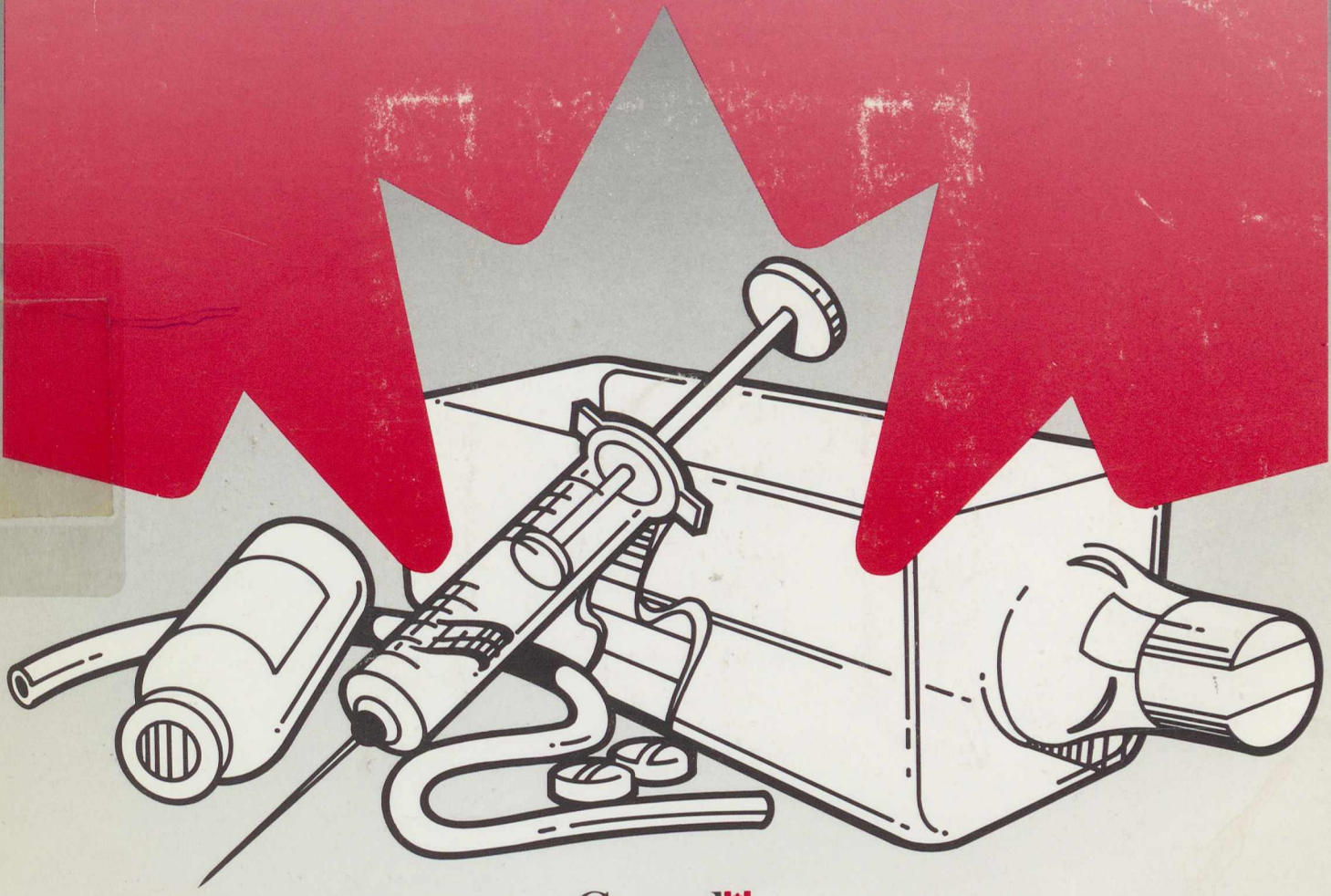
HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

"BOOZE, PILLS & DOPE"

Reducing Substance Abuse in Canada.



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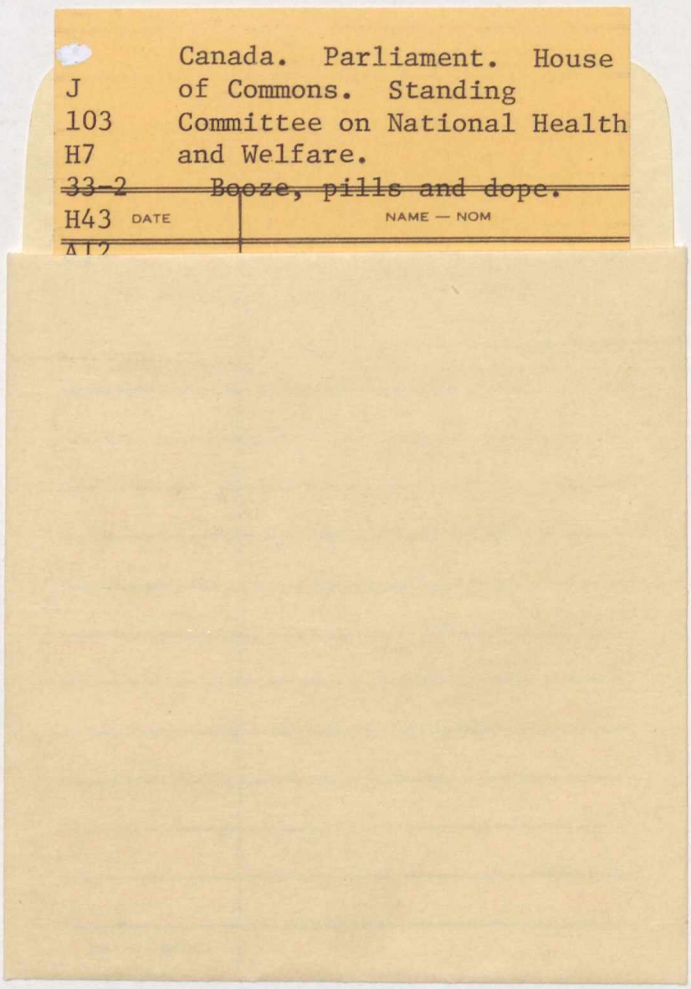

HOUSE OF COMMONS

Issue No. 28

Tuesday, August 4, 1987
Wednesday, August 5, 1987
Tuesday, September 1, 1987
Thursday, September 17, 1987

Chairman: Bruce Halliday

CHAMBRE DES COMMUNES

Fascicule nº 28

Mardi le 4 août 1987
Mercredi le 5 août 1987
Mardi le 1 septembre 1987
Jeudi le 17 septembre 1987

Président: Bruce Halliday

Minutes of Proceedings and Evidence of the Standing Committee on

NATIONAL HEALTH AND WELFARE

Procès-verbaux et témoignages du Comité permanent de la

SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL

RESPECTING:

In accordance with its mandate under Standing Order 96(2), a study of Alcohol and Drug Abuse in Canada.

INCLUDING:

The First Report to the House

CONCERNANT:

En conformité avec son mandat en vertu de l'article 96(2) du Règlement, une étude de l'abus de l'alcool et des drogues au Canada.

Y COMPRIS:

Le Premier Rapport à la Chambre

Second Session of the
Thirty-Third Parliament
1986-1987

Deuxième session de la
Trente-troisième législature
1986-1987

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THE STANDING COMMITTEE ON NATIONAL HEALTH AND WELFARE

has the honour to present its

FIRST REPORT

In accordance with its mandate under Standing Order 96(2), your Committee agreed to study alcohol and drug abuse in Canada. Your Committee has heard evidence from individuals and organizations in the field of addictions and urges the Government to consider the recommendations contained herein.

ACKNOWLEDGEMENTS

The Standing Committee on National Health and Welfare wishes to express its appreciation to the individuals and organizations who cooperated with this study of substance abuse. The Committee is most grateful for the contribution of witnesses who appeared, often on very short notice, at public hearings in Ottawa, Toronto, Vancouver, Victoria and Edmonton.

We wish to thank the Alcoholism and Drug Addiction Research Foundation in Toronto and the Nova Scotia Commission on Drug Dependency in Halifax who served as hosts to the Committee and as expert witnesses.

