HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 022 • 2nd SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, April 10, 2014

Chair

Mr. Ben Lobb

Standing Committee on Health

Thursday, April 10, 2014

● (0850)

[*English*]

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

We're here for committee. I welcome everybody here. It's a beautiful spring morning. It was nice walking in this morning.

We have two witnesses here today from the Canadian Pharmacists Association. We also have Mr. Lopatka, from the Association of Faculties of Pharmacy of Canada, by teleconference. It's not video conference today; it's teleconference.

We'll get started here. We have two meetings inside our two-hour meeting. We'll start off first with the Canadian Pharmacists Association.

You have 10 minutes or less for your presentations. Go ahead, Mr. Emberley or Ms. Cooper.

Ms. Janet Cooper (Senior Director, Professional and Membership Affairs, Canadian Pharmacists Association): Thank you, Mr. Chair.

I'm Janet Cooper. I'm the senior director of professional and membership affairs at the Canadian Pharmacists Association. With me is Phil Emberley, CPhA's director of pharmacy innovation. We're both pharmacists. CPhA represents the pharmacist profession in Canada. With over 37,000 pharmacists, ours is the third-largest health care profession. CPhA is also Canada's leading publisher of drug and therapeutic information for health care practitioners.

As the most accessible health care professionals in Canada, pharmacists are in a unique position to deliver a range of health-related services to Canadians. We are very pleased to meet with you today and highlight the unprecedented changes in pharmacists' scope of practice over the past several years. In fact, in terms of best practices, other countries look to Canada, as we are leading the way for expanded scope of practice for pharmacists. To support change, CPhA has been leading the blueprint for pharmacy initiative to achieve the vision for pharmacy, “Optimal drug therapy outcomes for Canadians through patient-centred care”.

We'll also discuss with you the significant role the federal government played in some of these changes in pharmacy. For decades our profession has been saying that we need to better use the unique knowledge and skills of pharmacists to improve drug therapy outcomes for Canadians. However, some of the major catalysts for the changes that we see today came from the federal government over a decade ago, working with their provincial/territorial counterparts and health care professional organizations, such as CPhA.

In 2002 both the Romanow commission and the Kirby Senate committee reports recognized the accessibility and underused skills of pharmacists and the need to expand their role. The 2003 health accord also identified pharmacists as a priority profession. The $800-million federal investment in the primary health care transition fund, or PHCTF, helped deliver change. Health Canada's health human resources strategy division played a leading role in engaging with the jurisdictions and health care professionals on primary care reform, health human resources planning, expanded scopes of practice, and supporting interprofessional education and collaboration.

I'll share with you some examples of the federal role that are specific to pharmacy.

The primary health care transition fund funded the IMPACT project in Ontario, which integrated pharmacists into family practice clinics. A focus of this project was to facilitate collaboration between pharmacists, family physicians, nurses, and other team members in this new model of practice. Today there are pharmacists working within such family practice teams across Canada.

PHCTF also funded CPhA for the development of e-Therapeutics, an online resource to provide physicians, pharmacists, and other providers with just-in-time access to evidence-based clinical decision support. Today e-Therapeutics is widely used, but we need to work with Canada Health Infoway and the jurisdictions to take it further. It needs to be integrated at the point of care into electronic medical records to improve prescribing and safe and cost-effective medication use.

Human Resources and Skills Development Canada funded the pharmacy human resources moving forward study, led by CPhA. The research and recommendations from this study were a key driver for the changes that have occurred since. HRSDC also funded further work by pharmacy regulators to support international pharmacy graduates and the introduction of a new health care profession, regulated pharmacy technicians.

Health Canada also funded, in part, the development of CPhA's online ADAPT training program. ADAPT focuses on patient care skills, such as assessment, documentation, evidence-based decision-making, and interprofessional collaboration. ADAPT provides pharmacists with the skills and confidence needed to take on an expanded role and to move from a focus on dispensing prescriptions to a focus on safe and effective outcomes. Not only has ADAPT won a national award, it is so effective in transforming pharmacists' approach to practice that we are now adapting it for use in the United States to support pharmacists there to take on expanded roles, as part of their health care reform.

Without the past support of the federal government, pharmacy in Canada would not be where it is today, and we would not be recognized as the world leader in pharmacy practice change. So where are we today, and what more needs to be done?

I'll turn it over to Phil.

Mr. Phil Emberley (Director, Pharmacy Innovation, Canadian Pharmacists Association): Over the past several years, there has been a great deal of change with respect to the scope of practice of pharmacists in Canada, starting with legislative changes in Alberta in 2006. The level of change in practice is unprecedented in the history of the profession. This includes changes in pharmacists' prescribing, such as renewing prescriptions, prescribing in emergency situations, adjusting doses and dosage forms, and discontinuing or starting new medications. Changes also include assessing and prescribing for minor ailments, which can greatly reduce the burden on emergency rooms and walk-in clinics; immunizing and ordering of lab tests to enhance monitoring of drug therapy—

Ms. Libby Davies (Vancouver East, NDP): Mr. Chair, point of order.

Mr. Phil Emberley: —for safety—

The Chair: Pardon me, Mr. Emberley. We have a point of order.

Yes, Ms. Davies.

Ms. Libby Davies: Thank you very much, Chairperson, and I'm very sorry to interrupt you, Mr. Emberley, but Chairperson, I would like to move a motion that we invite the Minister of Health to come to the committee at the earliest opportunity to speak about the health accords. So I'd like to move that motion right now.

The Chair: I can provide some clarification. I wanted to confer with the clerk on my thoughts, and it's out of order, Ms. Davies. You don't have the floor right now.

Obviously, you know when you will have the floor, and if that's what you choose to do with your time, that would be the appropriate time to do it. Okay? Great. Thank you.

Mr. Emberley, go ahead, please.

Mr. Phil Emberley: In addition, we now have regulated pharmacy technicians in several provinces. They do a final check on dispensed prescriptions, freeing up pharmacists to focus on patient education, adherence, and medication-monitoring services.

We have provided the clerk with a one-page summary of the range of expanded scope of practice for pharmacists across Canada, which members should have now in front of them.

Although specific scopes of practice differ across the jurisdictions, the trends have all been the same. Increasingly, governments are recognizing that pharmacists can deliver accessible, high-quality care to Canadians at a lower cost to the health-care system. Research shows that pharmacist services improve patient adherence and outcomes, and reduce hospitalization.

In addition to regulatory changes to scope of practice, provincial governments are also paying pharmacists to provide new services, such as flu shots, treatments for minor ailments, diabetes management, smoking cessation, and meeting with patients to do comprehensive medication reviews and develop annual care plans.

In fact, last summer Canada's premiers at a meeting of the Council of the Federation directed the health care innovation working group to examine opportunities within the team-based model framework to increase the important role that paramedics and pharmacists play in the provision of front-line services. We are pleased that Health Canada, through the FPT committee for health workforce, has recently engaged in this work.

In terms of recommendations and next steps, the pharmacist profession welcomes these developments. However, there are three core areas in which we feel the federal government could play a stronger role.

First, provincial governments have enabled an expanded role for pharmacists not only through legislative changes but also by paying for new medication management services. The same has not happened federally. Although the majority of health care in Canada is delivered by the provinces, the federal government does have populations for which it is responsible for provision of health services. These include groups such as aboriginals, veterans, refugees, and the RCMP. In fact, Health Canada is the fifth-largest health care provider in the country. However, unlike provincial governments, the federal government does not cover the cost of extended pharmacist services. This situation is placing these federal populations at a disadvantage. They are not able to receive the same level or accessibility of services that most other Canadians are receiving. As a result, our first recommendation to the committee is to instruct Health Canada to review the services it insures for its federal populations, particularly pharmacist-provided medication management services so that, at a minimum, coverage policies are aligned with the corresponding provinces' programs.

Second, as we undergo primary care reform and expanded scopes of practice, all health care professionals need support for change, in particular, having the patient care documentation and collaboration skills to practise as part of a team. Our ADAPT skills training program is an excellent example of a best-in-class course to support pharmacists to transform the way in which they practise. But we need more of these types of programs to support intraprofessional and interprofessional collaboration between pharmacists, pharmacy technicians, physicians, nurses, and other health care providers.

Our third recommendation is about the federal government's leadership to support pan-Canadian health human resources—HHR—planning and innovation to achieve better health, better care, and better value.

As we've described, the pharmacist profession is very much in flux. In addition to changes in professional practice, there have been unprecedented changes to the pharmacy business model. With lower generic drug prices in all jurisdictions, the pharmacy business model has been squeezed. Pharmacists are in a situation of being asked to do more with less. As well, we went from an acute shortage of pharmacists a decade ago to a surplus in some cities now. With so much change afoot, it is becoming increasingly difficult to plan and manage the pharmacy labour supply.

The sustainability of the health care system requires that cost-effective models of practice be explored and human resources be deployed effectively. Therefore, we recommend that the federal government assume a greater role in human health resources planning, health care needs assessment, and support for interprofessional collaboration. Specifically for pharmacy, we need to do more research on the supply, workplace challenges, and labour market needs for both pharmacists and regulated pharmacy technicians across Canada. We need to track and forecast pharmacy human resources so that our profession can contribute its drug therapy expertise to ensure that Canadians' medication use is as safe and effective as possible.

● (0855)

Thank you.

Ms. Janet Cooper: Thanks, Phil.

