use going on. You can have it in a place where people suffering from the most severe form of this illness can protect their remaining health and hopefully be enticed into treatment, for whatever treatment can work for them.

The point that I'm going to end with is a nod to good clinical practice. It's a very general, non-specific statement but it has to be said.

There is an enormous knowledge gap between what we know about the disease of addiction and how it is managed in medicine generally—the present company excepted, naturally. Anything you can do to support good clinical practice would be appreciated. I'm sad to say that in my experience—perhaps it's a self-selection process, because the people whom I see are the people who, by definition, are in trouble with opioids—all I see are the failures. But I find there are cases where medicine still does poorly and unloads much of society's stigma and true ignorance onto opiate addiction patients.

In terms of good clinical practice, I'd ask you to consider this question—

● (1625)

The Chair: Dr. Bromley, are you close to concluding there?

Dr. Lisa Bromley: Yes, sir.

I failed to come in under 10 minutes. Thank you for your patience.

The Chair: You were almost on your way to winning the award for closest to 10 minutes there. The little bit at the end put you over. Sorry about that.

Okay, this is our first round of questions. There are four of these for seven minutes.

Dr. Morin, for seven minutes, please, sir.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Mr. Chair. I will also try not to exceed my seven minutes.

My first question is for Ms. DeGroote.

Thank you very much for your testimony. I especially liked the part where you talked about your work in the two clinics—in Burlington and in Hamilton. You saw that Canadians were reluctant with regard to those types of clinics.

When I heard that, it made me think of a Conservative campaign titled "Keep heroin out of our backyards", which can be found on their website. The campaign is clearly targeting supervised injection sites. The Conservatives are trying to provoke fear in people and make them not want those clinics close to them or close to their family. So it is clear that the government is trying to frighten people, even though those clinics are ultimately supervised, regardless of how they operate.

Do you think it is okay for the Canadian government to spread fear among people, and try to convince them that those clinics have no place in their neighbourhoods and that they pose a danger to their family?

What do you think about that, Ms. DeGroote?

[*English*]

Ms. Eve Adams (Mississauga—Brampton South, CPC): Chair, I apologize as I know it is the holiday season, but on a point order, I don't think this line of questioning is relevant to the current study before us.

The Chair: Thank you for that interjection, Ms. Adams.

[*Translation*]

Mr. Dany Morin: Can I answer?

[*English*]

The Chair: Yes.

[*Translation*]

Mr. Dany Morin: Regarding those clinics that help people struggling with addiction—the topic we have been discussing since the beginning of the study—Ms. DeGroote talked about experiencing a similar situation, where people were afraid of how individuals with addiction issues were being treated. I know that your government has conducted a relevant campaign, and I want to know whether it thinks that this kind of an attitude is appropriate. I think that this has as much to do with the witness's testimony as with the topic of discussion.

In addition, Ms. Bromley talked about supervised injection sites during her testimony. Consequently, I truly believe that my comments are not outside the purview of the study.

[*English*]

The Chair: Okay, Ms. Adams. By the way, your time is not getting used up here, unless you want it to be.

Ms. Eve Adams: Mr. Chair, I believe that our honourable colleague from the opposition is really trying to reference and debate Bill C-2 here in the committee. It's really not the appropriate forum for it. We are here to study prescription drug abuse, and while witnesses may speak to the broader experiences that they may have had, it's incumbent on the members of Parliament to stay directed and focused in their questions.

The Chair: Thank you for those comments. What I will add is that to my knowledge this study to this point has been very professional and non-partisan. The questions, if they are trying to get around that way, are done in a very respectful manner.

I think it has been a fine point of order. That point of order should go out to all members on this committee.

Mr. Morin, you have five and a half minutes to go with your time, sir. I'm not going to tell you how to ask your questions; it's for you to ask your questions. However, we'll try to keep it to the point.

● (1630)

[*Translation*]

Mr. Dany Morin: So I will let Ms. DeGroote answer. She should also feel free to tie her answer into today's topic of study. I think her answer will explain why I asked this kind of a question.

[*English*]

Mrs. Peggi DeGroote: I think it's very important to differentiate the various clinics and sites that are available. I came to my definition of what I wanted to have at my clinic by having a bottom-up model. We clinically helped people in our community with whatever their needs were.

I don't want to denigrate or make claims for other people who offer their services to others. I can tell you that my early education in this field was very enlightening; it was frightening, and I couldn't believe it was Canada. I have been in clinics in third world countries that I have felt safer in, and that's what led me to say that we need a new model. Within that model, and by educating people in our community, I think we can change the face of what's out there so that people are not afraid to accept other people in their communities.

We originally had some people on the front page of our local newspaper, who said, "Don't bring these heroin addicts to our location. Children are going to get hurt on the way to school. This is going to be awful." Those people have now come forward because of the model we use—and because we're no nonsense, zero tolerance, we run a tight ship, and we're by appointment only, like a traditional medical clinic would be—and are now welcoming us in their community. People who once were on the front pages of our papers, in fact, now have come for treatments and are very, very happy that we're there.

I think we need to educate our communities. We need to educate our physicians. We need to educate our pharmacists.

