HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 012 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, February 6, 2014

Chair

Mr. Ben Lobb

Standing Committee on Health

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● (0845)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning, ladies and gentlemen. Welcome back. This is our first official meeting for 2014 on the health committee.

Most of our committee members are here to start the morning meeting. We have three witnesses. I think what we'll do is start off with Dr. Skinner, who's by video conference, and then we'll follow up with our witnesses who are here in person after he has completed. It's 10 minutes or less for your presentations. Our first round of questions is for seven minutes, followed by rounds of five minutes.

Dr. Skinner, if you're ready, go ahead, sir.

Dr. Roger Skinner (Regional Supervising Coroner, Office of the Chief Coroner for Ontario, Ontario Ministry of Community Safety and Correctional Services): Good morning, Mr. Chair, members of the committee, staff, and witnesses.

It is my privilege to assist you today, both as a physician and as a representative of the Office of the Chief Coroner for Ontario.

The issue of prescription drug misuse, especially in regard to opiates, is one of great significance to our office and to physicians as a whole. There is no doubt that this is a complex public safety concern of import and urgency. The Office of the Chief Coroner for Ontario investigates all non-natural deaths and some specified natural deaths in the province, totalling about 17,000 deaths a year.

The coroner's investigative mandate is threefold: to determine the identity of the decedent, the place and date of death, the medical cause of death, and the manner of death; to determine if an inquest is necessary; and to make recommendations to prevent deaths in similar circumstances, where appropriate. In Ontario, the coroner has powers of entry, inspection, and seizure that allow for a thorough examination of the circumstances of death, and for the compilation of detailed information about individual deaths and about broader population trends.

The Office of the Chief Coroner recognized the growing number of prescription opioid deaths a number of years ago. Opioid-related mortality in Ontario doubled between 1991 and 2004. This was in large part due to the misuse of sustained-released oxycodone. By 2008, the number of opioid deaths had grown to surpass the number of deaths of drivers in motor vehicle collisions. It has since continued to increase. The rate of death from opioids is more than twice that from HIV, and approaching that from sepsis. In Ontario, more than 500 people die from opioid toxicity each year. If deaths attributed to alcohol plus opioids are included, the number exceeds 700.

Accidental prescription drug deaths affect a broad range of age, from children to the elderly. Studies have shown that accidental drug deaths are more likely to be due to opioids, while suicides more often involve other prescription drugs. The source of drugs in declining order is: prescription, then a combination of prescription and illicit purchase, and then illicit purchase. The likelihood of the source of drugs being from a person's prescription increases with increasing age.

Our investigations and the studies of others indicated that a number of factors had contributed to the development of this crisis. These included: liberalization of the utilization of opioids for the treatment of non-cancer pain; lack of knowledge on the part of health care providers with respect to potential toxicity; lack of dosage guidelines; lack of effective means for monitoring who was prescribing and who was using opioids; aggressive marketing campaigns by manufacturers; and law enforcement restrictions due to health privacy legislation.

It was clear from our review that the problem cases were not coming from the cancer care sector. The problems were related to the treatment of chronic non-cancer pain, to illicit diversion of legally obtained opioids, and improperly prescribed opioids or improperly utilized opioids. The Office of the Chief Coroner identified the following issues in opioid-related deaths that required further investigation: the management of chronic non-cancer pain; the diversion or abuse of opioids, specifically oxycodone; access to prescribing information; and legislative hurdles to sharing of information.

The Office of the Chief Coroner for Ontario has endeavoured to share our information and experience with policy-makers, prescribers, and dispensers. We have participated in a number of efforts to address these issues, such as the College of Physicians and Surgeons of Ontario's report, " Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis"; the National Opioid Use Guideline Group's "Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain"; the National Advisory Committee on Prescription Drug Misuse's report "First, Do No Harm: Responding to Canada's Prescription Drug Crisis"; the public health division of the Ministry of Health and Long-Term Care's "A Review of the Impacts of Opioid Use in Ontario, Interim Summary Report"; and the Institute for Safe Medication Practices Canada's report "Death Associated with Medication Incidents".

● (0850)

I know you are aware of these reports, each of which sets out the problem and suggested solutions much better than I can in this brief presentation.

In addition to these collaborations, the Office of the Chief Coroner identified two related deaths that became the subject of an inquest focusing on the issue of prescription opioid misuse. The inquest was broad in its scope and examined addiction, access to drugs, prescribing and dispensing, enforcement, and legislative challenges. The jury made 48 recommendations that can be categorized and summarized as follows.

Regarding drugs, the jury recommended: the removal of sustained release products with more than 100 milligrams of morphine equivalent per dose, and the removal of products with more than 40 milligrams of oxycodone; the review of all approved opioids; the inclusion of dose recommendations in monographs; and a review of tamper-resistant formulations.

Regarding monitoring and data, the jury recommended the development of a database accessible to prescribers and dispensers in Ontario through eHealth and through the Narcotics Safety and Awareness Act.

In regard to treatment, the jury advocated for resources for comprehensive pain and addiction treatment programs and facilities.

In regard to education, the recommendation was for renewed public and professional education, including the development and maintenance of national guidelines and relevant research.

In regard to legislation and enforcement, the jury recommended the funding of provincial and municipal drug enforcement units, a clarification of privacy issues, and recommended mandatory sharing of information between health care providers and between police and health care providers.

These jury recommendations mirror the findings of the other reports referenced.

The problem of prescription drug misuse is complex. There is no simple solution. The answer lies in a nationally coordinated, multipronged approach. This is a difficult task that will become more difficult the longer we delay. The evidence is in, the analyses are done, and a pathway has been charted. What is needed now is a unified political and professional will to move forward and to keep the resolution of this public safety crisis as a priority. If we do so, I am confident that many premature deaths can be prevented.

Thank you.

The Chair: Thank you, Doctor. Very good.

Next up we'll have Cameron Bishop, director of government affairs for a pharmaceutical company.

Go ahead, sir.

Mr. Cameron Bishop (Director, Government Affairs and Health Policy, Reckitt Benckiser Pharmaceuticals Canada): Mr. Chairman, and members of the committee, I'm pleased to appear before you today for Reckitt Benckiser Pharmaceuticals Canada, and as a member of the National Advisory Council on Prescription Drug Misuse. It's being co-ordinated through the Canadian Centre on Substance Abuse.

I'm proud to be part of that council and to serve as one of its two co-chairs of the legislation and regulation committee with Dr. Mel Kahan of Women's College Hospital in Toronto.

The National Advisory Council on Prescription Drug Misuse, as you all know, released its strategy in spring 2013. For the most part, I will confine my remarks to the top-line recommendations contained in the report under the legislation and regulation committee.

Before that, however, let me give you a bit of background on Reckitt Benckiser Pharmaceuticals.

We are only an addiction treatment company, to my knowledge, the only one in Canada. We manufacture one product, [N]Suboxone. It's a combination of buprenorphine and naloxone. They are sublingual tablets. They are the first opioid medication for the substitution treatment of opioid dependence in an office-based setting.

However, above and beyond that, we also have a very different approach in how we operate in that we have a focus on working, obviously, with government and key stakeholders on everything from industry reform efforts, legislative and regulatory recommendations, and of course, breaking down barriers to treatment for patients.

[N]Suboxone was approved by Health Canada in May 2007. It is a fixed-dose combination of buprenorphine, which is a partial agonist, and naloxone, which is an opioid antagonist. It is indicated for medication-assisted treatment in adults who are opioid-dependent, and is available in two strengths: 2 milligrams of buprenorphine with 0.5 milligrams of naloxone and 8 milligrams of buprenorphine with 2 milligrams of naloxone.

For those who don't know what the naloxone component is for, it is to deter intravenous and intranasal misuse. Naloxone has poor bioavailability when it's taken orally or sublingually. However, if [N]Suboxone is taken intravenously, naloxone is 100% bioavailable and precipitates withdrawal symptoms in patients dependent on opioid agonists.

As Dr. Skinner pointed out—and as I'm sure other witnesses have—opioid dependence is a chronic relapsing medical condition of the brain, a well-recognized clinical and public health problem in Canada.

A 2009 study by Popova et al indicated that between 321,000 to 914,000 non-medical prescription opioid users were among the general population in Canada. Further, the estimated number of non-medical prescription opioid users, heroin users, or both, among the street drug using population was about 72,000, with more individuals using non-medical prescription opioids than heroin in 2003.

Historically, heroin has been the main source of opioid dependence; however, the current reality of illicit opioid use has become much more diverse and complex. In Canada, illicit opioid use includes a diversity of prescription opioids including: oxycodone, codeine, fentanyl, morphine, and hydromorphone. As a result, there has been an increase in demand for opioid dependence treatment across Canada.