To quickly summarize, CPhA is submitting three recommendations for your consideration. One, extend coverage of new pharmacist-provided services to federal populations; two, invest in education and training that supports practice change and expands its scope of practice; and three, increase the role and capacity of the federal government in pan-Canadian health human resources planning that includes pharmacy labour market studies and forecasting models.

While we recognize that health care is mostly regulated and delivered at the provincial-territorial level, the federal government does have a key leadership role to play. With our aging population and the challenges of health care costs and chronic diseases, we still have a lot more to do to make sure Canada has the right mix of health care providers with the right skills in the right place and at the right time.

Once again, Mr. Chair, on behalf of the Canadian Pharmacists Association, thank you for undertaking this important study. We look forward to your questions and comments today, and also to working with the federal government and other stakeholders in implementing solutions.

● (0900)

The Chair: Thank you very much.

Next up from the Association of Faculties of Pharmacy of Canada, Mr. Lopatka.

Go ahead, sir. You have 10 minutes to deliver your presentation.

Mr. Harold Lopatka (Executive Director, Association of Faculties of Pharmacy of Canada): Good morning, all.

Thank you to the chair for allowing me to make the presentation on behalf of the Association of Faculties of Pharmacy of Canada. As mentioned, I'm the executive director for the organization. I do have a pharmacy background as one of my first educational credentials.

I've submitted a written copy of my presentation notes and I'll be highlighting some sections of those notes. My presentation is divided into six parts, and I'll just mention each part as I'm going along.

First, some information about AFPC, and I'll use the initials throughout because the name is quite long. AFPC is a national, not-for-profit organization advocating for the interests of pharmacy education and educators in Canada. The AFPC mission is to promote and recognize excellence in pharmacy education and scholarly activities. Canadian pharmacy education is highly rated in international comparisons and new graduates are highly sought after upon completion of their studies. They're approximately 5,000 undergraduate students enrolled at any time, and approximately 1,250 students who graduate from Canadian pharmacy faculties each year.

AFPC has established national education outcomes for educating students to become pharmacists in Canada. The educational outcomes are routinely used in planning, implementation, and evaluation of all university pharmacy degree programs. The current educational outcomes are formatted with the overall goal of graduating medication therapy experts.

Next is some information about post-secondary pharmacist education. There are 10 pharmacy faculties in Canada. Faculties are located at the following universities: British Columbia, Alberta, Saskatchewan, Manitoba, Toronto, Waterloo, Laval, Montreal, Dalhousie, and Memorial. Canadian universities provide a bachelor's; master's; doctor of pharmacy, known as the Pharm.D.; and a doctor of philosophy, known as a Ph.D. They are different.

Until recently, the first professional practice degree in all faculties was the baccalaureate degree. Students in two provinces now—Ontario and Quebec—receive a doctor of pharmacy, or Pharm.D., as their first professional degree. Faculties in other provinces are in the process of transitioning to an entry-level Pharm.D. For example, they're developing proposals, obtaining university and provincial approvals, and then revising their curricula. AFPC has a vision for all pharmacy faculties in Canada to offer the Pharm.D. as their sole professional degree by 2020. The University of Montreal was the first faculty to transition to the entry-level Pharm.D.

The following are a few highlights and elements of this new curriculum provided to Pharm.D. students at the University of Montreal, and it's representative of approaches taken in other provinces.

The curriculum is based on a competency-based framework with generic competencies including professionalism, communication, teamwork, and interprofessional collaboration, scientific method and critical thinking, lifelong learning, and leadership. The program is well adapted for today's students. Students in the program are active learners, with the faculty acting as coaches. For example, students receive faculty guidelines and questions to guide them through the discovery process. Of the curriculum, 44% is what we call experiential learning, which is a mix of skill laboratories, integration activities, and clerkships. The program relies on a pool of over 1,200 trained pharmacist preceptors from all practice settings. It also integrates multiple interprofessional learning modules.

The experience from Quebec suggests that the newly graduated Pharm.D. graduates are very well equipped to practise pharmacy in alignment with the newly defined, expanded scopes of pharmacy practice. All pharmacy programs in Canada meet the AFPC educational outcomes, which I referred to as a requirement for the Canadian Council for Accreditation of Pharmacy Programs.

Next is a brief history on national pharmacist human resource activities. In the period 2006-08, the initiative named Moving Forward: Pharmacy Human Resources for the Future was conducted, involving a multipronged research and analysis program to gather qualitative and quantitative information on Canada's short-term and long-term challenges in the area of pharmacy human resources. My colleagues from the Canadian Pharmacists Association have explained this activity briefly.

● (0905)

Meaningful workforce planning can only be conducted based on available data. Since the moving forward initiative, the Canadian pharmacists database has been further developed and refined. The database is administered through the Canadian Institute for Health Information, known as CIHI. The database has collected information about pharmacist manpower since 2006, with six years of data currently available. The database contains information on the supply and distribution, demographics, geography, education, and employment of pharmacists in selected provinces and territories.

The Canadian pharmacy practice and business environment were stable for many years. However, the environment for the pharmacy profession has changed dramatically. These changes have been summarized by my colleagues from the Canadian Pharmacists Association. There have not been any recent national reviews of pharmacist manpower. Given the recent changes in pharmacies, there is a need to review pharmacist workforce planning, including pharmacist supply and demand.

Next, from the perspective of AFPC, are some words about the pharmacist workforce balance.

In the late 1990s and early 2000s, there was a pharmacist shortage in Canada. The shortage was addressed through increases in the numbers of international pharmacy graduates, abbreviated as IPGs. Immigration policies were adjusted to allow foreign-trained pharmacists to gain entry into Canada. Annual quotas were established for IPGs, and formal IPG training programs were established to assist foreign-trained pharmacists adjust to the Canadian pharmacy practice environment.

According to the most recent 2012 CIHI pharmacist workforce report, 24.5% of the Canadian pharmacist workforce is made up of IPGs. While these pharmacists are qualified pharmacy practitioners, their skills and abilities to address the expanding scope of practice of pharmacy in Canada are often limited by their educational background, which usually has focused on drug distribution and not on the new clinical services pharmacists can offer.

In addition, the capacity of the Canadian pharmacy faculties to produce Canadian pharmacy graduates was increased, including the addition of one faculty at the University of Waterloo. In the 10-year period of 2003-2012, the size of Canada's pharmacy faculty graduating classes increased by 42.8%. Based on current enrolment figures, the number of new graduates projected for the year 2018 is 1,398.

A coalition of national pharmacy organizations, including the Canadian Pharmacists Association and AFPC, met with representatives from Health Canada and Citizenship and Immigration Canada to discuss the concerns about changes in pharmacist supply and about the quotas of internationally trained pharmacists. The meetings resulted in Citizenship and Immigration Canada making a minor adjustment in immigration quotas for internationally trained pharmacists.

AFPC believes the Canadian pharmacist manpower balance has changed from a shortage to a surplus. The deans of pharmacy and pharmacy faculty members began receiving anecdotal feedback from new graduates about changing employment conditions; for example, being unable to secure pharmacist positions. In response, AFPC has instituted a graduate employment survey to track the employment situations for newly graduated pharmacists. The results from the survey indicate that 17% to 19% of new graduates were unemployed at the time the survey was administered after the completion of their winter term classes in their last year.

CIHI data shows that the percentage of unemployed pharmacists increased from 6.2% to 7.7% over a four-year period.

Next are some recommendations from AFPC.

It is recommended, first, that Health Canada, through the health human resources strategy division, and Citizenship and Immigration Canada reset immigration quotas for internationally trained pharmacists until a comprehensive assessment of current and future pharmacist manpower is completed.

● (0910)

The second recommendation is that Health Canada, through the health human resources strategy division, establish a multi-stakeholder pharmacist workforce planning initiative to conduct a comprehensive assessment of current and future pharmacist manpower, focusing on the supply and demand for pharmacists. My colleagues in the Canadian Pharmacists Association have identified this as their third recommendation.

In summary, I've presented AFPC observations, reflections, and suggestions about the pharmacist manpower situation in Canada. AFPC is submitting two recommendations for your consideration: one being resetting immigration quotas for internationally trained pharmacists; and two, conducting a national multi-stakeholder pharmacist workforce planning initiative.

Thank you on behalf of the Association of Faculties of Pharmacy of Canada for the opportunity to present our views and suggestions on this important topic for pharmacy educators, students, and other pharmacy organizations. I look forward to your questions and look forward to working with the federal government and other stakeholders in addressing this topic.

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

We're now entering the question portion of our meeting.

First up for the first seven minutes is Ms. Davies.

Ms. Libby Davies: Thank you very much, Chairperson.

Thank you to the witnesses for being here today, in person and also on the phone.

I do think that looking at the scope of practice for pharmacists is probably one of the best examples of where some really practical things could be done that would improve health care and, as you have pointed out, where pharmacists could become much more part of a community-based team approach.

I really like that you've put out this spreadsheet that shows the different aspects of expanded practice across the country. It's very helpful. Looking at Alberta where everything is ticked off, I think Alberta and Nova Scotia are the best.

How aware is the general public? I'll give you an example. We've been using a lot of our personal experience in scope of practice. In B. C., I did not realize that pharmacists could provide emergency prescription refills or extend or renew. How does that happen? Who activates that? I have prescriptions; most people do. I didn't know that. How is this public knowledge and how does one activate it?