One of the things we do that's perhaps different from other places is that we ensure that every one of our prescriptions is automatically faxed to a pharmacy, so nobody takes a prescription out of our office. On the bottom of every prescription is a notation to the pharmacist, which he must adhere to and which is directed by our physician, that says “Any opioid prescription must be dispensed in a locked box”.

Mr. Dany Morin: Madam DeGroote, thank you so much. I have other questions. That's why I have to cut you off. I'm very sorry.

My next question is to Dr. Bromley. The topic of this study will eventually become a part of Canada's anti-drug strategy, which is the end goal of this study. We know that the Canadian anti-drug strategy was changed in 2007 by the Conservative government to remove the fourth pillar, that is, harm reduction.

Do you think it was smart to remove that fourth pillar? The other three pillars are prevention, treatment, and enforcement of the law. Do you think the fourth pillar should be brought back again as part of the continuum of care for those people who are suffering from addiction, who abuse prescription drugs and other types of drugs?

Dr. Lisa Bromley: What I will say is that in medicine nothing is black and white; it's not all or nothing. We strive in medicine to do the best we can with what we have. I think that we reduce harm in medicine all the time, by whatever means we can, and wherever that patient is at.

● (1635)

Mr. Dany Morin: If I understand correctly, it should again be part of the Canadian anti-drug strategy?

Dr. Lisa Bromley: Sure.

[*Translation*]

Mr. Dany Morin: I have one last question. It's for Ms. Cooper.

Ms. Cooper, you talked a lot about people who were ashamed of their great suffering, while no one believed that they were in much pain. They are accused of faking symptoms, pretending to be in pain and abusing medication.

Can you tell us more about that? What can the Government of Canada do to assist those people in terrible pain who have so few tools to truly help them?

[*English*]

The Chair: Please make it a brief response, Ms. Cooper.

Ms. Lynn Cooper: Thank you.

There is a great deal that can be done. The most important thing is to provide appropriate pain management, because once you have multidisciplinary pain care that you can access, once you know about your pain condition, once you're familiar with all of the coping strategies, you learn how to make adjustments in your life. You learn how to take control back in your life. Then it doesn't matter so much if someone calls you a druggy or a pusher or a malingerer, because you know that you've taken control back, that you are living the most productive life that you can. Limits that you thought you had when you could not access appropriate pain management and get the help that you needed, you no longer have.

The Chair: Thank you. That was good.

Ms. Adams, for seven minutes, please.

Ms. Eve Adams: Thanks very much.

Our government has been investing significantly when it comes to pain management. In fact, through the CIHR we've invested about $55 million into pain management research.

I recently met with one of the leading neurosurgeons in our nation. He's based in Montreal and does quite a bit of work at the CIHR. They were focused primarily on arthritis research, but they're very patient-focused. They had provided a questionnaire to their patients, asking them to rank their priorities. The patients came back and ranked as their number one priority pain management, which came as quite a surprise to the physicians and the clinicians. So they have completely changed their focus moving forward so that they are able to address this patient concern.

Can you tell me a little bit about the importance of research into pain issues to ensure that patients' needs are being met? Through you, Mr. Chair, if I might direct my question to Ms. Cooper first, and if there are any others who would like to augment the answer, please do speak up.

Ms. Lynn Cooper: I would defer to Dr. Buckley as well.

The importance of research into the effectiveness of pain management is key. With each study that is completed, we learn more and more about how different modalities will interact with one another and produce the best results.

As I said, I would defer to Dr. Buckley as well on this one.

Ms. Eve Adams: Dr. Buckley, do you have anything further, through you, Mr. Chair?

Dr. Norman Buckley: There are a couple of things. One is that it is the case—and you can look at examples like the strategy against HIV—that concerted attention to a specific problem has led to dramatic improvement in our capacity to deal with conditions. Montreal is unique. McGill University, in particular, has a glorious history of leadership internationally in the problem of pain—except that's coming from somebody who lives at McMaster, so it's probably even valued more highly than the actual words—

Ms. Eve Adams: That's okay, though. I was a Hamilton girl for 16 years, so I will accept your bias happily.

Dr. Norman Buckley: There you go.

Granted, $55 million is not trivial but relatively speaking, pain does not have a pillar. I appreciate the fact this sounds like scrinching, or something, because $55 million is not trivial but there are no pillars, for example, directed towards pain management. As you heard from Ms. Cooper, and if we are able to forward the editorial from Mary Lynch, you will see it delineates quite clearly the cost of untreated or inadequately treated pain, and it far eclipses HIV, cancer, and even cardiovascular disease in terms of its impact. The problem is that it's not a straightforward biochemical question. As I suggested, it is complex. It includes psychological responses and social situations, all of which have an impact. The importance of research cannot be underestimated. There is quite a bit known now. One of the issues is to try to move forward with quality treatment.

The CIHR is actually a splendid organization, and many kudos to them.

● (1640)

Ms. Eve Adams: Thank you.

Ms. DeGroote, in the proportional breakdown at your clinic, how many folks are coming to you with prescription drug abuse issues and how many with illicit drug issues?

Mrs. Peggi DeGroote: There's a lot of polysubstance abuse.

For instance, it may be that the person is receiving a prescription from their family physician but in addition on Saturday night they did a line of cocaine. If you're asking for only the people who have their prescription abuse, there is a significant number. I can get back to you with what that exact number is. I would guesstimate that one-third of the people have issues of pain and don't want to admit any addiction issues. We know that if they were asked by their family physicians to stop cold turkey, they would be going through withdrawal, and that's part of the definition of the addiction.