The Standing Committee acknowledges the excellent work of Paul D. Rosenbaum, Research Branch of the Library of Parliament, whose expertise, patience and dedication facilitated the progress of this work; and of Garth McNaughton, formerly of the Library of Parliament, who provided research and background papers during the initial stages of the inquiry.

The Committee expresses its appreciation to Patricia Russell, Clerk of the Committee, for excellent service in the management of the administrative and logistical aspects of the study.

Special thanks are extended to Gilles Grondin, M.P. and Lorne McCuish, M.P., who travelled with the Committee, and whose participation was appreciated.

Finally, the Committee wishes to thank the staff of the Committees and Private Legislation Directorate, Dominique Soudet of the Translation Bureau of the Secretary of State, June Murray, from the Library of Parliament, and Georges Royer, editors of the text, and the other services of the House of Commons which have provided assistance in this study.

BOOZE, PILLS AND DOPE: REDUCING SUBSTANCE ABUSE IN CANADA

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Bruce Halliday, M.P.
Chairman

OCTOBER 1987

REPORT OF THE HOUSE OF COMMONS STANDING COMMITTEE ON NATIONAL HEALTH AND WELFARE

BOOZE, PILLS AND DOPE: REDUCING SUBSTANCE ABUSE IN CANADA

INTRODUCTION

In December 1986, the House of Commons Standing Committee on National Health and Welfare began its study of drug abuse in Canada. While the initial focus of the examination was to be the illegal use of drugs, in response to consistent testimony heard by the Standing Committee the scope of the study was soon broadened to encompass other forms of substance abuse, both legal and illegal, including the abuse of alcohol, but excluding tobacco.

Throughout this report, the use of the terms "drug abuse" and "substance abuse" will refer to the abuse of any drug, whether licit or illicit. The terms will be applied to the abuse of "street drugs" such as cannabis and cocaine, use of solvents, abuse of prescription drugs and the abuse of alcohol.

In its hearings across Canada, the Standing Committee heard from experts in the field of addictions who voiced their concern about the abuse of all drugs, including prescription drugs and alcohol. In oral testimony and in briefs presented to the Standing Committee, witnesses expressed special concern about the extent and severity of the abuse of alcohol which, it became clear from these representations, is the most widely abused drug in Canada. It is also the most damaging in terms of prevalence of drug-related illness, premature death, accidents, family disruption, violence and other social and personal problems.

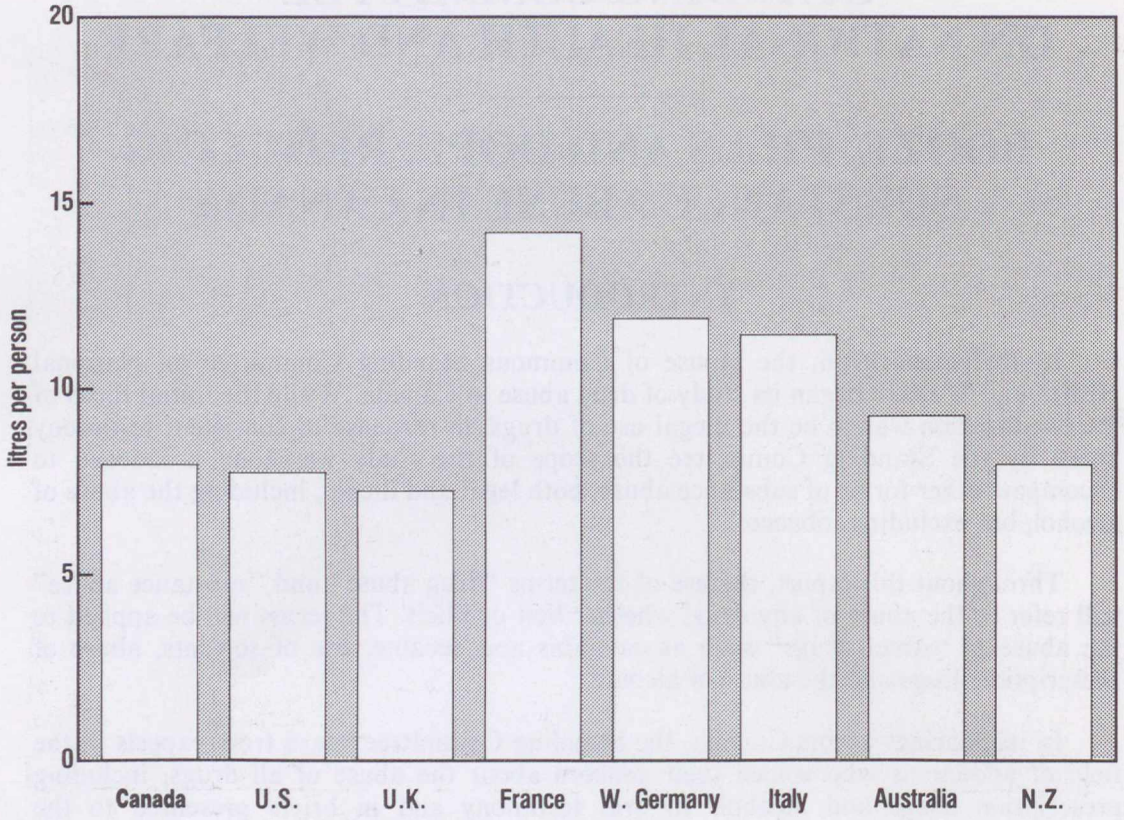
Concern over the extent of alcohol abuse was repeatedly expressed by health and social services professionals, addictions workers, those in the provincial addictions commissions, and parents' groups and educators appearing before the Standing Committee. This concern was supported by the substance abuse statistics presented to the Standing Committee by researchers and program planners from provincial and federal agencies.

Dr. Reginald Smart, Director of Prevention Studies at the Alcoholism and Drug Addiction Research Foundation (Addiction Research Foundation or ARF), commenting on per capita alcohol consumption told the Committee:

> Canada ranks about twentieth out of 129 countries for which we have data on alcohol consumption. I think we want to constantly keep in mind that alcohol is the most important drug in Canada. It is the most important drug we have to worry about on all levels; on the level of epidemiology, on the level of education, on the level of treatment.

Comparisons in average alcohol consumption in 1984 between Canada and selected western countries are presented in Figure 1. Self-reported use of drugs by Canadian adults is presented in Figure 2.

Figure 1:
Per capita alcohol consumption for selected western countries, 1984



Source: Brewers Association of Canada

In a 1985 survey of Ontario high school students conducted by the Addiction Research Foundation, approximately 70% of students in grades 7 through 13 reported some consumption of alcohol within the last year.[1,2] Among these alcohol users, most of whom reported alcohol use within the last month, almost half reported having consumed five or more drinks on a single occasion. No other drug in the survey approached alcohol in prevalence of use. But, as with almost all other drugs of abuse, Dr. Smart reported that there has been a recent decline in the rates of alcohol use among students. Results of these surveys are summarized in Figure 3.

Concern was raised by several witnesses about the tendency of Canadians to minimize alcohol's potential for harm. Many Canadians do not consider alcohol to be a "drug". Mr. Howard Greenstein, Executive Director of the Saskatchewan Alcohol and Drug Abuse Commission, indicated to the Standing Committee:

