Committee Transcripts: Standing Committee on Social Policy - October 18, 2010 - Bill 101, Narcotics Safety and Awareness Act, 2010
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COMMITTEE ON
SOCIAL POLICY
COMITÉ PERMANENT DE
LA POLITIQUE SOCIALE
Monday 18 October 2010 Lundi 18 octobre 2010
SUBCOMMITTEE REPORT
NARCOTICS SAFETY
AND AWARENESS ACT, 2010
LOI DE 2010 SUR LA SÉCURITÉ
ET LA SENSIBILISATION
EN MATIÈRE DE STUPÉFIANTS
INSTITUTE OF CANADIAN JUSTICE
DR. ALEXANDER FRANKLIN
ONTARIO COLLEGE
OF FAMILY PHYSICIANS
MR. BILL ROBINSON
COLLEGE OF PHYSICIANS
AND SURGEONS OF ONTARIO
DR. PHILIP BERGER
ONTARIO PHARMACISTS' ASSOCIATION
MS. PEGGI DEGROOTE
ACTION PNP
DR. RAMESH ZACHARIAS
MEDAVIE BLUE CROSS
CENTRE FOR ADDICTION
AND MENTAL HEALTH
ADDICTIONS ONTARIO
DR. ANGELA MAILIS-GAGNON
REGISTERED NURSES' ASSOCIATION
OF ONTARIO
DR. RICK GLAZIER
DR. ALLAN GORDON
The committee met at 1406 in committee room 1.
SUBCOMMITTEE REPORT
The Chair (Mr. Shafiq Qaadri): Ladies and gentlemen, colleagues, I officially call to order the Standing Committee on Social Policy. As you know, we're here to hear Bill 101, An Act to provide for monitoring the prescribing and dispensing of certain controlled substances.
The first order of business is having the previous subcommittee report read into the record, for which I will call upon Mr. Johnson.
Mr. Rick Johnson: Your subcommittee met on Tuesday, October 5, 2010, to consider the method of proceeding on Bill 101, An Act to provide for monitoring the prescribing and dispensing of certain controlled substances, and recommends the following:

(1) That the committee meet in Toronto on Monday, October 18, and Tuesday, October 19, 2010, for the purpose of holding public hearings.
(2) That the committee request authorization from the House to meet on Monday, November 8, and Tuesday, November 9, 2010, for the purpose of holding public hearings in Sandy Lake, Sioux Lookout, Sudbury and Timmins.
(3) That the committee clerk, with the authorization of the Chair, post information regarding public hearings in Toronto in the Globe and Mail, the Toronto Star and L'Express for one day.
(4) That, subject to the authorization of the House, the committee clerk, in consultation with the Chair, post information regarding public hearings in Sandy Lake, Sioux Lookout, Sudbury and Timmins in a local paper of each community for one day.
(5) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on the Ontario parliamentary channel, the Legislative Assembly website and Canada NewsWire.
(6) That interested parties who wish to be considered to make an oral presentation in Toronto contact the committee clerk by 12 noon on Thursday, October 14, 2010.
(7) That groups and individuals be offered 10 minutes for their presentation. This time may include questions from the committee.
(8) That, in the event all witnesses cannot be scheduled for Toronto, the committee clerk provide the members of the subcommittee with a list of requests to appear.
(9) That the members of the subcommittee prioritize and return the list of requests to appear by 2 p.m. on Thursday, October 14, 2010, and that the committee clerk schedule witnesses based on those prioritized lists.
(10) That, subject to the authorization of the House, interested parties who wish to be considered to make an oral presentation in Sandy Lake, Sioux Lookout, Sudbury or Timmins contact the committee clerk by 12 noon on Friday, October 29, 2010.
(11) That groups and individuals be offered 10 minutes for their presentation. This time may include questions from the committee and is subject to change de-pending on the number of requests to appear.
(12) That, in the event all witnesses cannot be scheduled for any of these locations, the committee clerk provide the members of the subcommittee with a list of requests to appear.
(13) That the members of the subcommittee prioritize and return the list of requests to appear by 12 noon on Monday, November 1, 2010, and that the committee clerk schedule witnesses based on those prioritized lists.
(14) That the deadline for written submissions be 5 p.m. on the final day of public hearings and that the deadline may change, subject to the authorization of the House.
(15) That the research officer provide the committee with the requested information prior to the commencement of public hearings.
(16) That the committee clerk, in consultation with the Chair, be authorized, prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.
That's the report. I do have a number of amendments that I would like to make on behalf of the government, if I may, Chair.
The Chair (Mr. Shafiq Qaadri): You have the floor.

Mr. Rick Johnson: I would like to delete points (2), (4), (10), (11), (12), (13) and (14) and, in the case of items (10) and (11), insert a new point in both of those places.
The Chair (Mr. Shafiq Qaadri): The new points are?
Mr. Rick Johnson: The new point in (10) would be: That, for administrative purposes, amendments to the bill be filed with the clerk of the committee by 10 a.m. on Friday, October 22, 2010.
For (11), the new point would be: That the committee meet on Monday, October 25, 2010, and Tuesday—it should be the 26th—for clause-by-clause consideration of the bill.
The Chair (Mr. Shafiq Qaadri): Could you repeat that, please?
Mr. Rick Johnson: The second one was: That the committee meet on Monday, October 25, 2010, and Tuesday, October 26, 2010, for clause-by-clause consideration of the bill.
The Clerk pro tem (Mr. Trevor Day): Can I get the amendment deadline again? The amendment deadline was—
Mr. Rick Johnson: That, for administrative purposes, amendments to the bill be filed with the clerk of the committee by 10 a.m. on Friday, October 22, 2010.
The Chair (Mr. Shafiq Qaadri): Mr. Johnson, do you have this in written form for the committee?
Mr. Rick Johnson: Yes, I do.
The Chair (Mr. Shafiq Qaadri): We'd accept that.
Now I'd open the floor up for consideration before we vote. Ms. Elliott.
Mrs. Christine Elliott: I really would like to speak to these proposed amendments, because it was made clear during debate by all parties that this was a bill that really needed to travel. The views of people in the north in particular, who would find it difficult to come to Toronto for hearings, particularly those people in Sandy Lake—we really need to hear their views on this, and unless we travel, we aren't going to know. So I'm really strongly not in favour of these amendments.
The Chair (Mr. Shafiq Qaadri): Thank you. Ms. Jones?
Ms. Sylvia Jones: Yes. Actually, it's a question. Can you tell me: What is the motivation behind the change?
Mr. Rick Johnson: There have been a number of committees travelling to the north. I would let Parliamentary Assistant Sandals expand on this.
The Chair (Mr. Shafiq Qaadri): Ms. Sandals?
Mrs. Liz Sandals: A number of the places that have been listed as places that we visit were in fact places which the Select Committee on Mental Health and Addictions has already visited, specifically Sandy Lake, Sioux Lookout and Sudbury. One of the things which the select committee did was to identify that we need to move on this immediately. While what we heard there was extraordinarily interesting, I'm not sure that we need to take another whole committee back to rehear the same information, much of which is already recorded.
But if we may, Chair, I would like to point out that we did have delegations scheduled for 2:10. It's now 2:15, and I wonder if it would be procedurally acceptable for us, because obviously various committee members feel strongly about this: Can we defer the debate on the amendments to the subcommittee report until we've heard this afternoon's delegations? Because there does appear to be some time at the end of the afternoon today.

The Chair (Mr. Shafiq Qaadri): We'll proceed to, first of all, the commentary, and then we'll proceed to vote on the amendments to the subcommittee report, as amended. Ms. Gélinas?

Mme France Gélinas: It's no surprise to anybody: I represent a riding from northern Ontario. The prescribing and dispensing models for narcotics are substantially different in the communities that I represent than the typical "you see a physician or a dentist and you go to your nearest pharmacy and you go home." We did have a bit of research. They said that not many physicians currently dispense in their practices, but those "not many" are in northern Ontario. The problems of narcotic use and abuse in northern Ontario are huge. It's devastating communities, and what we have here right now is going to help them very little. We need to change this bill to take into account the reality of health care delivery in northern Ontario, in remote Ontario and in rural Ontario, and this is not in there.

The motions silence the voice of the north. I can never stand for this. We are having a really hard time with the abuse of narcotics in northern Ontario. Here we are as legislators, and we have a chance to help those people but we're only going to help southern Ontario. We're not willing to go and listen to the needs of northern Ontario, and I cannot stand for this.

The fact that another committee travelled dealing with mental health—I agree that the select committee for mental health did go out and travel, but it was talking about mental health; it was not talking specifically about the abuse of narcotics. You would attract a completely different set of providers and a completely different set of witnesses and players if you were to go out and listen specifically to the abuse of narcotics in remote communities, in fly-in communities and in northern Ontario.

To be here listening to you taking out anything that has to do with northern Ontario is not acceptable to me.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Are there any further comments on the other side before we proceed to the vote? Ms. Elliott.

Mrs. Christine Elliott: I would just like to support what Ms. Gélinas just said. The fact that the mental health committee did travel there was for a different purpose, and I think that what we really need is the perspective of people who are providing health care in the north and their views on how this particular bill will deal with or not deal with prescription drug abuse. So I think it is essential that we go back to those communities and get the perspective from the north, because you're quite right, it's lacking if we don't travel.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. If there are no further comments for which the floor—yes; Madame Gélinas.

Mme France Gélinas: I have been committed to speak at a conference. I booked this 18 months ago. I'm speaking at a conference on October 25. I will not be here if you move clause-by-clause on October 25, and I would very much like to be there for clause-by-clause because I will be bringing a lot of changes to this bill so that the needs of the people of the north are heard. If I'm not there on the 25th, there won't be anybody speaking for northern Ontario.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Again, the floor is still open for comments, but if there are none, we will be proceeding to the vote on the amendments.

I just want to confirm from members of the committee that you have in your possession the written versions of these amendments so that it's clear to all members precisely what you're voting for or against. Do all members have the written submissions? Fair enough.
Once again, if there are no further comments—going once—then I'll invite the vote. Those in favour of the amendments, as distributed and read by Mr. Johnson? Those opposed? I declare those amendments to have been carried.
We'll now proceed to the adoption of the subcommittee report, as amended. Are there any further comments or debate on that issue? Seeing none, we'll proceed, then, to the vote on the subcommittee report.
Ms. Sylvia Jones: Recorded vote.
The Chair (Mr. Shafiq Qaadri): Is it the will of the committee that the subcommittee report, as amended, be adopted?
Ayes
Dhillon, Johnson, McMeekin, Ramal, Sandals.
Nays
Elliott, Gélinas, Jones.
The Chair (Mr. Shafiq Qaadri): I declare the subcommittee report, as amended, to have been carried.
NARCOTICS SAFETY
AND AWARENESS ACT, 2010
LOI DE 2010 SUR LA SÉCURITÉ
ET LA SENSIBILISATION
EN MATIÈRE DE STUPÉFIANTS
Consideration of Bill 101, An Act to provide for monitoring the prescribing and dispensing of certain controlled substances / Projet de loi 101, Loi prévoyant la surveillance des activités liées à la prescription et à la préparation de certaines substances désignées.
INSTITUTE OF CANADIAN JUSTICE
The Chair (Mr. Shafiq Qaadri): If there's no further comments, I will now invite our presenters to please come forward.
To begin with, we have Mr. Parker, the executive director and general counsel of the Institute of Canadian Justice, who is also going to share with us a PowerPoint presentation. Mr. Parker, and for all those presenters, you have exactly 10 minutes in which to make your presentation. Any time remaining in that will be distributed evenly amongst the parties for questions and comments, and it will be enforced with military precision.
I invite you to please begin now.
Mr. Gerald Parker: Good morning, members of Parliament. My name is Gerald Parker. I am the executive director and general counsel of the Institute of Canadian Justice. I am a 25-year public policy expert as it pertains to health care and people with disabilities. I've helped European commissions, deputy Prime Ministers, ministers and the very best and brightest municipalities and provinces and countries across this good world, as well as our good private sector.
1420
I am also a chronic pain sufferer as a result of a workplace injury that I suffered when I was going through university—ironically, taking disability issues—for which I was again

before this standing committee on social justice as it pertains to the Workers' Compensation Board, which is, bar none, the number one procurer-administrator of this particular suite of drugs in the country and needs to have particular attention focused upon it.

Today my focus will be to speak to a necessary bill, because over-prescription of pharmaceutical products is a problem in this country, not just narcotic drugs. Even drugs that are being used in lieu of narcotic drugs, off-label, are killing people. Do the chief of staff, the minister to the Premier of Ontario, the Minister of Health, the CPSO, the Workers' Compensation Board, my MPP, and my MP all know of this very important and very dangerous situation? I can tell you right now that there are eight concurrent investigations taking place about what I'm about to tell you, so if I don't have your attention yet, I hope I do.

Diversion in the process, cause and effect: We're talking about the effect today. Let's get real and talk about the cause—contributing undertones and process failures, the alternatives and how they're being deliberately sabotaged and compromised, catastrophic results and liabilities thereof, criminality, investigations in the other context as it pertains to this particular issue, and the specific issues as further identified and manifested in this particular bill.

A necessary bill with concerning cause and effect: Bill 101 is primarily motivated by the use and abuse of opioid drugs that plague our streets and innocent chronic pain sufferers like myself. I have had three major surgeries. I have hardware in my spine. Trust me, I'm the last guy to take a narcotics prescription, for reasons that I presented before. I live my life as a parent of three kids, a very active member of my community—right, Christine?—and as a result of that, as a professional I need not be doped or perhaps sidelined or further marginalized by drugs that would either take me out of the commission of my livelihood or my duties to my family and community. But that is indeed the case right now, and it will continue with this bill. Let's make this perfectly clear: You're focusing on the effect, not the cause.

Preferred deadly off-label pharmaceuticals are being prescribed in lieu of by doctors, by processes that have already been determined to have $4 billion worth of criminal fines in the US. Gabapentin—Neurontin—is the replacement for opioids for most chronic pain sufferers and is being prescribed off-label. It is killing me. The last doctor that I saw was a chief of staff at Windsor's Grace hospital. You know that name, don't you? Yes, it's a very, very notorious hospital. I showed up on government business at 2 o'clock in the morning suffering from what is now known as acute neurotoxicity of the brain because of the alternative of this style of drugs, gabapentin. Four billion dollars worth of criminal charges thus far in the US—where's Ontario? We have a centrally procured and publicly managed health care regime. Why is it $4 billion in the United States, but our province doesn't even show up for the class action certification? Why is that? There is a very, very knowing and unfortunately deliberate conflict of interest in that situation, and I will stand by every single comment that I make here today. Increased dependency results as a matter of this.

I want you to walk through this situation with me, as an individual. Do I look like the kind of guy who sits on the corner like some kind of junkie? Seriously, do I? No, I'm not. On the CBC just two weekends ago, chronic pain is the number one form of disability—in a maturing population, absolutely. We can deal with it holistically—perhaps MS

liberation treatments that cost $1,000—as opposed to adjunctive therapies that the pharmaceutical industry would love us to keep taking every day, all day, for the rest of our lives. A thousand dollars or a million dollars—it's pretty simple to me.

Let me make this clear: I moved to Whitby, as Christine knows, four years ago. I am a person with a disability, and I do centralize my health care through my specialists because anybody who doesn't centralize their health care through their specialists and their pharmacist is simply foolish. But I, as a proactive individual, the son of an ex-police officer and a magistrate, manager of the substance abuse bureau for the Ministry of Health, I do know better.

I will tell you conclusively that when I moved to Whitby, I couldn't find a doctor. I still can't find a doctor. This is Whitby, 50 kilometres that way. Forget about the north; let's talk about 50 kilometres there. I don't mean to dismiss France—in no way—because your point is absolutely legitimate. You think we've got a problem here or in Windsor? You go up north. I've been to Windsor. I've been to the places that you folks, the recorded vote, don't want to go to. You're not doing us any service, and I would have to very seriously question why that is the case. You are here with an epidemic. People are dying before your eyes right now.