Mr. Chairman, the individuals living with prescription drug addiction are—and it has always surprised me since I started this job—just like you, me, and everybody sitting around the table. They are a soccer mom who got into a car accident, broke her back, was prescribed Percocet, and found herself addicted. Then down the road, when she had been dismissed from the clinic by her doctor because the doctor in question wouldn't “treat patients like her”, she turned to prostitution while her kids were at school so that she could afford her Percocet. They are the returning soldier from Afghanistan—or Iraq, in the case of the United States—who used prescription opioids, either for soft tissue injuries or to numb the pain of watching their comrades in arms blown up by a landmine, then came home with an addiction to those opioids, and at times with PTSD.

These are the faces of prescription drug addiction, individuals who by way of voluntary action wound up with an involuntary addiction.

I have met a lot of addicted patients and I have yet to meet one of them, whether they use heroin, or whether they use prescription opioids, who told me that they took that first hit because their goal in life was to be an addict. Nobody in their right mind would want that for a life.

The stories I shared are real stories. They speak to a problem that is not just confined to the alleys and gutters of Canada, but rather one that is widespread, growing, and at crisis levels.

We as a society, however, through lack of access to treatment and at times policies that criminalize disease versus treating it in the context of what it is, a public health crisis, often force men and women like that soldier and that soccer mom down the slide from a contributing member of society to one on the margins, in the gutter, or in jail, or worse yet, dead.

● (0855)

While we must expand treatment in Canada in all of its forms, so too must we battle the stigma of addiction that allows Canadians struggling with this condition to avoid treatment because of the perception, and at times the reality, that if you admit that you have a problem with abuse or dependence, then you are somehow not worthy of being part of what we define as normal. Our treatment and view of individuals who battle substance abuse in all its forms is too often one of the lowest common denominators. In many respects it is the soft bigotry of low expectations.

Mr. Chairman, in the context mentioned above, I will now present to you the recommendations from the legislation and regulation committee of the National Advisory Council on Prescription Drug Abuse. Taken together these recommendations would help put Canadian public health, patient safety, and patient dignity at the forefront while seeking to mitigate the unintended consequences of prescription opioids.

The recommendations are as follows:

One, amend the general labelling requirements under part C of the food and drug regulations to require that all prescription opioids carry the warning—and these prescription opioids should be either painkillers or addiction treatments—that there is a possibility of addiction, misuse, or death with drugs in this class even if the drugs are used as prescribed. Also, the labels on painkillers should be restricted to severe pain only. As well, all labelling should reflect what the clinical trials actually showed.

Two, the federal government should mandate that federal public drug plans require physicians to apply for exceptional status approval should they wish to prescribe opioids over the 200 milligram a day dosage level. This is the watchful dose under current Canadian guidelines.

Three, the federal government should move to change Health Canada's existing drug approval process for both generic and branded pharmaceuticals to require the denial of approval if a conflict of interest is found, for example, if the maker of a prescription opioid painkiller also manufactures a treatment for that same addiction that can result from the painkiller, or if a company manufactures a treatment and then goes on to market a painkiller.

Ideally, no company should be permitted to drive volume of one product with another. If a company wishes to manufacture and sell addiction treatment, regulations must be put into place to stipulate that it first stop selling the products that have addictive properties.

Four, Health Canada should deny drug approval to any company that does not have safety provisions built into its prescription painkillers that aim to reduce abuse and diversion. All companies that manufacture generic or branded prescription medications or addiction treatments must be required to contribute funding to surveillance systems for prescription drug abuse, misuse, and diversion, as well as to general drug safety awareness.

As well, the Minister of Health should be empowered to deny notice of compliance to any pharmaceutical company that manufactures painkillers or addiction treatment if that company fails to comply with the provisions that I've outlined above.

Additionally, the federal government should propose that plans delist high-dose opioid formulations, that they should add weak dose opioids, and mandate only tamper-resistant formulations and child-resistant packaging be placed on formulary.

Five, they should require mandatory review every two years by Health Canada of the product monographs of companies that manufacture prescription drugs with high abuse potential, and that would include opioids, stimulants, etc.

Six, the federal government needs to review regulatory requirements relevant to opioid medication—I'm referring to section 56 of the Controlled Drugs and Substances Act—and implement changes as required to remedy barriers that may exist to treatment.

Seven, they should increase the transparency of all clinical trial data by requiring industry to provide all data related to clinical trials, and for Health Canada to make that information public.

Further to that, they should also add an offence to the Food and Drugs Act for misleading the federal regulator.

Eight, they should require that all federal drug formularies cover naloxone.

Nine, they should require that all companies, both branded and unbranded, that manufacture or distribute opioids, sedatives, hypnotics, or stimulants comply with full drug submission requirements before listing. This would include the conducting of clinical trial testing for generic manufacturers.

Ten, they need to review international evidence and existing programs for risk evaluation and mitigation strategies to identify and develop effective risk mitigation strategy standards and models for pharmaceutical companies that must be adopted by industry players.

● (0900)

Eleven, they should require annual reporting to Parliament, Health Canada, all provincial ministries of health and provincial medical colleges on all aspects of a branded or unbranded company's risk mitigation strategy activities.

Twelve, they should implement stringent financial and regulatory penalties for branded and unbranded companies that fail to report and/or comply with their Health Canada-approved risk mitigation strategies.

Last, they should establish a national take-back day—and I think Mark will agree with this—for prescription drugs. Let's get the old drugs out of the medicine cabinet and into a place where they can be disposed of safely. To that end, the federal government should request that the Canadian Centre on Substance Abuse work with key stakeholders across the country to develop the national standards for the take-back and disposal of these medications, because currently none exist.

That concludes the recommendations of RBP and its committee. We look forward to working with parliamentarians to implement these. I'd be happy to meet with any member of this committee to discuss how we can work together to get this done.

Thank you very much.

● (0905)

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

Up next, from the Canadian Association of Chiefs of Police, is Chief Mark Mander.

Go ahead, sir, for 10 minutes.

Chief Mark Mander (Chair, Drug Abuse Committee, Canadian Association of Chiefs of Police): Good morning. By way of introduction, my name is Mark Mander. I am the chief of police with the Kentville Police Service, and I'm the chair of the Canadian Association of Chiefs of Police drug abuse committee.

On behalf of CACP president Chief Constable Jim Chu, I would like to express our sincere appreciation to this committee for allowing us the opportunity to contribute to this critical issue. I would also like to congratulate Mr. Lobb on his reappointment as chair of this very important committee, as well as the other members for their appointments.

The CACP, through its 20 public safety and justice related committees, contributes primarily through the justice and human rights, and public safety and national security committees of the House of Commons. For your own background, the CACP represents in excess of 90% of the police community in Canada, which includes federal, first nations, provincial, regional, and municipal police leaders and services. Our mandate is the safety and security of all Canadians through innovative police leadership.

In 2007 the CACP adopted a drug policy that was developed through the drug abuse committee. This policy sets out the position of the CACP on this very important national issue that has a direct impact on Canadians on a day-to-day basis.

Let me provide a brief overview of our drug policy. We believe in a balanced approach to the issue of substance abuse in Canada consisting of prevention, education, enforcement, counselling, treatment, rehabilitation, and where appropriate, alternative measures and diversion of offenders to counter Canada’s drug problems. We believe in a balanced continuum of practice distributed across each component.

In addition, the policy components must be fundamentally lawful and ethical, must consider the interests of all, and must strive to achieve a balance between societal and individual interests. We believe that to the greatest extent possible, initiatives should be evidence based.

You in your deliberations have no doubt heard and will continue to hear the countless stories of families who have painfully and helplessly seen their loved ones succumb to the abyss of substance abuse or even die as a result. Some of these deaths have been from a single experimentation with prescription narcotics. We need to continue to listen to and learn from their voices, as they are the ones who have suffered from what is termed the "unintended consequences" of prescribing.

In 2004 the Canadian Association of Chiefs of Police, through resolution 08-2004 called upon the federal, provincial and territorial ministers of health to prioritize the implementation of safeguards, in consultation with Canadian policing and pharmaceutical representatives, to prevent the further diversion of prescription drugs to the illicit drug trade.

In this resolution we expressed concern that the illicit use of prescription drugs is a serious health concern and that this could be mitigated through safeguards, which would include enhanced inspections of distributors, enhanced inspections of pharmacies, and the monitoring of excessive doses prescribed in prescriptions. In 2012 we reiterated our position through another resolution.

This problem has grown to impact many communities across Canada. My policing colleagues across this country are increasingly concerned about the number of young people abusing prescription narcotics often accessed from family medicine cabinets and friends. We are concerned about the increase in pharmaceutical-related crimes, including pharmacy robberies, prescription drug diversion, break and enters, trafficking, double doctoring, prescription theft and forgery, drug-impaired driving, as well as theft-related offences committed to fuel the financial needs of people seeking drugs. Most concerning is the large number of deaths that have a direct link to prescription drug abuse. Some of our first nations communities have been hit the hardest, where addiction rates are said to be many times the norm.