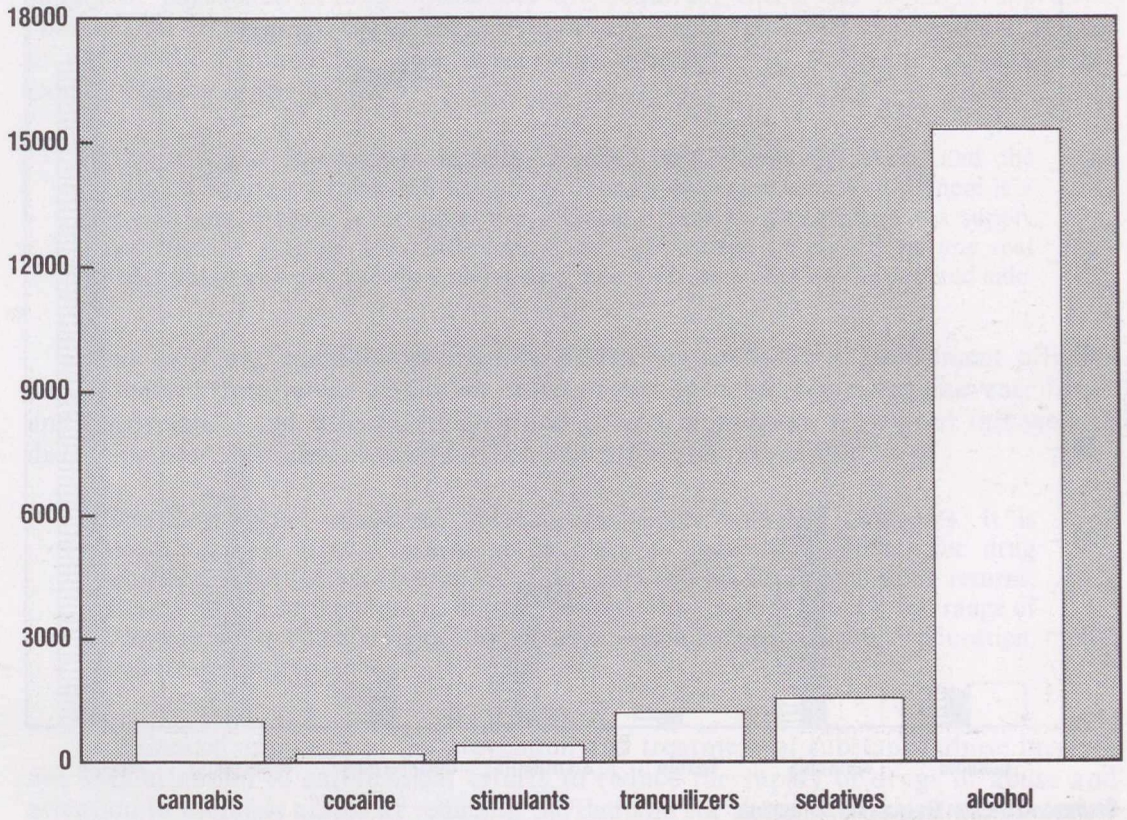
> It [cannabis] tends to receive the most media attention. I think we also have to consider the fact that alcohol is an accepted drug of use within this country and... alcohol use is in fact promoted very vigorously in all the media. Many parents for several years were quite willing to tell their kids, "Look, I do not care if you drink, just do not use drugs".

---

[1] R.G. Smart, M.S. Goodstadt, E.M. Adlaf, M.A. Sheppard and G.C. Chan, "Trends in the Prevalence of Alcohol and Other Drug Use among Ontario Students: 1977-1973", *Canadian Journal of Public Health*, 76, May/June 1985, p. 157-162.

[2] R.G. Smart, E.M. Adlaf and M.S. Goodstadt, "Alcohol and Other Drug Use Among Ontario Students: an update," *Canadian Journal of Public Health*, 77, Jan/Feb 1986, p. 57-58.

Figure 2:
Self-reported licit and illicit drug use by adults in past 12 months, in thousands of users



Source: Health & Welfare Canada

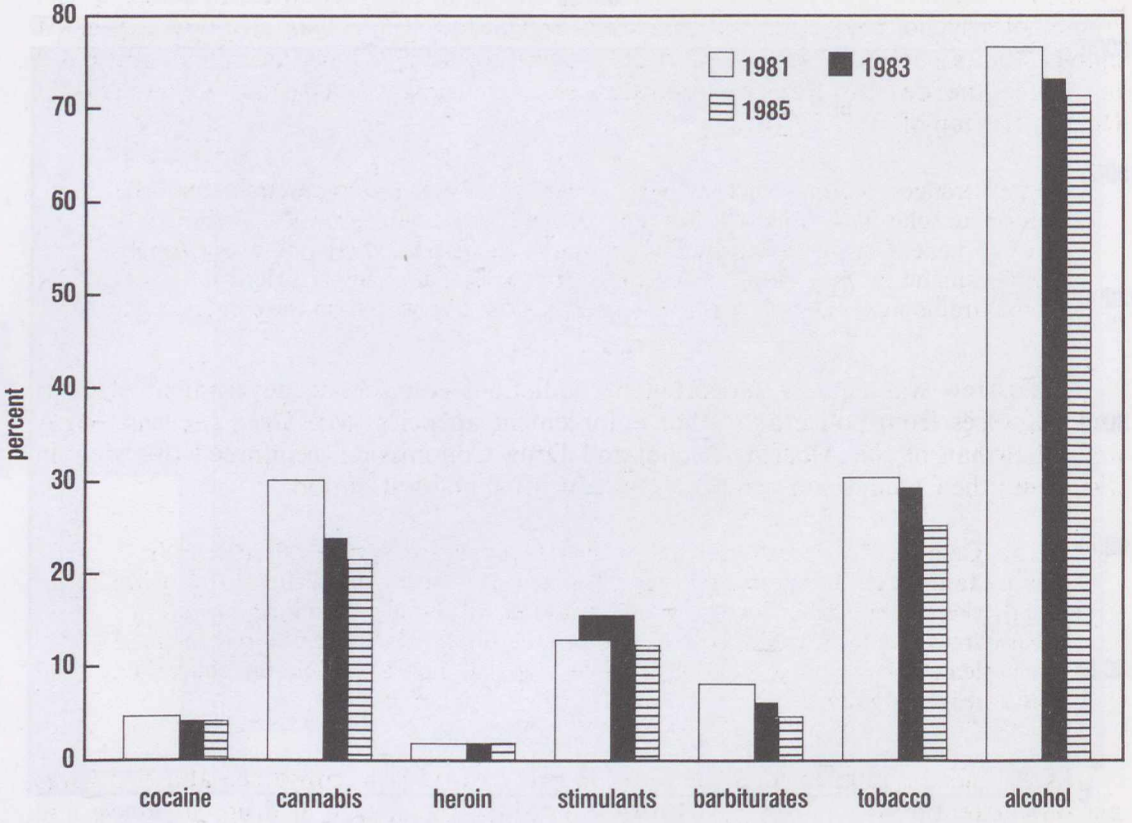
The now widespread use of alcohol by Canadian adolescents is, for many, cause for concern. In addition, the Standing Committee heard testimony about the growing number of young people experiencing alcohol-related difficulties in their personal lives. This is reflected in the number of young people being referred for treatment because of the abuse of alcohol or multiple drug abuse.

While many witnesses expressed their concern about the extent of alcohol abuse in Canada, the Standing Committee was cautioned by some witnesses to consider substance abuse generally, rather than placing emphasis on any one particular drug. As Mr. Ross Ramsey, President of the Kaiser Substance Abuse Foundation, told the Standing Committee:

> The media would have us believe the problem in Canada is cocaine, heroin or whatever happens to sell, but these are not the problem. Instead, the problem is the use of mood-altering chemicals by our culture, and the most often and repeatedly used drug in Canada is alcohol. I am not saying that cocaine and heroin are not serious concerns, but if you focus a national drug strategy on those drugs, you are missing the boat.

The Standing Committee heard as well that the problem of substance abuse in Canada is increasingly a multiple drug problem. Evidence indicated the growing tendency for individuals to abuse alcohol along with other substances. For example, Mr.

Figure 3:
Prevalence of non-medical drug use, Ontario students grades 7 to 13



Source: Addiction Research Foundation

Neil Ruton, the Director of Stonehenge, a residential treatment facility for drug abusers aged 18 to 35, confirmed in a personal communication that the majority of Stonehenge clients are cross-addicted with alcohol. Recently, Stonehenge applied the Michigan Alcohol Screening Test (MAST) to its client population. MAST is a questionnaire which yields a numeric measure of alcohol involvement. The test indicated that 89% of the Stonehenge residents also had moderate to severe alcohol problems.

Representatives of the Addiction Research Foundation indicated that alcohol abuse places young people at increased risk of the abuse of other drugs. Many witnesses spoke of the growing number of multiple drug users in addictions treatment. These most often include abusers of alcohol along with other drugs, such as prescription tranquillizers or cannabis.

Addressing the need to consider substance abuse generally in prevention programs, Dr. Harold Kalant, of the Faculty of Medicine at the University of Toronto and the Addiction Research Foundation, stated:

> It makes no sense to take one drug or group of drugs in isolation. One has to look at the attitudes towards, and the factors underlying, the use of drugs of all kinds in order to be able to make sense of changes with respect to individual drugs.