What we try to do, because they don't want to accept that they have any addictions—it's just their family doctor who is writing the prescription for them, so how can they be addicted—is to reduce the pain. Our treatments are multitudinous, and there's a chart where it shows all of the different things we do. Then the physicians can actually titrate them to a lower, more acceptable level. In some cases people totally get off their medications. I would say probably one-third of the patients who come to see us have an issue with just the use or overuse of their medication from the family physician, without buying any street drugs or anything else.

Ms. Eve Adams: What proportion would you say are actually purchasing prescription drugs?

Mrs. Peggi DeGroote: A large percentage will supplement. People who live in pain will do anything they need to do to not live in pain. We shouldn't fault them for it. It's how they get through life. It's their coping mechanism to sometimes be able to get out of bed in the morning to get their children's lunch made and get to their soccer game.

Ms. Eve Adams: Thank you.

One of the things we've been hearing from parents is the need to provide more information on how to keep prescription drugs out of their children's hands. You've got a very practical experience with the services that you've been providing at your clinic.

What would be the top recommendations that you would have?

Mrs. Peggi DeGroote: Our top recommendation is to keep them in a locked med box. Even if your 14-year old jimmies the lock, you now have a springboard to have a discussion because you know that they've taken something from it.

In lots of cases, do you really pill count if you have medication? Say you had a sore back, and you don't use the medication all the time—you usually keep it in your golf bag when you go golfing and just take it then. Do you really know if you have 42 pills left or only 38? Did those other four pills go out with your kids on Saturday night when they went to a salad party? Do you know what a salad party is? It's where your kids will take legally prescribed medications, in most cases from your medicine chest. Their entrée into the party that night is to take things out of your medicine chest, have a pocketful of pills, then put them into a big salad bowl when they get to the party. They just take a handful whenever it's time and ingest whatever they get. They don't even know what they're getting because it's life on ground level.

The Chair: Okay.

● (1645)

Mrs. Peggi DeGroote: That happens, and so you need to make sure, if your kids are going to take things, that at least you know they're being taken so you can address that issue.

Ms. Eve Adams: Thank you for sharing your insights.

The Chair: Good. We're not having a salad party here after committee, I can tell you that.

Mr. Dion, you're up, for seven minutes, sir. Go ahead.

Hon. Stéphane Dion (Saint-Laurent—Cartierville, Lib.): Thank you very much, Mr. Chair.

One of the best experts I know on this issue is Dr. Hedy Fry, and I'm supposed to be her. I'm replacing her but I'm not at all an expert. She has certain questions I will ask, but first I have one of my own.

What would be your top recommendation to the federal government? We are not the provincial government; we don't have the same ability to intervene on these files, but I'm sure you have an idea about the federal government's specific role. I was the minister of intergovernmental affairs long enough to know that sometimes people put all their hopes in the federal government when the federal government has little means to intervene. But this does not mean we cannot find a way to intervene that would be helpful.

I would like to hear from each of you what top priority you would assign to the federal government.

Dr. Lisa Bromley: I would say, decide who owns the issue of opioid safety. We have road safety, which is a big and complicated issue, but I can't see.... There are lots of people who own a little piece of the opioid safety issue, but figure out who owns the issue and then make them accountable.

Hon. Stéphane Dion: But according to the Constitution, it's not us. So what specific role do you think we might play that the provinces are not doing alone?

Dr. Lisa Bromley: I would ask you to forgive my naïveté and ignorance, but does Health Canada not have a stake in opioid safety as a public health issue?

Hon. Stéphane Dion: Yes, in public safety we have a role to play. That's why I need to ask you if you are able to clarify what exactly you would like us to do differently.

The Chair: Mr. Dion, maybe what we'll do is to let Ms. Bromley think about it.

Mr. Buckley or Ms. Cooper, would you like to interject here?

Dr. Norman Buckley: The jurisdictional issue is a big problem, but what's crucial is the capacity to have readily accessible information transferred amongst provinces so that health-care providers at the front line are able to understand what is going on with their patients and know what medications they've had, what previous treatments they've had. There are individual provincial initiatives in these regards in many provinces right now, but there is not a unified strategy across the country to support a communications strategy. And even though the actual implementation may be provincial, it occurs to me that there should be a role amongst the federal transfer payments to link to communications strategies that require communication between the provinces as well as within provincial health care systems. In fact, if you look to your Canadian Centre on Substance Abuse strategy, you'll see that this group is working hard to try to bring the players together. I think supporting that strategy would be hugely effective, because one of the challenges we face all the time is the adequacy of information.

Hon. Stéphane Dion: Mr. Buckley, Madame Fry was leading towards this point, because she requested that I ask which provinces or communities have the best practices and what role the federal government may play to make them known.

Dr. Norman Buckley: Right now, to the best of my knowledge, Calgary has a multidisciplinary pain clinic that probably is unequalled—I'm not sure if this is a province-wide strategy or just specific to Calgary—in the country in its capacity to identify and treat patients with complex chronic pain problems.

Nova Scotia has rolled out an excellent strategy that includes support for pain education amongst its primary providers. It also addresses issues to deal with opioid prescribing, which obviously was one of the drivers in that province.