Ms. Janet Cooper: That's an excellent question because one of our top priorities is awareness and supporting a national public relations campaign. I think many Canadian patients have already accessed these services, but most Canadians don't even know. When they do experience it, they like it. It's fast; it's accessible. You can go out on your lunch break, get your flu shot, and be back and still have time for lunch. A lot of Canadians are aware of flu shots, but the ability to have an appointment to sit down with your pharmacist and spend 15, 20, or 30 minutes to review your medications, most of them don't know about that and all these other services. Some of it will be word of mouth but I think we need to be putting more effort into it.

For example, when the Ontario government introduced the MedsCheck program they had TV ads.

Ms. Libby Davies: If I could get specific, I think most people do know about the flu shots because the pharmacies advertise. And most people know, certainly in B.C., if you get a prescription they automatically sit down with you and go over it.

I think what is not so well known is that they can provide an emergency refill and renew and extend and change the formulation. Who activates that? Is it the patient who says she thinks she needs a change in dosage, or is that the pharmacist? Do they check with the doctor? How does it happen?

● (0915)

Ms. Janet Cooper: It depends on the province. Alberta is the most advanced. They have something called additional prescribing authority, and the pharmacists can start new drugs and stop. It has to be within a collaborative practice model. The community pharmacist has to communicate with the family doctor, because they have to know of any changes. You can't just go and do these things and not tell anybody. If you have electronic health records, it certainly enables that kind of communication in a better way.

A lot of times it's very simple things, like a prescription for amox antibiotic suspension and the mother says her child won't swallow that. The pharmacist can change it to two tabs: very simple, practical things. Or somebody can't get in for the refills for their hypertension medication because their doctor's away, so the pharmacist can extend those refills, check the patient's blood pressure while they're in the pharmacy, and make sure things are okay.

Awareness will increase with time. We would like the awareness to be much greater, of course, and we're working toward that.

Ms. Libby Davies: Do I have some more time?

The Chair: You have, yes, two and a half minutes.

Ms. Libby Davies: I have a couple other questions, then.

Changing the scope of practice goes through provincial legislation, does it not? In all of the provinces in which it has happened, it has been through specific legislation.

Is there a negotiation process, say, with you and the College of Physicians and Surgeons or some regulatory body in coming to agreement when a scope of practice is seen to infringe on somebody else's scope of practice?

How does this happen? Or do you just wait for a provincial government to say, this is a good idea; we're going to do it?

Ms. Janet Cooper: I think Alberta was first. It really was driven in a big way by the pharmacy regulatory body, and by their volunteer association as well. There was a lot of angst within the physician community, and we had many discussions with the Canadian Medical Association and others. But once it rolled out, it was not an issue. Everybody figures out a way to work together. New Brunswick was next. The health minister said: we like what Alberta did; make it happen here.

So it has happened in various ways; sometimes it has been pharmacy pushing it, sometimes governments.

What we've seen over the years is that the level of angst and concern, with physicians in particular, has decreased so much. Over the last few years, the provinces that have rolled out—Saskatchewan, Nova Scotia—have worked very closely with the medical regulatory organization and the advocacy organization to talk through it. As long as everybody understands what it means—and the word “prescribing” means different things to different people—it will work out in the end.

Ms. Libby Davies: Here is one last quick question to Mr. Lopatka.

In your recommendation you say that you want to “reset” immigration quotas. Could you explain what you mean by that? Do you mean reset it up or reset it down? Who would decide what the number is? I'm just not quite clear what you're saying in your recommendation.

Mr. Harold Lopatka: Thank you.

Our understanding is that the immigration quota is determined by CIC or the immigration group within the federal government. The last we understood, in the neighbourhood of 1,000-plus individuals were being allowed to immigrate into Canada. We would like to see the number lowered until the manpower situation is completely studied.

Ms. Libby Davies: All right, thank you. So you want to see it lowered.

Mr. Harold Lopatka: That's correct.

The Chair: That's perfect timing, Ms. Davies.

Mr. Lizon

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

Welcome, all the witnesses.

The first question I have is on expanded scopes of practice and the prescribing of medicine by pharmacists.

Would this include, in your view, or should it include, diagnosis as well?

● (0920)

Mr. Phil Emberley: I think there's widespread awareness that diagnosis is strictly a physician capability. We do not feel that pharmacists have the education to diagnose disease. We do, however, feel that pharmacists are the drug therapy experts, so they can definitely weigh in on which medications are most appropriate for a given diagnosis. But no, I don't see diagnosis per se; that's something that physicians should be doing.

Mr. Wladyslaw Lizon: I'll tell you why I asked this question. When I was growing up—and I wasn't growing up in this country, I'm originally from Poland—for many things I didn't go to see the doctor. I would go to the pharmacist and say, sir—or ma'am—I have this; can you do something for me? It always worked. Seriously, it always worked; they knew very well. It was for nothing major, but for minor ailments you wouldn't go to the doctor. I don't even know whether it was regulated or not, to be honest.

Mr. Phil Emberley: Absolutely. Pharmacists perform that valuable function on a daily basis. Patients will come in with a bug bite or they have acne or they have an allergic reaction. Pharmacists are definitely capable of providing the medications to support and to treat those conditions. We're not talking strictly about diagnosis. Very often the patient knows what they have or has a good sense, and the pharmacist is essentially confirming it.

Ms. Janet Cooper: The other thing to add to that is, "What's new?" Pharmacists have been doing that with over-the-counter medications forever. Now, with expanded scope, they can prescribe prescription-only medications to treat these types of minor ailments.

Mr. Wladyslaw Lizon: This would probably work very well especially in areas in which we have a shortage of doctors. We have remote areas.

Mr. Phil Emberley: Absolutely it does. It also takes away some of the pressure on emergency rooms, because they are really being inundated with patients presenting with varying degrees of severity. If minor ailments can be handled at the pharmacy level, it will reduce some of that strain, most definitely.

Mr. Wladyslaw Lizon: The committee just completed a study on prescription drug abuse. It's a growing problem. What is your view; would the new, expanded scope of practice for pharmacists add to the problem? Would it address the problem?

If someone comes to you as a pharmacist and says, I'm on such and such medication, especially with the abuse or misuse of opioids for both medical and non-medical use growing very quickly, would this add to the problem? If someone comes to you and says, "Listen, I'm travelling and I need this; I don't have any more", what would you do? I guess it would not work very well and might actually increase the problem.

Mr. Phil Emberley: One thing I want to make very clear is that we're talking about appropriate drug therapy to enhance patient outcomes. In many cases, the proper thing to do is not to recommend a medication. I think that pharmacists are in an ideal position to make that assessment.

There's also an educational component to this, explaining the role of medication where it is warranted and explaining when drug therapy is not warranted.

I don't see expanded scope as increasing the prescription burden. I see it as a second set of eyes that pharmacists can provide to enhance patient outcomes in an accessible way and also do what is right for the patient's health, ultimately.

Ms. Janet Cooper: Let me add to that, to clarify, that prescribing of narcotics and controlled drugs is federally regulated, and pharmacists don't have that authority. The government recently allowed a number of other providers to prescribe narcotics—midwives, nurse practitioners, podiatrists, maybe—but not pharmacists. So they couldn't.

We've suggested that pharmacists should be allowed to do this. Often it might be helping to get somebody off narcotics, because that is a slow process. Changing the dose to slowly wean them off their narcotics would be something pharmacists could certainly help with.

Mr. Phil Emberley: Or changing to a narcotic that might not be as problematic, as, for example, in the case of OxyContin changing maybe to another narcotic that is similar in terms of pain relief but doesn't have the same problematic attributes as a drug like OxyContin.

Mr. Wladyslaw Lizon: I have a question for Mr. Lopatka, to clarify this for me. You mentioned that quota of 1,000 per year. Can you tell me why would you ask to lower the quota?

● (0925)

Mr. Harold Lopatka: As I mentioned in my presentation, we believe that we've tipped from being in a shortage environment to being in a surplus environment. In Canada we're producing more than 1,000 graduates from our own pharmacy schools—we're actually approaching 1,400—and we believe that, at least from what we can tell, this supply should be enough for our needs over the next little while, or at least until the time that we find what the true need is per year, with the pharmacists who would be exiting from the workforce due to retirement and such factors.

As to the precision of our calculations in knowing what CIC is doing, it is only from the conversations we've had with them that this 1,000 number has come up. We don't really have any better information on whether it's even more than that.

Mr. Wladyslaw Lizon: I don't know whether you have these or not, but if you have statistics from the past years, what percentage of foreign-trained pharmacists after arriving in Canada actually get accreditation?

Mr. Harold Lopatka: I don't have any numbers on that. But all I see from the information that is available from the current Canadian Pharmacist database is that over the course of probably five to eight years, the international graduates have now become one quarter of the labour force, if the numbers are all correct. So certainly the number of people who have made it into the system has grown quite significantly in the last four or five years.

But I don't have any other numbers about how many are out there who have not been accredited or licensed to practise.

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

Next seven-minute round, Ms. Fry, please.

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

It was a very excellent presentation from all of you and I do support the concept of scope of practice expansion with pharmacists working in a team setting. However, I just wanted to pick up on some of the things that Mr. Lizon asked earlier on. I think I agree with Mr. Lizon. I believe that the ability to diagnose a patient is a scope of practice for a physician.

I have myself been the beneficiary of having my asthma medication quickly given to me from the pharmacist when my doctor has been away. I understand that this is all very appropriate scope of practice.