While we know that drugs are intrinsically linked to crime, we cannot, however, simply enforce our way out of this problem. We require a national community response to address this crisis.

For us, the way forward has been written. The "First Do No Harm: Responding to Canada's Prescription Drug Crisis" strategic plan was developed through extensive consultation and work by many stakeholders under the expert guidance and leadership of Michel Perron of the CCSA team.

● (0910)

For the implementation of this strategy to be successful, however, there is a need for continued resourcing. Most important, the federal, territorial, and provincial governments must lead the way by working together to adopt this plan and ensure that it remains a priority over the next number of years.

For policing, the most critical path in this strategy is monitoring and surveillance so we can ensure we are collecting and acting upon the most current and relevant data. Having a nationally coordinated prescription monitoring program is the natural first step.

In the plan for law enforcement, we have undertaken a number of things.

First is to determine the extent of the impact of prescription drugs on law enforcement resources and public safety. Currently we are undergoing a study, which is being facilitated by Public Safety Canada, to determine some of that data.

Second, we want to raise awareness among key law enforcement and justice bodies.

Third, and Cameron referred to this, is to promote safe storage and disposal of prescription drugs. Based on a model used by the DEA in the United States, and the experience of some extensive work in Ontario, the CACP along with Public Safety Canada held a national prescription drug drop-off day on May 11, 2013. Police recorded receiving just over two tonnes of pharmaceutical products on that one day. We plan on continuing this program. This year's date has been set; it's May 10.

Fourth, we want to identify the gaps in tools or training for criminal justice professionals to better address the illicit use of prescription drugs.

Fifth, we want to ensure death investigations across Canada are conducted in an evidence informed and consistent manner. This process is currently under way as well.

Sixth, we want to identify and address barriers to immediate access to and sharing of relevant information. We feel the prescription drug monitoring program is the way we can do that.

In closing, prescription drug abuse cuts across a multitude of service providers and stakeholders. The CACP is but one of the players. We are willing to step up and do our part in resolving this national crisis.

Thank you.

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

Those were three good presentations.

We're going to start our first round of questioning with Ms. Davies, for seven minutes, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you to the witnesses for coming today. You made excellent presentations.

I have a lot of questions. They are going to take me way over seven minutes.

Mr. Bishop, your information was fascinating. I'm happy that you gave so many detailed recommendations. I didn't manage to scribble them all down, but I'm sure the analyst has them. They were very specific and very good.

I'd like you to tell us a little more about Suboxone. I'm very familiar with methadone. I have many constituents on methadone, and many of them have terrible experiences. Methadone is very addictive and people often go back to illicit drugs and they end up mixing things. Suboxone is not nearly as addictive.

I'm curious. Do you know how many people are on methadone compared to Suboxone? Do you have a general idea? I could be wrong, but why is methadone so commonly prescribed but Suboxone isn't? Is it the price, or is it that doctors are so familiar with methadone?

In Vancouver we have pharmacies that basically dispense nothing but methadone. It seems to be so readily available, yet I hear people hate it. I've encountered people who have used methadone as pain management and then become very addicted, and some have even died. I'm very curious about Suboxone and the fact that it is much less addictive and how commonly it's used.

Is it correct that it has been withdrawn in the U.S.? Our notes suggest that some formulation of it has been withdrawn. Maybe you could explain that.

Anyway, I'd like to know a little more about the differences between these two drugs.

● (0915)

Mr. Cameron Bishop: First of all, let me mention one of the things we don't do at our company. We will never bash another treatment. We won't say that methadone is any better or worse, or that Suboxone is. The reality is that if you sell treatment, then Suboxone, methadone, psychosocial support, everything will be successful by extension. Treatment will be successful.

There are different patient profiles for which methadone is very appropriate. I don't like to pigeonhole the patients who take Suboxone versus the ones who are commonly on methadone, but we'll often find that when physicians prescribe methadone for patients, it's normally because they've suffered some sort of very big trauma, sexual trauma, violence, what have you, in their formative years. What happens with the Suboxone component.... As you well know, with methadone you have almost a dazed feeling and a dazed look when you take it. Often patients who take Suboxone will say that their mind is too clear and they don't want to think about the stuff that happened in the past, so put them back on methadone. Depending on the patient profile, methadone might be a better fit.

With regard to how many people are on Suboxone and methadone and why Suboxone is not more widely prescribed, it's a multi-layered reply. First is that some of the provinces and their medical colleges will require that you have your exemption to prescribe methadone before you're able to prescribe Suboxone. In Ontario that is not the case. Anybody can prescribe Suboxone.

Ms. Libby Davies: What about in B.C.?

Mr. Cameron Bishop: B.C. is a funny place in many good ways. They're so progressive in a lot of ways in terms of making sure that treatment is available. In B.C. you have a situation where Suboxone can be prescribed, providing the doctor has entered into what's called a collaborative prescribing agreement with the provincial Ministry of Health, but there are requirements as well for methadone exemptions.

I can tell you that 50% of the physicians I've met will say they don't want family doctors prescribing Suboxone, and then 50% of addiction specialists will say they don't mind family doctors prescribing Suboxone, and let the specialists handle the more challenging cases.

There's a bit of a hodgepodge in terms of what's going on nationwide on the price. When you look at the price compared to methadone—I'm going to pull a number out of the air—methadone is literally pennies. What they don't factor in when they look at methadone is.... There was a study done by Neil McKeganey, which I'm happy to provide to the committee, that looked at the social cost associated with the use of methadone. They found that over time, in comparison to Suboxone, the methadone costs were very high. That was actually proved by a paper that just came out from CADTH, Canadian Agency for Drugs and Technologies in Health, that said in the long term, cost-effectiveness of Suboxone, even though the price point is a little bit more expensive, is much better.

Last, regarding the formulation piece that you touched on, yes, it is true that we did apply to the FDA to remove the tablet formulation. We've gone to the film. It's the same with Australia. The reason, though, is that in the United States there was no requirement by the FDA to have child-resistant or even tamper-resistant packages. In Canada you get the foil packs. In the United States, it was literally a bottle of 30 tablets that could be opened by children. We went to the FDA and said we were withdrawing it, and we thought that everybody should, or at the very least, that they should make sure that it's child-resistant.

Ms. Libby Davies: That's very responsible. Thank you for telling us that.

I have one other quick question. Does RBP or any other company that you know of participate in any research, either in Canada or globally, around finding other medications that can deal with opiate dependence which don't create further dependence? What kind of research is going on? Can we expect to see some new developments there?

● (0920)

The Chair: Mr. Bishop, you have 30 seconds to respond, please.

Mr. Cameron Bishop: I can't go into conversations about pipeline, but I can say there is research ongoing to broaden opiate dependence treatment, but also in a litany of other treatment areas as well. We will only ever be an addiction treatment company. We will not go into other areas, because our focus has to be on this population.

The Chair: Thank you very much.

Ms. Adams, for seven minutes.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thank you very much for joining us today on this very important subject.

If I might direct my first question to the coroner, I'm looking at the report for Mr. King from 2011, and it states that the means of his death was accident. Then when I look at the report for Ms. Bertrand, also in 2011, it states that the means of her death was suicide.

Could you tell me how many types of means there are?

Dr. Roger Skinner: The coroner and all physicians have a choice of five manners or means of death: natural, accident, suicide, homicide, or undetermined.

Ms. Eve Adams: It would be beneficial to have an additional category that would allow you to properly categorize these prescription drug overdoses. Do you think that perhaps we are masking the issue?

Dr. Roger Skinner: No, I don't think so.

What we do in Ontario and in most provinces is in line with the World Health Organization. It allows us to implement a system that is transferable between jurisdictions. Although there is some movement on the definitions of each of the manners, overall I think it is the best classification system.

Ms. Eve Adams: For instance, when I'm looking at Mr. King's report and it says that the means of his passing was an accident and it is due to an overdose, do you really think that it is fair to characterize an overdose as an accident?

Dr. Roger Skinner: Yes.

It's not always possible to make the determination of someone's intent, but based upon the balance of probabilities, which is our standard of proof in most circumstances, we can. The data that's collected is not just the manner of death or means of death, but also the cause of death. Drug toxicity would be the cause of death in both Mr. King's and Ms. Bertrand's circumstances. For those of us who would go then to collect the data, we wouldn't miss either of them because we would base it not just on the manner of death, but on the cause of death as well.

Ms. Eve Adams: To be fair, I suppose to the layperson, when you read “accident” you think of possibly a car accident. You think of somebody injuring themselves, that it was unpredictable, unexpected. If someone is habitually overdosing on prescription drugs, I don't know as a layperson if it would be fair to characterize that as an accidental cause of death. I think and I hope that's what we're all sitting around here discussing, trying to determine how we might intervene to assist Canadians that are suffering from this terrible issue.