Dr. Kalant went on to explain that it is the root causes of drug abuse that must be addressed, not the use of specific drugs.

The Standing Committee heard consistently from witnesses about the need to work toward a balanced approach to the reduction of substance abuse and resulting problems. While there was an understanding that legal controls aimed at reducing the supply of psychoactive drug substances are required, there was strongly expressed opinion that a successful reduction in drug abuse would rely most heavily on strategies to reduce the demand for these substances. According to Assistant Commissioner Donald Heaton of the RCMP:

> The strongest enforcement activity is really only a holding action, and the ultimate solution I think will have to be found somewhere else. And if there is a ray of hope, I see it in the area of preventive education. Drug abuse is a supply and demand activity. Law enforcement only affects the supply side in any real measurable way and I think a major emphasis must be placed on the demand side.

This view was equally supported by addictions counsellors, government officials and witnesses from police and other enforcement agencies. Mr. Greg Stevens, MLA and Chairman of the Alberta Alcohol and Drug Commission, reinforced this view in discussing the Commission's emphasis on education and prevention:

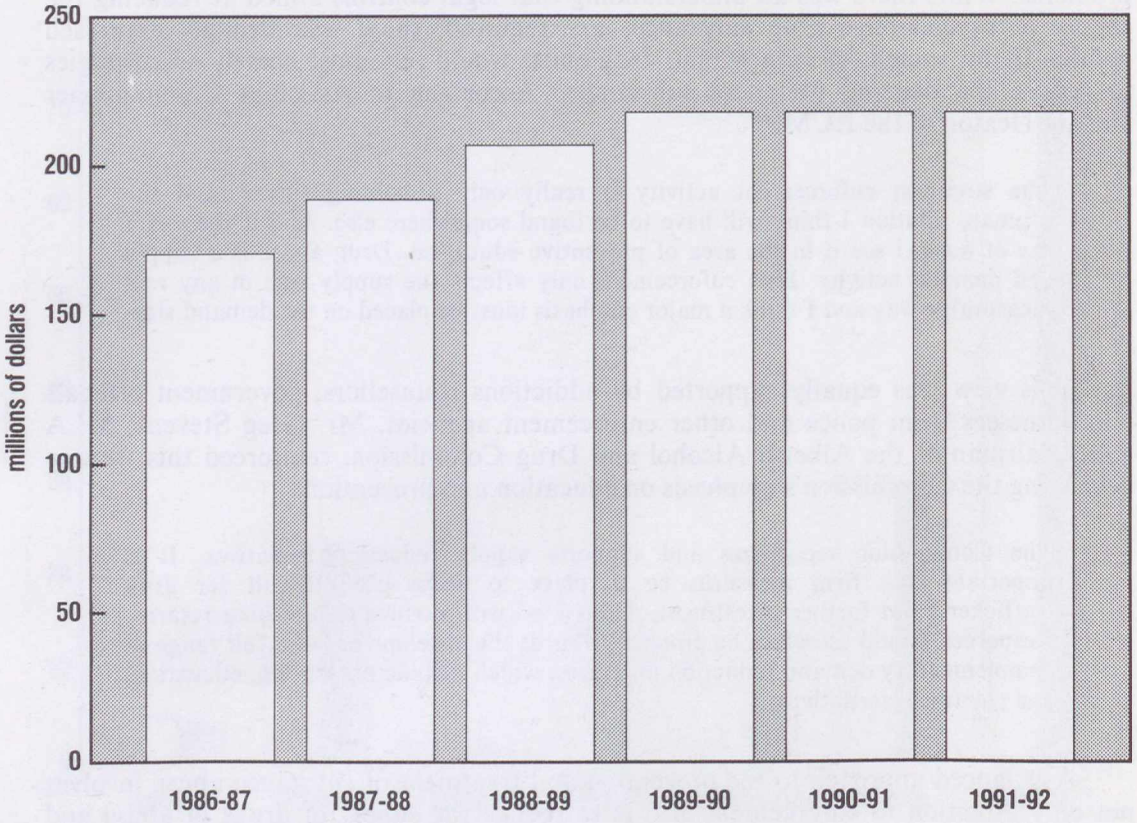
> The Commission recognizes and supports supply reduction initiatives. It is important that firm measures be in place to make life difficult for drug traffickers. But further investment of this kind will produce diminishing returns. Resources should therefore be directed towards the development of a full range of complementary demand reduction measures, which include prevention, education, and treatment initiatives.

A balanced approach to the prevention and treatment of substance abuse involves not only attention to enforcement efforts to reduce the supply of drugs of abuse and attention to methods aimed at reducing the demand for them; there must be, as well, a balance among the various strategies to discourage people from wishing to use drugs. These strategies include improved and more widely available prevention programs, new and expanded treatment programs, improved training of health care, social service, and addictions services workers, and research into preventing abuse and responding to abuse and related problems.

Across Canada, witnesses before the Standing Committee called for a renewed role for the federal government in this area. While it was understood that the responsibility for the direct provision of health care, prevention services and educational programs falls within the jurisdiction of the provinces, there was a general consensus that the federal government must work in collaboration with them. Through the development of appropriate funding and cost-sharing mechanisms, by providing coordination and leadership, by developing and disseminating model programs, and through improved legislation and enforcement, an active role for the federal government was suggested.

On 25 May 1987, the Government of Canada announced a new "National Drug Strategy", involving a five-year commitment of additional funds to combat drug abuse. Currently, the Government of Canada spends approximately $168 million annually in this area, including both supply control and demand reduction programs. Beginning with an additional $20 million in 1987-88, the National Drug Strategy will rise to $50 million by 1989-90 for an increase by year three of 29% over the previous level of expenditure (see Figure 4). The total five-year additional commitment will be $210 million.

Figure 4:
Effect of the National Drug Strategy on federal substance abuse expenditure



Source: Health and Welfare Canada

Additional funds will be provided to five departments of the federal government — National Health and Welfare, Solicitor General, Revenue Canada (Customs & Excise), Justice, and External Affairs (see Figure 5). These funds will be used in support of federal government programs and, in the case of funds to Health and Welfare Canada, also for transfer payments to provinces and community groups.

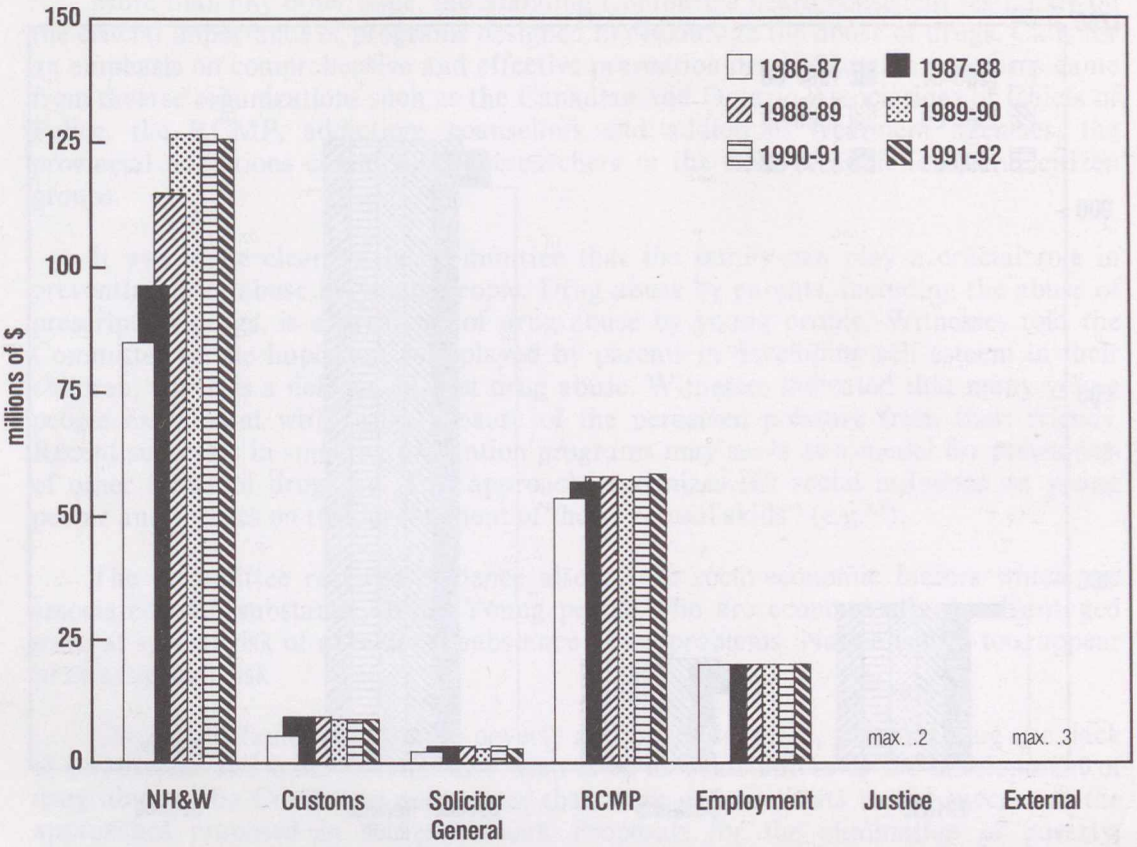
These are minimum estimates of measurable federal expenditures on drug and alcohol programs. They do not include certain direct and indirect costs which are difficult to measure; for example, it is not possible to attribute drug interdiction costs resulting from routine customs inspection or RCMP general law enforcement.