There is one thing that I keep hearing and so I wanted to ask about it. If someone walks into a pharmacist office and as Mr. Lizon asked, had what seems like a cold, it's very easy to say well let's give them some antihistamine, some Tylenol to bring down the fever, etc. Is that appropriate practice, however, if one hasn't had the ability to be in touch with the family physician or the attending physician to find out if that person has other coexisting reasons or is taking other kinds of medication? It may be inappropriate to give the kinds of medication you may be giving them.

For me, that ability to talk to each other before giving any kind.... Even over-the-counter stuff, as you well know, can be harmful if somebody is taking medication that's going to be contra-indicated to take those things. How does that happen if somebody just walks in? This isn't a patient you've always seen, somebody you've talked to the physician about on a constant basis and therefore shared the history and shared the knowledge about the patient.

That's the first question I want to ask. How does that work and what are the risks of that kind of practice?

The second thing is, and this is the one that I've heard possibly from physicians and others, so it's a biased question actually.... I'm just asking it because I really would like to hear the answer and I'm sure you have a good one. Is it because pharmacists, generally speaking, tend to benefit directly from prescribing anything or giving anything even if it's over the counter because they also own or run the pharmacy or drug store? Anytime they give anything, they get a financial benefit from that medication.

What are the ethical guidelines? Maybe the college might answer that better.

What are the ethical guidelines put in place to ensure that pharmacists are not being pushed from monetary gain only to make sure that everybody who walks in and has something, gets a medicine, over the counter or otherwise? That's a big question in terms of the ethics of it. I don't know if you have ethical guidelines on that. I don't know how one tracks how that works. Of course, the prescription fee that one gets for dispensing and all that.... I can see all of this working so well in a community care setting, as you said.

But I just wondered if there is a way of looking at how that ethical guideline is observed. What are the ways that one is ensuring that those monetary gains are not made from pharmacists who may or may not...? We've got doctors who do all kinds of things that they shouldn't be doing. I'm asking the same thing. How do you monitor that and make sure that there isn't medicine being given every time somebody walks in even for a little cold because one gets a monetary gain from it? So that's the ethical piece I wanted to talk about within the scope of practice.

● (0930)

Mr. Phil Emberley: I think, to answer your first question, very often the person who presents in a pharmacy and is asking for advice or help over the counter is not in an immediate position to access their physician or an emergency room. Often you see them in the evenings or weekends. As a pharmacist, you are presented with what appears to be something self-limiting. It could be a cold you detect.

What I think is important is after that consultation, the pharmacist will often say, “Keep an eye on this. If after a couple of days you're not feeling better, you need to see someone. You need to see a physician or you need to see another health care provider.” So we're not losing these patients to follow-up in situations where it could be something more severe than that because we don't want them to go home and think that every ailment they have can necessarily be treated in this way.

A lot of these patients are coming in to pharmacies and they are self-selecting these products. They are seeing advertisements on TV or on the radio and they come in and they choose something. The pharmacist's value-add is really being able to assess them, and given the information that they may already have about these patients in their database, suggesting something that is a realistic therapy for them. But there is a need to collaborate with other health care providers and not do it in isolation.

Hon. Hedy Fry: I understand that, but I'm talking about the times when you can't collaborate. For instance, somebody comes in and they pick up, say, Tylenol Sinus. Do you ask them what medications they are taking?

Mr. Phil Emberley: Absolutely.

Hon. Hedy Fry: You do. Okay.

Mr. Phil Emberley: Absolutely. You really need to do that assessment because there are definitely medications that are not appropriate for everyone.

Hon. Hedy Fry: Yes, absolutely. That was what I was getting at.

The second one?

Mr. Phil Emberley: The second part is, as many professions, we have a code of ethics. Our code of ethics in pharmacy is very much to do whatever it takes to meet positive health outcomes for patients. To suggest something or prescribe something to a patient that could ultimately cause side effects or make things worse, I think all pharmacists are aware that it is not in our interest to do that. It's a short-term benefit that could lead to long-term pain. Especially from a professional point of view, to lose that scope of practice after coming so far as we have as a profession is not somewhere we want to go. I think most of our members have that same sense.

Hon. Hedy Fry: Do you have a tracking system?

● (0935)

Mr. Phil Emberley: I believe provincial governments are able to track the prescribing habits of pharmacists, yes.

Hon. Hedy Fry: I have just one last question. With regard to prescribing opioids, I know in B.C. there's a triplicate prescription system. I know, as a physician, people would come in and they would say, “I'm from Alberta and, my gosh, I've been taking this medicine for 20 years. My doctor has been giving it. My back is so bad”, and blah, blah, blah. In the past, without the triplicate prescription, you didn't know what to do so you would try to call their doctor to say, “Is this true?”, because these are the patients who are shopping around for opioids. Do you have that problem? How do you assess that when it happens?

Ms. Janet Cooper: It is a problem. B.C. has had a province-wide drug network for more than 15 years. A pharmacist knows every prescription that is ever dispensed for that patient. We certainly don't have that here in Ontario. We need it. There are different things that have been put in place to try to prevent double doctoring and prescription drug abuse, but ultimately, province-wide drug systems, profile systems, electronic prescribing, electronic health records that everybody has access to are going to make a huge difference in addressing a lot of those challenges.

Mr. Phil Emberley: If I could just add to that, the Controlled Drugs and Substances Act regulates the controlled drugs in Canada, but it doesn't have a monitoring and surveillance side to it. I think maybe it's time to look at that. I think we need a national monitoring vehicle because people do move from province to province as well. So I think we need to look at this nationally.

The Chair: Very good. Thanks a lot.

For the last round, Ms. Adams.

Ms. Eve Adams (Mississauga—Brampton South, CPC): Thanks, Mr. Chair. If you would be kind enough, please alert me to the last two minutes so that I might split my time with Mr. Young, because I know he's keen to get some questions in to these witnesses.

If I might just pick up on what my colleague Mr. Lizon had said, I've had the very same experience when I've travelled through eastern Europe. If you're ill, you present yourself to the pharmacist and much like the traditional apothecaries, they would look and actually give you the medication you require and you're on your way. It seemed very efficient—just very, very efficient and very, very convenient.

While I understand what Ms. Fry has been indicating about the need to make sure that we're obviously not over-prescribing opioids and all sorts of other serious medications, I do think that there is an opportunity with expanded scope of practice to offer innovation and savings to the health care system and added convenience to Canadians across the country. I think especially, for instance, to experiences when my son would have an asthma attack at night and I would run out of refills for his puffers. It would have been so handy to just go straight to the pharmacy and have them refill the puffer. Instead I had to hike and try to find a 24-hour clinic that would give me a prescription that I could then take, and my son is in distress the entire time. I think that there are opportunities for savings here and convenience for consumers.

I also think what a terrible waste it is when people are about to travel, for instance, and they're taking up valuable physician time when they're simply seeking prophylactic antibiotics if they're about to go to some country. I think there is certainly an opportunity there where our pharmacies could play a role, where you do have laid out for you that these are the types of medications you ought to be taking with you. I'm thinking of some basic things like Cipro if you're going to go somewhere. Instead, what we find right now, though, is people are sitting in doctors' offices taking time and very limited, valuable resources. I think we've all had that experience, where you're sitting in the doctor's office and you're waiting, and these things I think could be more conveniently dealt with elsewhere.

I wonder, you know, just following up on Ms. Davies' question, how open is this renewing and extending prescriptions and so on? I wasn't familiar with it here in Ontario. I didn't think that you could just go to a pharmacy and have a prescription renewed.

Mr. Phil Emberley: This was actually put into place a couple of years ago. What we typically see is someone running out of their medication on a late evening or weekend, and it's a medication they've been taking routinely. It could be something for their blood pressure, or their cholesterol. Rather than get in touch with a doctor and perhaps have to wait a little bit, we're able to continue that therapy. Doctors are always made aware of this. There is a requirement that they be informed.

Ms. Eve Adams: So the following day you then call in and ensure that the prescription refill was appropriate?

Mr. Phil Emberley: Yes, exactly.

Ms. Eve Adams: Does the patient have to come back for the full refill, or you give them enough to go home with?

Mr. Phil Emberley: Usually it would be, for example, for a month on a maintenance medication or three months. Again, it's at the judgment of the pharmacist. There's real judgment involved here. It's not simply a case of saying “oh, this is fine”. There is some degree of assessment that is required as well.

Ms. Janet Cooper: If I could add to that, in Alberta it's best in class in the world what they do in scope of practice. I think in a few years time we won't have a chart, it will be green checks everywhere. But also the government pays for pharmacists to provide these types of services, and they have a very good payment model.

But I spoke to somebody recently. They were travelling to somewhere in Africa. They went into a Rexall pharmacy and they got all their injections for their vaccines, they got the prophylactic prescriptions that they needed, they got other advice, all that type of stuff, in and out. They paid for it because those aren't usually covered by government services, but it was so convenient, and that level of convenience is a huge part of what's driving this, that access to care. There are over 9,000 pharmacies out there and they're open evenings and weekends, and you don't need appointments.

Ms. Eve Adams: Yes.

Can I pop it back to part of our federal role in providing, obviously, services in the far north and to our first nations communities—

● (0940)

The Chair: Just in fairness to Mr. Young there.

Ms. Eve Adams: We're at time?

The Chair: You probably should pass it over.