Could you give us your best recommendations on what we could do as a federal government and at Health Canada to prevent prescription overdose, so that somehow we would distinguish those individuals who are using medications obviously for legitimate purposes from those who end up becoming addicted to prescription drugs?

Dr. Roger Skinner: I think one of the issues, and I think both Mr. Bishop and the chief referenced this, is that there may not be a huge benefit in separating those groups because the risk applies to all those groups. I'd start by saying that.

In answer to your question about what can be done at the federal level, perhaps I could give you a short list of what I think should be done, after being involved in the inquest and what we've been doing over the past number of years.

First would be to continue to resource the national initiatives to develop an approach, such as the CCSA.

Second would be to resource appropriate research, especially into the management of non-cancer pain and into addiction treatment.

Third would be to control access to dangerous preparations, particularly in opiates—that has been referenced by the other speakers as well—primarily access to high dose preparations.

Fourth would be to facilitate a national data collection and sharing system for prescribers, for dispensers, and also for researchers.

Last—

● (0925)

Ms. Eve Adams: If I might just jump in on that one, is there a good model elsewhere that you would recommend?

Dr. Roger Skinner: I'm not aware of a national model. I think most jurisdictions have difficulties with piecemeal-type collection systems. Within the country, I think Alberta and Nova Scotia lead us. Ontario is well behind, but has made an initiative and is starting to collect that information. The next steps are to get all provincial and territorial jurisdictions to collect the information, but then someone has to provide the means to share that across borders.

For example, when I was practising in the emergency department, one of the difficulties we had is we often would get stung or scammed by people who were looking for drugs. A young couple came in. They said they were in that small town to attend a funeral. They had forgotten their prescription and all they wanted was a week's worth of the opiate that they were on, so seven or eight pills. After much discussion, I gave it to them, and off they went.

The next month the RCMP came to my office and said they had done a traffic stop in Alberta because somebody's vehicle had a tail light out. The officer looked in the back seat and saw hundreds and hundreds of empty prescription bottles. This is how the couple made their living, by travelling from coast to coast getting small amounts of opiates and selling them as they went.

There's no way to track that. There's no way from jurisdiction to jurisdiction to track that. If we could, we could make a difference.

Ms. Eve Adams: Once we have the e-health records fully available and accessible, that might be one way. I know that Alberta, for instance, is a leader.

Dr. Roger Skinner: Correct.

Ms. Eve Adams: In Ontario we've had obviously the big scandal with the e-health investments that went astray under the Liberal government. Alberta actually has brought this to bear and are able to check what patients are requesting. Do you think that would be helpful?

Dr. Roger Skinner: Correct. Yes.

Ms. Eve Adams: We are funding that as a federal government.

The Chair: You're up around seven minutes there.

Thanks very much.

Our next round of questions is from Ms. Fry. Go ahead for seven minutes, Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I want to congratulate everyone on excellent presentations. They were very clear, very concise. There are a couple of questions that I want to ask.

Mr. Bishop mentioned that one of the biggest things was the tampering and the ability of our FDA or our Minister of Health to start looking at issues of tampering and tamper-proof formularies. Why do you think that we continue to have OxyContin as a drug when the federal Minister of Health was told about this by every single public health officer across the country? Every single minister of health across the country wrote a letter, and the United States also asked that Canada move away from the ability to use OxyContin on the street. This is one big step the federal government could take.

Do you have any idea if there's an argument why the federal government would not do that? That's my first question.

Mr. Cameron Bishop: No. To be honest, in this respect, I think that Health Canada should follow the lead of experts across the country, and the drug should be tamper-resistant 100%. There is no reason to have non-tamper-proof generic forms of oxycodone or fentanyl or anything. The technologies exist, and if you're going to bring them to market, you should be required to make sure they are tamper-resistant.

Hon. Hedy Fry: Thank you, because not only did they not bring in the regulations with regard to tamper-proof, but they also allowed six new companies to start putting forward this very, very important drug that can be tampered with and used as a street drug.

Anyway, I wanted to ask something else. You talked a lot about Suboxone. I know the value of it and I appreciate your answers with regard to individual patient clinical information that might define what they go on, whether it's methadone or something else. Do you have any comment on the recent work that has been done in British Columbia by UBC researchers with regard to the use of hydromorphone and other morphine-related drugs being used with heroin? These are going to be drugs that have to be prescribed. What is your comment on that?

We know that in Europe, for instance, HAT, heroin assisted therapy, programs are going on in most countries with regard to that kind of substitution therapy for people who use street drugs and who need to have a prescription drug to help them get off street drugs. If we don't initiate that, what we're doing is forcing people who have had very good help under some of these programs to go back to street drugs.

Do you have a comment on that?

● (0930)

Mr. Cameron Bishop: This is why we will never say that our treatment is the best treatment, or that methadone is the best treatment. The reality is, as with cancer treatment or any other treatment, there is a variety of different ones that will work for different patient profiles. Treatment is what should be promoted, versus a one-size-fits-all model, which just simply doesn't work because the patients vary across the board. I would say that any treatment that has viability, that is safe for patients, should be explored, and if it's scientifically sound, then yes, I think that any treatment is worthwhile.

Hon. Hedy Fry: We know, for instance, that it was recommended that this be an allowable treatment by registered and certified physicians by the Department of Health, and the minister stepped in and said no.

I think Mr. Mander talked about evidence-based policies, and I think this is clearly a matter of non-evidence-based policies. It's a matter of ideological interference in what the evidence has shown to be so. I know that the Chiefs of Police have looked at very creative ways of dealing with this and have actually been very concerned about the lack of harm reduction policies in many areas.

Do you have a comment on that?

Chief Mark Mander: First to Cameron's point about using tamper-resistant strategies, we would believe that has to be done proactively at the initial stage, versus reactively once you determine that something has caused harm within the community. We're all about getting at the front end, at the front end of the river versus the downstream impact. Quite often from a policing perspective, we see the downstream and then we see the reactions from health care from a reactive perspective.

We think we need to change our thinking and move to a proactive stance that for any drug, and not just the current drugs that we have now, but any new drug in the future, we need to be looking at what the potentiality for harm is within the community, and what we need to do to reduce that risk within the community.

A lot of it is education of the physicians and the entire system about the drug and the potentiality, and the steps and measures needed to put it in place. Certainly you can have a great prescription monitoring program across this country, but you also have to make sure that people use it. It's well and fine to have a system, but it has to be somehow more than just a guideline. It has to be one of telling the prescriber, “You need to access this before can give a script for anything.” That's our thinking on it.

The Chair: You have a minute left.

Hon. Hedy Fry: I want to talk about one of the steps which I think has made a great deal of difference in terms of prescription drug use in British Columbia. Street drugs are the drugs in British Columbia, and not so much prescription drugs. Has the triplicate prescription program made a difference in British Columbia?

Mr. Cameron Bishop: Anecdotally, yes, I would say that the folks in B.C. are rightfully quite pleased with the triplicate program. I hear a lot of good things about it, and so yes, in that sense I think anecdotally...and I'm thinking about 30 doctors who I've heard from in that province, they have been very pleased with it.

Hon. Hedy Fry: Could it be nationally implemented in some way, shape, or form?

Mr. Cameron Bishop: I think anything that you can do to cut down on the diversion aspect, the abuse aspect in any way, shape, or form, best practices should be explored and if necessary made national, yes.

Chief Mark Mander: Could I add a comment to that?

The Chair: Briefly, yes.

Chief Mark Mander: In Nova Scotia we have a very robust prescription monitoring program and double doctoring has virtually disappeared in Nova Scotia. The trouble is, they can then go to P.E.I. and get a scrip. That's why you have to—

● (0935)

The Chair: That's a very good point.

We're on to our last section of seven minutes, and certainly someone who is no stranger to Parliament Hill, but a new member to our committee, Dr. James Lunney.

Welcome. You have seven minutes, sir.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thanks very much, Mr. Chair.

I thank the witnesses, all of you, for appearing today on a very important study that we're continuing with in 2014. We're wrapping up a study that began last year with a committee of different composition.

You've come up with a lot of very interesting suggestions collectively here on how to manage a very difficult problem.

One of the issues today, I think it would have been helpful for committee members if we had your written testimonies in front of us, but of course there was very much a shortage of time. I appreciate your being here on very short notice. There wasn't time to translate documents, and so on. Recognizing that, some of us were not quick enough on the draw to get down all the things that you listed, so I hope you'll forgive us if we repeat some questions on things you've already covered.

Dr. Skinner, you mentioned a rather alarming statistic, that by 2008 the opioid deaths exceeded the number of motor vehicle accidents. Am I correct in that statement, in understanding what you said?