La belle province is perhaps one of the premier in terms of having developed a province-wide strategy. It includes linking I believe five key academic centres as tertiary resources responsible for secondary and primary care education and care delivery within five regions in Quebec.

British Columbia has a strategy under way. It was announced two years ago, I believe. It continues to work forward, but I suspect in terms of primacy it's going to be Alberta, Nova Scotia, Quebec at the lead, I think, or British Columbia close behind. Ontario is in the process of putting together a strategy that it has yet to roll out.

● (1650)

Hon. Stéphane Dion: Does anybody else want to address this issue? No? Okay.

I have another question from Madam Fry. We have heard that in remote and rural communities there are higher rates of prescription drug misuse because of limited access to comprehensive pain management services, such as physiotherapy and pain management specialists.

Is it true, and is there a role here where the federal government can help with more equivalency in the quality of service through the country?

That's for anyone who is aware of this issue.

Mrs. Peggi DeGroote: It was a great surprise to find out that Halton was one of four areas that was noted as having a great need. It was a great surprise to me. So you don't have to be rural and you don't have to be remote to have lack of care. You can be in a central location, with everything available to you, to have services still not available.

That, for me, is one of the reasons I did what I did. I couldn't believe it wasn't available in our community.

Hon. Stéphane Dion: Thank you very much.

The Chair: Thank you. You're right on time there. Good work.

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

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

Thank you to all of the witnesses today, those on the screen and those who are here at committee this afternoon.

First I will allow myself a comment. We're doing this study on prescription drug abuse, and really, a lot of the witnesses during the meetings are focusing on opioids and pain medication. So far we've left aside others, but it would be good to know what the impact is of other medications that are misused, abused, or overused.

Since all four witnesses today deal with issues relevant to pain, my first question is this. And I'm not directing my question to anybody in particular. On the one hand, a doctor sees people who need treatment for pain, whether it's chronic pain or it's pain that occurs once in a while. Some people suffer from migraines once in a while and they can't function. The doctor is faced with the problem of giving some kind of pain relief to the patient. How do you strike the proper balance so that you as a doctor or a medical practitioner don't over-prescribe, or don't prescribe what is not needed, and then the right treatment is used? I guess sometimes the easiest way is to just prescribe the pain medication, and it's probably the easiest for the patient, because the pain goes away usually very rapidly.

Could you maybe expand on this? Where do you strike the balance?

That's for anybody.

Dr. Lisa Bromley: Perhaps I can start.

We have a most excellent *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*. That is a definitive authoritative source for striking that balance.

I think it's good medicine to take a good history and to monitor your treatments after you've prescribed them.

Regarding your first question about other prescription drugs that are not opioids, this is where we need good epidemiological data.

● (1655)

Mr. Wladyslaw Lizon: Okay.

Would anybody else like to speak on striking a balance on how to deal with pain, or how to not prescribe opioids or other medication or pain relievers?

Ms. Lynn Cooper: I believe one of the keys to appropriate management is improved communication between the health care provider and the person living with pain.

There are many tools that can be used to improve communication and have a better conversation. One of them would be a brief pain inventory that an individual can fill out and take to their visit with their doctor to explain where their pain is. It gives the physician an immediate snapshot of what's going on, what's being affected. For instance, is their sleep, their appetite, their functionality, or their mobility being affected?

When you have this type of communication, over time it builds trust, and eventually the two parties can determine together what type of medication might be needed, based on the physician's recommendation and what course of action comes next.

You happened to mention migraines. When I went in to see my doctor with an uncontrolled migraine, it was interesting because I had lost a little bit of weight. She looked at me and said she felt she couldn't give me what she prescribed the last time. She felt it would be far too much in my system. She asked would I be okay with a lesser amount. I said, “Absolutely, you are the expert on this.” So communication worked that day and my pain was reduced enough that I could go home and get better.

Mr. Wladyslaw Lizon: On the topic of monitoring prescription drug abuse, what tools can be used to gather relevant information? What are the challenges in gathering and sharing that information on prescription drug abuse?

Dr. Norman Buckley: If I may, I'll note that there are several layers of information. At the large population level, there's obviously epidemiologic data that's obtained from the surveys that have been referred to previously, some of them looking at health behaviours, and some of them looking at reports of drug use.

The RADARS program in the United States that Dr. Bromley referred to is one that captures a great deal of population data, which can describe specific drugs of abuse. We don't have a comparable system in Canada—certainly not realized at that level of complexity.

In terms of the individual physician's capacity to effectively monitor and treat their patients, a prescription monitoring program that captures not just specific drugs but all of the drugs that a patient may receive, from whatever source, allows physicians to actually be fully aware not only of drugs of abuse, but of a variety of relevant drugs that may have other impacts.

It is the case, for example, that certain drugs enhance liver enzyme activity, which means that other drugs will be less effective because they are more quickly metabolized, and you may have to adjust doses. There are other drugs that interfere with each other, so that a painkiller may be more or less effective.

If you're not aware of a patient's full receipt of medications, you're frequently hampered. In my pain practice, for example, I will ask a patient what drugs they take. They will limit themselves to telling me about the pain medications they take that I have prescribed them. I have to actively seek to find out the remainder of their drugs.