Ms. Eve Adams: Just very quickly, do you have a position on drug sampling for nurses in remote communities?

Ms. Janet Cooper: No, we don't.

Ms. Eve Adams: Okay.

Mr. Young.

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

I'm very concerned about the number of patients who have adverse drug reactions, which are the fourth leading cause of death in North America, 70% of which are preventable. I have tremendous respect for pharmacists. I wish you had more power in your scope of practice to challenge doctors' prescriptions. But I am concerned that some drugs like Remicade, for example, which, if memory serves me well, is approved for up to three months for rheumatoid arthritis, which is prescribed off-label by doctors for longer periods of time for Crohn's disease, and 11% of patients who take Remicade long term will get cancer, or may get cancer. Are pharmacists allowed to prescribe off-label? And are they allowed to continue prescriptions or renew prescriptions that are off-label?

If you can give me a short answer, I have one more quick question.

Mr. Phil Emberley: Again, there is a high degree of judgment involved in this. It has to be within the pharmacist's level of expertise. I would say most pharmacists are not going to be in a position to prescribe Remicade. This is something that a specialist is going to be prescribing.

A pharmacist may be able to detect if a patient is perhaps failing on the Remicade and that maybe it is not the best medication for them. There would be a lot of collaboration with a patient like this. Obviously this is a serious drug that we are talking about, and the potential for cancer cannot be overlooked.

Mr. Terence Young: Here is something else that concerns me a great deal. I support a broader scope if, and only if, it's safer for patients.

How can pharmacists prescribe if they are not allowed to diagnose? Diagnosis is critical to a prescription. How can you have the power to prescribe if you don't know how to diagnose?

Ms. Janet Cooper: A good example is a physician could write “diagnosis: hypertension” on a script. It goes to the pharmacist, and then the pharmacist, based on the evidence and the clinical practice guidelines, could then manage the drug therapy. They can start insulin, adjust insulin doses, those types of things.

They may be the first person to detect that the patient has high blood pressure, send them to the physician for that workup—

Mr. Terence Young: It still requires a prescription from a doctor.

Ms. Janet Cooper: It's a collaboration, it doesn't have to be a prescription—

Mr. Terence Young: So a patient can go into a pharmacy and just say, “I think I have high blood pressure—

Ms. Janet Cooper: No.

Mr. Terence Young: —what are you going to give me?” Do they have to go to a doctor first?

Ms. Janet Cooper: They would have to. You would have to get that diagnosis. A pharmacist would not start anti-hypertensives on a patient without some kind of collaboration with a physician.

Mr. Terence Young: Okay. I note, by the way—

The Chair: Mr. Young—

Mr. Terence Young: —in British Columbia, they pay doctors to not prescribe, which results in a lot of—

The Chair: Excuse me, Mr. Young.

Mr. Terence Young: —interventions that are good for patient safety.

The Chair: Thank you.

This brings a close to our first hour of our meeting.

I would like to thank all our guests today—really great presentations.

What we will do is suspend for a minute or two, and then we will ask our guests who are in for the second hour to come up and get ready. You're going to get an upgrade in the second hour because Ms. Davies is going to take my position. You're going to get a real chair for the next hour.

We are going to suspend, and we will be back in a couple of minutes.

● (0940)

(Pause)

● (0945)

The Vice-Chair (Ms. Libby Davies): I think we are ready to begin again. We are ready to go to our next hour of the committee.

We have two witnesses.

Ms. Cohen, chief executive officer of the Canadian Psychological Association, thank you for being here.

Our second witness is Mr. Bland from the Canadian Psychiatric Association. Thank you for attending today.

We will begin with Ms. Cohen. It is up to 10 minutes for your presentation.

Dr. Karen Cohen (Chief Executive Officer, Canadian Psychological Association): It should be eight minutes, actually.

Thank you very much for the invitation to join you today to talk about best practice and barriers for health care professionals in Canada.

First I'll talk a bit about the Canadian Psychological Association. It's the national association of Canada's scientists and practitioners of psychology.

There are about 18,000 regulated psychologists in Canada. They are employed by many publicly funded institutions, including health care centres, family health teams and primary care practices, schools, universities, and correctional facilities. Correctional Services Canada is in fact the country's largest employer of psychologists.

Increasingly, however, psychologists practise in the private sector. Across sectors, their scope of practice includes the psychological assessment and diagnosis of mental disorders and cognitive functioning, the development and evaluation of treatment protocols and programs, the delivery of psychological treatments, and research.

Needs for mental health services in Canada are considerable. One in five Canadians has a mental health problem in a given year, the most common problems being anxiety and depression. The fastest-growing category of disability costs is depression. The annual cost of mental illness to the Canadian economy is $51 billion, while the impact on productivity in the workplace is estimated at tens of billions of dollars annually.

Forty per cent of disability claims to Treasury Board are related to mental health, a figure not atypical for large employers. The significance of the gaps related to mental health was recently acknowledged by Treasury Board when Minister Clement announced that federal employees and retirees will see their coverage for psychological services double as of October 2014. The CPA applauds the federal government for this needed benefit enhancement, particularly for having made it within its climate of fiscal restraint.

The importance of this announcement by Treasury Board is underscored by the very significant barriers created by the way in which health care is funded in Canada, particularly mental health care. Only about one-third of those who need mental health care will receive it. This can be attributed to stigma, but also to the lack of access to service.

Psychologists are Canada's largest group of regulated, specialized mental health care providers. Their services are not funded by provincial and territorial health insurance plans. In the private sector, Canadians either pay out of pocket for psychological service or rely on the private health insurance plans provided by their employers.

The coverage through private plans is almost always too low for a clinically meaningful amount of psychological service. Imagine cardiac care without access to cardiologists or obstetrical care without access to obstetricians and midwives. This is the situation we find ourselves in in the case of psychological services and mental health. While much has been made of not wanting to create a two-tiered health care system for Canadians, when it comes to mental health service, arguably we already have one.

Psychological treatments work for a wide range of mental disorders as well as contribute significantly to the management of chronic health problems and of such conditions as obesity, heart disease, and chronic pain. They are less expensive than and at least as effective as medication for a number of common mental health conditions.

People with depression who are treated with psychological therapy tend to relapse less frequently than those treated with medication. Successful treatment with psychological therapies results in decreased use of other health care services, with the costs of treatment being more than mitigated by reduced costs attached to those services.

Recent research suggests that combining psychotherapy with medication enhances treatment compliance, reduces the subjective burden of disease, and is associated with lower suicide rates. For anxiety disorders, psychological treatments are first-line interventions and generally are as effective as medication.

The Council of the Federation commissioned a health care innovation working group in which I participated as co-chair of the Health Action Lobby, or HEAL. It has tasked itself with three priorities, namely pharmaceutical drugs, appropriateness of care inclusive of team-based models, and seniors care. CPA joins HEAL in calling on the federal government to participate in this important work.

For Canada to innovate and improve the way in which it delivers health care to Canadians, we need to work as collaboratively to change the system, as we do to deliver care. If we want a health care system that will deliver cost- and clinically effective care, then we must re-vision policies, programs, and funding structures through which health care is provided.

For its part, the CPA commissioned a group of health economists to cost out alternate models of making psychological services more accessible to Canadians. CPA has been bringing the findings of this report and its recommendations to all of Canada's stakeholders in mental health: employers, governments, and private sector insurers. We hope that, like Treasury Board, stakeholders will take seriously the individual, workplace, and societal cost offset of making psychological services more available to Canadians who need them.

Although there may be no appetite to spend more on health care, little spending now means spending more later: more on health care utilization, more on absenteeism, presenteeism and disability at work, and perhaps most importantly more in the costs borne by individuals and families.

● (0950)

A second issue affecting psychological practices is chapter 7 of the Agreement on Internal Trade. The AIT mandates provincial and territorial regulatory bodies to create the mechanisms necessary to support the mobility of professionals across Canada. The challenge is that, while regulatory bodies have considerable responsibility for mobility, they have little authority in establishing the criteria for mobility.

Entry to practice standards for psychologists vary across the country. What has resulted with AIT is that mobility has become based on the least rigorous of these standards rather than upon the very robust standards for training in psychology established and maintained by the Canadian and American Psychological Associations for decades, standards that define training in psychology across North America. It is CPA's position that entry to practice standards for Canadian psychologists should be at the doctoral level and based on these accreditation standards.

Finally, there are gaps when it comes to training, recruitment, and retention of Canadian psychologists. We have heard about the very significant needs for mental health services among members of the military. We know that recruitment and retention challenges are faced by public employers of psychologists such as correctional and educational facilities. There are generally three factors that impact the success of recruitment and retention.

First, employers need to participate in the training of the resource they want to attract and retain. We have suggested that the federal government consider the development of a federal residency program to enable doctoral students in psychology to complete training in federal departments where there is need.

Second, employers need to pay attention to compensation. Federal employers of psychologists have historically offered salaries lower than those offered by other public sector employers for similar work.

Third, employers need to pay attention to conditions of work. Workplace success depends on the meaningful engagement of individual employees and teams. We have recommended to the Department of National Defence, for example, that they consider putting clinical psychologists in uniform, giving them a chance not just to work to support the delivery of health care, but to deliver their considerable skills in shaping its delivery as well.