Dr. Roger Skinner: Yes. The number of deaths due to opioid toxicity exceeded the number of deaths of drivers in motor vehicle collisions in Ontario. It continues to do so significantly now.

Mr. James Lunney: Do you have an idea of what that death number would be, going back to 2008? I think it was 2008 you'd mentioned.

Dr. Roger Skinner: The first year we broke the 300 mark was 2008. We approached about 350 in 2008. The number of deaths of drivers in the province was well below the 300 mark, but since then the number of deaths due to opioids has increased. As I said, it's in excess of 500 now.

Mr. James Lunney: Thank you for that.

I'll go back to Dr. Skinner and the coroner's office in just a moment, but first I want to pick up on something that Cameron Bishop said.

You made a very extensive list of recommendations. You talked about amending the generalized labelling on the products. You also talked about painkillers and addiction, and that they should clearly mention the possibility of addiction or death. For over 200 milligrams, you said that doctors probably should have special qualifications. Doctors are regulated provincially. Would you recommend a pan-Canadian strategy of some kind to address this, that all of the provinces might work on together to make sure that anybody prescribing these higher doses has special qualifications?

Perhaps you could comment on that.

Mr. Cameron Bishop: When you look at section 56 and the requirement to have an exemption to prescribe methadone—that has to come through Health Canada, but the colleges handle it—this is something where I think the federal government could look at it and say, "What's going on with the addiction treatment side? Do we need to add some sort of wording, some sort of amendment, that would require some form of an exemption for anybody wanting to go over and above that?"

I can tell you that on our committee, that's been a debate in terms of how that looks. We're not 100% sure what that should look like. I would say that because of section 56 and the language in there, I would think the discussion could start at the federal level, and see if there is a way to kind of work language in that would allow for some form of qualification over and above what they already have.

Mr. James Lunney: I appreciate that.

You made a reference to increased transparency in all the clinical data. I think you went on to talk about making it an offence if a company is convicted of misleading the regulator.

I think we had a pretty egregious example of that back in 2007, of a company, part of Purdue, that I think was charged in the United States with misleading the regulator. There was a fairly hefty fine involved. That would be on the U.S. side, wasn't it? It had to do with OxyContin.

Is that what you're driving at with this?

Mr. Cameron Bishop: One of the things we do lack is an accountability mechanism for some of the regulators for the companies. I have to say I'm pleased with, for example, Bill C-17, but in that context there's a lot of stuff that could be done to tighten it up, based on the recommendations here, that could make Bill C-17 stronger and could go a little bit of the way to addressing some of the things we've talked about here today.

● (0940)

Mr. James Lunney: I'll turn to the Chiefs of Police now. Thank you for being here today.

Mr. Mander, I want to ask you about some of your comments regarding the tools police have available in terms of surveillance tools, or tracking tools, for pharmaceuticals.

Chief Mark Mander: First, when we thought about this as an issue....

We're very adept at tracking all the illicit drugs. We're very good at tracking the criminal element that's involved in that, but quite often we're cut short when all of a sudden the drug of choice in the community becomes a prescribed drug. It becomes very difficult for us to manage that from the investigative and enforcement perspective.

If you have a number of people in the community who have drugs, and they're trading among each other, you can't distinguish between one person's scrip for 20 Dilaudid pills and another's. You can't tell whether or not those have been exchanged, but quite often that is what happens. In the culture that these folks are in, someone can score some drugs from a physician and trade them to someone else.

When we talk about deaths in Nova Scotia—we've had roughly 400 in the past five years—that's what we're seeing, this cocktail of alcohol and drugs, some illicit and some licit, methadone, etc. That is what, unfortunately, people are succumbing to. From an investigative perspective, when we go to these scenes, it's very difficult to manage from a policing perspective, especially when you have the families asking what we can do from a policing perspective, as someone sold this person those drugs.

Certainly we're getting there. There have been some charges laid in relation to folks trafficking those drugs to people who have subsequently succumbed.

Mr. James Lunney: I can see that Mr. Bishop wants to jump in. I'm heading your way anyway, so—

The Chair: If you have a brief comment, that's fine, or we'll just go on.

Mr. Cameron Bishop: I was just going to say, Dr. Lunney, that in terms of a monitoring system, I would encourage committee members to look at the RADARS system in the United States. It's quite fantastic.

Is it the best there is? That I can't say, but I do know it's certainly one model we could look at.

The Chair: That's good. Is that in California?

Mr. Cameron Bishop: It's based in Colorado.

The Chair: I was thinking about maybe a committee trip to go and have a look at that, but I—

Voices: Oh, oh!

Mr. Cameron Bishop: You can go skiing in Colorado, Mr. Chair.

The Chair: Okay, very good.

Our next questions are going to be from Mr. Morin *en français*.

[*Translation*]

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

Dr. Skinner, my first question is for you. You stated in your opening remarks that one of the problems is lack of knowledge about the toxicity of medication. What do you feel is lacking? Is it knowledge on the part of the medical profession or continuous training on addictive prescription drugs?

I would like you to give us some more information so that we can better understand Canada's situation.

[*English*]

Dr. Roger Skinner: Yes, I think the shortcomings are twofold.

First of all, there's inadequate research evidence about the effectiveness of treatment of non-cancer pain, especially with opiates. That's an area that needs to be looked at in a more in-depth and scientific way.

Second, you are absolutely correct when you say that physicians receive very little formal training when it comes to pharmaceuticals and when it comes to prescribing, and when it comes to prescribing opiates in particular. During their medical school training and residency, there are very few hours spent on that subject.

It's often learned as we go. After we are licensed, there's no requirement to learn anything more. This might be the benefit of looking at some sort of an exemption system, such as we have for methadone, in that in order to get that exemption and be allowed to prescribe high doses of opiates, you would have to show some evidence of training and knowledge in order to be able to practise in that way.

● (0945)

[*Translation*]

Mr. Dany Morin: Thank you.

My second question is also for you.

In your opening remarks you also stated that one of the problems is aggressive marketing on the part of companies. In Quebec, where I come from, the rules on drug-related advertising are not the same as those in the rest of Canada. I think that drug-related advertising in Quebec is more subtle—

[*English*]

The Chair: Pardon me for a second. I think we just got the last two seconds. We'll tack the time back on and start over again, okay? I'm sorry about that.

Mr. Dany Morin: It's not a problem.

[*Translation*]

As I was saying, my second question is for you, Dr. Skinner.

In your opening remarks you referred to aggressive marketing on the part of companies. I come from Quebec. Drug-related advertising, especially on television, is quite different there compared to the rest of Canada. I would even say it's more subtle.

Could you speak to us about the situation throughout Canada and give us some concrete examples of just how aggressive marketing is? « Aggressive marketing » are the words you used.

[*English*]

Dr. Roger Skinner: I'll speak from my experience when I was practising, especially during the 1980s and 1990s when drugs like OxyContin were on the rise.

We, being physicians, obviously don't get our information from TV commercials. We get it from advertisements in medical journals and also from representatives of pharmaceutical companies who come to the office for the purpose of educating us about their new products. It was in that forum where the message of the safety of the product and the message of changing our practice to prescribing whatever dose it took to completely eliminate pain was made.

As was referenced, I think this was some of the issue that came out with Purdue south of the border as well. The marketing was targeted at prescribers at the office level.

[*Translation*]

Mr. Dany Morin: Thank you very much.

My last question is for you, Mr. Bishop. In your opening remarks you said that it is important to expand treatment of all kinds. Do you believe that harm reduction should be one of those kinds of treatments?

In Canada, there are various kinds of harm reduction, especially when it comes to drug abuse, whether those drugs have been prescribed or not. Prior to 2007, harm reduction was the fourth pillar of Canada's National Anti-Drug Strategy. That was eliminated under pressure from the Conservative government.

Do you feel that harm reduction is still indicated in Canada in 2014?

[*English*]

Mr. Cameron Bishop: I would submit that "harm reduction" is a very charged term; however, I would submit that any form of treatment is necessarily harm reduction. Whether you're taking methadone or Suboxone, or psychosocial support, or whatever it might be, I would suggest that yes, it does need to be a pillar. Does it need to be specified? Yes. However, I would suggest that for a variety of reasons the term "harm reduction" rubs some people the wrong way, and they don't understand it.

I think when you look at anything, you are lessening the harm to somebody when you're getting them into some form of treatment. Whether or not you want to officially call it harm reduction, or you want to put it into a pillar, or this, that, or the other thing, the reality is that if you're in any form of treatment, you're necessarily in harm reduction.

The Chair: Thank you very much.

Next up, for five minutes, is Mr. Terence Young.

Mr. Terence Young (Oakville, CPC): Mr. Bishop, could you please tell the committee, is your background in practising medicine, or clinical research, or...?

● (0950)

Mr. Cameron Bishop: I don't have a background in medicine.