British Columbia has a program whereby the physician can run online a complete drug record during patient visits. It's captured at the pharmacy dispensing level, so it doesn't matter who pays for it. Alberta, I believe, has a similar system.

Many of the provinces have systems that report the drugs that are paid for by a provincial benefit program. In Ontario, for example, the Ontario drug benefit formulary can permit its pharmacists to track that medication list. It's hard for a physician to capture that.

Other provinces are bringing into play prescription monitoring systems, but that is one of the areas where a national program linking those...but first of all, allowing the dispersal of best practice.... Some provinces have already solved this problem, so you may not need a unique solution if you don't already have one. The other thing is to make them communicate.

● (1700)

The Chair: Those are very good points, Mr. Buckley—

Dr. Norman Buckley: You're aware of my predilection for talking.

Voices: Oh, oh!

Mr. Wladyslaw Lizon: Thank you.

The Chair: Thank you, Mr. Lizon.

Ms. DeGroote, I apologize. We're over time with Mr. Lizon's round. Perhaps one of his colleagues can direct their questions towards you in a subsequent round.

Next up for around five minutes in our second round here is Mr. Marston.

Please go ahead, sir.

Mr. Wayne Marston (Hamilton East—Stoney Creek, NDP): I have to figure out a way to get into the first round, because I always have more questions than time.

Ms. DeGroote, I want to thank you for something you did today. I watched the body language of our friends across the way when you talked about a salad party, and I think you have reached some people with a very important message, because life on the ground is so different from the reality faced by many of us, our families, or extended friends and that.

We've been pounding away for a while in trying to get some attention for this particular issue. It's one I've raised here. One of our witnesses talked about the fact that 80% of new inmates get there with addictions already. This is far more extreme than anybody has really comprehended, I think.

You've also noted that there's a slight difference of view on injection sites between the two groups here, but clearly, for those people who are addicted to heroin, many of them got there by starting with prescription drug abuse or copping the pills out of their parents' cabinet and then later moving on up the chain. I'd like to hear your view on safe injection sites as a start to the process of bringing these people back into society.

Dr. Bromley, if you'd like to add anything to that, feel free.

Mrs. Peggi DeGroote: As Dr. Bromley already mentioned, I am non-partisan in all of this. I look to the patient first and I look to our communities and ask what we can do to make a difference in our communities. We know we can't stop people from doing what their going to do in the addicted world, but we can ensure community safety with some of the things we do.

We have a safe injection site in Burlington and a needle exchange program, which I am quite certain serves a number of people in our community. I would rather have it monitored and cared for and have an opportunity to interact with somebody and to maybe get them to care, because you never know sometimes what a kind word will do.

When I was working at the methadone clinic, the thing that changed my life was when a six foot seven, 350-pound man with tattoos all over him, looking like a biker, broke down and cried when the doctor said to him she knew he could make a difference in his life and she believed he could get off those drugs. He started to cry and he said that no one had ever believed in him in his whole life. I know for the rest of the time I was there as a volunteer, that man came back every week and had negative urines, which meant he wasn't using any drugs, because for the first time someone said she believed in him.

You never know what interaction, what a smile can do one day. I was a teacher so you never know. I see some of my kids now, and they will remind me of things that happened in the classroom that I had no idea had any impact whatsoever on them, but they did. That's what we need to do and reach out to people in our communities. When we look after the people who are the most vulnerable in our communities and we give them a hand and we help them, then we will have better communities.

● (1705)

Mr. Wayne Marston: Thank you.

Dr. Bromley, would you like to add?

Dr. Lisa Bromley: Yes, I would.

I've been in the area of opiate addiction treatment for 12 years and I was initially opposed to supervised injection sites, but 12 years in the field has changed my mind. I think when someone starts treatment right away that is obviously the best outcome.

I'll reiterate what I said in my opening statement, that treatment for any illness doesn't always work right away in medicine. Supervised injection sites would be reserved for people with severe and advanced forms of the illness. Of course, after failing treatment it should not be the first line.

Mr. Wayne Marston: Ms. Cooper, listening to your presentation, the complexity of the information and knowledge required for a patient to manage pain is quite clear. It jumps out at me.

Forty years ago a telegraph pole I was working on broke off and put me through a fence and I had about 30 years of pain. We suddenly discovered physiotherapy that dealt with it. I felt like kissing that young lady every day I went for treatment because she found a way of correcting my neck. It sounds to me as if we've got a long way to go to inform patients, because in my case I had no concept whatsoever. I was in a travelling kind of job and not with a doctor who could spend the time.

What could the federal government do to assist in this kind of education? Do you see a role there at all?

Ms. Lynn Cooper: Yes, I do.

First and foremost, I firmly believe that if the federal government officially recognized chronic pain as a disease, and also stated that it is a health priority in Canada, Canadians would listen and take the situation seriously. I believe that if there were funding to develop a chronic pain self-management program so it could be delivered across Canada, a community-based six-week program run by two facilitators, one usually being a health care provider and the other a peer, that is, a person living with pain.... These are individuals trained in giving this program. The way that lives are changed for Canadians just by attending that program gets them started. Nothing about pain management is the fix, but this helps them to get involved in their pain care to be able to see solutions, to identify and problem solve and to gain back some control.

If this could be implemented across Canada, it would be perfect.