In sum, our recommendations to the committee on health are as follows: we urge the federal government to participate in the health care innovation working group with the Council of the Federation. It is through collaboration that we will successfully re-vision how health care can best be delivered to Canadians. We ask that the federal government review the provisions of the Agreement on Internal Trade to permit alignment with the robust systems of training and credentialism long established by the profession. We urge the federal government to participate in the training of the resource it needs, and upon which its success depends. The development of residency training programs and careful consideration of the conditions of work will go a long way to enhancing recruitment and retention of health care professionals.

The CPA would be very glad to assist work towards these goals.

Thank you.

The Vice-Chair (Ms. Libby Davies): Thank you very much, Ms. Cohen. You were actually under eight minutes.

Next we'll turn to Dr. Bland.

Welcome to the committee, and you have up to 10 minutes to make your presentation.

Dr. Roger Bland (Member, Professeur Emeritus, Department of Psychiatry, University of Alberta, Canadian Psychiatric Association): Thank you very much, and thank you for asking the Canadian Psychiatric Association to make a presentation to your committee today. We have chosen a limited number of topics but invite a broader discussion of these topics and any other questions that the committee may wish to raise afterwards.

First, let me introduce myself. I'm a psychiatrist and the deputy editor of the *Canadian Journal of Psychiatry*, a researcher and former chair of the department of psychiatry at the University of Alberta, and a former assistant deputy minister for mental health in Alberta. I am a member of the joint Canadian Psychiatric Association and College of Family Physicians of Canada shared working group and have been since 1998.

The Canadian Psychiatric Association, founded in 1951, is a voluntary organization, and represents approximately 4,500 psychiatrists and 600 residents. The association advocates for the mental health needs of Canadians and for the highest standards of professional practice.

The CPA—that is, the psychiatric, not the psychological association—works with governments and other mental health stakeholders, and we provide continuing professional development and promote research. The Canadian Psychiatric Association is not a licensing body, does not control education or training requirements, and does not set fee or payment schedules for psychiatrists.

Perhaps one might ask, what is a psychiatrist? Psychiatrists train first as medical doctors, then undergo a further five years of training in behavioural medicine before being certified through national examination. The ability to integrate medicine, psychiatry, neuroscience, psychology, and social science is a skill set unique to psychiatrists. Perhaps more than any other medical specialty, psychiatrists work with multidisciplinary teams. Increasingly we are called upon to work within a collaborative team framework; that is somewhat different from a multidisciplinary team.

Moving on to what is a relatively innovative way of delivering health care services, what does “collaborative care” mean? It involves practitioners from different specialties, disciplines, or sectors working together to offer complementary services and mutual support to ensure that individuals receive the most appropriate service from the most appropriate provider in the most suitable location as quickly as necessary and with a minimum of obstacles. It is built on personal contacts, mutual respect, trust, and the recognition of each partner's potential roles and contributions, and also on effective practices that are preferably evidence- and experience-based.

Collaborative care can be seen as part of the overall picture of primary care reform advocated by the World Health Organization. Canada adopted the principles of primary care reform from the World Health Organization, and all provinces have supported them to a greater or lesser degree.

However, after initial enthusiasm and in our case the support of the Canadian Collaborative Mental Health Initiative, which involved 12 organizations and was funded by the primary care innovation fund, the federal government seems to have somewhat lost the initiative in pursuing collaborative care. It would be appreciated if the federal government could reiterate its support for primary care reform and ensure that it includes a strong mental health component.

Increasing the number of specialists does not necessarily increase the health of the population and may in fact make it worse and more expensive, whereas increasing the number of primary care providers does improve population health and tends to reduce costs in the long run. The task, then, of the specialist is to ensure that the primary care providers are well supported and have ample access to different levels of specialist service, preferably as close to their work site as possible.

Psychiatrists and family physicians have worked together for 15 years to promote collaborative care and have had considerable success in having the concept adopted by both organizations. There are now many programs in place across Canada that provide ample evidence of its uptake.

One document produced by the Canadian Collaborative Mental Health Initiative analyzed the evidence behind best practices in collaborative care. It found that collaborative relationships require system-level collaboration, preparation, service reorganization in many cases, and time to develop.

● (0955)

Co-location of services was important to patients. Systematically following up on patients, rather than leaving it to chance or "see me when you feel like it", produced better outcomes. Patient education delivered by other health care professionals improved patient outcomes, and giving patients treatment options improves their engagement in treatment.

Collaborative care also significantly reduces stigma, which is a major factor in mental health. Payment systems, however, which are usually provincially set, can be an obstacle to collaborative care and there is no consistent payment system and therefore no consistent way in which collaborative care is really supported.

Looking at mental health and some of the federal services, there are several collaborative opportunities here. First, as an employer, the CPA applauds the pilot of the national standard for psychological health and safety in the workplace at Health Canada and encourages its wider adoption.

With regard to the RCMP, training the RCMP in mental health crisis intervention would be a good move. Some of this happens, but clearly not enough. For example, some police forces have adopted the mental health first aid program and put large numbers of their members through that program, but not, I believe, the RCMP.

For the military, the prime problem facing the military seems to be the management of post-traumatic stress disorder and the comorbidities that go with that. New programs have been developed and seem to be reasonably effective. The problem of military families involved in this, though, may not have been adequately dealt with and they may need further support, as may some of the self-help groups that are being started, often on a voluntary basis, in some locations for the military.

Turning to federal prisons, over the last 40 years the incarceration rate has increased 75% in federal prisons. That's not numbers, that's the rate per 1,000 population. In a one-year period, 60% of federal offenders received mental health services, and 30% of women offenders and over 14% of male offenders had previously had a psychiatric hospitalization. Substance use problems affect four out of five offenders. Women prisoners had a 50% rate of self-harm, and 85% had been physically abused and over two-thirds sexually abused. I understand the Correctional Service has suggested that there is difficulty in recruiting physicians, and this may be true. But earlier this week I checked the Government of Canada jobs website and found no advertised vacancies for physicians or psychiatrists in the Correctional Service.

With regard to research, the federal government is perhaps the largest research funder in Canada, and there is a need to support demonstration projects on how collaborative care can help address common problems faced by health care systems, particularly with reference to underserved populations, such as the aboriginal, homeless, rural, and isolated communities.

Questions have been asked about multidisciplinary training, and many of the health science faculties in Canadian universities now offer combined courses for several health disciplines. While this is a strong move forward, there is probably still scope for further improvement. Instruction on how to work collaboratively as part of a team, including situations in which the physician may not be the anointed team leader, is certainly needed.

Residency training programs in psychiatry—that's now the post-M.D. specialty training—now include a mandatory experience in collaborative care. There is also scope for multidisciplinary continuing professional development programs. The Canadian Psychiatric Association has run some of these, but they are difficult to maintain financially, since they receive little support except for contributions from people who attend. It is not quite clear what the federal government's role in this could be, but encouragement of and support for continuing multidisciplinary professional development activities would certainly be appreciated.

Thank you very much.

● (1000)

The Vice-Chair (Ms. Libby Davies): Thank you very much, Dr. Bland.

We'll now begin our first round of questioning. It's seven minutes for both questions and responses.

We'll begin with Mr. Morin.

● (1005)

[*Translation*]

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

I am going to take four minutes and give the remaining three to my colleague, Mr. Boulerice. Could you kindly let me know when my four minutes are up?

[*English*]

Mr. David Wilks (Kootenay—Columbia, CPC): On a point of order, could we allow Dr. Bland to get his earpiece in?

[*Translation*]

Mr. Dany Morin: My question is for Ms. Cohen.

You talked about barriers in terms of the general public's ability to access psychological services. Mental health treatment isn't among the range of services that provinces and territories provide under public health plans, at least not in Quebec. Please tell me if there are any provinces that do cover the cost of psychological services under their public plan. The bottom line is that access to treatment is seriously limited.

Do you think the federal government should give the provinces and territories financial support, perhaps increase health care transfers? The idea would be to bring mental health care under the umbrella of services available to Canadians through public health plans.

[*English*]

Dr. Karen Cohen: I'm going to answer you in English. I could try in French, but I'm going to answer you in English because I think that's actually a really tough question.

There are of course jurisdictions where psychologists are salaried by public institutions, and in fact, in essence, there is no charge to the patient or the client or user of those services. There are psychologists involved in primary care teams and family health teams, but increasingly what's happened is that public institutions face their own pressures, they decrease their salaried resource, and psychologists go to the private sector. When I graduated with my doctorate years ago, most of us went on to work for universities and teaching hospitals. Now, young psychologists are graduating to work in private practice.

It's a challenge. I think, if I'm to be candid, that we have a public medical insurance system, not a public health insurance system. We pay designated providers to deliver designated services in designated venues.

So it's tough when we're talking about providing collaborative and multidisciplinary care, particularly for chronic conditions, of which mental health conditions can be one, because there is no magic bullet. There is no one solution. There is no one health provider, be they a physician, a psychologist, a social worker, or a counsellor who has the answer. To support team-based care in a model that pays designated providers for service is a huge barrier.

Is there something the federal government could do in terms of targeting funds or transfers for mental health? I would probably leave that for economists more knowledgeable than I to answer, but there is certainly a need for a solution.

[*Translation*]

Mr. Dany Morin: Thank you.

[*English*]

The Vice-Chair (Ms. Libby Davies): Mr. Morin, you're just a little over three minutes.

[*Translation*]

Mr. Dany Morin: My second question will be quick.

[*English*]

For private insurance reimbursement, a lot of them request a prescription from a medical doctor. Do you think it adds an extra barrier that is not needed, especially for preventative measures?