Mr. Terence Young: Or clinical research?

Mr. Cameron Bishop: No.

Mr. Terence Young: I'm sorry, because it says here that you're director of health policy and treatment.

Mr. Cameron Bishop: Yes, that is correct.

Mr. Terence Young: Does your company recommend any non-drug therapies to treat addictions?

Mr. Cameron Bishop: Yes. Actually, if you look into our product monograph, we will always say that any form of medication-assisted therapy should always be used in the context of psychosocial support. You can't just do one-offs.

Mr. Terence Young: Thank you.

I want to read you something. I do a lot of research on prescription drug safety, so while I was sitting here with my BlackBerry, the first website I went to was drugs.com, and I looked up Suboxone, and here's what it says: "Misuse of narcotic pain medication can cause addiction, overdose, or death." This is on the information for the drug that you're proposing. It also says who shouldn't take it, what other drugs affect it, and it issues a warning.

I think you heard the coroner say there are a lot of comorbidities or co-addictions, and I'm sure you're aware of that. It says for Suboxone, "Dangerous side effects or death can occur when alcohol is combined with Suboxone."

You're recommending to this committee that we recommend that all formularies include Suboxone for all hospitals and any centres—

Mr. Cameron Bishop: No, I didn't include Suboxone.

Mr. Terence Young: That was one of your recommendations.

Mr. Cameron Bishop: No, I said "naloxone".

Mr. Terence Young: Oh, sorry.

Getting back to your product, basically your company has one product, a drug, which is an opioid, which is the problem we're dealing with, and your product can become addictive.

Mr. Cameron Bishop: Yes, right.

Mr. Terence Young: Also, it's dangerous with alcohol. I don't understand.

Mr. Cameron Bishop: Well, yes, that comes from the belief that you're giving a drug to somebody to treat addiction, so you're giving a drug to a drug addict. That being said, there are a number of studies that prove the safety of it when used as prescribed.

Mr. Terence Young: Thank you very much.

Dr. Skinner, I want to follow up on what the parliamentary secretary was talking about with regard to manner of death.

I've done a lot of work on prescription drug safety. One of the roadblocks we have is that deaths related to prescription drugs end up being covered up in the media, etc., first of all because they don't publish suicides, and I understand why, because it can create clusters, but also because when a doctor gives a prescription drug to a patient and they die, the manner of death is always natural, so no one sees a need to investigate.

I pleaded with the justice committee—with two other parents who had lost children to prescription drugs—in 2005, with the Province of Ontario that a new category for manner of death be created that would be either prescription drug or iatrogenic error. They totally ignored us, and they changed the act to get the minister's responsibility right out of it altogether.

Don't you think it would be better if there were a category so that families and patients, and the public and the media could be aware when a doctor had given a prescription drug to a patient and the patient died?

Dr. Roger Skinner: No, I don't.

Mr. Terence Young: Could you please explain that?

Dr. Roger Skinner: I don't think it would add anything to our ability to investigate, to obtain that information, or to share that information over what we have. What it would do is it would make it very difficult for us to share information with other jurisdictions because of the addition of that category.

Mr. Terence Young: To help cover up deaths. Don't you think that helps absolve doctors of mistakes they've made?

Dr. Roger Skinner: No.

Mr. Terence Young: Here's another question, then. When patients get addicted to opioids, which is one of our biggest health problems in Canada, whose fault is it?

Dr. Roger Skinner: That's a very difficult question to answer. If you're asking me as a physician.... I think what you're getting at is whether the physician has a responsibility if someone dies as a result of a medication prescribed by that physician. Is that your question?

Mr. Terence Young: Yes, or if they get addicted. Let me give you an example.

Dentists in Ontario, and I don't know about the rest of Canada, are giving young people who get their wisdom teeth out opioids. They are giving them oxycodone or OxyContin, the most addictive drug known to man. I have at least two in my riding of Oakville whose parents drive them to Burlington every week, sometimes twice a week, to get the methadone they've become addicted to when they got their wisdom teeth out. Whose fault is that?

● (0955)

Dr. Roger Skinner: The prescriber does bear some responsibility. Dr. Buckley addressed that in your last meeting, that the college of dentistry is addressing that issue within their profession as well.

Similarly among physicians, when I presided at that inquest that was referenced earlier, it's an uncomfortable position to be responsible. As physicians we have to step up and take ownership of our role in that. It's not the only factor and that's why it's necessary to have this multipronged approach to the problem.

You're absolutely right that one of the important features is education of physicians. Yes.

The Chair: Thank you very much.

Ms. Morin, for five minutes.

[*Translation*]

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

Thank you all for your testimony.

Mr. Mander, my first question is for you. You spoke about the increase in crime that is due to prescription drugs. In Canada, how many of those crimes are committed on a yearly basis?

[*English*]

Chief Mark Mander: I'm still looking at that. I wouldn't know, but if you talk to any chief of police, generally most crime is driven by drugs. I wouldn't be able to tell you whether it's prescription drugs or heroin, but most crime is driven by drugs.

[*Translation*]

Ms. Isabelle Morin: There is currently no data for that?

[*English*]

Chief Mark Mander: On prescription drugs and what drives that? No. That's part of our research project.

[*Translation*]

Ms. Isabelle Morin: Thank you.

You provided us with several examples, including driving under the influence of drugs. Do you carry out tests? How do you know whether or not an individual is driving under the influence of drugs?

[*English*]

Chief Mark Mander: There are DRE, drug recognition expert, officers across the country who are specifically trained to identify that. From a policing perspective and talking to my colleagues, we're seeing an increase in folks who are not driving while impaired by alcohol but are driving while impaired by drugs.

[*Translation*]

Ms. Isabelle Morin: Are these cases of drug abuse, or rather poor indications for use?

I would like to tell you about a personal case. When I had to take my driver's licence exam, I was very young and I had taken a medication. A dentist has prescribed codeine for me but there was no indication on the label that I could not drive after taking it.

Do you think we need better practices that would involve informing individuals that they should not drive after taking certain types of medication, or would you say that drugged driving always involves abuse?

[*English*]

Chief Mark Mander: It's a little bit of both, but if you do look at the labels of the drugs prescribed now, it says to avoid operating heavy machinery. I would include a car as heavy machinery. When we talk about education and labelling on any drug that can affect a person's cognitive ability or ability to drive, it should be very specific.

That's where education comes in for the physician or prescriber that prescribes it, like your dentist and/or pharmacist. That's where they can come in and say, "By the way, you shouldn't be driving with these, and especially when you have that combination of opiates and alcohol." That increases the risk.

[*Translation*]

Ms. Isabelle Morin: Thank you very much.

My next question is for you, Mr. Bishop. You said that there is a conflict of interest when pharmaceutical companies are selling both anti-addiction treatments and addictive drugs. I also think that is a conflict of interest.

Do you have any recommendations to make in that regard? Do you feel there should be regulation or laws about this? Should pharmaceutical companies be prohibited from selling one or the other of those products? What measures should the federal government take?

[*English*]

Mr. Cameron Bishop: What our committee has said is that if somebody wishes to manufacture a painkiller or an addiction treatment, the minimum standard should at least be that it has to be abuse-deterrent; that is the minimum standard, if you're going to bring them into market.

Ideally, if we, marketing Suboxone, decided that we were going to start to manufacture prescription opioids that could be treated by the very drug that we manufacture, that to me would be wrong. If you talk to the average person, and I've talked to folks.... Mr. Young will know Ada Thompson, from the association of responsible prescribing for opioids. She agrees as well that you cannot allow the double-dipping, because you're essentially allowing volume driving.

If the federal government can look at that when they are doing NOCs, they should have that bare minimum standard of abuse deterrence, but the end goal should be that nobody should be able to do both.

● (1000)

[*Translation*]

Ms. Isabelle Morin: Are many businesses currently finding themselves in this situation?

[*English*]

Mr. Cameron Bishop: I'm sorry. The audio cut out at the end.

[*Translation*]

Ms. Isabelle Morin: Do many pharmaceutical companies find themselves in that situation at this time?

[*English*]

Mr. Cameron Bishop: There are some coming onto the playing field, yes, especially when you get into the conversation about unbranded or generic manufacturers. There are standards, but there are not aggressive enough standards to prevent this.

As a person, I find it unfortunate that we would allow that kind of stuff to be happening. I don't think it's right, and I think the average person doesn't think it's right either.

The Chair: We have gone past five minutes.

For the committee's knowledge, Mr. Bishop is going to have to leave at approximately 10:10. He has to appear before a Senate committee.

Next up we have Mr. Wilks, for five minutes.

Mr. David Wilks (Kootenay—Columbia, CPC): I want to continue with what my colleague, Mr. Young, was speaking about concerning deaths that are investigated by police, commonly referred to as sudden deaths, that involve these types of drugs.