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

I want to remind all my honourable colleagues today, for purposes of our study, to focus their questions on prescription drug abuse, because if we get off that, it's highly unlikely that the analyst will include the responses because they go away from the scope of our study. It's just a reminder to all honourable colleagues to try to keep this focused on prescription drug abuse. But again, it's your choice what you want to ask your questions on.

Mr. Wilks. Five minutes, sir.

Mr. David Wilks (Kootenay—Columbia, CPC): I believe it's Mr. Young.

The Chair: Okay.

Mr. Young, five minutes.

Mr. Terence Young (Oakville, CPC): Thank you, Mr. Chair.

Before I ask a question, Chair, I would like to get something on the record here. Mr. Marston's question was an apparent attempt to characterize the members on this side of the committee as somehow naive about teens and drugs. You heard Mrs. DeGroote say that Halton has some of the worst problems in this respect. Marijuana is the drug of choice for young people. In grades 7 to 12, 34% use marijuana. And it causes depression, it's linked with many cancers including brain cancer, it can cause psychosis, and it leads to diabetes. It's also linked to automobile accidents and industrial accidents, including death. So we're the party who wants to keep marijuana illegal for all of those reasons.

And it's your party and the Liberal Party who want to legalize marijuana, Mr. Marston. So I want to point out who was actually being naive about the risks of drugs.

Dr. Buckley, I think you remember that we met in Oakville at a seminar for young people with connective tissue disorders.

● (1710)

Dr. Norman Buckley: Yes.

Mr. Terence Young: And I admire your work very much. I wanted to ask you a specific question about the dental use of prescription drugs. In 2007, Purdue Pharma paid a $600-million fine in the U.S. to settle charges that they had illegally marketed OxyContin. OxyContin is thought to be, if not our worst, one of our worst drug abuse problems in Canada and the United States. When they originally sold it in 1996, they told doctors that it was not addictive, or at least not as addictive as other painkillers, and that's how they marketed it. The exact opposite was true, so they paid a $600-million fine to settle this, and everybody walked away, nobody went to prison.

I have a problem now with some of my teens in Oakville who were given oxycodone or OxyContin when they went to get their wisdom teeth out by dentists and got addicted to those painkillers. Their parents have to drive them now to Peggi DeGroote's methadone clinic in Burlington to get help. It seems like everyone's just sitting on their hands. Is there any way to get a message to dentists that this is an overuse of medication? For getting wisdom teeth out, all you need is Tylenol, and it's foolish and irresponsible to give young people such powerful painkillers when they're getting their wisdom teeth out.

Dr. Norman Buckley: It turns out that's actually a question I know the answer to, which is comforting. The college of dentistry in Canada and in Ontario, the Royal College of Dentists, is actually addressing that issue specifically. I mentioned David Mock, the past dean of dentistry at the University of Toronto, who's the co-leader of the CCSA education strategy. He is working with his colleagues, taking the example from the College of Physicians and Surgeons of Ontario, to disseminate guidelines specifically to dentists about what constitutes an appropriate prescription after a minor dental surgical procedure.

So that problem is recognized. It turns out that although the total volume of prescribing is not huge, dentists do in fact write a very large number. Somewhere between 30% and 40% of the prescriptions for opioids written in Ontario are written after dental surgical procedures.

So that issue is being addressed.

Mr. Terence Young: Thank you for that.

Mrs. DeGroote, addiction leads to abuse and abuse leads to addiction. You were talking about “salad” parties. What can we do to stop that kind of thing?

Mrs. Peggi DeGroote: The first thing we have to do is ensure our children don't get the pills they need for entree into this. At a younger age, we first need to begin by educating our children that if your name isn't on the prescription, you shouldn't be taking it. I can tell you that I'm an avid golfer, and if I'm out and I say, “Oof” after a stroke, because I did something wrong and it hurt, three of the other four people in the team will say, “Well, here's something”, because in my age group we don't think that sharing prescriptions is wrong or that we shouldn't do it. That's also misuse, and we're doing it and not teaching our children that it's not right to do that. It's trouble.

Mr. Terence Young: We discussed at some point earlier your idea regarding the use of fentanyl. Fentanyl is 10 times stronger than heroin. How might it be better controlled?

Mrs. Peggi DeGroote: I think the fentanyl issue is a real issue. We first came upon it we knew even before it was announced that it was going to be an issue, because at my Wellbeing clinic, we actually tested for fentanyl as soon as it came out on the street, and we were finding that people who didn't have fentanyl prescriptions were testing positive for it. We were also finding that people who had prescriptions were testing negative for it. So that tells us that while a physician is writing the prescription, the person is likely diverting what he or she is getting, because it's not actually in his or her system.

I think what we could easily do, an easy fix, is to ensure, as with methadone or as with fentanyl patches, that before you get a reissue of your prescription you take your seven patches or your seven empty methadone bottles back to the pharmacy. Because if you're diverting, you're not going to have that to give back, and that should be a clear signal.

● (1715)

The Chair: Yes, Mr. Marston.

Mr. Wayne Marston: I want to be very brief and to the point.

Mr. Young, I certainly appreciate your—

Mr. Terence Young: That's not a point of order, Chair.

Mr. Wayne Marston: Well, you don't know what I'm going to say. You're getting pretty good if you can figure me out before I even say it.

The Chair: Let's try to raise the level of debate here.