The last time I saw a doctor was on October 26, 2009. It was the chief of staff at Grace hospital. He dismissed me summarily, with one drug being presented—Neurontin, or gabapentin. I had not seen a doctor in a year and a half because I couldn't find one, and my specialist was off with breast cancer. They could have moved; they could have retired. But the College of Physicians' standard operating policy suggests—or doesn't suggest—directs that it's okay to refuse people with narcotic prescriptions because they've been misinformed, misunderstood or whatever the case may be. But then when you start prescribing drugs that are also killing them, having chiefs of staff refusing to report adverse events—and then having the process backing up and trying to protect everyone in the process.

On October 26, I'd already been speaking to the Premier's chief of staff and the Minister of Health in this province. None of them, not one of them, has returned one single email or phone call. Christine, I include you in that list. That is unacceptable. You're my MPP. I almost died on your watch on February 20. You won't return my phone calls? Who will?

Next point—I'm sorry, folks. I don't mean to get my blood pressure up, but I'm telling you, when I was at—last Tuesday, October 12. I think you guys need to very much pull up the podcasts from the CBC and look at the medical errors town hall—two hours. It will tell you every solution that you need to know—two hours of medical professionals telling what the problem is. One of the major issues, to which I spoke and to which is my purpose here today, is to reveal the fact that the province of Ontario's motivations on this bill are not honourable. It is a knee-jerk reaction to the effect rather than the cause. Opioids are the most available drugs on the street. Why? Because they're the most available drugs on the street. It is the pipeline; it is the supply. Let's not talk about the demand, because the demand is very, very clearly established in the New England Journal of Medicine dated January 8, 2009.

"Journal Highlights Concerns over Drug Industry Influence"—CBC, New England Journal of Medicine, October 25, 2002. These are the folks you're surrounding yourselves with. I'd hazard to say, probably a few of them are in this room today.

“Cut Ties Between Health Canada, Drug Companies, Grieving MP Urges.” “Pray that I’m persuasive,” he says. That was in an interview with CBC news and in his book, Death by Prescription—April 2009.
“Doctors Like Industry Perks”—yes, they are being incentified, wined and dined, and it’s called “detailing.” The New England Journal of Medicine, January 8, 2009, clearly establishes that on that one drug—$4 billion in criminal fines.
I’ve talked to the department of justice expert witness. The Minister of Health doesn’t want to talk to them. The executive and legal counsel at the WSIB doesn’t want to talk to them. The College of Physicians has sent me letters, as has the WSIB—but more tacitly, so has the ministry, refusing to talk about these issues.
People are dying, folks, right now, and this bill will further reinforce that reality. Professional allowances and the price of generic drugs: It’s a kickback. You have to understand, the causal relationship between the scientific quantification of drugs that are ever increasingly being—I’m trying to pick my words carefully.
The Chair (Mr. Shafiq Qaadri): I’ll need to intervene there, Mr. Parker. I would like to thank you for your presentation. I presume you have a number of slides left. What I would suggest is that you give either an electronic or paper copy to our clerk and we can have that distributed to all the members of the committee.
Mr. Gerald Parker: So this is my two-minute warning?
The Chair (Mr. Shafiq Qaadri): I’d like to thank you for your presentation.
1430
DR. ALEXANDER FRANKLIN
The Chair (Mr. Shafiq Qaadri): I would now like to call our next individual to please come forward: Mr. Alexander Franklin.
Interjections.
Mr. Ted McMeekin: —everybody got 10 minutes to make their presentation?
The Chair (Mr. Shafiq Qaadri): It was clear to me, Mr. McMeekin.
Mr. Alexander Franklin—Dr. Alexander Franklin.
Interjection.
The Chair (Mr. Shafiq Qaadri): Yes, please come forward. Welcome. You’ve seen the drill, and I know you’re very conversant with it. Please begin.
Dr. Alexander Franklin: Thank you, Mr. Chairman.
Mr. Chairman, members of the committee: Forty years ago I used numbered prescription pads with a non-carbon paper (NCR) copy, which was stapled in the chart. Sadly, the OHIP MRC audit gave no credit for this extra expense and enterprise. Not unreasonably, I followed the local medical norm and then used the cheap, insecure prescription pads often provided free by drug companies or pharmacies.
Two years ago, the USA took strong action against falsified prescriptions. In 2008, the following appeared in the American Medical News:
“Physicians Face Medicaid’s April 1 Deadline for Tamper-proof Rx Pads
“Doctors must use pads with at least one security feature by next month and three features by Oct. 1.”
By Doug Trapp, amednews staff, March 24/31, 2008—and his article has been shortened by me.

“By April, written Medicaid prescriptions must have at least one feature to prevent unauthorized copying, erasure or modification, or counterfeiting. Written prescriptions must have a feature from all three categories by Oct. 1....”
“The American College of Physicians is encouraging doctors to begin using prescription pads with three security features immediately to meet the October 1 requirements and save time later, said Neil Kirschner, PhD, ACP senior associate for regulatory and insurer affairs. Prescription pad orders can be delivered in about two weeks on average, he said....”
“The law was originally to take effect on Oct. 1, 2007, but in late September 2007 Congress delayed implementation by six months because of concerns there wasn’t enough time for affected parties to understand the law’s requirements, much less meet them....”
“Recommended Rx pad features
“Category one: Features to prevent unauthorized copying
“1. The word ‘void’ appears when the prescription is photocopied.
“2. Security back print: Words, such as ‘security prescription,’ printed on the prescription’s back.
“3. Reverse ‘Rx’ or white area: ‘Rx’ symbol or white area that disappears when photocopied at a light setting.
“4. Watermarking....”
“Category two: Features to prevent erasure or modification of information
“1. Non-white background: Paper’s background features a solid color or consistent pattern.
“2. Quantity ranges: Boxes that can be checked by the physician to indicate the number of doses.
“3. Refill indicator: Indicates the number of refills allowed.
“4. Rx limit: A line specifying the number of prescriptions allowed for different drugs on the same form.
“5. Quantity and refill borders: For EMRs, quantity or refill limits appear between asterisks; quantity or refill limits also could be spelled out.
“6. Chemically reactive paper: Exposure to solvents, oxidants, acids or alkalis will leave a visible mark.
“7. Paper toner fuser: Special toner bonds tightly to paper, making modification difficult.
“Category three: Features to prevent counterfeiting
“1. Features list: A complete list of security features on the paper (highly recommended).
“2. Serial number: Unique number for each prescription, which may or may not be sequential, but should be reported to the state to be valid.
“3. Batch number: For states with approved vendors (in some states only police-cleared printers can supply prescription pads) a number identifying each batch of prescriptions.
“4. Encoding techniques: Bar codes used to encode a serial number.
“5. Logos.
“6. Metal strip: A strip of metal embedded in the paper.”
The source is the National Council for Prescription Drug Programs. Today, the cost of prescription pads is approximately C$260 for 5,000. In a busy practice, I estimate about $2 a day per doctor for pads with the 10 security features. The Web link is cited below: The American Medical Association on Medicaid tamper-resistant prescription pad rules.

There's no need for many physicians to prescribe narcotics—for example, dermatologists, psychiatrists and public health doctors. In Michigan, a physician can choose to have or not to have a narcotics licence, which is separate from the licence to practise medicine.

Some Ontario GPs now have signs on their doors saying "No narcotics prescribed." This avoids the physical and verbal threats of people demanding narcotics. At present, the Ontario College of Physicians and Surgeons' government-based confidentiality laws prohibit doctors from notifying the local police drug squad about persistent illegal narcotics seekers.

We would be glad to discuss this matter further through email at scandiamed7@gmail.com. The submission is complete. My name and honorifics are at the bottom of the page. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Franklin. We have about a minute or so per side, beginning with the PC Party.

Mrs. Christine Elliott: Thank you very much, Dr. Franklin, for your brief. I'm just wondering, in terms of the legislation, are you suggesting that these features should be instead of or in addition to the way that—

Dr. Alexander Franklin: In addition to.

Mrs. Christine Elliott: In addition to. Okay.

Dr. Alexander Franklin: Considered. Let's put it this way: Considered.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Shafiq Qaadri): Madame Gélinas?

Mme. France Gélinas: It was most interesting, especially your opening comment that you were doing it 40 years ago and certainly did not get the support needed to continue quality care.

What percentage of the abuse out there do you see related to forging prescriptions? Would you know?

Dr. Alexander Franklin: No idea.

Mme France Gélinas: We know that some of it happens, but we can't quantify it?

Dr. Alexander Franklin: I couldn't, but I'm sure that with research—one could look into medical-legal Quicklaw, but I don't know at the moment.

Mme France Gélinas: Okay.

The Chair (Mr. Shafiq Qaadri): Ms. Sandals?

Mrs. Liz Sandals: Thank you, sir. That was a very interesting presentation. I was just trying to figure out from the articles—because the one headline talks about one security feature and then three features—the status of all these features now. Are all the features required or is it still sort of a "choose three"? I guess my second question would be, if you had to choose three, which are the most important three?

Dr. Alexander Franklin: Well, ma'am, as you know, each of the States have their own regulations. It's very interesting to—because of the time limit, I would have liked to produce appendices of all the States. Some of them have standard prescription forms. I'm sure your research department will be able to provide them. They're very interesting. Some of the prescription forms have quite a firm template.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Dr. Franklin. Once again, you are welcome to communicate to the members of the committee in writing through the clerk and through the Chair.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair (Mr. Shafiq Qaadri): I now invite our next presenter to please come forward, Ms. Kasperski, chief executive officer of the Ontario College of Family Physicians, who does not need to be reminded of the drill. I'd invite you to please begin.

Ms. Jan Kasperski: As you know, the Ontario College of Family Physicians represents about 9,500 family physicians in this province. Our members provide care in every community in Ontario—north, south, east and west—and in every sector of the health care system. We see patients in our offices. We're the physicians who work in your emerg departments and walk-in clinics. We look after patients in in-patient beds, long-term-care facilities and patients' own homes. We're the family doctors who deliver babies. We assist in the operating rooms and in day surgery units. We're the palliative care physicians. We're the GP psychotherapists. We're also the methadone prescribers. On a daily basis, we see people who are in pain, both physical and emotional, and we deal with the addictions that plague so many of our patients, are so harmful to their families and are so costly to society in general.

We see the suffering when patients do not have their pain adequately managed. We see the suffering when we try to withdraw them from narcotics. We see the suffering of patients and their families when addictions take over their lives.

On behalf of the Ontario College of Family Physicians, I'd like to formally commend the work of the Select Committee on Mental Health and Addictions. Having all three parties work so well together is an accomplishment in and of itself, but the work was absolutely spectacular. We were so pleased with the report. It's very timely, and it's a solid road map for improving a sector of the health care system that is woefully in need of resources.

In keeping with the Excellent Care for All Act, it's a plan to improve and integrate services with the rest of the health care system to ensure that patients do not fall through the cracks. We're very pleased to see that the Ministry of Health and Long-Term Care, led by the Honourable Deb Matthews, acted so quickly on one of the recommendations of this report by crafting and submitting to legislation Bill 101, the Narcotics Safety and Awareness Act.

From a historical perspective, pain management has been a problematic area of practice for many years. In the pre-oxycodone era, physicians knew that narcotics were highly addictive and were very reluctant to order them. In addition, the powerful ones were given by injection or by intravenous routes. By and large, patients needed to be in hospital to receive these medications from our nursing staff. Unfortunately, our patients with chronic pain disorders suffered needlessly during this period.

Then, along came opioids with proof from the pharmaceutical industry that they were non-addictive, safe and easy to use. They revolutionized the field of pain management. They allowed us to discharge patients quicker following surgery since they gave the same level of pain relief as the drugs that we have previously given intravenously or by injection. The whole field of day surgery opened up since we could send our patients home with their post-op pain well managed. Dentists started using it.

Chronic pain was well managed by a class of pharmaceuticals that truly seemed like miracle drugs. But these miracle drugs had a hidden underbelly—they were addictive,

and they were highly addictive. Once on the drug, we had a hard time helping to wean our patients off opioids. People using street drugs began to recognize the power of opioids to create a high, especially when crushed and smoked or injected. Over 50% of people being treated in methadone clinics today are addicted to opioids. It's rapidly becoming the drug of choice on the streets.

A whole drug diversion industry has evolved around prescription drugs being sold, and the drugs themselves can sell for $40 a pill in our southern communities, but when you go up north, it's $120 per pill. You can feed an amazing number of people on these reserves with that kind of money being exchanged. As a result of drug diversion, many emergency departments, walk-in clinics and family offices are now refusing to provide prescriptions for pain management. People without family doctors are suffering needlessly or are finding ways to obtain pain relief on the streets, and the cycle continues: poor pain management, addictions and more drug recycling.

Our physicians have been caught in the middle. They truly want to relieve the suffering of their patients, and we need sustainability of the system. It requires us, therefore, to use our hospital resources more effectively by finding even better ways of decreasing use of our high-cost beds.

Family physicians faced with a patient who needs pain relief to get on with their life feel compelled to sign that prescription pad; however, when they begin to realize that the patient has become addicted to the drug that has provided them with acute or chronic pain relief, there are few services available to help them. A life spent going to a methadone clinic is really not the answer.

The collective set of recommendations by the select committee needs to be implemented, and Bill 101 is a first step in addressing some of the problems facing family doctors and their patients.

We believe that this bill will encourage research into safer drugs and alternative methods of pain relief to ensure that we do not go back to the bad old days when pain was simply poorly managed. We believe that it will stimulate the education of physicians, from medical students to our residents to practising physicians, on the proper use of narcotics and on how to better manage addictions. We believe that it will provide access to a wider range of medications and therapies that will help us to ensure that our patients receive the relief from pain that they need and deserve. We believe that tracking prescriptions so that we can reduce and, hopefully, eliminate drug diversion will take place as a result of this bill. Lastly, we believe that identifying and providing support for those addiction treatment modalities that are proven to be effective in helping patients become drug-free will be a key part of this particular bill.

As part of your package, I have included information about two of the nationally and internationally recognized programs developed and managed by the Ontario College of Family Physicians, thanks to the support of the Ministry of Health and Long-Term Care. There's an educational program called Medical Mentoring for Addictions and Pain and our Collaborative Mental Healthcare Network. Both programs are providing family doctors with the knowledge, the skills and the confidence to provide care for their patients who suffer from both physical and emotional pain and addiction. Bill 101 is needed to help them do an even better job.

As we look towards improving the bill even further, we know that we will end up, at the end of the day, with supports in this direction.

In summary, we have far too many people's lives, and those of their families, that have been disrupted or ended by the inappropriate use of narcotics. Bill 101 provides the framework for supporting appropriate prescribing of narcotics while reducing the unintended consequences: addictions and drug diversion. Thank you.
The Chair (Mr. Shafiq Qaadri): Thank you. About 20 seconds or so per side. Madame Gélinas.
Mme France Gélinas: Just quickly, I agree with you that we need to look at what we do with all those people who already have an addiction. Any quick answer to this?
Ms. Jan Kasperski: There's no quick answer. I think the recommendations that came through from the select committee give us a road map to move forward and need to be done. This is a very great first step, but it's not what's needed.
The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Ms. Sandals.
Mrs. Liz Sandals: I'm just wondering if there are any specific changes that you're looking for with respect to educating family physicians around appropriate prescription practices.
Ms. Jan Kasperski: I think that as we look towards our medical schools, both our med students as well as our family medicine residents are saying very clearly that a strong curriculum in pain management is absolutely needed. Our practising family physicians—
The Chair (Mr. Shafiq Qaadri): Thank you. Ms. Jones.
Ms. Sylvia Jones: Thank you for your presentation. I'm pleased that you raised the importance of the treatment option. It needs to be there as well.
Ms. Jan Kasperski: Absolutely.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Kasperski, for your deputation on behalf of the Ontario College of Family Physicians.
MR. BILL ROBINSON
The Chair (Mr. Shafiq Qaadri): I now invite our next presenter to please come forward, Mr. Bill Robinson. Welcome. You've seen the drill: 10 minutes in which to make your presentation. I invite you to please begin now.
Mr. Bill Robinson: I would like to thank the Standing Committee on Social Policy for allowing me to appear here today and give my views on Bill 101, which now stands before you.
1450
Nine years ago this Christmas, both my brother and I discovered that we had cancer. After three years of treatment, I am now cancer-free. My brother underwent six years of treatment and died from his illness three years ago. In his case, the cancer had metastasized to his bones and his death was long and painful. Without the use of opiates such as hydromorphone and OxyContin, his final months would have been unbearable. The medical staff at the cancer ward constantly monitored and adjusted the dosage to keep the pain at bay. They were experts in pain control. The use of opiates, properly prescribed, monitored and administered as needed, is a wonderful thing, as chronic pain takes away all quality of life.
Item 1 of the government's strategy to provide for access to narcotics and other monitored drugs when they are medically appropriate to treat pain is imperative. Physicians cannot feel your pain. They are therefore compelled to make a judgment call or trust what you are telling them in order to decide on a course of action to alleviate that pain. But far too many patients are becoming addicted to prescribed opiates. Medical

professionals need to be better educated about pain control and addiction as they apply to treatment with these strong painkillers. This would encourage more appropriate prescribing habits and hopefully result in fewer addictions.