Dr. Karen Cohen: Absolutely. There is no reason by regulation. Psychologists are regulated in our jurisdictions to deliver care. They can accept self-referrals. It is a requirement of some insurance programs and not others. It's a gatekeeping requirement. It's not a requirement that's at all tied to the scope of practice of the psychologist.

I agree with you. Not only does it create a barrier of access for the client or the patient, it also burdens the public health system, which is burdened enough.

The Vice-Chair (Ms. Libby Davies): Thank you.

Mr. Boulerice, you have three minutes.

[*Translation*]

Mr. Alexandre Boulerice (Rosemont—La Petite-Patrie, NDP): Thank you, Madam Chair.

Ms. Cohen and Mr. Bland, I quite appreciated your presentations.

First, I'd like to hear your opinion on a very specific issue, post-traumatic stress disorder affecting members of our military and our veterans.

I attended a meeting of the Standing Committee on National Defence a few weeks ago. I was rather stunned to learn that no systematic or regular follow-up is done on the men and women in uniform we send into combat situations overseas. And what's happening as a result, unfortunately, are terrible tragedies, family tragedies.

In your view, what should the federal government do to improve how mental health care is handled when our men and women in uniform return from missions?

● (1010)

[*English*]

Mr. Terence Young: Madam Chair, on a point of order. This is a very important and interesting topic, but it's not what we're studying. It has nothing to do with scope of practice.

The Vice-Chair (Ms. Libby Davies): Well, I think it is involved with what psychologists do in terms of how far afield they go, what kinds of constituencies or demographics they cover—

Mr. Terence Young: That wasn't the question.

Mr. Dany Morin: Yes, it was.

The Vice-Chair (Ms. Libby Davies): I don't see it is as out of order, so I'm going to allow the witness to respond.

Dr. Karen Cohen: Post-traumatic stress disorder certainly is a condition for which there are some very robust interventions. We have a section within our membership of 7,000 that specializes in traumatic stress, in terms of research as well as practice delivery.

One of the challenges, I think, within military populations, is access to that care and the way in which care is contracted out. There are no clinical psychologists in uniform, as far as I know. There are some who work on the personnel or industrial organizational side, but not on the clinical side.

There are robust treatments. I think maybe more attention needs to be paid to the mechanisms of accessing them.

Dr. Bland may have some other points of view on that topic, as well.

Dr. Roger Bland: Many of us have heard the comments made by Roméo Dallaire, for instance, who years and years after his traumatic episode is still having problems, and I don't think his problem is unusual. I do not know how long the military extend their services to people who are no longer in the military.

Another example would be Colonel Ethell , who is the Lieutenant-Governor of Alberta and who talks frequently about his post-traumatic stress experiences in Bosnia. This was many years ago, and he is still having trouble.

I think that the need for supportive services to continue, in some cases for many years afterwards, and for those supportive services to be extended not only to the individual who was in the military but to the family members who also become victims of this, is incredibly important. I can't—

The Vice-Chair (Ms. Libby Davies): Dr. Bland, we've now reached the seven minutes, so thank you. We'll perhaps pick it up later.

Dr. Roger Bland: Thank you.

The Vice-Chair (Ms. Libby Davies): Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you very much, Madam Chair. It's nice to see you in the chair. It's the first time since I've been here, I think.

Thank you very much to both of our witnesses for being with us this morning.

Dr. Bland, you were discussing collaborative models of care as opposed to multidisciplinary teams, and I think you drew a distinction there. You mentioned a study that had been done recently about examining the models.

Could you tell us what the name of that study was, or where was it published, or where we would access that?

Dr. Roger Bland: It was published as a supplement to the *Canadian Journal of Psychiatry*, in, I think it was 2008. We'll certainly be able to make copies available to you.

Mr. James Lunney: Thank you very much. We would very much appreciate that.

Now, back to your collaborative models. Multi-providers, I think I heard you say, are based on personal context, mutual respect, understanding each other's competencies, evidence, and experience-based. I think those are very appropriate comments.

Can you describe the genesis or development of this type of model? How do you get these groups together, and is it contingent on the size of the population or the pool of resources you have to draw on, and so on? Could you please describe an example of that?

Dr. Roger Bland: The history is that this started as a collaboration between the College of Family Physicians and the Canadian Psychiatric Association, based on problems that the College of Family Physicians was getting from its members about its relations with psychiatry, difficulty in getting referrals and so on.

To give you a single example, I worked for about five years in the Northeast Community Health Centre, in Edmonton, on a part-time basis as the psychiatry consultant. This is a community mental health centre, which had family medicine, maternal care, public health, child care, and a couple of other things as well. All of these services work collaboratively. The mental health program was set up there to be a support to the other programs and not to assume an independent life of its own.

In my work there and the work of the staff, which included an addiction service as well, this mostly meant seeing patients the other services had seen and thought had a problem. It was seeing those patients with them, developing a treatment plan jointly, and assigning who was going to do what. We had some problem cases and we'd have a large case conference and assign responsibilities. It was not a case of saying this is my problem and I'm handing it over to you; it was a case of which of us was going to do what to help this patient with these defined problems.

Does that—

● (1015)

Mr. James Lunney: That's very helpful. Then you would get together as a team once a week. What was the funding model for that? How did they manage that aspect because that seems to be a barrier to some of these problems?

Dr. Roger Bland: The program as a whole was getting funding through the Capital Health Authority as it was in Alberta at that time.

I just billed fee-for-service on the fee schedule. I got no extra funding for this. The Alberta fee schedule is quite conducive, though, to spending time in case conferences and discussions with other professionals. That is not true in a lot of the other provinces.

Mr. James Lunney: In building teams like this, is physical proximity an essential ingredient or is it relationship proximity? Can you build those relationships and then maintain them through online or through other e-forms of connecting?

Dr. Roger Bland: It tends to be difficult to build distance relationships. It can be done, but it takes a long time.

The person you're seeing on a regular basis down the corridor and can go and ask a question of, you tend to build a closer relationship with much more quickly.

Mr. James Lunney: Exactly. Then in building a team like that you might get people together in remote communities, bringing some resources in, spending a weekend together once every three months or something so you establish relationships, and then maintaining more of a collaborative distance relationship.

Might that work?

Dr. Roger Bland: That could, and I think there are some models like that. I think probably once every three months isn't frequent enough. You have forgotten who was there.

Mr. James Lunney: That is a good point.

You mentioned that increasing the number of primary care providers improves access and outcomes for the patients. I think that's a very reasonable assessment. Did I quote you accurately on that?

Dr. Roger Bland: It's not quite what I said, but I would agree with it.

Mr. James Lunney: Could you repeat what you said so I could get it your way?

Dr. Roger Bland: I said that increasing the number of primary care providers tends to increase population health.

Mr. James Lunney: You said population health—very good. Okay. I think they are not mutually exclusive.

Dr. Roger Bland: No. I like what you said.

Mr. James Lunney: The third-largest health care providers' primary contact in this country are actually doctors of chiropractic.

Does it strike you that the third-largest primary contact—do you see them involved in collaborative models? If not, why not?

We're talking about the scope of health care providers.

Dr. Roger Bland: I can't think of any situation I know of where chiropractors have been involved. They tend, as far as I know, not to practise in close collaboration with other health care providers.

Mr. James Lunney: There are some very good examples of better collaboration. St. Michael's Hospital has had a program going on for many years.

But it does strike me as odd since maybe 40% of the cases seeking help in a physician's office are musculoskeletal cases that there's clear evidence chiropractors are getting very good results with, and there are 9,000 of them out there.

It seems to me there's something missing in that collaborative model.

Dr. Roger Bland: When the Canadian Collaborative Mental Health Initiative was in place, there were 12 organizations involved in this, and chiropractors weren't one of them. I don't know why.

Psychologists were part of it.

Dr. Karen Cohen: Can I say something?

Mr. James Lunney: Absolutely. Please do.

Dr. Karen Cohen: If that was the Mental Health Initiative, there was another one around EICP, which was primary care across health, not just in mental health, so perhaps the chiropractors were involved in the latter one as opposed to the mental health one.

In terms of your point about collaborative practice, I just want to make one point. In tertiary care facilities where other health care professionals who are not covered by provincial health insurance plans are salaried, there's terrific support for collaborative care.

I spent 10 years working in physical medicine rehabilitation helping people with spinal cord injuries and chronic pain adapt and manage their conditions. Chiropractic probably would have been involved at some point if not in the tertiary care facility itself.

That works exceedingly well. It's not that health professionals don't know how to work collaboratively. The funding model breaks down when it's in community, when it's in primary care.

Mr. James Lunney: Well, that being—

The Chair: Your time is up, unfortunately, Mr. Lunney.

Ms. Fry, you have the next round, for seven minutes, please.

Hon. Hedy Fry: Thank you very much, Mr. Chair.

I think that as we look at scope of practice we cannot separate it from looking at some of the better ways of delivering health care. It used to be, as you well know, that health care was delivered in a hospital by a physician or a licensed dentist, and that was what the Canada Health Act covered. Today one is realizing that it's a costly way to deliver care, and that there are, as all of you are saying, a lot of other people who can, in a multidisciplinary team, provide extremely good care by appropriate caregivers.