As in the past, federal government support for treatment and prevention will be primarily based on transfer payments to the provinces. The approximately $20 million transfer payments for 50-50% cost-shared alcohol and drug treatment under the Vocational Rehabilitation Program will be doubled by the third and subsequent years of the National Drug Strategy with incremental funding of an additional $20 million.

Most personnel resources within the federal government are in support of supply control programs. Of the 249 relevant person-years[3] in National Health and Welfare, 197 (79%) are in Dangerous Drug Regulation and Control with the remaining 52 in health promotion, prevention and treatment areas. Other federal government person-years are located in Canada Customs (123) and the RCMP (961).

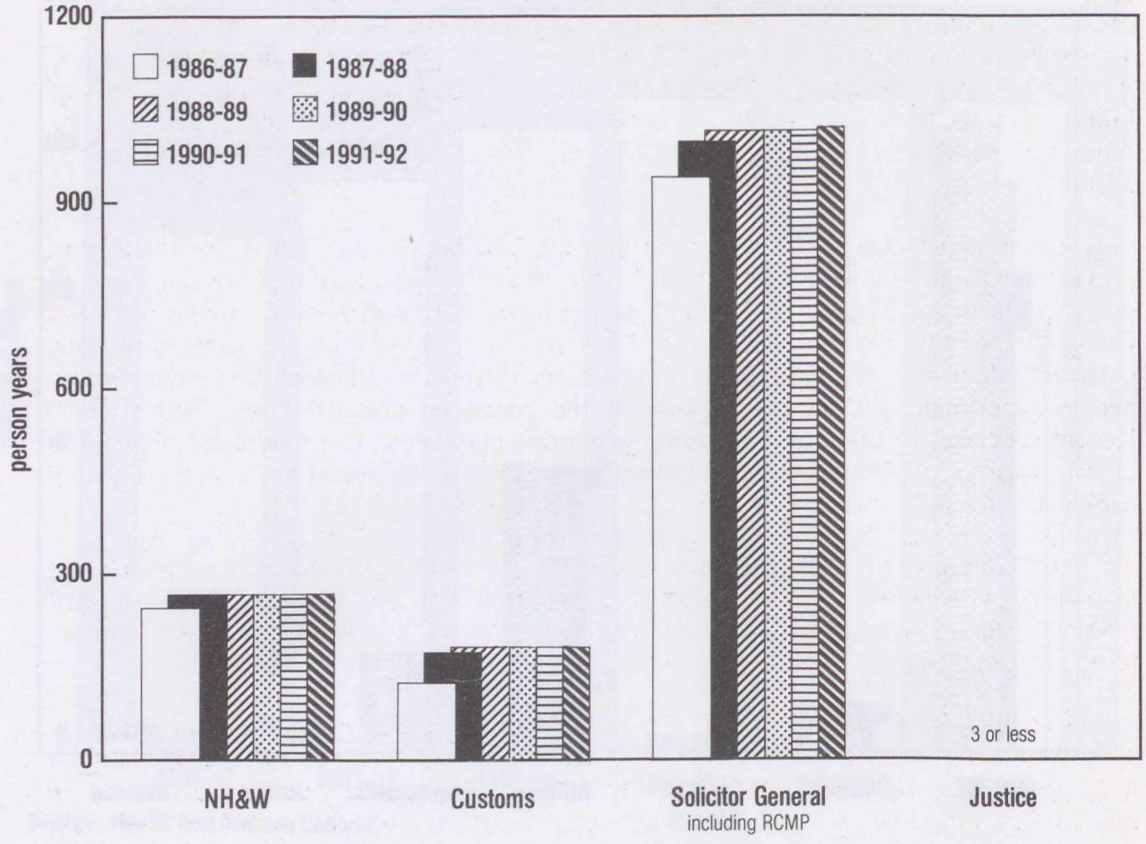
[3] A "person-year" is a unit for measuring human resources and refers to the employment of one person for one full year, or its equivalent.

Figure 5:
Effect of the National Drug Strategy on funding, by department



As can be seen in Figure 6, 182 new person-years will have been added to the federal government programs by the fifth year of the National Drug Strategy. These increases consist of 85 person-years in the Department of the Solicitor General (including 82 in the RCMP), 63 person-years in Customs, 31 person-years added to Health and Welfare Canada, and 3 to the Department of Justice.

Figure 6:
Effect of the National Drug Strategy on person-years, by department



Implementation of the National Drug Strategy presents challenges to the federal and provincial governments. It is essential that the proper balance between prevention and treatment on the one hand, and interdiction and enforcement on the other be maintained. Additional funds for detection, interdiction and enforcement will remain with the federal government. Funds in support of treatment and prevention programs will generally be transferred to the provinces. This will impose a special obligation on the federal government to ensure that transfer payments to the provinces in support of these programs maintain the proper balance between supply control and demand reduction. As treatment programs are cost-shared between the federal and provincial governments, the federal government must ensure the equitable distribution of these treatment and rehabilitation funds to programs where there is demonstrated need.

PREVENTION

More than any other issue, the Standing Committee heard consistent testimony on the crucial importance of programs designed to discourage the abuse of drugs. Calls for an emphasis on comprehensive and effective prevention drug education programs came from diverse organizations such as the Canadian and Ontario Associations of Chiefs of Police, the RCMP, addictions counsellors and addictions treatment agencies, the provincial addictions commissions, researchers in the field of addictions, and citizen groups.

It was made clear to the Committee that the family can play a crucial role in preventing drug abuse by young people. Drug abuse by parents, including the abuse of prescription drugs, is a predictor of drug abuse by young people. Witnesses told the Committee of the important role played by parents in developing self-esteem in their children, which is a defence against drug abuse. Witnesses indicated that many young people experiment with drugs because of the perceived pressure from their friends. Recent successes in smoking prevention programs may serve as a model for prevention of other forms of drug use. This approach recognizes the social influence on young people and focuses on the development of their "refusal skills" (e.g.[4,5]).

The Committee received evidence also of the socio-economic factors which are associated with substance abuse. Young people who are economically disadvantaged seem at special risk of developing substance abuse problems. Native youth, too, appear to be at special risk.

The role of family disruption, poverty and unemployment, parental drug use, lack of self-esteem and other factors have been cited as contributors to the development of drug abuse. The Committee recognizes that there will be limits to the success of the approaches proposed in this document. Proposals for the elimination of poverty, unemployment, and social alienation, for example, are outside the scope of this study although these factors have been implicated in the occurrence of some drug problems. The Committee believes it is of crucial importance, however, that these and other contributing factors be fully understood so that effective prevention strategies can be developed and implemented.

1. The Standing Committee recommends that the Minister of National Health and Welfare through the National Health Research and Development Program support research on the causes of drug abuse.

Evidence presented to the Standing Committee suggested that the primary governmental responsibility for prevention programming rests with the provinces through the provincial departments of health, departments of education and the addictions commissions. The Standing Committee was urged to consider the development of a program of support for prevention efforts by the provinces and by community groups.

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[4] A. McAllister, "Research approaches to primary prevention", in *Toward the Prevention of Alcohol Problems: Government, Business and Community Action*, D.R. Gerstein, ed., National Academy Press, Washington, D.C., 1984.