Item 2 of the government's strategy is to reduce the abuse and misuse of narcotics through a proposed monitoring database and proposed legislation.

In May of this year, my son James died of an overdose of OxyContin. He was 24 years old. I cannot begin to describe the horror and anguish of finding my youngest son dead on the floor of his room. This is an image seared in my soul that I will carry with me every day of my life.

Just a few months ago, four months after his death, James's friend and the love of his life also died of an overdose of OxyContin. She was just 21.

I could spend the next 10 minutes talking about what a wonderful person my son was and the events in his life that led to this tragic event, but that is not my purpose here today. Both my wife and I believe that it is important for us to speak out and raise awareness of this problem in our community.

When I visit my family doctor and am given a prescription, the doctor manually enters the information into his family practice database to keep a record and to allow other physicians in the practice to share the records if necessary. He then prints a copy of the prescription and gives it to me. I then take that prescription to our local pharmacy, where they manually enter the information into their separate database to keep a record of it before dispensing the prescription. Ontario's narcotics strategy suggests that three copies of the prescription be made so that the third copy is forwarded to the governing body, where it is one again manually entered into a database for monitoring purposes.

The problem that I see here is that three separate individuals are manually entering information into three separate databases, and none of them are connected. By the time all of this is done, drug dealers have already visited three other doctors with the same complaints of pain, they have made copies of those three prescriptions, and have visited several different pharmacies. Shortly afterwards, they are on the street selling hundreds of OxyContin tablets for thousands of dollars.

I suggest that we must go beyond monitoring opiate drugs and start a database accessible to both doctors and pharmacists in order to control the dispensing of them. Surely, we could develop a common database wherein the information only has to be entered once and all concerned can access it in real time.

The physician could enter the patient's OHIP number into the database to ensure that no other physician has prescribed an opiate to this patient. The prescribing physician could then enter the information manually into a database and print the prescription. This should be the only time that it is necessary to manually enter the information.

The dispensing pharmacist looks up the OHIP number and the physician's prescription number in the database. The database will confirm that the prescription is valid, that only one physician has prescribed this opiate and that no other pharmacy has already dispensed it. The governing body does not have to do anything but monitor it.

Item 3 of the government's strategy is to support treatment for and reduce narcotics-related addictions and deaths. The ministry does this by currently providing funding for a number of substance abuse treatment programs which they feel are easily accessed. All an addict has to do is call a helpline or click on the appropriate website and they can get all the help they need.

That isn't going to happen. Very often, the programs do not match the needs. In most cases, addicts are not able or willing to help themselves. An addict's only concern is getting more drugs to satisfy that craving. They will lie, cheat, steal, prostitute themselves or do anything else that they have to do to satisfy that addiction. This is their new life. This is their reality.

The reality is that there are very few easily accessed places in Ontario for an addict to go to for help, and without help, death, accidental or not, is a strong possibility.

There are some in our community who feel that drug addicts and those with mental health problems are horrible people who come from somewhere else and should be shunned. They do not want clinics in their backyards because it would attract what they feel are dangerous criminals. The reality is that these addicts are their sons and daughters, brothers and sisters, mothers and fathers.

OxyContin does not discriminate by age, gender or ethnicity. The reality is that OxyContin is a highly addictive opiate which has claimed patients who are both prescribed this narcotic legally and those who use it illegally. It is also a drug with some of the strongest addictive qualities, and for many, there is no real cure.

The reality is that OxyContin sold illegally generates millions and millions of dollars, and drug dealers will do anything to attract new clients and keep them. Parents with schoolchildren must be made aware of what lengths a dealer will go to to hook these young people on drugs. They must also learn to recognize the signs of drug use so that they can get involved early.

The drug industry, both the legal and the illegal one, is the most successful industry in the world. The main objective of the industries that manufacture these drugs is to sell more. This means that they are part of the problem. I believe that we must approach these industries and make them part of the solution.

We must find a way to keep prescribed narcotics from getting into the hands of drug dealers, and to do that, we must do more than just monitor the situation.

Thank you for your time.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Robinson. About 30 seconds or so: Mr. McMeekin.

Mr. Ted McMeekin: Mr. Robinson, Ernest Hemingway in his book A Farewell to Arms wrote that the world breaks all of us and then some of us become stronger in the places that are broken. I just want to say to you, sir, thank you for having the courage to share your story. It has touched a lot of us and is driving much of what we're trying to do and what we're trying to improve on doing. Sir, thank you.

Mr. Bill Robinson: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you. Ms. Elliott.

Mrs. Christine Elliott: Thank you, Mr. Robinson. I'd also like to thank you very much for coming forward with your personal stories. I'm very sorry for your losses.

You have raised some really important points, one being that we can't just monitor the situation. We also have to provide treatment and help to people. That's why it's our hope that this select committee's entire 23 recommendations—I'm not sure if you've had a chance to look at them. We do offer some solutions.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms, Elliott. Ms. Gélinas.

Mme France Gélinas: I will continue. The select committee for mental health did make 23 recommendations in its report. They certainly deal with some of the issues: databases

that don't talk to one another, and industry being part of the problem. It is bigger than just—what this bill does is bring in a new database, entry of data into a database. It's not going to solve the problem. You understand that it's way bigger, and so do we. Many more steps need to be taken.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. And once again, on behalf of the committee, Mr. Robinson, we all thank you for sharing your very poignant stories.

Mr. Bill Robinson: Thank you.

1500

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenters to please come forward: Messrs. Mandel and Gerace of the College of Physicians and Surgeons of Ontario, accompanied by Ms. White and Ms. Verity, counsel and director of policy and communications. Welcome. I'd invite you to please identify yourselves as you're about to speak. Please begin.

Dr. Jack Mandel: Thank you for this opportunity to appear before the committee. I'm Jack Mandel, president of the college. I'm a family physician practising in Toronto. With me today are Rocco Gerace, our registrar; Vicki White, counsel; and Louise Verity, director of policy and communications.

Ontario is in the midst of a public health crisis, a crisis stemming from the inappropriate prescribing, dispensing and illicit use of opioids and other narcotics. OxyContin deaths have increased by 240% between 2002 and 2006. This public health crisis requires immediate action, and Bill 101 is a good start. The broader narcotics strategy announced by the Minister of Health and Long-Term Care is also a positive move forward.

Over the past year, the college has worked with a number of organizations and experts to produce Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis. This report contains 31 recommendations, recommendations that we feel should be seriously considered.

We'd also like to take this opportunity to recognize the members and contributors to the report of the Select Committee on Mental Health and Addictions. It's a very thoughtful report.

The college supports the general intent of the bill. It's broadly consistent with a recommendation in our report that government make all opioid prescription information available to all prescribers and dispensers. The college also supports the provision in the bill that would require prescribers to affix their college registration number on prescriptions.

One limitation of the proposed system is that narcotics prescription information will not be readily available to physicians and other prescribers. In order to improve prescribing at the point of care, prescribers need access to a patient's narcotics history before prescribing. For this reason, we believe that eHealth Ontario and the government of Ontario should move quickly to develop and implement the planned drug information system. A drug information system will help prescribers improve clinical outcomes by providing access to comprehensive medication profiles and give them the ability to check for allergies, drug interactions and accurate dosages.

While we support the direction of Bill 101, we believe it can be improved with amendments that would accomplish three objectives.

(1) Recognizing the role of regulatory colleges: It's the role of the college to regulate physician practise, including prescribing in the public interest, yet there is no mention of the role of regulatory colleges in the bill or the circumstances in which information will be shared. This is certainly a departure from what exists in other provinces. Information gathered under Bill 101 will be limited to data about the volume, quantity and type of drugs prescribed by physicians. It will not gather information on the nature of the illnesses treated by any particular physician nor the reasons why one prescriber may have an unusually high volume of prescriptions.

The CPSO is the body that has the ability to evaluate prescribing in the context of that physician's clinical practice, identify and then address any problems, ideally using an educational approach. It's crucial that the link between the ministry program and the CPSO's role be clarified to ensure the information can lead to meaningful observations about physicians' practices and, where necessary, to ensure that the body charged with regulating the medical profession in the public interest has all the tools required to achieve this goal.

(2) Ensuring information-sharing with regulatory health colleges: The collection of narcotics information by the new system generates new responsibilities for the Ministry of Health. In order to make the best use of the data collected through the program, we believe that both the college and the government should be entitled to access the prescribing information. For example, where the college is investigating a member's prescribing, consolidated information about the member's prescribing would be critical for determining the best regulatory outcome. Similarly, where the government has concerns about a member's prescribing, it should notify the college so that further analysis can occur.

It is our view that this type of sharing of information is permitted under the current legislation. However, to ensure that it actually occurs, we recommend explicit language in the legislation that clarifies it is the intention of the government to make this information available to regulatory colleges.

To ensure that regulatory colleges receive information at appropriate times, we recommend that an additional section be added to the legislation, subsection 5(6), that would trigger a mandatory sharing of information whenever the minister or executive officer has concerns about a member's prescribing or dispensing activity.

Similarly, in order for the regulatory colleges to work effectively and cohesively with the ministry and to prevent duplication of efforts, amendments may need to be made to the Regulated Health Professions Act to permit the colleges to share information with the ministry. Without this amendment, the CPSO could find itself in a situation similar to that it currently faces when it receives information from hospitals: Although the college is entitled to receive and act upon the information, the legislation imposes barriers on its ability to communicate the results back to the body that provided it with the information.

(3) Allowing comparable access to system information for prescribers and dispensers: There should be comparable access to system information for prescribers and dispensers. Currently, the legislation permits disclosure to dispensers if they are determining whether to dispense a monitored drug or after they have dispensed a monitored drug. Disclosure to prescribers is permitted only after a prescriber has prescribed a monitored drug. Physicians need to have access to system information to ensure they can make informed prescribing decisions.

While the technology may not yet exist to permit disclosure of this information in real time to physicians, the legislation should permit such disclosure. The technology will soon exist, and the authority to disclose real-time information to prescribers should be established.

We recommend that clause 5(5)(a) be amended as illustrated in our written submission before you. In the meantime, it would be helpful for prescribers to have access to information about narcotics history via a call centre or other such mechanism.

In summary, the college supports the government's decision to take action. Our response to Bill 101 and the recommendations contained in our report, Tackling the Opioid Public Health Crisis, are offered in the spirit of working with government and other partners to alleviate this public health crisis.

We appreciate the opportunity to appear before you and we would be pleased to answer questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Mandel. We have a minute or so per side, beginning with Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Dr. Mandel, for appearing before the committee and for making the suggested amendments as you have. Is there anything else that you would like us to consider as we move forward with this? Will you be submitting more formal amendments to us to consider for clause-by-clause, or just in the format that we have them here now?

Ms. Louise Verity: We've really identified three areas where we're seeking amendments. In two, we've been precise in terms of the wording that we're seeking; in the third, not so much so. Rather, we've provided examples of what exists in other provinces. But we'd certainly be happy to continue talking about opportunities that may exist.

Mrs. Christine Elliott: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. Madame Gélinas?

Mme France Gélinas: If you could expand a little bit as to—you want to mention the role of the regulatory college in the bill for circumstances where information will be shared. I understand that this has been an issue. If you could either give an example or expand.

Dr. Rocco Gerace: What we know in other provinces where it has been successful is that the regulatory colleges have access to prescribing and dispensing information. It would seem to us to be leading to silos, if there is sequestered information that one body has that the other body doesn't have. Ideally, it would be helpful for the college to have access to the same information that the ministry would have, in terms of these drugs that are being prescribed. In the absence of that, there has to be, we think, free sharing of information.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Ms. Sandals.

Mrs. Liz Sandals: I would just echo what the other parties have said: It would be quite helpful, if you've got more specific suggestions, if you could share those with us so we can understand what you're thinking, because you've made some really interesting, positive suggestions that it would be useful to be able to explore. So if you have anything more specific, please let us know.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals, and thanks to you, Dr. Gerace and Dr. Mandel, and your colleagues Ms. White and Ms. Verity, for your deputation and presence on behalf of the CPSO.

1510

DR. PHILIP BERGER

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenter to please come forward: Dr. Philip Berger. Welcome, and I invite you to please begin.

Dr. Philip Berger: My name is Philip Berger, and I am a family physician who has treated addicts since I started my medical practice in 1978. Since 1991, I have prescribed methadone, which is the gold standard treatment for narcotic addicts. I sat on the College of Physicians and Surgeons of Ontario methadone committee from 1999 to 2002. I am chief of the St. Michael's Hospital department of family and community medicine and an associate professor in the University of Toronto faculty of medicine. In my capacity as an educator, over the years I have talked and lectured to many students on addiction.

I support Bill 101 because it addresses poor narcotic prescribing by physicians and will hopefully curb illegal or unjustified use of narcotics by Ontario residents. The bill also provides for clear, legal and non-discriminatory authority to confront the misuse of narcotics in Ontario. And finally, the bill does not single out or target only one group that uses narcotics, which is the current situation for patients treated with methadone for narcotic dependency.

I will speak about Ontario's methadone program administered by the College of Physicians and Surgeons of Ontario under a contract with the Ministry of Health. I will also inform you of a critical governance matter raised by a decision issued last year by the Information and Privacy Commissioner of Ontario.

Methadone is an orally administered narcotic, usually mixed with orange juice, and has been used as a treatment for narcotic dependency since the mid-1960s. It is legally approved in Canada for this purpose and is considered a lifetime treatment. Its availability has been shown to reduce death rates, HIV and hepatitis incidence and crime rates.

Since 1996, methadone treatment has been managed by the college after the federal government, which officially issues methadone prescribing licences to doctors, delegated and downloaded both the responsibility and the cost of methadone administration to the province. The federal government did so in the absence of any contract with the government of Ontario.

As of September 20, 2010, almost 30,000 narcotic-dependent patients in Ontario were being actively treated with methadone by 309 physicians. The College of Physicians and Surgeons methadone program is administered through rigid, arbitrary, discriminatory and intrusive rules which shackle patients to the health care system and preclude any professional judgment by their physicians. For example, at the very best, patients must attend their pharmacy every week and see their doctor every month for the rest of their lives. They must provide urine samples witnessed by lab technicians, and, as a condition of receiving treatment, authorize unfettered disclosure of their personal health information to anybody in the health care system.

Unlike any other doctors, physician prescribers of methadone undergo inquisitorial audits every one to three years, which drives some doctors out of the field. In rural and northern Ontario, where drugstores are closed on Sundays, the college prohibits take-home doses for patients who normally require a daily dose of methadone dispensed at their drugstore. No provision is made for these patients to receive methadone, thereby promoting illegal drug use by those patients on Sundays.

None of these rules apply to other narcotics such as OxyContin. Under the college regime, the death rates of patients in the methadone program have actually increased

since the college took over in 1996. Further, 50% of patients leave the program within two years of enrolment, a miserably low retention rate. These ex-patients become the very people who seek narcotics on the streets. Beyond the over half-million dollars annually provided to the college by the ministry for the program, OHIP and other costs are in the tens of millions of dollars each year.