I want to ask Dr. Cohen a question. If one looks at the ideal multidisciplinary practice in a community care setting, it shouldn't, I believe—and I would hope you agree—be there only to look at management of chronic mental disease. Could it not be that one could link with schools in such a way that psychologists, say, could be hired by a school board to detect early childhood behavioural problems, early bullying, the early things that could lead to suicide and other psychoses? That could then be brought into the community care team with a primary care physician, with a psychiatrist if needed, etc. Could you see that being a good model? I know that the U.K. has that model. It's an extremely good model.

● (1020)

Dr. Karen Cohen: I think you raise an excellent point. Health happens in a lot of places, not just in hospitals and not just in doctors' offices and schools.

One of the things we've often suggested in terms of the best deployment of psychologists' skills...and, like psychiatrists, we're only one member of a large team. It might be a social worker or a peer support worker or so on who's the best person for the problem. But really, it's at the front end and knowing what the problem is...I think it's really critical to have the expertise of someone who can assess and diagnose, to know where the person should be triaged, and then there's great room in the middle for a lot of care and a lot of kinds of providers.

Psychologists do work in schools. The challenge is that schools face funding pressures. There are fewer and fewer resources. People don't want to wait a year and a half on a waiting list to have their child's learning disability assessed, or whatever it is, and then go to the private sector, and then there may be some breakdown in communication back with the public sector.

But I think you raise an excellent point.

Hon. Hedy Fry: I understand that schools are under funding pressures, but if this is going to be a new model of delivering multidisciplinary care in a community setting, could it be that the health portfolio provides that chunk for that kind of school, a psychologist system...? You may need, I don't know—you'd probably know better—one psychologist for six schools, etc., but I think that really is going to be at the front end of preventing some issues.

I wanted to ask Dr. Bland this, because I met with some psychiatrists when I was in Halifax. I was always very impressed and moved by something that one of the psychiatrists said to me. He was a forensic psychiatrist who had been working in the prison system for 11 years. He quit and went back to do pediatric psychiatry because he believed that if you could get the kid before the age of four you could prevent a lot of the hard-wiring that goes on and that leads to certain behavioural problems later on. That links to the school thing that I was talking to Karen about.

Do you see this linking to preventing a lot of the forensic psychiatry that's needed in a prison system? I wondered if you could also comment on why there have been no ads for prison psychiatrists or psychologists from the federal government—that you have seen—because this is absolutely necessary in a corrections setting.

Dr. Roger Bland: I can't comment on why I haven't seen them. Maybe I didn't find them.

You're asking other questions.

Most adult psychiatric disorders have their origins in childhood or in adolescence: about 70% or 80%, excluding dementias. Mental health programs in schools used to be a big feature of mental health services. They disappeared for a long time. They're now reappearing. Certainly, Alberta has put a substantial amount of money into developing mental health programs in schools.

Not all schools need the same level of mental health program. There are some real problem schools and problem populations going to those schools who need far more intervention than some of the others. So it shouldn't be that every school should have a cookie-cutter program, but I do think this is very useful. School mental health, for detection, is a very useful mechanism.

Whether you can actually prevent adult disorders, I don't know. Remember that the child guidance movement started in 1928. It was set up on the premise that if you only treated the children you'd have no adult mental disorders. It hasn't quite worked out like that.

● (1025)

Hon. Hedy Fry: No.

As I'm told by a group from Dalhousie doing a great deal of research on this now and working with children in schools for early diagnosis, a lot of these kids end up in the prison system for various reasons that they feel could be prevented or in some way mitigated before they get into the prison system.

Dr. Roger Bland: If you look at the prison population and at the proportion of people who have been physically abused and sexually abused, who have substance use problems, it seems to be a population with a lot of disadvantages and a lot of strikes against them. It's also not that easy to treat. If you can prevent family abuse, child abuse, sexual abuse—and there are programs aimed at that—through national public health programs preventing abuse, it would be a very significant move.

Hon. Hedy Fry: Thank you.

How am I doing on time?

The Chair: You have 40 seconds to go.

Hon. Hedy Fry: I just saw one such school doing this work in an inner city in Saskatoon. It was remarkable the results they were getting after three years. They have a psychologist there. It's a one-stop shop, really, for parents and kids and everybody. The school has become a hub for prevention and intervention at an early stage.

Thank you very much.

The Chair: Thank you very much.

Next up is Mr. Wilks, please.

Mr. David Wilks: Thanks, Mr. Chair.

Thank you to the people who are here today.

I just wanted to quickly comment, Mr. Chair, on something Dr. Bland said with regard to RCMP mental health training; I'm retired from the RCMP.

This is touched on at Depot in Regina, but the reality of the situation is that for most police officers across Canada, they're probably the first person to see someone with a mental health issue. To be quite blunt, they don't have the time. If they come across a situation, their job is to just hand it off to whoever it needs to get handed off to and get to the next call. They recognize that it's a significant issue, but it's not their job. It just isn't.

I'll leave it at that, because I have some questions I want to ask.

Our government established the Mental Health Commission of Canada to develop a mental health strategy. I understand that you people may be part of that. I was wondering if you could give some comments on that. It was a good first step, but how do we go from there?

Karen, perhaps you can start, and then Dr. Bland.

Dr. Karen Cohen: The investment in the Mental Health Commission was terrific. The strategy is excellent. The challenges for the strategy are implementation, I think, because there are so many authorities of implementation in health, as you know. Care is delivered provincially and territorially. So it's a matter of taking those recommendations and building the collaboration and goodwill to make the changes on the ground that I think will be the biggest challenges to the mental health strategy.

Certainly our organization has been involved. They now have a number of really wonderful initiatives looking at guidelines for e-mental health, suicide prevention; I think certainly they have the time and attention of all stakeholder communities. Sometimes, for me, it's like picturing a bunch of people milling around outside a bus. We all know where it needs to go, but we're not quite sure who can get up and drive it.

I think that will be the biggest challenge.

Dr. Roger Bland: I would agree with your comments.

I think there's an awful lot in that strategy, and I don't think anybody could say we're going to do 100% of that. I think it will be a case of finding the things that are feasible and doing them, both feasible in terms of practical, the ones you can do and the ones you can afford, and moving down the road.

With regard to your police comments, I go out about 150 times a year with the police. I go out with RCMP in Sherwood Park and St. Albert and some of the rural areas. I also go out with the city police in Edmonton. There's no comparison in how they deal with things. The city police seem to be far better able to deal with mental health crises.

Mr. David Wilks: We'll agree to disagree on that.

I wonder if you could comment on the extent that psychologists are integrated into the health care system in general.

Dr. Karen Cohen: Psychologists are employed by many public institutions. CSC is the largest employer of psychologists. They do risk assessments and they deliver treatment, depending on venue, provincial and territorial. They work in schools. They work in hospitals. One of the challenges, though, is that we've really seen the practice profile of the profession change over the past couple of decades, the prime example being Toronto. A lot of teaching hospitals decreased their salaried resources, so psychologists are more in the private sector. Hospitals may maintain, well, this resource is still accessible to people; it's in the private sector. But once it's in the private sector it's no longer funded.

The other challenge I just want to underscore is that psychologists are very successfully self-employed; it isn't a pocketbook issue. It's a challenge because you have people coming in needing care who don't have the resources to pay for it, and that's difficult when you're a health provider and what you want to do is help people.

● (1030)

Mr. David Wilks: Thank you.

I wonder if both of you could just expand upon some of the barriers Canadians face in accessing the services of both psychologists and psychiatrists.

Dr. Bland, do you want to start with that?

Dr. Roger Bland: Usually it's a wait time issue.

Mr. David Wilks: What is that average wait time, do you know?

Dr. Roger Bland: That would probably depend on where you are and what sort of a service you're seeking. If you're in a crisis, you can probably get some sort of service within the same day. If you're not in a crisis, your wait time could be up to several months.

I know we had a problem with children's wait times and reduced it from about 60 days down to 30 days. But in my opinion, 30 days is still too long.

I think most of the provinces have been doing work to try to reduce these wait times, and they've tackled it in different ways, of course. It's not satisfactory, but it's better than it was.

Dr. Karen Cohen: The barriers in the public system for psychologists are probably similar. There are bottlenecks in terms of the public system, how referrals have to go. In some institutions you can see a psychologist directly; in other institutions it has to go through medicine.

In the private sector the bottlenecks are created by whether you have the resources to pay for it, whether you require a medical referral to access the service, but generally you can see one more quickly in the private sector.

Mr. David Wilks: One minute? Thank you.

You touched upon a point there and I just want to clarify that. Do patients require a referral from a family physician with regard to the health care opportunities through psychologists or psychiatrists?

Dr. Karen Cohen: Not to see psychologists.... If it is a requirement at all, it's either a requirement of a tertiary care institution that requires that the triage be done by medicine, or it's a requirement of the insurer that has a gatekeeping requirement, but it's not by licensure.

Mr. David Wilks: Go ahead, Dr. Bland.

Dr. Roger Bland: I don't think I have anything to say on that.

Mr. David Wilks: Okay, thank you.

I'm good, Chair. Thank you.

The Chair: Okay, very good.

We're just a little past 10:30 now so this would probably be a good opportunity to suspend our meeting and give an opportunity for our guests to leave, and then we have about 10 minutes of in camera business that we need to take care of.

If it's okay with the committee, I think what we'll do is suspend for a couple of minutes.

Again, I thank our guests for being here today and providing some great, insightful ideas.

The meeting is suspended.

[*Proceedings continue in camera*]