No, I'm not pointing at you, Mr. Marston. I'm just saying, go ahead. Sorry.

Mr. Wayne Marston: That is what I'm trying to do. There was something mis-stated here, and I just want to correct the record.

Mr. Terence Young: This is debate, Chair.

Mr. Wayne Marston: I haven't completed my statement. Then you can judge it.

Mr. Terence Young: You said it was mis-stated. You're talking—

Mr. Wayne Marston: You went ahead talking about our position on marijuana.

The Chair: Mr. Young.

Mr. Wayne Marston: Now let me respond to it. It's very simple. Our position is not legalization of marijuana, it's decriminalization. And it has been 40 years since the Le Dain commission studied it. It's as simple as that.

That's all I wanted to say.

The Chair: Okay. Very good.

Mr. Terence Young: It wasn't a point of order.

The Chair: You're correct, Mr. Young. It wasn't a point of order. It was a point of debate.

Ms. Mathyssen, are you prepared?

Ms. Irene Mathyssen (London—Fanshawe, NDP): I think Mr. Morin had one more question.

The Chair: Mr. Morin, start your five minutes.

Mr. Dany Morin: Thank you very much. I have pressing questions.

I was quite surprised and amazed to see some statistics. Probably some of you are aware of them, but in the documents that our analysts have provided for us, it is said that—and I'm going to say it in French—

[*Translation*]

> [...] a study of post-operative pain control after coronary artery bypass grafting found that less than 30% of the ordered dose of pain medication was given, with approximately 50% of patients continuing to report moderate to severe pain one to five days after surgery.

[*English*]

I'm quite surprised to learn about this new piece of information. We have talked a great deal in the past few weeks on this subject, regarding the fact that people are in pain and they need drugs that will relieve their pain, but then in a hospital setting, for people in acute care, either because they've been to the ER or because they had some minor surgery, they do not receive the proper quantity of pain relief medication.

[*Translation*]

Are any of our witnesses today familiar with this issue? If so, why are hospitals trying to save on drugs to the detriment of patients?

[*English*]

Is anyone aware of that fact?

Madam DeGroote?

Mrs. Peggi DeGroote: First of all, you must know that I'm not a physician. However, I do know that not all medications work the same for everybody, so something that may work well for me may not work for you, and sometimes it takes a bit of trial and error to find out what is best for a particular patient.

Mr. Dany Morin: Dr. Buckley, Dr. Bromley, are you aware of the fact that some people do not receive the proper quantity of drugs after going to the ER, in the hospital setting?

Dr. Norman Buckley: Yes. I think I referred to that in my remarks at the beginning. That information is well known, and it's a function of a number of things.

It's a function of belief about the dangers of giving analgesics, although in the setting that you described, that danger is minimized because of the close observation that occurs after cardiac surgery.

It's partly because pain is not routinely assessed. If a researcher comes and asks a patient if he or she has pain, the nurse and physician responsible for caring for the patient may not have done the same thing. So if the nurse has not assessed the patient, if the nurse is not aware that the patient is experiencing pain, the nurse may not deliver the necessary analgesic.

I believe the same study to which you're referring also noted that even when the patients were making their pain known, they did not receive the maximum dose or least-frequent-interval dose, and part of that has to do simply with a lack of awareness of the importance of treating pain. There is an often-said statement that pain never killed anyone, which is actually entirely untrue.

Mr. Dany Morin: If I understand correctly, in your point of view, this study is flawed.

Dr. Norman Buckley: No, this study is brilliant. The care is flawed.

● (1720)

Mr. Dany Morin: Thank you.

[*Translation*]

The National Advisory Council on Prescription Drug Misuse has established that seniors were the group most at risk for prescription drug abuse. Since the population is aging, that abuse problem will worsen.

My question is for anyone who may have a solution to suggest. What kind of prevention methods do you think could be used with future seniors, so that they don't end up in the same situation as the current generation of the elderly, who are abusing prescription drugs?

[*English*]

The Chair: We'll hear from Ms. DeGroote, and then we'll go to Mr. Wilks.

Mrs. Peggi DeGroote: This also goes back to the question by Mr. Lizon about appropriate care. If we look at the number of hours that a family physician spends learning about pain while in medical school, it's about three hours in total. Our veterinarians have about 15 hours of pain education. Even though you were told last week that dentists get the same medical training on pharmacological information and that that ought to be good enough, if we look at the number of three hours, it's not at a good standard.

I will suggest that if a family physician doesn't have confidence in what they're doing—through no fault of their own, because we can say that they're not getting good education to begin with—they perhaps don't know even how to do things. My big concern right now for people suffering from pain is that the physicians then will decide not to write prescriptions for opioids, so that people can't even manage their pain. There is a program out of the University of Toronto called the ECHO program, which comes from the University of New Mexico. It is about training front-line family physician workers in pain and addiction. I know this is going forward in Ontario, because we will be one of the hubs for it. I think that kind of thing will help to manage and give confidence to the doctors who are seeing the patients.

Honestly, in lots of cases and through no fault of their own, the doctors don't know what to do.

The Chair: Thank you, Ms. DeGroote.

Mr. Wilks, you have five minutes.