The unnatural conditions of the college methadone program have contributed to the very narcotic epidemic the program was intended to remedy. Thousands of addicts have left the college methadone program, left without treatment, impelled to acquire narcotics illegally, placing them and others at high risk of illness and death.

The college should change its practices to reflect normal medical standards. Patients must be able to receive treatment no matter where they live in Ontario; otherwise, the beneficial effects of Bill 101 will be greatly diminished.

And speaking of normal circumstances, the Information and Privacy Commissioner of Ontario made an astonishing decision last year, allowing the college, and in fact all regulatory bodies established by the Regulated Health Professions Act, to collect personal health information and establish patient registries without patient consent. The colleges can collect this information, provided that such action relates to the objects and purpose of the regulatory body, which, in the case of the College of Physicians and Surgeons of Ontario, is "to serve and protect the public." It does not matter to the Information and Privacy Commissioner whether the object or purpose is actually met. In the case of the college, the effectiveness or outcome of the methadone program is irrelevant to the IPC, as it granted unprecedented power to the college to engage in a massive privacy breach and constitute a patient registry.

The alleged purpose of the college's registry is to prevent double-doctoring, yet not a single patient in the college's methadone program has attempted to secure methadone from more than one doctor in the program. Because the college does not keep lists of patients using methadone for pain or using other narcotics, such as OxyContin, the college has no idea if methadone program patients are double-doctoring outside the program. The college's registry provides no protection to the public.

Finally, the college maintains patient names for 10 years after they are off the program, including those patients who have died. Perhaps the Information and Privacy Commissioner could explain how the public is protected by keeping the names of dead addicts on the college registry for 10 years.

Nonetheless, according to the IPC, the college does not require legislative authority such as that contained in Bill 101 to keep a registry of addicts using methadone for treatment or to establish registries of any other groups of patients.

The RHPA was created to license the acts and conduct of physicians. The college, with IPC sanction, is using this power to collect and maintain patient information outside of the codified protection enunciated in the Personal Health Information Protection Act and now outside Bill 101. It is further using such information to regulate patient conduct and deny treatment to patients who do not agree to the college's conditions of treatment.

The effect of the IPC sanction is to bypass the democratic process of the cabinet and Legislature in making decisions on privacy matters. Colleges are now allowed to invade privacy under cover of public interest with zero accountability. No patient record in Ontario is safe from such unwarranted and intrusive regulatory scrutiny.

I am relieved that through Bill 101 the Legislature is asserting its rightful position as the only entity that can authorize the mass disclosure of personal health information and the establishment of patient registries, if it deems fit. The IPC should pay close attention and cease granting unprecedented powers of intrusion to regulatory bodies in the absence of any express statutory or legislative authority to do so.

It is essential that Bill 101 pass to achieve the objectives I described earlier and to prevent the misuse of authority that has crept up in the bill's absence. Thank you for so patiently listening to me.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Berger. With Ms. Gélinas, about 30 seconds or so.

Mme France Gélinas: So the conditions for treatment with methadone are not set by the federal government, they're set by the college?

Dr. Philip Berger: They're set by the college.

Mme France Gélinas: Are they the same in every province?

Dr. Philip Berger: No.

Mme France Gélinas: Which one's the best?

Dr. Philip Berger: I couldn't tell you which one's the best. I don't think any of them rank as particularly helpful.

Mme France Gélinas: Okay. Any jurisdiction that does better than us?

Dr. Philip Berger: I don't think achieving a 50% retention rate and an increased death rate is doing better in any fashion, to be quite frank.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Ms. Sandals.

Mrs. Liz Sandals: That was interesting. It happened to click with a personal experience I had in Guelph last week, talking to a young man who was trying to move into methadone treatment.

With respect to Bill 101, are there any changes you want to see in Bill 101 or are you satisfied with the bill as it's currently framed?

Dr. Philip Berger: Ironically, I agree with the previous presenters about providing real-time information to physicians, pharmacists or the CPSO so that illicit prescriptions can be frozen at the point of access before it gets on to the streets.

Mrs. Liz Sandals: So this is the pre-prescribing access to information?

Dr. Philip Berger: Pre-dispensing, yes.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Ms. Jones.

Ms. Sylvia Jones: Thank you for your presentation. I don't have any questions.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Dr. Berger, for your deputation and submission today.

ONTARIO PHARMACISTS' ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter to please come forward: Mr. Malek of the Ontario Pharmacists' Association. Welcome and I invite you to please begin.

1520

Mr. Allan Malek: Good afternoon. My name is Allan Malek. I am the vice-president of professional affairs with the Ontario Pharmacists' Association. I am also a part A pharmacist registered with the Ontario College of Pharmacists, providing direct patient care to patients in a community pharmacy in the GTA.

The Ontario Pharmacists' Association is a voluntary organization representing the professional interests of Ontario's more than 12,000 pharmacists, who work in a wide variety of practice locations but primarily in the community and hospital settings. Our mission is to support, promote and advance the professional practice of pharmacy for improved health outcomes and the general well-being of all Ontarians.

Today, I bring to this committee the perspectives of OPA and its members on Bill 101, the Narcotics Safety and Awareness Act. I would like to begin by saying that the OPA is supportive of this bill. We see drug abuse and diversion, along with the over-prescribing and dispensing of narcotics and controlled substances, as a blight on society as a whole. If left unchecked, it will continue to worsen.

Our members have conveyed to us that not only has the number of legitimate prescriptions for opiates steadily increased, so too has the number of cases of forged or altered prescriptions. While oxycodone seems to be the ingredient most often cited within the media, pharmacists are reporting a greater propensity for the prescribing of codeine-containing and other narcotic preparations.

Bill 101, as introduced on September 15, is a good first step. From the perspective of our members, who are doing their best in their role as gatekeepers to prescription medications, any first step means progress. The bill seeks to employ the Health Network System, or the HNS, as a means to track the prescribing and dispensing of narcotics and controlled substances to any Ontarian with an OHIP card. Currently, pharmacists must rely on word of mouth to identify and alert each other to suspicious patient activities and irregular prescribing habits.

While prescription drug monitoring by any government has raised some concerns about its impact on patient confidentiality, OPA agrees that the risk to general public health and safety is sufficiently high to warrant such actions.

The safety of pharmacists and technicians is also of huge concern. I can speak personally to many situations in my 22 years as a pharmacist where my own safety was at significant risk. I have also spoken with physicians who were threatened or coerced into writing narcotic prescriptions. I have seen more than my fair share of forged and altered prescriptions, which typically follow a pattern in terms of how they are presented to the pharmacy staff.

It's come to a point where certain shifts at certain locations have become inherently dangerous for pharmacists and technicians. Late at night, we often follow stereotypes and gut instincts to determine the veracity of a narcotic prescription, and finding a physician after hours to validate that prescription is just not going to happen. At the end of the day, gut instincts often become irrelevant when the pharmacist honestly believes his or her health and safety are in question.

What Bill 101 offers is information not only to the ministry but also to prescribers and to pharmacists. This information is critical. In our view, ePrescribing and a drug information system cannot come soon enough.

But while we welcome this information, we also recognize its limitations. For individuals who legitimately require the use of narcotics and controlled substances, the system will track their information and may, in fact, assist in understanding prescribing behaviours. For individuals who are abusing drugs and the system, the tracking process may make it harder for them to obtain their narcotics.

Our concern with tracking is that it's only a partial solution. According to front-line pharmacists, it may not eliminate the intimidation tactics drug abusers employ, and our members are concerned that the pharmacy break-ins and armed holdups will continue.
In spite of these limitations, we still support this bill but also believe it doesn't go far enough. Minister Matthews, as quoted in Hansard on September 27, indicated that the database is but one element of a broader strategy. There was mention of a public awareness campaign, including a youth component. She spoke of efforts to move forward with more effective treatments for addictions. We hope this includes a reconsideration of the current methadone program as well as alternatives such as Suboxone.
The Ontario Pharmacists' Association is encouraged by the minister's remarks, but would like more detail on the bigger picture. Pharmacists can and want to do more, but need details on the broader strategy. As health care professionals, pharmacists, along with others, have the responsibility to educate patients, caregivers, the public and each other. Chronic, non-cancer pain is multi-faceted and requires a more concerted effort by all stakeholders: health care providers, patients, caregivers and all levels of government. We therefore urge the government to proceed without delay on the additional elements of the narcotics strategy and to include OPA in its discussions.
The Ontario Pharmacists' Association is pleased to be one of the contributing organizations driving the Ontario community workshops for improved opioid use. These workshops aim to provide physicians and pharmacists with new knowledge and tools from the recently released Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. At the same time, OPA is working in partnership with the Ontario Medical Association on pharmacist-physician focus groups that aim to foster improved communications between the professions. Equipped with these new resources and tools from the community workshops, physicians and pharmacists will see greater efficiencies in interprofessional communications, which will be one of the cornerstones in a consolidated approach to optimal prescribing and dispensing.
Finally, with the dramatic increases in armed robberies and break-ins, OPA has prepared pharmacists with tools and strategies for staying safe and secure in the pharmacy. While theft and diversion of product are very serious matters, protection of health human resources and pharmacists' patients is a top priority.
Once again, I would like to convey the support by OPA and its members of Bill 101. We look forward to the increased flow of information it promises to deliver. However, we urge this committee to remind the government of the additional work that will be required. This involves the provision of necessary support for health professionals in their efforts to educate their patients and themselves, and of course, it requires increased resources to ensure the safety and security of health professionals in the course of their important work for Ontarians.
Thank you very much for your time.
The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Malek. About a minute or so per side, beginning with Ms. Sandals—actually, 45 seconds, but go ahead.
Mrs. Liz Sandals: You talked about appropriate support and tools for pharmacists, and you mentioned the one series of education workshops that I take it you're doing jointly with the physicians. Is there anything else that you'd specifically like to mention in that area?

Mr. Allan Malek: I think it's just a matter of just providing—whether it's financial support or assistance from ministry resources to help facilitate this process, to help facilitate the sharing of information. This database will certainly go a long way, but it's, as I said, just the tip of the iceberg.
Mrs. Liz Sandals: Okay, thank you very much.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Ms. Elliott?
Mrs. Christine Elliott: Thank you for pointing that out, that it is just a first step. I guess that pharmacists, being on the front line, are the ones who sort of bear the brunt of the increase in crime and break-ins.
Have you noticed this within the last couple of years or just the last year? Could you give us some idea of how much it's escalated, and over what time period?
Mr. Allan Malek: I'm sorry, I don't have any specific numbers. A lot of this is anecdotal, but the anecdotal reports are astounding. The challenge is getting formal documentation of the numbers. The unfortunate thing is that a lot of the forgeries—and even getting to the break-ins—are dependent on how much of that information is actually reported to the regulatory bodies. There are no guidelines and no direction to report that type of information at this time.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. Madame Gélinas?
Mme France Gélinas: You mentioned that right now, pharmacists rely on word of mouth to identify and alert each other of suspicious patients or prescribers. What would you do if you knew that a physician in your community, or a dentist or whoever, was prescribing narcotics illegally?
Mr. Allan Malek: Often it's based on suspicion, so our first course of action, typically, is to contact the College of Physicians and Surgeons to register a concern and to initiate an investigation. If it is a blatant example, then often the law enforcement agencies are contacted.
Mme France Gélinas: When you contact the college, are you satisfied with the follow-up that they offer?
The Chair (Mr. Shafiq Qaadri): I need to intervene there, Madame Gélinas.
I'd like to thank you, Mr. Malek, for your presentation and deputation on behalf of the OPA, the Ontario Pharmacists' Association.
MS. PEGGI DEGROOTE
The Chair (Mr. Shafiq Qaadri): Now I invite our next presenter to please come forward: Ms. Peggi DeGroote. You've seen the drill, and I understand you're going to present one of those to each of us, so thank you in advance, I guess. I'd invite you to please begin now.
1530
Ms. Peggi DeGroote: Thank you very much, Mr. Chair, members of the standing committee, and ladies and gentlemen. I address you today as an Ontario citizen, a parent, a patient and president of Wellbeings Pain Management and Dependency Clinic.
I know that Ontario faces a really serious problem of epidemic proportion because of the inappropriate use of prescription narcotics as well as diversion of prescription narcotics. We need to work together to solve the problem and not to lay blame.
It is well known that our physicians receive little training in medical school in the areas of pain management and/or addiction. As you may be aware, veterinarians receive more than five times as much training as do our family physicians. We need to help out and

make sure that we give the proper training to our doctors to give them the skills they need to be able to address the problems of pain and addiction. Action has to be taken now to ensure that people receive the care that they so desperately need in a timely fashion and that there is a comprehensive pain management strategy developed alongside a strategy to diagnose and treat people who suffer from pain and/or addiction.

It is possible to more effectively treat acute and chronic pain by ensuring that people have access to more timely intervention. There are alternative methods of pain relief that our physicians at Wellbeings offer. It's possible that if diagnosis and treatment were done while the person was still in the acute phase, many people would not endure pain into the chronic phase and people would enjoy an improved quality of life and reduce health care costs.

There are many differing opinions and theories as to how to treat pain, even within the pain community specialists. It's clear that there are many treatments which do reduce the debilitating effects of pain. Health care professionals need to address the issues of pain so that the effects of becoming addicted to prescription medications are lessened. I believe that if all health care professionals who prescribe narcotics were required to engage their patients and take the opportunity to educate them about the narcotics they wish to prescribe and had them sign a contract, that would be a good start.

I know, myself, as a patient, three years ago I underwent some surgery, and three days before, the physician's nurse called me and asked if I had filled my prescription. I didn't know that I had received one. I had seen the doctor. But the nurse told me that it was in the Duo-Tang that I had been presented with, and I found it. It had turned sideways. I took it out, and, only as a result of the fact of my more recent education in this area, I found that it was oxycodone that was prescribed. I asked the physician if she could please prescribe something that wouldn't be as potentially addictive and something that had a lesser value—some Tylenol would be a good idea—which they did. I think that people need to become their own advocates, to know what it is that the doctors are actually prescribing for them. I think I'm in the generation where we do question our doctors, where my mother doesn't question a thing, and I'm really happy to learn that the younger generations are asking a whole lot of questions about what it is that they're getting.

I also was diagnosed seven years ago with a Morton's neuroma in my foot—very, very painful. I went and saw four different physicians: my family physician, as well as a foot specialist and two surgeons. It was recommended by the two surgeons that I get surgery on my foot—which is, of course, what they do anyway, so I shouldn't have been surprised—but I was given only a 20% chance of improvement in my foot. I didn't like those odds as a mathematician and didn't opt for that. I had one intramuscular infiltration injection in the bottom of my foot about 18 months ago, and I haven't had one bit of pain since. It's wonderful.

I know from what I'm doing now, which I'm doing because of my volunteer work initially, I've seen people who were addicted and who needed help in our community. It's not just northern communities that are suffering. We happen to come from an area that is well populated but was already identified in 2007 by the methadone maintenance task force as an underserviced area. We have underserviced areas right here where we're not helping people, and I think it really behooves us to offer treatments to people who want treatment and who then can become active community people, be good parents, good brothers and sisters. I don't want to hear any more stories like the gentleman who spoke

here about his poor son who died. I attended two weeks ago, at McMaster, the pain symposium, where I learned of the death of a two-year-old as a result of diversion from methadone. The child thought it was orange juice in the fridge.

It's really sad to hear those tragic stories. I think it's important—one of the things I want to ensure is that people lock up their medications so that they are kept safely. It is part of a best-practice model to do that. We know that; we've been told—not that everyone follows that. But I think that if we did that, at least the tragic stories would be prevented.

As well, our youngsters now—from the Ontario secondary school drug survey in 2009, 21% of all kids in grades 7 to 12 report stealing their parents' pain medications. That's an alarming rate. Of that 21% who reported—the number might actually be higher, I think—72% report that they got them from home.