[5] J.M. Polich, P.L. Ellickson, P. Reuter and J.P. Kahan, *Strategies for Controlling Adolescent Drug Use*, Rand, Santa Monica, 1984.

Witnesses agreed on the importance of providing a federal-provincial cost-shared program for the prevention of substance abuse. Such a program should provide for targeted programming to address identified needs. Witnesses indicated that current programs are aimed more at treatment than at prevention. While providing for 50-50% cost sharing, these programs are not generally applicable to youth or may require income testing, both of which criteria are inappropriate for substance abuse prevention programs.

As part of the National Drug Strategy, the Minister of National Health and Welfare announced that a joint federal-provincial committee would examine the appropriateness of these mechanisms for funding addictions programs in treatment and prevention. This review will bring forth recommendations with regard to future cost-sharing mechanisms. The Standing Committee urges a speedy review and implementation of a new, more appropriate cost-sharing mechanism.

In view of the importance of preventing substance abuse, rather than attempting to deal with it after it occurs, the Standing Committee is concerned that funds identified within the National Drug Strategy for the support of community-based prevention initiatives will be inadequate.

2. The Standing Committee recommends that the Minister of National Health and Welfare, in collaboration with the provinces, introduce a new 50-50% cost sharing program with increased funding for the prevention of substance abuse.

Across Canada, a wide range of community groups are concerned about drug abuse. The Committee feels strongly that such local community initiatives be encouraged and supported.

The guidelines for the distribution of funds under a new prevention program should take into account the need for diverse methods and diverse targets and should encourage innovation at the federal, provincial and community level.

3. The Standing Committee recommends that program funds under the proposed new cost-shared prevention program be made available to both professional and community groups through the relevant provincial bodies.

Many witnesses before the Standing Committee addressed the need to target specific groups for prevention activities with special emphasis on young people. While there were differing opinions as to the precise age at which school-based drug programs should start, there was general agreement that they should begin early, should be sustained rather than sporadic, and should be tailored to the ages and cultural backgrounds of the youth.

The Standing Committee agrees that the highest priority in prevention programming should be to discourage the initiation of drug abuse by young people.

4. The Standing Committee recommends that the Department of National Health and Welfare identify children and youth as the first priority for funding under the cost-shared substance abuse prevention program.

The Government of Canada has announced a media campaign aimed at increasing public awareness. The Standing Committee is concerned that the campaign focus not only on illicit drugs, but that it accurately reflect all dimensions of the substance abuse problem.

One difficulty with the traditional, mass media approach to public education is that it is not directed to those most requiring information or to those most at risk. Two recent approaches which allow individuals access to necessary information through use of toll-free telephone numbers were described to the Standing Committee. In Saskatchewan, a toll-free telephone line has been installed at the Calder Treatment Centre in Saskatoon; callers make contact with a counsellor who is able to provide information on the availability and locations of treatment services.

In Ontario, the Addiction Research Foundation (ARF) operates a drug and alcohol information telephone line using more than 60 pre-recorded messages. The service, which is confidential, allows callers to request tapes by title or number and these tapes are then immediately played in either French or English.

The ARF information system is especially suited for national application at minimal cost. The Standing Committee was informed by Mr. Henry Schankula, Director of the Educational Resources Division of the Addiction Research Foundation, that the introduction of the pre-taped information program on a national basis would have a capital installation cost of approximately $20,000 and an annual operating cost of approximately $1 million. The cost of advertising the service, which would be in addition to the operating cost, would be best provided by the relevant provincial agencies.

The Standing Committee would like to see established a national system which combines these two approaches: a confidential information system which is also equipped to provide telephone numbers of health care organizations prepared to offer help to those requesting assistance with substance abuse problems.

5. The Standing Committee recommends that the Minister of National Health and Welfare negotiate with the Alcoholism and Drug Addiction Research Foundation (ARF) and with the appropriate provincial bodies the extension of the ARF Drug and Alcohol Information Line.

Witnesses before the Committee indicated that evaluations of school-based prevention programs have shown many to be ineffective. Witnesses also suggested, however, that there is reason to be more optimistic about new approaches to prevention. The Committee believes that it is essential that programs be evaluated so that their impact can be known and resources wisely used. Evaluation is crucial to the development of prevention programs which work. Crucial too is the dissemination of the results of evaluations to those planning or delivering prevention programs.

The Standing Committee has addressed the need to evaluate substance abuse prevention and treatment programs and to make the results of these evaluations clearly known, in the chapters on research and program evaluation and on a National Centre on Substance Abuse.

TREATMENT AND REHABILITATION

With some exceptions, the provision of treatment and rehabilitation services in Canada is the responsibility of the provinces. The federal government has also been involved in this area, providing leadership in policy development, program funding and collaboration in program design. One significant exception, which is considered separately below, is the area of health services for aboriginal people.

Provincial governments are now using federal programs to a varying extent to assist in the funding of substance abuse treatment programs. Treatment of drug abusers by medical practitioners may be an insurable service under the *Canada Health Act*. Such treatments include necessary medical attention in hospitals and in physicians' offices. Witnesses before the Committee called for the development of new residential treatment programs for adolescents. Where these programs are to be delivered by medical practitioners, the provinces should accept their responsibility to provide such services.

Most substance abuse treatment, however, is not eligible for funding under this program. Assessment services, counselling services, group homes, day programs, and restorative programs are often provided by a range of health care workers and are generally not insurable medical services.

Two other federal programs have been used as mechanisms for cost sharing substance abuse treatment programs between the federal and provincial governments — Vocational Rehabilitation for Disabled Persons (VRDP) and Canada Assistance Plan (CAP). Many witnesses addressed the inadequacy and inappropriateness of these mechanisms.

Witnesses indicated that although the 50-50% cost-sharing formula between the federal and provincial governments could provide an appropriate funding mechanism, eligibility requirements create difficulties in applying the formula to substance abuse treatment. Two problems with these programs were cited by witnesses before the Standing Committee: the general exclusion of young people from these programs and their application to persons "in need" which results in income testing under CAP and exclusion of employed persons under VRDP.

Several witnesses indicated the importance of removing all impediments to substance abuse treatment programs and ensuring accessibility for all persons requiring service. The Committee agrees that these programs should be made available to all Canadians requiring them regardless of age or ability to pay.

In addition to the concern about the applicability of these cost-sharing mechanisms for drug abuse treatment, there was also concern expressed about the amount of funding available. As discussed below, the Committee has identified young people and non-status aboriginal people as two groups requiring significant expansion of treatment resources. This should require additional federal funding in support of these programs. In view of these concerns, the development of a new and targeted cost-shared program with additional funding may be most appropriate.

6. The Standing Committee recommends that the Minister of National Health and Welfare initiate discussion with the provinces aimed at developing a 50-50% federal cost-shared program within Health and Welfare Canada with increased funding for the provision of treatment and rehabilitation services for substance abusers.

There are serious gaps in the availability of treatment services for drug abuse in Canada. Of special concern is the scarcity of treatment resources for adolescents. Providers of services indicated that increasing numbers of young people with drug problems, most notably alcohol-related, are appearing at treatment centres. There is a shortage of treatment places for these young people. Even where treatment for adolescents is available, waiting lists are unacceptably long.

Early intervention is crucial in dealing with drug problems. Young people experiencing difficulty should be seen early and treatment should, where possible, involve the family. The damage to family relationships that can be caused by drug use, and the use of drugs by children in troubled homes, often require the participation of other family members in treatment in addition to the young drug user. Sufficient resources for substance abuse treatment for young people are not now in place.

7. The Standing Committee recommends that the Minister of National Health and Welfare identify children and youth as the first priority for funding under the proposed new cost-shared substance abuse treatment program.