You may not be aware, Mr. Skinner, but my previous career was with the RCMP, and I have investigated a significant number of sudden deaths.

I want to hear from both of you with regard to a problem.

Most of the sudden deaths that police go to involve an overdose of some form, whether it be of an illicit or non-illicit drug, or of alcohol for that matter. They are difficult to investigate. The police officer goes in, but his or her authority is not to remove the body; his or her authority is just to determine what has happened.

I can remember many cases in which we would go in and we would see a multitude of pills and would think “sudden death”. Yes, the person is dead. We call the coroner. The coroner gives the authority to remove the body. From there the police have no investigation at all, because it is turned over to the coroner.

It seems to me, from what I'm hearing today and from what Mr. Young said, that we need to better identify how far the police need to go in these investigations. It seems to me that if you go into a residence in which you have a sudden death and in which you have a multitude of prescribed drugs—from more than one doctor, let's say, for argument's sake—it should ring some bells really quickly, but there's nothing there, because it's a coroner's case.

Do you have any suggestions?

Let's hear from Chief Mander and then Dr. Skinner.

Chief Mark Mander: A certain part of our committee—we have Dr. Bowes, our chief medical examiner from Nova Scotia— is going to be looking at best practices across Canada in those situations. The police are doing it from an investigative perspective and learning what needs the coroners have in those situations.

You're right. Ten years ago when someone died from an opiate or an overdose, it was automatically determined that it was a coroner's case. Now what we're seeing is it's not just a coroner's case. This can have some police ramifications, not just from the investigative perspective that someone trafficked, but it could be that you have some doctor or physician or prescriber. That's the difficulty.

The other issue we have to wrestle with is that quite often we release the scene only to find out three months later that the person was full of a drug that they weren't prescribed, etc. That presents a lot of difficulty for police from an investigative perspective.

● (1005)

Mr. David Wilks: Prior to intervening, Mr. Skinner, I want to bring one more thing up. It has to do with Ms. Morin's question with regard to what I'll call “drug driving”. Aside from a police officer, as far as I understand, unless there are some new ways of doing it, the only way to convict on drug-impaired driving is through the receipt of a blood sample, which as all of us in this room know can be a difficult process and has to be done by a doctor. I believe that there need to be better ways for the police to be able to investigate these in a timely manner, because right now it ain't timely. It gets to the point, especially with drugs, that even though we have drug recognition people, you still have to formulate the demand and then go forward. We really need to focus on that.

I'll hear from Mr. Skinner, with regard to the investigations.

Dr. Roger Skinner: With regard to the investigations, in Ontario I'm blessed because our legislation actually gives us the authority to enlist the assistance of police in our investigation, which we do. In the circumstance that you're describing, where we would enter a scene and there would be prescriptions for multiple people or multiple prescribers, for example, the coroner has the authority then to ask police on their behalf to investigate both the prescriber and the dispenser. Often the police and the coroner together will obtain those records and investigate that problem

Mr. David Wilks: But that's not in each province, correct? You're specifically speaking about Ontario.

Dr. Roger Skinner: That is correct. I think the RCMP experience in some jurisdictions would be very different.

The Chair: Very good.

Ms. Davies.

Ms. Libby Davies: Dr. Skinner, I'd like to come back to something that you said at the beginning of your remarks.

A lot of the discussion today has focused on opioids, but of course in looking at prescription drug misuse, we're also talking about other classes of drugs, whether it's stimulants or anti-depressants. Something that you said caught my ear. I think you said that misuse increases with age. I think there is a stereotype of prescription misuse that maybe it's younger people, that it's younger addicts. The issue of seniors and what's happening is something which we haven't really paid a lot of attention to. I know from my work earlier as a municipal councillor in Vancouver, when we had a seniors committee it was a huge issue.

I wonder if you could speak a little bit about that and whether or not there are specific measures we need to pay attention to in terms of recommendations that focus on an older population, the fact that we are now seeing an older population, and what that means in terms of prescription use and particularly potential misuse. Is it more about education, or is it more about prescribing? How do you see that in terms of a specific problem?

Dr. Roger Skinner: What I said earlier—I think what I said and maybe I didn't say clearly—was that as people age, the source of their drug is more likely to be their prescription. Younger people are more likely to get their drugs from the street, and as you get older, you're more likely to get it from your prescription.

That being said, you're absolutely correct that from what we see and again—we only see the very end of the downstream as the chief has referred to—it is a problem in the elderly, either intentional or accidental drug toxicity.

Is the answer in education? I think probably it is. Again, it's physician education because we know that poly-pharmacy and the inappropriate use of opiates and other psychoactive drugs in the elderly is a problem. We see it regularly. Also it's education for patients to make sure they fully understand the appropriate use of the medication, that if one is good, five must be better doesn't apply when you're on sustained-release oxycodone, for example. If you're on a fentanyl patch, you really do have to take the old one off before you put the new one on. It's not an uncommon thing for us to see someone with five, and then we have to sort out if they simply did not understand to take the old ones off, or if they were actually intending to do that.

Yes, it is a problem, and yes, I think education probably is the way to go in that particular issue.

● (1010)

Ms. Libby Davies: Do I have more time?

The Chair: Yes, you do, two minutes.

Ms. Libby Davies: Okay. Thank you very much for that.

To follow up, I know you just represent the Ontario coroner's service and you can't necessarily speak for across the country, but in terms of the accidental deaths that you look at in Ontario, how many would relate to...? Can you give us an age breakdown? I'm curious to know whether or not we're looking at an older population in terms of the death rate.

Dr. Roger Skinner: I don't have the numbers in front of me. The majority of deaths from drug toxicity would take place in individuals between the ages of 20 and 50, but the relative rate in the elderly is probably higher. In other words, the incidence per individual in the population is higher and has increased as of late. I think that's because we're seeing people carry their problems through. As they get older, the addiction problem, the pain problem, or the poor prescribing problem travels with them throughout their life. They're living longer, and we're seeing it more and more at that end of the scale.

I apologize, I don't have those numbers in front of me today. I'd be happy to get those for you if you're interested.

Ms. Libby Davies: They would be helpful. If you'd like to submit them, I'd certainly appreciate that.

Do I have a little more time?

The Chair: Twenty seconds.

Ms. Libby Davies: I don't know, Dr. Skinner, if you have any comments about research and the fact that we do need to focus more on research of non-addictive pain management. I think you did mention that. I wonder if you have anything else you want to offer.

Dr. Roger Skinner: I think one of the frustrations of prescribers, of physicians, is that they have a limited tool box when someone comes to them with pain. Because of the issues of access to non-medical treatment or to non-pharmacological treatment, often the easiest or the most expeditious route is to write a prescription.

In fact, if we had better access to other modalities of pain relief and pain management, we might be able to avoid some of this issue.

The Chair: Thank you very much. I think that's touching on an important point.

Mr. Lizon, you have five minutes.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you, witnesses, for coming to the committee this morning.

Mr. Chair, I would like to direct the first question through you to Dr. Skinner.

Doctor, I've been on the committee for some time and on this study since we began it. A lot of the information we've heard today and most of the witnesses who appeared spoke about opioids. There must be some misuse or abuse of other prescription drugs, but on opioids I'm a bit confused. It seems to me there's some kind of a vicious circle, a catch-22 situation that includes patients, doctors, drug manufacturers, and the regulators at different levels of government. At one point, for the patient to get a drug, it is a doctor who prescribes it.

Doctor, how can we break that vicious circle? The statistics you provided about the number of deaths exceeding the number of people killed in car accidents, it is tragic. At one point there is a doctor prescribing a drug that's addictive and some people get addicted. Opioids have been known for more than a hundred years. Where is the problem?

Dr. Roger Skinner: In regard to why there's been a change in recent years, again, I think it goes back to availability and to a changing culture in medicine. It used to be that opiates were reserved for end of life care, acute management of injury or post-operative care. However, in that timeframe, from the late 1970s through the 1990s, there was a shift towards the use of opiates for non-cancer related pain, for chronic non-cancer pain. It was not just a shift to the use of them, but a shift in the thinking that we should give maximal doses to relieve people's pain completely, without the research basis for the effectiveness of that model. That's the spiral you're talking about.

We're now in the phase where we've seen that the pendulum has swung too far and we're trying to bring it back. It's going to be a process. It's not just the physicians who have their hands in this pot now. As you said, there are the manufacturers, the dispensers, those who would profit from it illegally, and there are the patients themselves and their expectations. All of this needs to be brought back to a more moderate approach and to one that's based upon evidence showing that, in fact, giving people these drugs does make their life and their situation better. We don't have that evidence right now.

● (1015)

Mr. Wladyslaw Lizon: Thank you very much.

Doctor, could you briefly talk about abuse of prescription drugs that are not opiates?