They have what are called "salad parties," I've learned, where you steal your parents' pain medications, you go to a party and your entree to getting into the party is to throw the pills in a big pile in a bowl. You have to take a handful sometime during the party as part of the fun that you're going to have. Kids don't even have a clue how lethal this can be. At the least, they're lucky if they only need to have their stomach pumped at the emergency ward. Hopefully, we don't see those kids in the morgue, but sometimes we do.

My focus here is: In terms of the diversion, I don't think you've done quite enough in ensuring that one of the ways that we can, in the long term, make a difference for our own communities is by stopping the children right now who easily get access in our own homes to those medications. Sometimes with the first OxyContin they take, or the first fentanyl, or the first Percocet, they're already hooked. That's a sad state.

It happens to all children. This is across Ontario. This isn't just in certain communities. It's rampant, and it's sad. Kids don't get that this could be lethal. They think, because the medications are prescribed by doctors, that it's okay and that they're invincible—and they're not.

Before you go today, this is a medium box; there are small ones, too. I know the Honourable Ted McMeekin already has one and—

Mr. Ted McMeekin: We use it, too.

Ms. Peggi DeGroote: Wonderful, because by using them, we will stop the diversion, if nowhere else, at least in our own homes.

There's also a track-it-back label. Dell Pharmacy has also got these now. There's a track-it-back label so that if it gets left on a bus, over 80% of anything that would be used that has a track-it-back will get returned to you—again, helping to stop diversion. We need to do that. We need to work together as community leaders to say, "We've got to make a difference, and we've got to do it now."

When I went and talked to our local LHIN three years ago and asked about the fact that we didn't have methadone maintenance treatment in Burlington and Halton, I didn't like the fact that they said, "We're going to wait 10 years until the David Caplan study, Every Door is the Right Door, is done." I knew that 10 years from now, it would be way too late for lots of people in our community.

That's why we're doing what we're doing. I'm so happy to support what you're doing, because it really is the right thing, the right way to go.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. DeGroote. We'll begin with about, I guess, 30 seconds or so per side, beginning with the PCs. Ms. Jones?

Ms. Sylvia Jones: Looking at trying to do more diversion, is there anything specifically that we could incorporate into Bill 101?
Ms. Peggi DeGroote: We don't want more diversion; we want less.
Ms. Sylvia Jones: Sorry.
Ms. Peggi DeGroote: Right now, as part of the best-practice model for methadone maintenance treatment, they specify that the medications must be dispensed in a lockable box. I can tell you that from the pharmacist's point of view—because that's required by the doctor; it's between the doctor and the patient. But I think we need to have a bigger picture here, where the pharmacist is also involved in that as well—
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Jones. Madame Gélinas.
Mme France Gélinas: You mentioned a number of kids who steal their parents' painkillers. I missed the percentage. Do you know it by heart?
Ms. Peggi DeGroote: It's 21% of all students in Ontario from grades 7 through 12. Of that 21%, 72% report that they got the stuff from home.
Mme France Gélinas: Do you now have methadone treatment in Burlington?
Ms. Peggi DeGroote: We do.
Mme France Gélinas: Good for you.
Ms. Peggi DeGroote: As well as pain, because my big thing was that we saw that so many people had pain.
The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. Mr. McMeekin.
Mr. Ted McMeekin: Peggi, I marvel at the work you're doing in our local community—with a lot of opposition in the community at different points. I just want to thank you for that and for the work that you're doing.
You mentioned early and informed intervention. Are there some tricks that we, as a government, should be looking at fostering to ensure that?
Ms. Peggi DeGroote: Absolutely. We talk about educating our children, and one of the things—
The Chair (Mr. Shafiq Qaadri): I'll need to intervene there. Thank you, Mr. McMeekin, and thanks to you, Ms. DeGroote, for your presentation, as well as the lockbox which I believe you'll be offering to us later.
1540
ACTION PNP
The Chair (Mr. Shafiq Qaadri): I now invite our next presenter to please come forward, Ms. Frampton, the co-chair of Action PNP, people with neuropathic pain. Welcome, Ms. Frampton. You have 10 minutes in which to make your presentation. I'd invite you to please begin now.
Ms. Janice Frampton: Good afternoon. My name is Janice Frampton. I am the co-chair of Action PNP, or people with neuropathic pain, the patient advocacy arm of Action Ontario.
Action Ontario is a non-profit organization made up of physicians, other health care workers, researchers and patients who are advocating on behalf of neuropathic pain and other chronic pain sufferers.
I would like to thank you for this opportunity to speak before the Standing Committee on Social Policy on Bill 101.
Seven years ago I was diagnosed with a rare neurological birth defect called tethered spinal cord syndrome. This syndrome occurs when the spinal roots at the end of the

nervous tissue are tangled up in scar tissue. It is degenerative and closely linked to spina bifida.

For the first 46 years of my life I lived with misdiagnosed, untreated neuropathic pain. Neuropathic pain is a particularly debilitating form of chronic pain that is the result of injury or disease of the nerves, spinal cord or brain. And because my pain went misdiagnosed and untreated, I self-medicated with alcohol to cope. The worse the pain became, the more I drank, until I could drink no more, because death was quite literally tapping me on my shoulder.

Eventually, I ended up in a rehab centre, not here but in the United States. When I arrived at the Betty Ford Center with my bagful of pills, it was discovered that I was indeed an addict, but not to opioids; I was addicted to antidepressants. Why? Because the doctors I was seeing at the time were convinced that I wasn't in pain, I was just depressed and the pain I was experiencing was all in my head. So they loaded me up with antidepressants even though they knew I was drinking—a very lethal combination. Misdiagnosis, untreated pain, addiction—a vicious cycle that didn't include opioids.

So what does my story have to do with the debate around the narcotics legislation in the province of Ontario? Quite literally, everything. A correct diagnosis and treatment by physicians properly trained in the field of pain and pain management would have alleviated years of suffering not only for me but my family, not to mention the thousands of dollars it would have saved the provincial health care system. Sadly, my story is not unique, which illustrates one of the tragedies of our system and the potential harm of this legislation if it is left to stand as is.

Too many actual pain patients are misdiagnosed and denied proper medication and treatment. These patients may end up going down destructive paths to alleviate their pain while the wrong medications are over-prescribed for other people, possibly causing the same addictive cycle without relief.

Opioids themselves aren't the enemy and putting the fear of God into physicians who prescribe them isn't the answer and could cause more damage. Let me give you an example. After the introduction of Bill 101 on September 15, one woman blogged three times within a matter of 12 hours in a panic because her family doctor now refused to refill her opioid prescription, using the legislation as his excuse.

So what is the solution? First and foremost, it is education: Education of physicians about chronic pain in general, including more time spent in the classroom itself, especially primary care physicians who deal with about 90% of pain patients. As the last woman said, veterinarians receive more education in pain treatment than our physicians do.

Patient education and awareness programs must also be part of this process. For the record, narcotics are included in my pain management program, but because of my own experiences, I have become very self-aware. I know what works for me and what doesn't and I do not take medications just because they are prescribed for me.

Channels of communication between all health care providers, including but not limited to physicians, pharmacists and nurses, must be established. It is vital that these gateways be opened. Family doctors need to be properly equipped in order to diagnose and treat chronic pain in its early stages. This can be done by giving them access to psychologists, nurses, self-management support systems and prevention tools like vaccines.

Chronic pain patients all tend to be lumped together. To be blunt, you wouldn't lump all cancer patients together; you would determine what kind of cancer a person has. So why

is someone with neuropathic pain treated the same as someone with arthritis or sciatica? Because pain is considered subjective and is not necessarily visible to the human eye—it is often considered to be all in a person's head. But if someone who has cancer is in pain, they would be treated accordingly. Think about it.

The truth of the matter is: We are not all the same; our pain is not all the same. And this, in part, is why so many narcotics are over-prescribed. Because isn't that what you give someone who is in pain? Narcotics? Around and around it goes.

To this end, there need to be more options in the management of chronic pain. This means improved access for pain medications other than just narcotics and more options such as psychological treatments, physical therapy and other complementary treatments.

The province needs to establish standards and outcome measures for pain clinics. This will also help to reduce waste within the current system, such as with block shops or nerve block and soft tissue injection clinics. According to a Toronto Star article, when OHIP audits were stopped in 2003, the cost of these injections was $24.4 million. In 2005, this number jumped by 44% to $33.1 million. Based on these numbers, this amount will have more than doubled to $67 million a year in 2010 dollars.

These clinics also dispense a large cocktail of medications, including narcotics, to the clientele, who usually visit them once or twice a week. They're called pill mills.

Having said all this, what Ontario needs are properly trained, licensed pain physicians. Right now, there is no such thing as a pain specialty in Canada.

Before I conclude, I'd like to take a moment to talk about insurance companies. Please consider this: Once this legislation is in place and a pain patient has gone over their quota, you can rest assured that an insurance company will cut that patient off. It won't matter if they have cancer or have undergone five spinal surgeries to correct a tethered spinal cord; the insurance companies will use this legislation to impose limitations and restrictions on their clientele that will cause more emotional, financial and physical strain on the patient—in other words, more pain. This potentially means no more medications, more substance abuse, and the cycle will continue. Remember, you don't need a prescription to go to the LCBO. There will always be someone there to sell something to someone, and a pain patient will do anything to alleviate their pain. Believe me, I know. This may sound desperate, but desperate people do desperate things. Remember the lady blogging? There will always be people who circumvent the system. You know that, and I know that. What would you do?

This legislation may be a good first step in tackling the issue of narcotics overuse in the province of Ontario. But unless we address the underlying issue of pain itself and the treatment of pain patients with the introduction of a comprehensive pain strategy for the province of Ontario, we will continue on the same myopic path and the same cycle of destructive, addictive behaviour.

Once again, on behalf of Action PNP, Action Ontario and pain sufferers without a voice in the province, I ask you all to consider a comprehensive pain strategy in Ontario. Without this step, we won't be able to truly tackle the narcotics problem. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Frampton. I believe we will go to the PC Party: Ms. Jones. About 30 seconds per side.

Ms. Sylvia Jones: Thank you for your presentation. You mentioned pain specialties. Are you familiar with other jurisdictions that would have that option?

Ms. Janice Frampton: Alberta.
Ms. Sylvia Jones: Alberta does?
Ms. Janice Frampton: Alberta, and I believe one of the provinces on the east coast; I think it's Nova Scotia.
Ms. Sylvia Jones: Thank you.
The Chair (Mr. Shafiq Qaadri): Madame Gélinas.
Mme France Gélinas: Are there centres of excellence in Ontario where they know how to look after pain?
Ms. Janice Frampton: Well, the one I go to: Dr. Mailis. She'll be presenting later. She saved my life.
Mme France Gélinas: Thank you.
The Chair (Mr. Shafiq Qaadri): Ms. Sandals.
Mrs. Liz Sandals: I believe she is appearing later, so she may be the better person to ask, but are there protocols that will help us determine the legitimate use of pain medications versus overuse and abuse?
Ms. Janice Frampton: There are. That's why I say there has to be more education at the primary care level, because there is a lack of diagnosis there, and that's where everybody comes filtered to—
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Frampton, for your deputation on behalf of Action PNP, people with neuropathic pain.
1550
DR. RAMESH ZACHARIAS
The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, Mr. Ramesh Zacharias, to please come forward. Welcome, Ramesh. I'd invite you to be seated and please begin now.
Dr. Ramesh Zacharias: Mr Chairman, ladies and gentlemen of the Standing Committee on Social Policy, I would like to thank you for the honour and privilege afforded me to present to you this afternoon on the narcotics strategy being put forward by the government of Ontario.
My name is Ramesh Zacharias. I graduated with my doctorate of medicine from the University of Western Ontario in 1980. For the first 20-plus years of my practice, I worked as an emergency room physician in this province and, over the last eight years, I have had a focused practice in chronic pain and care of the elderly as an attending physician and medical director of long-term-care facilities.
I consider myself one of the luckiest individuals alive, because I get to practise in two of the most exciting and rewarding areas of medicine: providing care to those suffering from chronic pain, and care for our elderly citizens to ensure that their lives remain active, functional and relatively pain-free.
As I have followed the landscape of pain management in this province and, more recently, the discussions around the use of opioids, I debated even appearing before this standing committee. What compelled me to seek this opportunity was reflection on the words of Martin Luther King Jr., who once said, "Our lives begin to end the day we become silent about things that matter."
I must declare my conflict at the outset. During my opening comments, I mentioned that my area of clinical practice is pain management and care of the elderly. You see, over 30 years ago, I was diagnosed with diabetes. I have benefited from the comprehensive and

interdisciplinary approach that this government and previous governments and we, as a society, have taken toward the chronic disease of diabetes.

Sixteen years ago, at the age of 42, I suffered a heart attack. Thankfully, because of the excellent care I received at Credit Valley Hospital, I not only survived that event but continue to enjoy a healthy life today.

Approximately two years ago, I started to develop early signs of another well-recognized complication of diabetes, in that I periodically get severe, shooting, burning pain in my feet, something we call neuropathic pain, which afflicts a variety of conditions, including diabetes. So, you see, I come before you not just as an individual who is practising in chronic pain, but as one who is starting on the long journey of being a chronic pain patient.

In preparation for presenting to this standing committee, I had the opportunity to review the narcotics strategy being proposed in this legislation and the document produced by the College of Physicians and Surgeons of Ontario entitled Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis. I believe that these documents are a good start, and I'm confident that, with some changes, they can serve as a great step forward in addressing an extremely complex but relevant issue affecting two million citizens of this province.

By the age of 55, 50% of the population has some form of chronic pain. By the age of 65, over 60% of the population has some form of chronic pain, and if you live in a nursing home—I manage nine facilities—you realize that the published data are that 80% of that population has chronic pain. If I look around this room, almost five, if not six, of you will experience chronic pain at some point in time. This is a very relevant issue, not just to citizens but in fact to you.

I will frame my concerns in three areas. The first area I'd like to address is what I call "people and patients."

This past September, the International Association for the Study of Pain held its biannual meeting in Montreal. At the conclusion of the meeting, they held the first international summit on establishing the bill of patients' rights. This summit had delegates from over 84 countries around the world. In its declaration that access to pain management is a fundamental human right, it describes 10 initiatives. I would like to mention just three of them: that all people have the right to access pain management without discrimination; that all people have a right to access an appropriate range of effective pain management strategies supported by policies and procedures appropriate for the particular setting of health care and health professionals employing them; and that all people have a right to access appropriate medicines including but not limited to opioids, and to access health professionals skilled in the use of such medications.

Ladies and gentlemen, health is a fundamental human right enshrined in numerous international human rights instruments. The International Covenant on Economic, Social and Cultural Rights, ICESCR, specifies that everyone has a right to "the enjoyment of the highest attainable standard of physical and mental health."

My first recommendation to you as a committee is that this committee set forth the foundation for the necessary change that will benefit the citizens of the province of Ontario by proclaiming that "access to assessment and treatment of acute pain, cancer pain and chronic pain is a fundamental human right for the citizens of Ontario."

The second issue I'd like to address is the issue of providers. Under-recognized and under-treated pain results in significant cost and loss, disability, impact on productivity and societal consequences. Comprehensive interdisciplinary pain management should be the standard of care in this province. The province can build on the model of diabetes to create a network of interdisciplinary pain management centres. Working in a long-term-care facility, I have the good fortune of being able to provide comprehensive services that are part of the global funding of the facility. In addition to the physicians, our residents benefit from assessments and treatment from the physiotherapist, pharmacist, occupational therapist, recreational therapist and psychiatrist, to name a few of the disciplines. Access to these highly trained professionals does not impose additional costs to the residents or to their families. In the long-term-care facility where I work as a medical director, we have been able to create a true interdisciplinary model of care involving 13 different disciplines, including our chaplain and the volunteer dog therapist. It would be my dream to be able to participate in a similar model in the community. Unfortunately, the beneficial complementary services are beyond the financial capabilities off the majority of my patients. Access to these additional health professionals with complementary skills is critical.