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

Each one of you here today has used the words “awareness”, “best practices”, “data collection”, “science”, and “reasoning”. I will bring up a term that is widely used: “medical marijuana”. I don't believe there is any awareness of it. I don't believe there are any best practices for it. I don't believe there's been any data collection whatsoever. There's been very little science done on it. There's very little reasoning as to why we're doing it, especially when we have synthetic models of Marinol, nabiximol, and dronabinol, which provide opportunities for those who are affected by some significant diseases and can aid them.

Seeing that a doctor can prescribe medical marijuana without it going through a pharmacy, I'm curious to hear your perspective, given the addiction issues you've seen, on two things. One, do you believe that marijuana can be an addictive drug; and two, from the perspective of medical marijuana, what needs to be done to ensure that that it is safely prescribed to those who fall under the prescription of a medical doctor?

I'll start with whoever wants to start. You have about one minute each.

Dr. Buckley, you seem to be quite enthralled. Go ahead.

Dr. Norman Buckley: No, I'm going to watch this one go by.

Mr. David Wilks: Dr. Bromley.

Dr. Lisa Bromley: Of course marijuana is an addictive drug. No one can debate that. We need clinical practice guidelines on physicians using it safely. The best I know of are by Dr. Mel Kahan from Toronto, who is planning to release a paper in *Canadian Family Physician* to guide physicians on how best to prescribe it safely given that it will be a matter of a clinical judgment now. Generally, physicians are quite unprepared to face this as an issue.

Mr. David Wilks: Ms. DeGroote.

Mrs. Peggi DeGroote: I think it's difficult for family physicians to have so many different treatment modalities in their medical bag with the limited time they have. I know that we have some patients, especially who have MS, where it has been the miracle drug for them. They're no longer in wheelchairs and they can really get out and function, and that's wonderful.

It's tough. I'm not a doctor. The doctor's have to make that clinical decision, and we give them full authority to do that, because that's what they're good at.

● (1725)

Mr. David Wilks: Dr. Buckley, I'll put you on the spot now.

Dr. Norman Buckley: I'm with Dr. Bromley. There are a variety of things that are addictive, and marijuana is probably one of them. Addiction is an interaction between a substance and a person. Some people are addicted to a variety of things, and that's a very complex story.

As far as clinical use goes, I'm entirely in agreement that we know precious little about it. We don't prescribe marijuana. We give them permission to use it with a “get out of jail free” card that we sign. This keeps them from getting busted unless they fail to adhere to certain rules about how much they can have and what they can have with it. My clinical choice is to use the commercially available preparations first.

The other challenge is that smoking itself is bad for you. I don't care what you're smoking—oregano, marijuana, or tobacco—smoking is bad for you. We also know precious little about the different strains. I have a patient who comes in with a book on different genetic strains of marijuana. He knows more about marijuana and genetics than I do about people. So it is a very difficult medical situation.

Mr. David Wilks: Thanks.

My three years of undercover drug work taught me quite a lot about THC, or Delta 9-Tetrahydrocannabinol. There are only two plants—indica and sativa—but there are hundreds of strains that can react differently to each person in this room and outside of this room. It's a challenging thing. In my opinion, the road is winding and unclear.

The Chair: Well put, Mr. Wilks.

Ms. Mathyssen, are you going to...?

Ms. Irene Mathyssen: Yes, I have a quick question.

I want to thank all of the presenters here today. I enjoyed listening to what you had to say.

It seems to me that you're talking about having to pay close attention to the reality of human beings. Whatever recommendations we make, compassion very much has to be a part of them. We have to consider the circumstances of individuals and what they're going through. I say that because there was great concern about having methadone clinics in my riding. Of course, the law-and-order types were dead against it until they discovered the people going there were people for whom we should have compassion. A number of veterans who had come back from peacekeeping with injuries and had been prescribed drugs that were difficult to overcome were going to the methadone clinic. So it's clear to me that we need to do a lot more looking.

The Lazarus project and the work at Inverness were mentioned. I'm wondering to what degree the Canadian health care field, the professionals, have engaged in similar efforts. Have we looked at these projects? What about the projects that would guide us compassionately with regard to the circumstances of the human being?

Is there anyone who could tackle that?

Dr. Norman Buckley: Looking at the clock, I'll rely on the chair to restrict this little excursion.

The Canadian Centre on Substance Abuse has initiated a national strategy that is not unlike the things you've described. They've brought together people from law enforcement, the pharmaceutical industry, addiction practice, pain practice, public health, nursing, first nations health, social work, coroners' offices, and a variety of other fields. What you describe when you refer to the Inverness project and Project Lazarus is integrated community strategies where everybody who's involved gets together to work towards a common goal, which is the compassionate care of people who require care. It integrates all of the necessary information into a treatment plan. The CCSA is working on that at a national level. Other groups have worked on it at local levels. At the end of the day, these templates need to be rolled out locally. In Hamilton, we've initiated a group that is working towards this at the local level, but it's necessary to do it in a variety of situations across the country.

● (1730)

Ms. Irene Mathyssen: Thank you, Dr. Buckley.

The Chair: Thank you very much.

Thank you to all of our witnesses here today.

If you have more questions, I'm sure Ms. DeGroote and Ms. Bromley would stick around for a few minutes to answer them.

I think that's it for today. We'll see you on Wednesday.

We have a new gavel here for the meeting, so the meeting is adjourned.