Dr. Roger Skinner: Yes, I've come and talked about opiates, but they're not the only drugs that kill people. You're absolutely right. As I said, the other drugs are more likely to be seen in isolation in incidents of intentional ingestion, but not absolutely. One of the difficulties is that people with chronic pain and people who access opiates often have other comorbidities. They may have mental health issues. They may have medical issues for which they are also prescribed other medications that are equally dangerous and in combination with opiates, even when individual levels are not fatal, the combined toxicity can be fatal. Most often these people are dying of what we call mixed drug toxicity, either opiate and alcohol, or opiate and psychoactive drugs plus or minus alcohol.

Mr. Wladyslaw Lizon: Thank you very much.

Mr. Chair, do I have any time left?

The Chair: You have 15 seconds for a final thought.

Mr. Wladyslaw Lizon: I think I'll give it up. Thank you very much.

The Chair: We have another five-minute slot here and Mr. Lunney is going to use that slot. If you allow me, I have one quick question I'd ask Dr. Skinner and then I'll turn it over to you.

Dr. Skinner, I just wondered if you could give some thought to this committee about whether or not anti-psychotics should be prescribed to patients in nursing homes who have Alzheimer's and dementia. Could you give the committee a thought on that?

Dr. Roger Skinner: Oh boy. You have only five minutes, right?

The Chair: I have 50 seconds.

Dr. Roger Skinner: I also chair our geriatric and long-term care committee that reviews specific deaths in long-term care facilities. This is certainly a hot topic within the industry.

The answer is, in selected circumstances, under conditions such that there is a trial of a dose and a withdrawal if there's no improvement, it might be appropriate. But there's no question that the widespread use of anti-psychotics in long-term care facilities is a factor in the deaths of individuals in those facilities.

The Chair: Mr. Lunney.

Mr. James Lunney: Thank you very much for that. It was an excellent question.

Dr. Skinner, you mentioned a couple of reports earlier. This is sort of a housekeeping thing. The committee, in the earlier part of this study before some of us were part of the committee, may have had access to those reports. You mentioned a report by the college of physicians and surgeons. Was that the Ontario college? What was the name of that report?

Dr. Roger Skinner: That's correct. It was the Ontario college, and the title of the report, and it's on their website, is “Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis.”

Mr. James Lunney: You also mentioned another report, “First Do No Harm”. Who was responsible for that? Can I ask the analyst whether the committee already has access to these reports?

Ms. Karin Phillips (Analyst, Library of Parliament): Yes I do, and I can send them to you.

Mr. James Lunney: I'd appreciate that.

Dr. Roger Skinner: That's the National Advisory Council on Prescription Drug Misuse under the direction of the CCSA, which Mr. Bishop and I participate in.

● (1020)

Mr. James Lunney: When was that published?

Dr. Roger Skinner: That was released in the fall, I think. Do you remember?

Chief Mark Mander: I have the report here.

Dr. Roger Skinner: It was later in 2013. That's correct.

Mr. James Lunney: It was March 2013.

That was good teamwork demonstrated there.

If I have just a moment left, I'll flip it over to my colleague Terence, who has a burning question.

Mr. Terence Young: Thank you, Mr. Lunney.

Chief Mander, I don't want to put you on the spot, because I realize you might not have accurate figures, but if you could, please give your most informed answer to this.

If no one were addicted to prescription drugs, if that problem did not exist, how much of your administrative and police officers' time would be freed up to investigate other important police matters? In other words, what percentage of your resources in the police services are used to deal with crimes related to prescription drug addiction?

Chief Mark Mander: I can only look at my own police service and you could probably extrapolate that for other places.

Probably about 5% to 10% of our time is driven by just prescription drugs.

Mr. Terence Young: Dr. Skinner, take as much time as you want.

What measures should governments take to stop creating new addicts to opioid prescription drugs in Canada?

Dr. Roger Skinner: Are you asking me on behalf of the federal government, sir, or all governments?

Mr. Terence Young: I mean on behalf of all governments. If you could make the decision for all governments to try to prevent creating new addicts to opioid prescription drugs, what would you do?

Dr. Roger Skinner: Do I have an unlimited list or are you going to make me pick one?

Mr. Terence Young: Please start with your priorities.

Dr. Roger Skinner: I think the difficulty is—and this is what we have found as folks across the country have put their heads together—there isn't one answer. If we don't look at it from all of the perspectives of prevention, enforcement, education, and treatment, and integrate those, we miss. If we pick one, we just don't get anywhere at all.

If you're asking me what could be done on a federal level, I think some of the things that have been highlighted are the control of access to these dangerous preparations, the resourcing of appropriate research, and the resourcing of initiatives like that of the national action council. We could somehow help to lead the way to develop a program of data collection and sharing and surveillance so we could do research, but also so we would know who the bad prescribers are and who the troublesome dispensers are, so we can pick those people out and educate them and improve their practice.

Finally, the piece that hasn't been mentioned is the need for a comprehensive pain and addiction treatment plan in first nations communities where the problem is absolutely astounding.

The Chair: Thank you.

We have our last questioner of the day, for five minutes. Ms. Fry, go ahead, please.

Hon. Hedy Fry: I don't think I'm going to need five minutes, Mr. Chair.

What I wanted to ask Dr. Skinner about is that among all the recommendations that were made, I don't notice one that talks about triplicate prescription. I'm not harping on this because I think it's a cute thing; it seems to have to worked in British Columbia to diminish the amount of prescription drug overdoses.

One of the reasons is that if you prescribe an opiate, every physician on the triplicate prescription must write a prescription. One must go to the college of pharmacists, one must go to the college of physicians, and one must be kept by the physician. It allows for monitoring on how these prescriptions are being written, whether they're appropriate or not. It allows, therefore, an identification of the patient who is seeking opiates and double or triple doctoring. It allows identification of the physicians who are inappropriately prescribing opiates, and for them to be given that, as you say, education, to be hauled out and called up by the college, which says, “Look, you're inappropriately.... Here's what you should be doing.”

That seems to have worked very well in British Columbia. I wonder why this isn't something that other provinces are looking at. It's not a federal thing; it's a provincial thing.

Can you explain that to me?

● (1025)

Dr. Roger Skinner: I would agree with you completely, Dr. Fry, that it has worked not just in B.C., but in other provinces. For example, Alberta, I think, led the way with the triplicate prescription. It's a beautiful low-tech way to collect data.

Some of the difficulties are in accessing the data in a timely manner, and so on. For example, in my situation in the emergency department, if I have somebody in front of me asking for OxyContin, how can I find out where they got their last three prescriptions and when that happened? There would be a significant time delay in the triplicate process. It's better than not having any data, but it still has some limitations.

In the absence of an electronic database, I think the triplicate form is an excellent way to provide some of that data and to give the professional college and the provincial ministries an opportunity to get a bird's-eye view of what's happening, and to identify the outliers, as you've said, and bring them up to speed.

Hon. Hedy Fry: To follow up on that, when I was practising in British Columbia, one of the things we had was daily computer-generated information coming out of the college of pharmacists and the college of physicians. Every single day we got lists of the people who were double doctoring, triple doctoring, and all of the alias names that they gave to doctors, so that we were able to flag these people as they walked into the office.

This doesn't work in the emergency room, as you say, because you won't get it within 24 hours, but it does work to curb the practice by physicians in the office who do this kind of stuff and don't think about it, who have been pushed by patients with a sob story saying their stuff fell down the toilet, and la, la, la. You get a sense of the people who are the ones you should look for. As well, the colleges get a sense of the doctors who are very easy marks and tend to prescribe very easily.

Dr. Roger Skinner: I would agree with that.

Do I have time for a brief comment?

The Chair: Yes.

Dr. Roger Skinner: The incident that led to the inquest with the two deaths was a situation where it was a single prescriber, two deaths separated in time, two different coroners investigating, so there wasn't that link made. Thank goodness the local police called me and said it was the same physician in both of those cases, and that he wasn't just doing it for them, that there were others.

You're right. If we had the ability to access that information of who was prescribing what to whom, there would be an opportunity for intervention, yes.

The Chair: You have time, Chief.

Chief Mark Mander: Certainly not to brag about Nova Scotia, because that's where I'm from—

Hon. Hedy Fry: But you will.

Chief Mark Mander: —but our program has that very system. We've just moved to a 24-hour access system. A physician anywhere can access that system and know what's being prescribed. As well, we have an integration with police so that with our heavy hitters, we can advise the prescription monitoring program, which then advises the physicians that, by the way, this patient they might have seen is selling their drugs. We have that whole system of information sharing, which works quite well.

The Chair: Thank you very much.

That wraps up the second round of questioning.

We do have some committee business, so I'd like to thank our witnesses who were here today. That was great information, and you fielded all the questions in a fine manner.

We'll suspend for a minute while our guests leave and then we'll come right back.

[*Proceedings continue in camera*]