My second recommendation to you is: Re-establish specific timelines for the creation of this model. Otherwise, it will unlikely occur in a timely manner, and unlikely in my lifetime.

The third area I'd like to address is the issue of pharmaceuticals. Inappropriate use and abuse of prescription narcotics and other controlled substances is a major concern for all involved in the delivery of health care to patients with chronic pain. The five key elements of the narcotics strategy provide a framework for addressing this critical issue. In addition, it is imperative to also address the issue of the formulary supported by the Ontario drug benefit plan, ODB, to ensure that all drugs that are part of national and international guidelines are also included. It is inappropriate that we do not pay for drugs most of which are not narcotics but have been part of established guidelines, yet for reasons hard to comprehend, are not covered by this province. In some cases, this could result in using opioids because other non-opioids or alternative medications are beyond the financial capabilities of the patients. This moral dilemma needs to be eliminated.

My third recommendation is that the committee have a sixth strategy with a defined timeline of 2011 to expanding the ODB formulary to include non-opioid medications that are part of clearly established national and international guidelines.

1600

Finally, I'd like to close with the fact that no one would dispute the current problem in the use and abuse of opioids. We should not ignore the fact that the vast majority of two million Ontario patients who suffer chronic disease are taking their medications appropriately and are not involved in criminal activity. As Mahatma Ghandi so aptly put it over 60 years ago, "You must not lose faith in humanity. Humanity is an ocean; if a few drops of the ocean are dirty, the ocean does not become dirty."

Once again, please accept my sincere gratitude for having the honour to present my thoughts. May God give you wisdom as you deliberate on this important issue.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Zacharias, for your precision-timed remarks and for your deputation.

MEDAVIE BLUE CROSS

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenters to please come forward: Mr. Haynes, vice-president, and Ms. Foran, director of Medavie Blue Cross. Welcome, and I invite you to please be seated. Please begin.

Mr. Martin Haynes: Mr. Chair and members of the standing committee, thank you for the opportunity to present this submission on behalf of Medavie Blue Cross. We have prepared a brief and wish to highlight the key points in that today.

At the outset, we wish to express our strong support for this important piece of legislation as well as the overall narcotics management strategy. We will confine our comments today, however, to the proposed legislation. In summary, we believe that this bill provides for the appropriate system-wide collection of data and the provision of information to prescribers and dispensers to support clinical decision-making. It will, we believe, also restrict opportunities for the diversion of narcotics. It is important to recognize, however, that this legislation is not a solution in itself but provides the foundation for Ontario's narcotics management strategy. In the remainder of my comments, I'd like to outline our basis for this support and also highlight two recommendations to further strengthen the legislation.

By way of background, Medavie Blue Cross is a not-for-profit organization with over 40 years of experience managing benefit programs on behalf of governments and private companies in Ontario, Quebec and the four Atlantic provinces. Of particular relevance to our submission today is our 14 years' experience in administering the prescription monitoring program on behalf of the province of Nova Scotia. This program has been acknowledged as being one that is progressive and proactive and held in high regard by stakeholders. Medavie Blue Cross has played a central role in advancing the program's scope through several evolutionary progressions. This program, initially a data collection and analysis tool, has matured to one that today promotes evidence-based outcome measures and successfully addresses barriers that exist between stakeholder groups, such as providers, prescribers and law enforcement.

As a stakeholder in the health care sector in Ontario, Medavie Blue Cross was invited to participate in the round table sessions held by the ministry to discuss the issues of narcotic usage in Ontario. Of the industry stakeholders that participated, Medavie Blue Cross was the sole organization with experience in managing a comprehensive narcotics management program. Our experience has allowed Medavie Blue Cross to provide the ministry with insight as to the complexity of managing such programs, and we are certainly pleased to see that some of the insight and some of the recommendations we made through those round table and other discussions have been taken into account as the strategy and the legislation have been developed.

We do, however, notice two areas that we believe are worthy of consideration for amendment.

(1) The lack of a provision for the delegation of authority regarding the administration of any or all aspects of the program to a party other than the ministry: At this time, all other prescription monitoring programs in Canada are administered by independent organizations. The reasons for considering this are varied. First is the ability for the program and its interventions with all stakeholders to be viewed as being at a reasonable arm's length from government. Second is the opportunity for data to be analyzed and acted upon by an independent third party. Given the contentious issues around

prescription drug abuse, Ontario may wish to build flexibility regarding the administration into the legislation at the outset.

(2) The lack of a provision to share data with regulatory colleges for the purposes of professional review: The ability of regulatory colleges to access or be provided data with regard to its members for professional review purposes is key to the value a prescription monitoring program can deliver. The information available promotes proactive intervention by the program and by the regulatory colleges when issues of inappropriate prescribing or dispensing are suspected. A provision in this area is strongly recommended, with the recognition that detailed regulations are required to control release of and access to professional information, as well as, of course, the underlying data.

In summary, Medavie Blue Cross strongly supports the proposed legislation. With the modifications as noted, we believe it will provide a solid foundation to support the objectives outlined in Ontario's narcotics management strategy.

Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you. You've left generous time for questions. We'll begin with the NDP and Madame Gélinas, about a minute and a half or so per side.

Mme France Gélinas: Thank you. You certainly seem to have experience in managing such a database. Could you explain to us some of the complexity of managing such a program? What can we expect?

Ms. Ann Foran: It's hard to put together in a minute and a half. There are a lot of complexities in terms of the requirements for privacy around the data, and the use of that data requires a lot of guidelines, a lot of regulations. So this legislation would have to be supported with very detailed regulations for all involved licensing authorities and stakeholders—access, research, use.

Another very integral part is how the program can support the stakeholder groups across the province in terms of moving the strategy forward.

Those are probably some of the complexities starting out that you're going to face in maintaining the balance in those relationships.

Mr. Martin Haynes: And I think, if I may add, as several other presenters have indicated, it's the complexity of relationships around narcotics management, particularly around pain management. All of those aspects are key as well—the appropriate intervention and inclusion of all stakeholders.

Mme France Gélinas: Thank you.

The Chair (Mr. Shafiq Qaadri): Ms. Sandals?

Mrs. Liz Sandals: I was looking at your second recommendation, which I believe is similar to one of the recommendations that the College of Physicians and Surgeons made. I guess the question would be, does the regulation in Nova Scotia allow for this exchange of information, and what's your experience in administering that?

Ms. Ann Foran: Yes, it does, and our experience with that has been very positive. We obviously have very strict guidelines that the college is part of our board to begin with, so they understand and support those regulations.

What we're looking at primarily in sharing the information is when the college is involved in, perhaps, a disciplinary hearing or a review of one of their prescribers, or the pharmacists as well, with that college. There are very clear privacy guidelines around

when they can access that data, and they have to provide a written submission for request to satisfy the program that it's required.
Mrs. Liz Sandals: And if we were to look at the Nova Scotia legislation and regulations, we would find a model for that laid out there?
Ms. Ann Foran: You may find the overlying model, but we could certainly give you the detail.
Mrs. Liz Sandals: That would be very helpful. Thank you.
The Chair (Mr. Shafiq Qaadri): To the PC Party, Ms. Jones, Ms. Elliott?
Mrs. Christine Elliott: We don't have questions. A very clear, concise presentation. Thank you very much.
The Chair (Mr. Shafiq Qaadri): Thank you very much, Mr. Haynes and Ms. Foran, for your deputation on behalf of Medavie Blue Cross.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair (Mr. Shafiq Qaadri): I invite our next presenters to please come forward from CAMH, the Centre for Addiction and Mental Health with the University Health Network: Ms. Luce and Ms. Sproule, manager of public policy and advanced practice pharmacist. Please be seated. I'd invite you to please begin now.
Ms. Beth Sproule: Thank you very much. We're here on behalf of the Centre for Addiction and Mental Health. My name is Beth Sproule, advanced practice pharmacist at CAMH, as well as a clinician scientist, and my research program is around prescription drug abuse.
First of all, on behalf of CAMH I'd like to say that we support the Ontario narcotics strategy and that we're very pleased to see this legislation moving forward. Much of what we have to say today actually supports the presenters we just had, because we wanted to provide some key features and examples from the Nova Scotia program that we think are really quite good. So it's mostly supportive, and we'd like to see the legislation be able to allow or support these key features in a prescription monitoring program.
First of all is what has already been stated, that there's an independent board that oversees and administers the program. I think that's quite important and it sounds like you'll get the details from them of who is involved in that program. I think it's quite important that this independent board is then responsible for overseeing the program. Some of the key features are that this board then is responsible for determining which drugs will be monitored, and also key features such as that for the drugs that are monitored, they are monitored for everybody in the province who will be prescribed those drugs, regardless of the payer, so that it's across the board and not just associated with specific drug plans.
1610
Also, this board is responsible for issues related to privacy that were brought up by the previous speakers as well. We think that it's quite important that this independent board is responsible for looking at issues of privacy and confidentiality, while at the same time ensuring that this prescription information is available in real time to clinicians—so for prescribers and pharmacists as they're working with patients—but balancing that with deciding what the appropriate disclosures would be to regulatory authorities or law enforcement authorities, for example. Having that independence, we think, is quite important.

We also think it's very important to make sure that there's the ability to have adequate evaluation of the program. It's not enough just to sort of be collecting the information; it's how it's used and analyzed to benefit patients—so having a clear way to be able to determine if it is in fact benefiting patients, if there is improved access to opioids for the treatment of pain, and at the same time reducing the harms associated with it. So, in particular, it's looking at whether the program actually reduces abuse and addiction towards these drugs.

The reason we want to emphasize that is because most programs don't have that as a goal, and they're not evaluated in that way. Often, it's just looking at whether there was reduced prescribing of opioids or something like that and not really looking at the clinical outcomes, both from the pain perspective and the addiction perspective. We know from other prescription-monitoring programs or control measures that they can have unforeseen consequences. The biggest example of that, as you may have heard, is the New York experience with triplicate prescriptions for benzodiazepines, where the program had the desired effect—that as soon as they were required to prescribe using triplicate prescriptions, the prescription of benzodiazepines dropped considerably—but the evaluation of the program showed that there was an increase in the prescription of other drugs, less desirable sedative hypnotics such as chloral hydrate or meprobamate, which was not the desired outcome. So I think it's important that there's a clear evaluation of the program.

Related to that, as far as looking at the outcomes for and ensuring access for the treatment of opioids for pain, we want to also emphasize ensuring that there's adequate access to these medications for the treatment of addiction as well and for people who suffer from both disorders. There's not a dichotomy of pain patients and addiction patients. Many people have both problems, and that's particularly complex to deal with. We want to make sure that there's adequate access to the medications needed for that as well.

The Chair (Mr. Shafiq Qaadri): Thank you very much. We have about a minute and a half, maybe two minutes per side, beginning with Ms. Sandals.

Mrs. Liz Sandals: You spoke about the Nova Scotia model, where there's an independent board. What aspects does the independent board have some control over?

Ms. Beth Sproule: It sounds like, from my understanding, that it has control over the whole program, that they set the policies and procedures, which they then recommend to the minister, and oversee the whole process.

Mrs. Liz Sandals: Who would be on the independent board?

Ms. Beth Sproule: My understanding is that there's representatives from the medical, dental and pharmacy regulatory authorities; there's independent representation; and there's also a non-voting member from the Department of Health.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Ms. Elliott or Ms. Jones?

Mrs. Christine Elliott: No questions. Thank you very much.

The Chair (Mr. Shafiq Qaadri): Madame Gélinas.

Mme France Gélinas: Do you share the belief by some people that this bill will make some legitimate prescriber shy about prescribing narcotics when they are needed and, as a consequence, drive the need for street drugs right through the roof?

Ms. Beth Sproule: I think, depending on how the program is set up, that is a risk. I think the way it's set up and rolled out needs to be clear that it's meant to help improve access and improve prescribing and not be seen as a punitive sort of program for prescribers. I

think it really depends upon how it's communicated and how it's administered, and I think having this independence feature that we've been talking about would really go a long way towards that.

Mme France Gélinas: I don't think physicians in Ontario are that different from physicians in New York, and the experience there has clearly been that as soon as you asked them to put something in triplicate, they all shied away from that medication and went to anything else where they didn't have to deal with the government. It's not a big stretch to think that the same thing will happen here.

Ms. Beth Sproule: And again, I guess it depends on how it's set up: if it is an actual triplicate program or if it's just recording electronically what they're prescribing anyway. Actually, having a specific pad to write it on certainly can influence prescribing in and of itself, regardless of whether it's just tracked electronically or not, but I think it depends on how the feedback is given. I think in New York it was seen as a very punitive, very—you know, the goal of the program was to reduce benzodiazepine prescribing. Whereas if it's made very clear that the goal of this program is to help improve opioid prescribing and for the safety—

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you both, Ms. Luce and Ms. Sproule, for your deputation on behalf of CAMH, the Centre for Addiction and Mental Health.

ADDICTIONS ONTARIO

The Chair (Mr. Shafiq Qaadri): I invite our next presenter to please come forward: Ms. Gatenby of Addictions Ontario. Welcome. Please be seated, and please begin now.

Ms. Deborah Gatenby: Hi, good afternoon. My name is Deborah Gatenby. I'm a member of the executive committee for Addictions Ontario, formerly the Alcohol and Drug Recovery Association of Ontario. We've been in existence for over 40 years, providing leadership for excellence in addiction services. Our members are service providers throughout the province of Ontario providing early intervention, health prevention and promotion, and treatment services. In the war on drugs, we're the troops on the ground. I'm here today to speak on behalf of those service providers, and grateful for the opportunity.

We've reviewed Bill 101 and all the presentations and commentary to date. Many of the concerns of our members have already been raised, so I won't discredit those speakers and my audience by belabouring the same points.

Our members want to commend Deb Matthews for her leadership in bringing the issue of opiate abuse to the forefront of our social policy agenda and for her commitment to action that will effect lasting change for our citizens. Two of the specific goals of the legislation are to reduce the abuse and misuse of narcotics, including medically inappropriate use, and to support treatment and reduce related deaths and addictions. Minister Matthews believes, as evidenced by her statement, that if passed, this legislation will save lives and protect individuals from harmful effects.

The bill, like the intentions of the health minister, has the full support of Addictions Ontario. We need to move beyond the disappointment and criticism of eHealth and recognize the merits of a tracking system that is simply done, uses OHIP and doesn't have to be complicated or drawn out.

The legislation is long overdue. It's so overdue, in fact, that despite its obvious merit, the window of opportunity for such measures has passed and will not open again until we get

through this crisis. We cannot responsibly support a move to implement whole supply control strategies at this point. The inevitable consequences would be devastating for Ontarians who have already fallen victim to what is now a full-blown epidemic.

As stewards of the health care system, we must ensure that our decision-making is based upon factual, relevant and timely information: evidence-based research, peer-reviewed scholarly articles, empirical data and scientific method.

Fact: Supply control strategies aimed at prevention and reduction are only effective at the onset of an epidemic. Once the drug problem has matured, optimal policy is not to stop the growth of the epidemic but rather to moderate it. Treatment should receive a larger share of resources than any control or enforcement strategies.

Fact: When the supply of one drug is reduced, consumers switch to an alternative. Our honourable Minister of Finance and fellow Windsorite already knows that economists call this a substitution effect.

Fact: Decreased supply with unchanged demand results in increased drug prices. Addicts turn to crime and adopt faster but riskier routes of using reduced drug quantities to produce the same desired effect. Injection use escalates.

Fact: Decreased demand with unchanged supply results in reduced drug prices. Addicts' total expenditures on drugs are reduced and there is less incentive for crime and high-risk use.

1620

Fact: To avoid a negative outcome, demand reduction must be at least equal to supply reduction. To achieve a positive outcome, demand reduction must exceed supply reduction. Reductions in supply are achievable without reductions in demand but only at an unacceptable cost to human rights.

Fact: In order to promise an unambiguously positive outcome to Ontarians, resources must be concentrated exclusively on demand reduction.