NATIVE ALCOHOL AND DRUG PROGRAMS

The Standing Committee received testimony as to the extent and severity of drug problems among aboriginal peoples. As with non-native Canadians, a complete statistical picture of substance abuse does not exist. From available statistics, however, it is clear that drug abuse, especially that of alcohol, is an extremely serious health and social problem among aboriginal peoples. Witnesses have argued that alcohol abuse may well be *the most* serious health problem. For example, evidence presented by the Federation of Saskatchewan Indian Nations in their report *Alcohol and Drug Abuse Among Treaty Indians in Saskatchewan* stated:

> Alcohol and drug abuse among Saskatchewan's Indian population represents the most serious and pressing social and health problem faced by Indian communities. While this has long been recognized by those concerned with the problem, there is a lack of authoritative statistical research which determined the actual levels of abuse in concrete terms... It is evident that a significant amount of Indian ill health and death is a consequence of alcohol and drug use. Indian people in Saskatchewan experience significantly higher disease and death rates than their non-Indian counterparts. The standardized death rate is double that of the non-Indian population as is the infant mortality rate. Deaths by injury and violence comprise half of all deaths among Treaty Indians.[6]

Other statistics underscore the severity of the drug problem among aboriginal peoples. For example, according to a departmental discussion paper on aboriginal alcohol abuse programs,[7] aboriginal people are more likely than the general population to be admitted to hospital or other health facilities with an alcohol abuse diagnosis. They experience a greater degree of personal and social disruption as a result of alcohol abuse. A greater proportion of aboriginal children are in the care of children's welfare agencies and a majority of these are related to alcohol abuse in the home. There appears to be a higher rate of fetal alcohol syndrome.

The federal government addresses Indian and Inuit drug problems primarily through the National Native Alcohol and Drug Abuse Program (NNADAP). NNADAP was established in 1982 with the objective of reducing substance abuse among Canada's Indian and Inuit communities. It provides support to communities wishing to develop prevention and treatment programs.

The estimated cost of NNADAP for 1987-88 is $56 million, which includes an increase of approximately $1 million under the new National Drug Strategy (see Figure 7). Of NNADAP funds, $52 million is provided in contributions to Indian Bands, Inuit Associations or local governments. NNADAP funds are generally available only to support programs for on-reserve status Indians and Inuit. Some resources have been made available for off-reserve status Indian programs, but eligibility is limited to a maximum period of one year, as the purpose of this funding is to ease the transition to urban living. Where program funds have been provided to non-status Indian groups, these programs are federally funded only in approximate proportion to the status Indians served.

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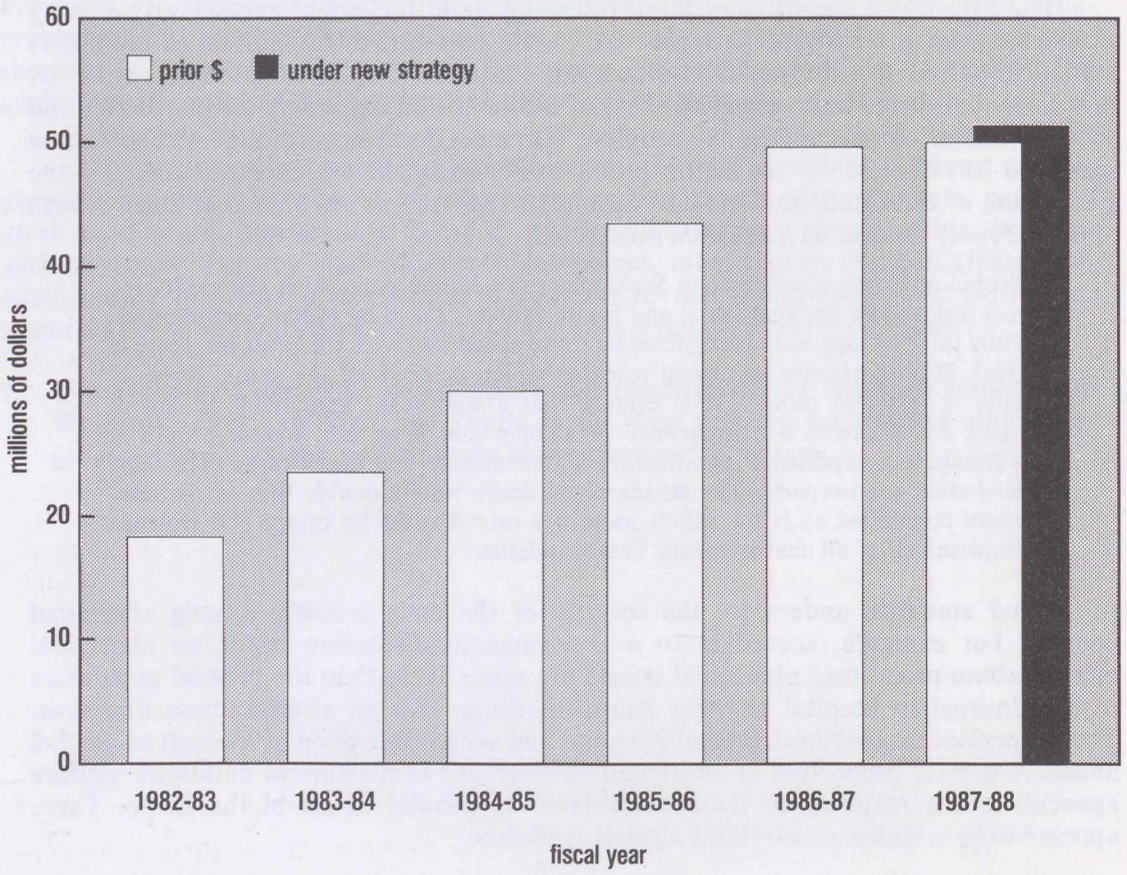
[6] Federation of Saskatchewan Indian Nations, *Alcohol and Drug Abuse among Treaty Indians in Saskatchewan: Needs Assessment and Recommendations for Change*, n.d., p. 112.

[7] Department of National Health and Welfare and Department of Indian Affairs and Northern Development, "Discussion paper: National Native Alcohol and Drug Abuse Program", February 1982.

Figure 7:
Effect of National Drug Strategy on NNADAP funding



Drug problems among aboriginal people are not, however, confined to the on-reserve status Indians and Inuit. Evidence was presented to the Standing Committee indicating that aboriginal peoples, regardless of status, are at greater risk of substance abuse and related health and social problems than the rest of the population. The recent well-publicized tragedy at Peerless Lake, Alberta, in which six people died as the result of drinking duplicating machine fluid, painfully illustrated the damage caused by substance abuse among Canada's non-status Indians. These tragic deaths have had a devastating effect on families and on the community.

Several witnesses before the Standing Committee addressed the jurisdictional issue with regard to the funding of programs for non-status Indians and Métis. While the federal government has taken responsibility for the funding of programs for on-reserve Treaty Indians and Inuit, other aboriginal people remain the responsibility of the provincial governments. Despite this jurisdictional difference, the Standing Committee believes the federal and provincial governments must act together to ensure better access to appropriate programs for all aboriginal people in Canada regardless of legal status.

The Standing Committee learned from officials of the Department of National Health and Welfare that at one time the federal government did provide funding to non-status Indians and Métis through the Native Alcohol Abuse Program, the forerunner to NNADAP. A 1981 report of the House of Commons Special Committee

on the Disabled and the Handicapped[8] identified some confusion over who should receive federal government support under this program. The Committee recommended changing the program "into an initiative which relates to the chemical dependency problems of Indian-Inuit people". In its response to the report, the Government of Canada indicated its development of the new NNADAP program.[9] However, at the time that Health and Welfare Canada discontinued funding of non-status Indians and Métis organizations, the Department did not take steps to ensure that the needs of these aboriginal people would be met.

Although the delivery of drug abuse treatment programs in Canada is largely the responsibility of the provinces, the funding for these programs is shared between the federal and provincial governments. Indeed, under the newly announced National Drug Strategy the federal government will be providing as much as $20 million annually in incremental funding for cost-shared substance abuse programs. The federal government can, and should, ensure that these funds are used to target identified gaps in service, including the need to serve non-status Indians and Métis.

As the allocation for additional cost-shared programs must address not only non-status Indians and Métis, but also other under-served groups, including young people, the Government of Canada should, in consultation with the provinces, carefully monitor the adequacy of these additional sums for the expansion of prevention, treatment, promotion and community programs.

8. The Standing Committee recommends:

i. that the Department of National Health and Welfare establish substance abuse programs for non-status native people as a high priority for funding under the new cost-shared substance abuse treatment program; and

ii. that *all* funding under this proposed new program be contingent on the provinces addressing the needs of non-status native peoples in their jurisdictions.