Fact: In order to achieve identical measurable impacts on rates of drug misuse, an investment of $246 million in control is required to deliver the same outcome as an investment of only $34 million in treatment. Reduced supply strategies deliver results, but only at a cost seven times higher than those aimed at demand.

Fact: Addiction is a disability—chronic, progressive and, if untreated, fatal. Societal, economic and cultural factors influence population vulnerability and cause variations in per capita rates. Availability and cost are not correlates to incidences of addiction disability, but rather to specific drug prevalence rates, quantities consumed, methods of use and negative consequences. Chemical dependency is distinct from addiction disability and is a separate focus of health care and social policy.

Fact: Prescription narcotics are manufactured under quality controlled conditions; have reliable, consistent and predictable concentrations of active ingredients; and are free from pollutants. While organized crime may profit off the illicit supply of these drugs, the net revenue generated from their initial production and manufacturing benefits legitimate domestic corporations who contribute to our tax base and have a vested interest in public health care. Heroin and other illicit substances are manufactured in uncontrolled environments, without consideration for quality. They have unreliable, inconsistent and unpredictable concentrations of active ingredients, and contain a host of pollutants that often pose greater risks than the drugs themselves. Organized crime profits off the supply and the net revenue generated from production and manufacturing. This benefits

illegitimate foreign interests and reduces our tax base resources available for health care by increasing criminal justice spending.

Women with addictions are at increased vulnerability for exploitation due to their low position on the criminal supply hierarchy. Terms like “drug lord,” “cocaine czar” and “kingpin” are gender specific for a reason; if we follow the money and power to the top, there are no women there. Women and children are the casualties of the war on drugs.

Fact: Intervention, treatment and harm reduction strategies are easier to apply and achieve better outcomes when applied to prescription narcotics than to heroin. Fewer accidental overdoses occur among users of prescription narcotics than heroin.

Fact: Opiate use gradually induces drug tolerance among users. Increased dosages among chronic, heavy users can commonly result in them using 28 times the amount that they started with just to reproduce the desired effect. Escalating consumption rates of a habitual user can single-handedly drive overall quantities up every year at rates that are double that of any new user. Intervention strategies aimed at heavy users will take illicit OxyContin tablets off the market twice as fast as any new users can begin to use them.

So, now that we’ve considered the facts of our situation, we need to re-evaluate how we’re going to tackle this problem. Addictions Ontario members are eager to work together with this government starting today. Unified, with a single priority of purpose, we want to build on the momentum that Bill 101 has already created. We cannot afford to waste any more time waiting for money to solve this problem while costs grow further and further beyond our reach. We need to make hard decisions quickly about the reallocation of resources within all of our existing base budgets. We need to draw concentric circles around our core services and then realign spending with actual and forecasted service utilization rates.

Each of us is responsible for ensuring that adequate resources are made available to invest in strategies that will produce meaningful outcomes for this priority. We have been entrusted by taxpayers to provide for them the best addiction treatment system possible, and we have been given a finite amount of money to do that with. We need to stop putting our energy into this idealized notion that a basket of services can be available around the province when what is needed is a triage system that places interventions in appropriate priority. Elective surgeries are a luxury when people are dying at the entrance to your emergency department. We need to use our expertise to preserve for the people of Ontario what is most valuable in a reality that cannot possibly sustain everything.

The Honourable Minister of Health says that she was working with a group of experts to develop recommendations for ways to move forward. We know, based upon the facts that we have considered, that we need to consolidate some gains in these areas first before we can get to the control and enforcement strategies that make up Bill 101. Even if the legislation were passed, it couldn’t be implemented without resources. Fiduciary responsibility prohibits investment at this time because we may end up squandering $2 in collateral costs for each $1 attempt to save in solving this problem.

Addictions Ontario is positioned to act. Our collective expertise uniquely qualifies us to provide recommendations that will enable the addictions system to move forward without any further delay and reverse the growth of this epidemic that has taken the life and health of too many Ontarians already. We request that each LHIN be empowered, in full partnership with their addictions—

The Chair (Mr. Shafiq Qaadri): I'll need to intervene there, Ms. Gatenby, but I'd like to thank you on behalf of the committee for your deputation on behalf of Addictions Ontario.

DR. ANGELA MAILIS-GAGNON

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenter to please come forward, Ms. Angela Mailis-Gagnon. Welcome, Ms. Mailis-Gagnon. You've seen the drill. You've 10 minutes in which to make your presentation—

Dr. Angela Mailis-Gagnon: I'm very aware.

The Chair (Mr. Shafiq Qaadri): Yes, please begin.

Dr. Angela Mailis-Gagnon: I'm Dr. Mailis-Gagnon. I'm the head of the comprehensive program of the Toronto Western Hospital University Health Network, I'm a senior investigator with the Krembil Neuroscience Centre at the University Health Network, I'm a full professor of medicine at the University of Toronto and I hold a master's of science degree as well, except in my specialty in physical medicine. I'm a popular science writer and my book Beyond Pain was published in Canada in 2003 and 2006, and in the United States as well. I'm a science writer for the Canadian Association of Retired Persons' electronic newsletter, the Advocacy newsletter, and my column is read by 80,000 people every two weeks across the country, 60% of whom are coming from Ontario.

I'm also the chair of the patient advocacy group for education and advocacy on neuropathic pain and chair of Action Ontario, and additionally, I had the honour of being a member of the Narcotics Advisory Panel of Helen Stevenson, now Diane McArthur, and Deb Matthews. So I have total knowledge of the problem.

I practised pain management for 28 years, and my unit has been the only one funded in the whole of the province by the Ministry of Health for the last 20 years. That's the only reason why I have survived with my team, simply because we have gone on salary, as the current system for fee-for-service does not really serve patients with pain.

Having given you my credentials, I have seen in 28 years over 20,000 patients with chronic pain. I'm one of the founders for the University of Toronto's Centre for the Study of Pain. So I come with a lot of baggage and a lot of patients with me.

Having said all of that, of course I will support Bill 101; I was part of the group that created it. But this is only treating the symptom of a disease. If you think that Bill 101 is treating the disease, it's a mistake, because opioid abuse is only an outcome of a broken-down system that never existed in the first place.

You cannot treat chronic pain if you're not educating your physicians and your health care providers from within the school. You cannot get out trained physicians if they receive five times less training in medical schools than a veterinary doctor who's going to treat your dog—your dog would have better treatment than my patients would. And when they come out there with no training and with a population of which one third has experienced or will experience pain, the physicians have no resources at the primary care level—(1) 90% of all pain is treated by the primary-care-level physicians, who have no training; (2) there are no resources for those physicians; (3) there is no time, because the current system of fee-for-service does not remunerate for time. It takes 30 seconds to write a prescription for opioids and 30 minutes to scratch the surface of a chronic pain patient.

Then you go a lot higher. You say, "We need pain clinics." But there is no formal training in this country. None of us has any training in this country. There is a process

now to try to establish a subspecialty at the Royal College level. It's going to take many years. People try to get the training through continuous medical education, but there are now absolutely no standards in this whole country about who is a good pain clinician and who is not.

1630

Many of us work there for the love of our hearts because this is what we love doing, against all odds, working very long hours. Others will use the system because there are only very few things in the system that are remunerated. One of those is nerve blocks. One of my patients already spoke to you about the cost of nerve blocks: $24.3 million in 2003. When the audits were stopped in OHIP, it went to $33.1 million. By estimates, today the cost to the system will be $67 million.

I'll give you an example. I saw a patient the other time, and this is a real patient, and he said to me, "Excuse me; follow up? Let me see if I can fit you in my book. Monday, Wednesday and Friday I have my blocks." He had these blocks for three years, three days a week, and he said, "Oh, by the way, I have a few emergency visits in a month," because the clinic is operating seven days a week at a cost to OHIP.

On the other hand, we talk about the abuse of opioids, and you heard all my other co-speakers, and they know very well there's no question about that. This is a big issue. I just saw a patient—this is really true—and he had Crohn's disease. He was on 180 tablets of Dilaudid—eight milligrams a day—plus 200 micrograms of a Duragesic patch. Let me give you the numbers in morphine equivalent. He was on 9,360 milligrams of morphine equivalent a day for the number of 5,400 Dilaudid tablets that he was taking. I asked the pharmacist about the cost, and the cost to the pharmacy was $3,350.39 a month for an amount of $40,740.75 a year, all paid for by the Ontario drug benefit program. This is one of the things that Bill 101 tries to establish and correct, but it would be a major mistake—if this committee goes out of here and says the narcotics, the doctors will be chilled off. They won't prescribe. I tell you, they don't prescribe now.

What we are facing is the dual tragedy of pain: We have a bunch of doctors or physicians or patients who abuse or overuse the medications, and we have hundreds of thousands of others who are under-treated. Opioids may make the difference between them being in bed and walking out. I have 92-year-old patients that I treat with morphine drops and I get all the hugs and the kisses because grandpa, instead of being in bed for eight years, is out there travelling to Holland. This is a reality: The dual tragedy of the bad management of pain is happening right now. That is what we cannot afford to miss.

Having said all of that, what do we do for a problem that is huge? First of all, all governments, all provinces shy away from a comprehensive strategy on pain. For what reason? "My God, it will be very expensive." Well, you don't establish new programs to clean up the mess without spending, but I would say to you, because I'm very fiscally responsible and I have operated on a government shoestring for 20 years—mind you, this government and all the other governments have never given an increase in my program for 10 years. But that's irrelevant; nevertheless, I survived. However, when you look at that, you have a waste in the system that you have to correct. First of all, look at the system where you are and cut the fat, rearrange resources, reallocate resources, and then when you look at a comprehensive pain strategy, from the primary care level all the way to the subspecialty clinics, go in steps. Look at the landscape first, all of the elements, all the players, all the stakeholders. Connect the dots. Never put a strategy in place if you

don’t have fiscal responsibility and if you don’t have outcome measures. If you don’t have metrics, if you don’t have performance indicators to make sure that the thing you put in place works, don’t put it in place.
This is indeed a complex issue, but it can be accomplished across a chronic disease model, very carefully bringing on the stakeholders.
The last thing that I want to tell you, because I’m about to finish: Don’t think you’re inventing the wheel or reinventing the wheel. Alberta: The Calgary region has already had a comprehensive strategy for 16 years. We are lucky to have imported from Calgary one of the godfathers of this strategy, who is now a permanent resident of Ontario. So there are others who have done that. Quebec has almost the form of an octopus in a very comprehensive strategy. Look at other jurisdictions in Canada. Don’t reinvent the wheel. It is possible that things can be done. They need care. They need comprehensive management from the bottom all the way to the top. What you have to ask is not only what it’s going to cost us to do it, but what it’s going to cost us if we don’t do it.
Thank you very much. I finished in time, sir.
The Chair (Mr. Shafiq Qaadri): Thank you, Professor Mailis-Gagnon. We only have 20 seconds a side, beginning with the PCs.
Ms. Sylvia Jones: Thank you.
The Chair (Mr. Shafiq Qaadri): Madame Gélinas.
Mme France Gélinas: What would you like to see as an outcome measure?
Dr. Angela Mailis-Gagnon: As an outcome measure, I would like to see, for example, the number of patients who are treated at the primary care level who would never need a clinic like mine. I would like to see—just to get a primary care understanding of what pain they have and what percentage of these people will go into—
The Chair (Mr. Shafiq Qaadri): Thank you.
Mrs. Liz Sandals: Actually, I had the same question, so keep going.
Dr. Angela Mailis-Gagnon: Yes. That would be one of the outcome measures you would like to have, and then there should be other kinds of metrics. For example, if you are going to put in place comprehensive pain teams, establish in advance what are the standards and credentials for these kinds of teams. When you establish them, find out what kind of people they treat, how many times they need to treat them, do they keep a revolving door, going there forever, and find out—
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals, and thank you, Professor Mailis-Gagnon, for your deputation. As I did mention earlier, please feel free to submit any further questions or comments in writing to the committee.

REGISTERED NURSES’ ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I’d now invite our next presenters, Ms. Cava and Ms. Mulrooney of the RNAO, the Registered Nurses’ Association of Ontario, to please come forward. Welcome, and I’d invite you to please begin now.
Ms. Maureen Cava: Good afternoon, and thank you. My name is Maureen Cava, and I’m a member of the board of directors for the RNAO. With me today is Lynn Anne Mulrooney. She is the senior policy analyst for RNAO.
RNAO is the professional association for registered nurses who practise in all roles and sectors in the province. We represent over 30,000 registered nurses, and our mandate is to advocate for healthy public policy and for the role of the registered nurse in enhancing

the health of Ontarians. We appreciate the opportunity to present this submission on Bill 101 to the Standing Committee on Social Policy.

Bill 101, if passed, would allow the Ministry of Health and Long-Term Care to collect, monitor and analyze, through an electronic database, information related to prescription narcotics and other controlled substances dispensed to anyone in Ontario.

RNAO supports Bill 101 as an important first step to address the urgent situation causing death and misery for so many individuals, families and communities across the province. RNAO recommends attentiveness to safeguards to ensure confidentiality and privacy. These elements are essential for all Ontarians when personal health data is collected. There is even more at stake for those with actual or perceived mental health and addiction challenges, who already experience societal stigma and discrimination. RNAO also urges further consultation with rural, remote and aboriginal communities and their front-line clinicians in order to address challenges that could hinder the bill's effective implementation.

RNAO congratulates the Select Committee on Mental Health and Addictions for their attentive listening in their travels across the province, and recommends implementation of the approaches in their thoughtful report, Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians.

As the committee found, and as too many inquests have confirmed, there is no coherent mental health system to help the one in five Ontarians living with mental illness and addiction problems. It is not surprising that only three in 10 Ontarians living with mental illness and addictions problems are able to access any help. This is because Ontario and Canada rank lowest of OECD countries in terms of spending on mental health services. Ontario cannot afford not to act on a comprehensive mental health and addiction strategy, because the human toll touches almost every family. For this reason, RNAO continues to advocate for the development of an integrated and seamless mental health care system for all Ontarians, with interprofessional collaboration, delivered at the individual's preferred location. Special consideration should be given to the following groups: members of aboriginal communities, older adults tackling both new and ongoing mental health and addiction challenges, people from racialized communities, new Canadians, people with disabilities, discharged members of the Canadian Forces, children and youth requiring increased and enhanced mental health and addiction services, inmates in correctional facilities, and rehabilitated ex-convicts.

1640

The title page of the provincial narcotics strategy describes it as "Ontario's plan to reduce the misuse and abuse of prescription narcotics and other controlled substances." Although there is a stated benefit that the strategy will "ensure those with legitimate medical needs get the medications they require," there is a danger that a focus on narcotic abuse could hinder access to essential pain control.

The WHO has observed that 50 years' focus on the prevention of drug abuse has resulted in severe under-treatment of severe pain in more than 150 countries, both industrialized and developing. The New York Times, for example, recently reported on how patients in nursing homes "have become unintended casualties in the war on drugs because of a new level of enforcement intended to prevent narcotics from getting into the wrong hands." Canada and the US both rank ninth in the Quality of Death Index that compares end-of-life care across 30 OECD countries and 10 selected others. The United Kingdom ranks

first in the quality of end-of-life care as a result of its hospice care network, statutory involvement in end-of-life care, access to painkillers, training availability, public awareness and physician-patient transparency.

At a recent meeting of the RNAO, a number of nursing leaders expressed concern about inconsistent and inequitable access to palliative care services across the province. Compassionate, knowledgeable, skilled nurses spoke of their frustrations, knowing that those in their care were not receiving the care they felt ethically obligated to provide at the same time as they were struggling with long hours, disproportionately low wages and the need to engage in fundraising for what should be essential health services.

These system gaps, including difficulties with poor pain and symptom management, have also been documented by the Ontario end-of-life strategy and Cancer Care Ontario. Nurses expert in palliative care are skilled at a wide variety of comfort and care measures to address pain and other symptoms. Narcotics are one of the essential interventions for pain control. Lessons from extended independent nurse prescribers in palliative care in the UK is an area worth exploring for its potential contribution to holistic, seamless palliative care for patients as well as for insight into challenges.

While it is obvious that we have a societal responsibility to ensure that those who are dying are as comfortable as possible, we must also be responsible in addressing the needs of the up to 3.6 million who live with chronic pain in the province. People in pain need to be able to access what they need without stigma. This includes people with addiction and mental health issues who also have pain control needs. While there may be a temptation to try to divide people into two distinct groups—legitimate patients with pain and abusers—reality is not that neat.

We would like to invite the Standing Committee on Social Policy to read our full set of recommendations along with our detailed rationale in our written submission.

The RNAO thanks the Standing Committee on Social Policy for the opportunity to present our feedback on Bill 101 and the opportunity to improve the health and wellness of all Ontarians through bold leadership on a comprehensive mental health and addictions strategy, as well as improving access to appropriate and humane pain control.

The Chair (Mr. Shafiq Qaadri): Thank you very much. We'll begin with the NDP—about a minute or so—Madame Gélinas.

Mme France Gélinas: I was most interested by your comment regarding end-of-life and palliative care fundraising for what should be essential health services. Do you mean that the palliative care hospice is not getting full operational funding? Is that what you were referring to?

Ms. Maureen Cava: That's correct.

Mme France Gélinas: Thank you.

The Chair (Mr. Shafiq Qaadri): Merci, Madame Gélinas. Ms. Sandals.

Mrs. Liz Sandals: I also was interested in your comments on palliative care. Are there any good guidelines that you're aware of around pain management for palliative care? Clearly, that's something that is part of education. We need to be working with physicians.

Ms. Maureen Cava: I do know that there are a number of different resources for palliative care guidelines. If there is a specific one that is used across the board, I'm not aware of it, but certainly we could provide that to you if that's something you're interested in.

Mrs. Liz Sandals: It seemed to me that as we look at education for NPs and people who are working in palliative care, it's really important that we figure out how to do that well.
Ms. Maureen Cava: Right.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. Now to the PCs: Ms. Jones.
Ms. Sylvia Jones: In the second page of your submission, which was excellent, you made a comment urging further consultation in the north and in rural and aboriginal communities. That opportunity for consultation was removed from us earlier this afternoon when the government removed the opportunity for travelling to the north. Why was it important for you to mention that in your submission? Do you see unique challenges that we need to hear about?
Ms. Maureen Cava: Certainly, I do think there are unique challenges in the north. There are many different challenges. One I'll highlight is just access to service. When you think about living in a northern community, albeit small, with perhaps not the resources and physicians and/or other health care providers—nurses, individuals who can deal with mental health issues—there is a huge problem with access to services. That's one of them. There are many other issues, but that's the one I'll highlight because I know time is limited.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Jones, and thanks to Ms. Cava and Ms. Mulrooney for your deputation on behalf of the RNAO.
DR. RICK GLAZIER
The Chair (Mr. Shafiq Qaadri): I'd invite our next presenter to please come forward, Mr. Glazier. How are you? Welcome, and please be seated. Please begin now.
Dr. Rick Glazier: Thank you very much. Good afternoon. I want to thank the members of the committee for giving me this opportunity to speak to you this afternoon. I will leave some notes afterwards. I regret I didn't get you notes ahead of time.
I'm speaking to you in my role as the father of an 18-year-old son, Daniel, who died of an unintentional oxycodone overdose in July 2009. I'm also a family physician in downtown Toronto, and therefore a prescriber of narcotic medications. I'm also a health services researcher here in Toronto who is deeply concerned with the connection between evidence, medical practice and health policy.
I first want to state that I strongly and fully support the provisions of Bill 101 and of the narcotics strategy. I wish to raise two further issues to consider in relation to that bill.
The first issue is that the collection of prescribing information for narcotics and other controlled substances is a necessary step to control widespread misuse of these medications and to prevent deaths. This step is insufficient, however. It is vital that this information be available in real time to prescribers and dispensers so that inappropriate and dangerous prescriptions are not written and, if written, are not filled. This would require regulations allowing and compelling prescribers and dispensers to consult an up-to-date listing of the narcotics and controlled substances prescribed to the patient before they wrote a prescription for or dispensed such a medication. It would also require regulations establishing these procedures as the expected standard of care and allowing oversight and discipline by the appropriate regulatory colleges if a member did not maintain this standard of care.
The second issue is that of treatment. To our dismay, my family and I found that no treatment facilities for Daniel's problems were available in Ontario in the needed time frame. My wife and I, both health professionals, faced three years of constant

bureaucratic and financial challenges in an attempt to obtain appropriate treatment for our son. No Ontario families should be forced to endure what we did just to obtain needed medical treatment for a sick child.

In Daniel's case, the problem was concurrent disorder: both a serious mental health problem and a serious substance use problem. This is an all-too-common combination for which treatment facilities for adolescents are almost entirely lacking in Ontario.

Investment in residential and outpatient treatment facilities for mental health problems, substance use problems and their combination is badly needed for all affected age groups in Ontario. I would like to see that investment as an integral part of the implementation of the narcotics strategy.

I appreciate this opportunity to speak with you about these matters, which are so very important to me personally and professionally.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Glazier. We have lots of time, with I guess two minutes per side, beginning with Ms. Sandals.

Mrs. Liz Sandals: Thank you so much for sharing your story with us and becoming such an advocate.

I have a couple of questions. The business of having prior prescription information available: If we were going to amend an act, that may not be something that is going to be instantly available. But what you would like to see is for us to at least put the legislative placeholder so that as the e-record capacity increases, it would be available in the future. Is that your thinking?

1650

Dr. Rick Glazier: My reading of the bill suggests that the minister does have the power to collect and release this information appropriately. The bill, I think, allows for that. Providing this information in real time to the prescribers and dispensers would be the only way to prevent these prescriptions from being written at the time that they're presented.

Mrs. Liz Sandals: So what you're asking for, then, is that the information which the bill authorizes the minister to collect, which is somewhat after the fact, at least be made available to the physician who's prescribing in the future.

Dr. Rick Glazier: Yes. I am able today, as a physician, to access the Ontario drug benefit plan prescriptions and check them before I write a prescription. So that system is actually already in place and already available to me, and I believe already available to pharmacists and in Ontario's emergency departments.

This would expand that to all prescriptions. It would also compel prescribers and dispensers—that would be my strong preference—to check that registry before writing or filling those prescriptions.

Mrs. Liz Sandals: Okay, thank you for clarifying what you're looking for, there. That's very helpful.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals. To the PC side: Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Dr. Glazier, for your advocacy on this. We take very seriously the comments that you're making.

I gather, with respect to Ms. Sandals' question, that it wouldn't take too much, then, in order to tweak the system so that it could provide that information in real time? That can be done? We could build that in fairly easily?

Dr. Rick Glazier: That's correct. The current system does provide access to an awful lot of prescriptions written in Ontario.
Mrs. Christine Elliott: And the other question, just on your comment with respect to treatment facilities—that is something that we did hear a lot from parents during the committee hearings on the select committee, so certainly there are recommendations in that regard. We intend to press for full implementation of the report.
Dr. Rick Glazier: I'm pleased to hear that.
The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. Madame Gélinas.
Mme France Gélinas: Along the lines of what you just heard, would you know if treatments are now available where you live, if then was now?
Dr. Rick Glazier: My understanding is that treatments for adolescents for concurrent disorders are currently in the same state—very close to the same state. There are a couple of private treatment facilities, not funded by OHIP, that have opened in Ontario in the ensuing years. Access to those remains poor. Waiting lists remain very long. The Centre for Addiction and Mental Health, for example, does treat concurrent disorders but not in adolescence. That's the province's leading facility, but it does not treat adolescents for these problems.
Residential treatment is very, very difficult to get, and aftercare for residential treatment. We found, in the system, that we could not get the combination of addiction and mental health treatments in the same health professionals or the same centre, and that is true today.
Mme France Gélinas: If you're not comfortable sharing, you don't have to answer the next question. Do you know how your son was getting the OxyContin?
Dr. Rick Glazier: Yes, I can answer that. My son Daniel was not a habitual narcotics user and we do not know how he got the medication. There was an autopsy. He had toxic levels in his blood, at the autopsy, of oxycodone. He was found with a bottle of OxyContin in his room, and it is our belief that he bought it on the streets. He did express intents at various times to do that, and unfortunately we believe that's what he did. So it is the wide availability of drugs like Percocet and OxyContin on the street that I believe contributed to his death.
Mme France Gélinas: Thank you.
The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Dr. Glazier, for coming forward.
Dr. Rick Glazier: Thank you very much.
DR. ALLAN GORDON
The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, Dr. Allan Gordon, to please come forward.
You've seen the drill, Dr. Gordon. I invite you to please begin now.
Dr. Allan Gordon: Mr. Chairman and members of the standing committee, my name is Allan Gordon and I am a neurologist and director of the Wasser Pain Management Centre at Mount Sinai Hospital in Toronto, and an associate professor at the University of Toronto.
The Wasser is an internationally recognized, multiprofessional academic pain management centre providing multimodal, multidisciplinary clinical care to chronic pain patients from all over Ontario and the rest of Canada, with about 10,000 patient visits a year. We are also involved in research and education in chronic pain. We advocate and

practice pain assessment and diagnosis and risk assessment. We use a wide range of pharmacotherapy agents, various interventional procedures, traditional Chinese medicine, psychological treatments and self-management. We use Telehealth and are developing Web-based education teachings, and we do it all on a shoestring; maybe a slightly smaller shoestring than Dr. Mailis, because we don't get the kind of funding that she gets from the ministry. But we do operate on a shoestring.

Our education mandate in chronic pain is at the undergraduate, postgraduate and community level, with health care professionals from Ontario and well beyond. We give lectures and provide preceptorship training for health care professionals.

We provide tertiary and quaternary care to men and women with pain and addiction and dependency issues. We treat intractable headache; failed back syndrome; excruciating pelvic, genital and abdominal pain; temporomandibular disorders; fibromyalgia; neuropathic pain such as shingles; and diabetic nerve pain.

According to a 2008 Nanos survey, 18% of Canadians suffer from moderate to severe chronic pain. This means that in Ontario, up to 2.5 million men and women have moderate to severe chronic, non-cancer pain. Various Canadian studies have shown that direct and indirect costs of moderate to severe chronic pain range between $10,000 to $15,000 per patient per year, yielding a $20-billion or more expenditure for Ontario citizens.

Pain is a real disease. Try it. You won't like it; I guarantee that.

We all agree that Ontario faces a serious problem with the inappropriate use of prescription opioids and that something must be done. Bill 101 is a good start at addressing this problem. However, Bill 101, as it currently stands, may not be enough. The bill seems to assume that the problem arises from opioid medications prescribed by doctors and dispensed by pharmacists.

But this is only a part of the problem. The bill does not seem to provide a comprehensive surveillance system aimed at discovering drug thefts; diversion practices; poison control centres, what happens there; stealing drugs from grandma, which is a new way of getting medication; forgeries of prescriptions; drugs imported from other jurisdictions; or even following the flow of medication from manufacturer to distributor to pharmacy.

A system like the US RADARS system is necessary, and we could model a made-in-Canada RADARS system, possibly paid for by the pharmaceutical companies, as occurs in the US. This is a system that does significant surveillance. It looks for noises in the system.

The bill also does not state what will be done with the information, with the data, how it will be analyzed and what uses will be made of this information. It does not look at the overall comprehensive management of pain and pain and addiction. Would this not be an ideal time to do it right and collect enough information to make the system right?

If we truly want to stop the inappropriate use of prescription narcotics, we must address some of the key factors that have caused these medications to be over-prescribed, flooding our community and fuelling illegal activity. Ontario needs to research, develop and embark upon a comprehensive pain strategy in tandem with a narcotics strategy in order to treat chronic pain more effectively, to better use health system resources and to decrease the social costs of the illegal use of pain medications.

I was fortunate to be a member of the working group that authored the CPSO document entitled Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis.

This document shows the need for a comprehensive pain strategy and the provision of more addiction expertise in Ontario. I would urge the members to read this document and act upon it. It is available on the CPSO website. I'm not sure if you have it.

We also ask that the government seek input from health care providers and patients on the development of this comprehensive pain management strategy. We do appreciate this opportunity to provide input through this committee hearing. However, many relevant stakeholders such as physicians with heavy clinical loads or patients who need to be heard will find it difficult to present on such short notice. These will be valuable opinions that can help to improve this legislation and the narcotics strategy going forward.

I urge the government to make chronic pain a priority, to increase the number of hearings and to travel outside of Toronto to accommodate regional issues. Northwestern Ontario, southwestern Ontario, southeastern Ontario, the nation's capital and even Toronto the Good are all crying out to tell you what their stories are about how they deal or do not deal with chronic pain—a human and economic disaster in the making.

My colleagues and I in the academic and general pain communities have much information and many ideas to give. Put chronic pain on the front burner: Consider it a disease complex, a series of debilitating conditions affecting 18% of the population. Like Rodney Dangerfield, pain gets no respect, unless you happen to have it, or you are annoyed that your employee is laid up with a migraine or fibromyalgia, or you are involved in the care of a relative with pain. Listen to health care practitioners, but even more important, listen to the pleas, stories and sufferings of the many people of the province who are touched by pain, with all its economic and humanistic costs. You may have to go outside of Toronto or appoint someone to do it for you. Certainly, a more comprehensive review is clearly necessary. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you. A minute per side, the PCs beginning, Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your comments. We really appreciate the fact that you commented on the need to get the perspectives across the province. I suppose you've heard that we are not going to be travelling with this bill; that, I think, is going to be a problem because we're not going to get that regional perspective.

But the chronic pain strategy and the comments that most presenters have made today indicate that this is a good piece of a very big picture that we need to take a look at and that we need to keep going with this.

I just want to assure you that consequent upon the report of the Select Committee on Mental Health and Addictions, and we're hopeful of Mental Health and Addictions Ontario being created, we'll be able to get into those issues, the development of a chronic pain strategy to go along with the narcotics strategy. So we will continue. We are listening. I just wanted to give you that feedback.

Dr. Allan Gordon: That's welcome news. Thank you.

The Chair (Mr. Shafiq Qaadri): Madame Gélinas.

Mme France Gélinas: I'd also like to know why you included travel outside of Toronto? What would you figure we would gain by that?

Dr. Allan Gordon: I've travelled all over the province, lecturing, seeing people. The problem in the northwest part of the province is horrible. It's chronic pain; it's underserviced. There are drugs all over the place. They're very concerned. You know, 22% of women going into the delivery room in Thunder Bay are on oxycodone—22%, a

huge number. There are pockets in the Chatham area, Ottawa and Durham county. You need to actually see what's going on. You need to talk to the practitioners, the ones whose licences have been suspended a little bit because they've been using opioids, but also the patients who have chronic pain. That's why I put it in.

Mme France Gélinas: Thank you.

The Chair (Mr. Shafiq Qaadri): Ms. Sandals.

Mrs. Liz Sandals: You mention at the bottom of your presentation that we should collect enough information. Are you saying the committee should collect information or that under Bill 101 we should be collecting additional information? Are you suggesting that the bill should be amended?

Dr. Allan Gordon: That's too upper for me to really think about. All I know is that if we're going to make changes, we have to know what's really going on. We have to get real-time surveillance of what's happening in the community. Who's dealing drugs? How do patients get their drugs? Who's selling drugs? What happens in poison control centres? What happens in emergency departments? We don't have any of this information. We need something that will do that.

Simply looking at prescriptions and looking at what happens I don't think is enough. Actually, when I'm looking at volume, should so many drugs be prescribed all at once? Should 200 OxyContin tablets be prescribed all at once? They should be limited. So there's a number of things that we need to know.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sandals, and thanks to you, Dr. Gordon, for your deputation.

That is the final deputation of the day. Just to remind members of the committee, amendments must be filed by 10 a.m., Friday, October 22, as the new number 10 point amendment and number 11. We'll be meeting here for clause-by-clause consideration on Monday, October 25 and October 26.

If there's no further business, the committee is adjourned.

The committee adjourned at 1702.

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CONTENTS
Monday 18 October 2010