The Standing Committee heard evidence that the program needs of off-reserve status Indians, like those of non-status Indians and Métis, are not generally being addressed by NNADAP. Mr. Pat Shirt, Executive Director of the Edmonton-based aboriginal treatment centre, Poundmakers Lodge, described the need for additional support for urban Indians. In his testimony before the Committee, Mr. Shirt described Edmonton as the largest "reserve" in Canada, as the city has such a high concentration of aboriginal people. Mr. Shirt indicated that this concentration of urban aboriginal people not only requires the delivery of treatment services, but makes such delivery particularly cost-effective. Such programs are not now usually eligible for funding under NNADAP.

Where the needs of urban Indians are addressed in treatment programs, such as those delivered by the National Association of Friendship Centres and by Poundmakers Lodge, the services address both status and non-status Indians and Métis. Such programs should be encouraged by Health and Welfare Canada.

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[8] House of Commons, Special Committee on the Disabled and the Handicapped, "Follow-up Report: Native Population", December 1981.

[9] Government of Canada, *Surmounting Obstacles*, Third Report of the Government of Canada response to recommendations arising from the International Year of Disabled Persons, June 1983.

For off-reserve aboriginal peoples, funds should be made available to a wide variety of organizations with appropriate expertise and interest in addressing the problems of substance abuse among aboriginal peoples.

9. The Standing Committee recommends:

i. that the National Native Alcohol and Drug Abuse Program (NNADAP) amend its objectives to allow program support for off-reserve status Indians and Inuit; and

ii. that this support be made available to appropriate community-based groups.

Although satisfaction with NNADAP was expressed by representatives of aboriginal groups appearing before the Committee, witnesses did criticize some aspects of its operation. Foremost among these concerns were the priorities established by NNADAP for program funding. Witnesses suggested greater emphasis should be placed on community-based programs in prevention and treatment. These might include mobile clinics and other non-residential programs aimed at enhancing aboriginal self-esteem, reinforcing native cultures, providing assessment services or direct counselling services, and program evaluation.

Currently, NNADAP seeks the advice of the National Native Advisory Council in its funding decisions. The Standing Committee believes this body should examine the degree to which current funding priorities accurately reflect needs and should ensure that program funding addresses the full range of required programs.

Witnesses indicated that the National Native Advisory Council must be more representative of aboriginal peoples across Canada. Increased and stronger representation of all aboriginal peoples will allow the Council to expand its mandate. It is also important that representatives on the Council have special knowledge of drug and alcohol problems among Canadian aboriginal peoples.

10. The Standing Committee recommends:

i. that the membership of the National Native Advisory Council be more broadly representative of the aboriginal peoples of Canada;

ii. that NNADAP and the broadened National Native Advisory Council jointly develop clear program priorities for aboriginal drug abuse programs; and

iii. that decisions to fund projects under these new program priorities be jointly made by NNADAP and the National Native Advisory Council.

DRIVING WHILE IMPAIRED

The Standing Committee heard disturbing testimony about the tragic consequences of impaired driving in Canada. Evidence supplied by Mr. John Bates, President of People to Reduce Impaired Driving Everywhere (PRIDE), indicated the degree of highway carnage produced by impaired driving.

> It is estimated that 2,500 Canadians are killed every year by impaired driving. Another 100,000 people are either seriously injured or are permanently maimed by alcohol-impaired drivers every year. It is estimated that it costs insurance companies $1.5 billion just to pay for the property damage alone. If we include things like loss of time from work, costs of civil suits, hospital and health care and so forth, the figure would easily double.

These statistics dispassionately describe the thousands of profound personal tragedies that occur each year as the result of alcohol-related motor vehicle accidents. There is, however, some reason to be optimistic. Recent increased public awareness of the dangers of driving while impaired by alcohol or other drugs appears to be changing behaviour. The growth of citizen groups concerned with this problem, such as PRIDE and Students Against Drunk Driving is indicative of a growing change in attitude. In the words of PRIDE president, John Bates, "Nobody thinks impaired driving is acceptable behaviour anymore, not even drunk drivers".

Witnesses representing diverse groups called for an increase in the legal drinking age to a uniform 21 years. They included such people as Dr. Reginald Smart, Director of Prevention Studies for the Addiction Research Foundation, Sgt. Michel Pelletier of the RCMP's Drug Awareness Program, John Bates of People to Reduce Impaired Driving Everywhere, Dr. Allan Clews of the B.C. Medical Association, and others. For some of these witnesses, the increase in drinking age is *not* related primarily to the question of impaired driving, but rather to a more general strategy of reducing the numbers of individuals dependent on alcohol. These witnesses have cited evidence that a delay in the onset of alcohol use appears to reduce both the likelihood of problem drinking and the use of other drugs.

For some witnesses, the increase in the minimum drinking age is seen as a mechanism for reducing the number of impaired drivers and the number of motor vehicle injuries occasioned by impaired driving. While there is some empirical support for this approach, the argument may not be sound.

In 1972 and 1973, researchers at the Addiction Research Foundation examined the effect of the then recent reduction in Ontario's legal drinking age, from 21 years to 19 years. During the first five months of this change there was a clear increase in alcohol-related motor vehicle accidents.[10] Similarly, some U.S. studies have concluded that increased availability of alcohol among teenage drivers increases the group's tendency to drive dangerously.

Some recent evidence, however, indicates that new drinkers, regardless of age, present a greater risk to safety than do other drivers. This evidence suggests that raised drinking ages may simply postpone the dangers associated with new drinkers and motor vehicles.[11] Thus, raising the drinking age may simply shift the risk into another age

[10] R.E. Popham, W. Schmidt and J. de Lint, "The Effects of Legal Restraint on Drinking", in *The Biology of Alcoholism*, Vol. 4, B. Kissin and H. Begleiter, eds., Plenum, New York, 1976.

[11] P. Asch and D.T. Levy, "Does the Minimum Drinking Age Affect Traffic Fatalities?", *Journal of Policy Analysis and Management*, 6(2), 1987, p. 180-192.

group without reducing the overall rates of motor vehicle injuries. Such policies may also lead to clandestine drinking or open defiance of law by individuals who in all other ways are considered to be adults. Such drinking may help to foster attitudes about the use of alcohol which run counter to those which encourage moderation and sensible drinking practices.

In view of the extreme importance of this issue, it is imperative that the federal government and the provinces very carefully examine the issue and the degree to which overall motor vehicle fatality rates may be likely to fall as a result of reduction in the legal drinking age. The recent raising of the drinking age in the United States may provide a natural laboratory in which to test the effect of change in legal drinking age.

Responsibility for establishing a legal drinking age is clearly that of the provinces. At this time, all provinces and the territories have legal drinking ages of either 18 or 19. A uniform national drinking age of 21 would require the voluntary agreement of the provinces and it is unclear to what extent such agreement is now possible. In view of the lack of clear evidence that such a change would reduce motor vehicle fatalities, it is important that there be a careful attempt to measure this relationship.

11. The Standing Committee recommends that the Minister of Transport initiate a study of the effect of various legal drinking ages on motor vehicle accident rates and related fatalities and injuries.

Whether or not raising the drinking age would reduce the number of motor vehicle injuries and fatalities remains to be demonstrated. Nevertheless, it is clear that young drivers are more likely to be involved in serious road accidents. While the Committee is aware that the majority of young people act responsibly, the Committee is also aware of the need to address this serious problem.

Recently, the British Columbia Task Force on Liquor Policy Review released its report. While this task force did not recommend raising the drinking age, it did recommend changes in driver licensing to reduce motor vehicle accidents. Following the advice of the Ontario Advisory Committee on Liquor Regulation, the Task Force recommended "creating a new category of probationary driver's licence and the creation of a special offence under the *Motor Vehicle Act* that would impose a zero blood-alcohol level on probationary drivers."[12] This change would prohibit new drivers from operating a motor vehicle after consuming any amount of alcohol.

The Standing Committee agrees with this approach to reducing motor vehicle accidents, especially as the imposition of a probationary licence system forbidding the consumption of alcohol by new drivers, and by drivers below the legal drinking age, would not penalize responsible young people.

12. The Standing Committee recommends that the provinces consider a probationary licence system for new drivers that would make it an offence to drive a motor vehicle during this probationary licence period, or to drive while below the provincial legal drinking age, with any measurable alcohol in the body.

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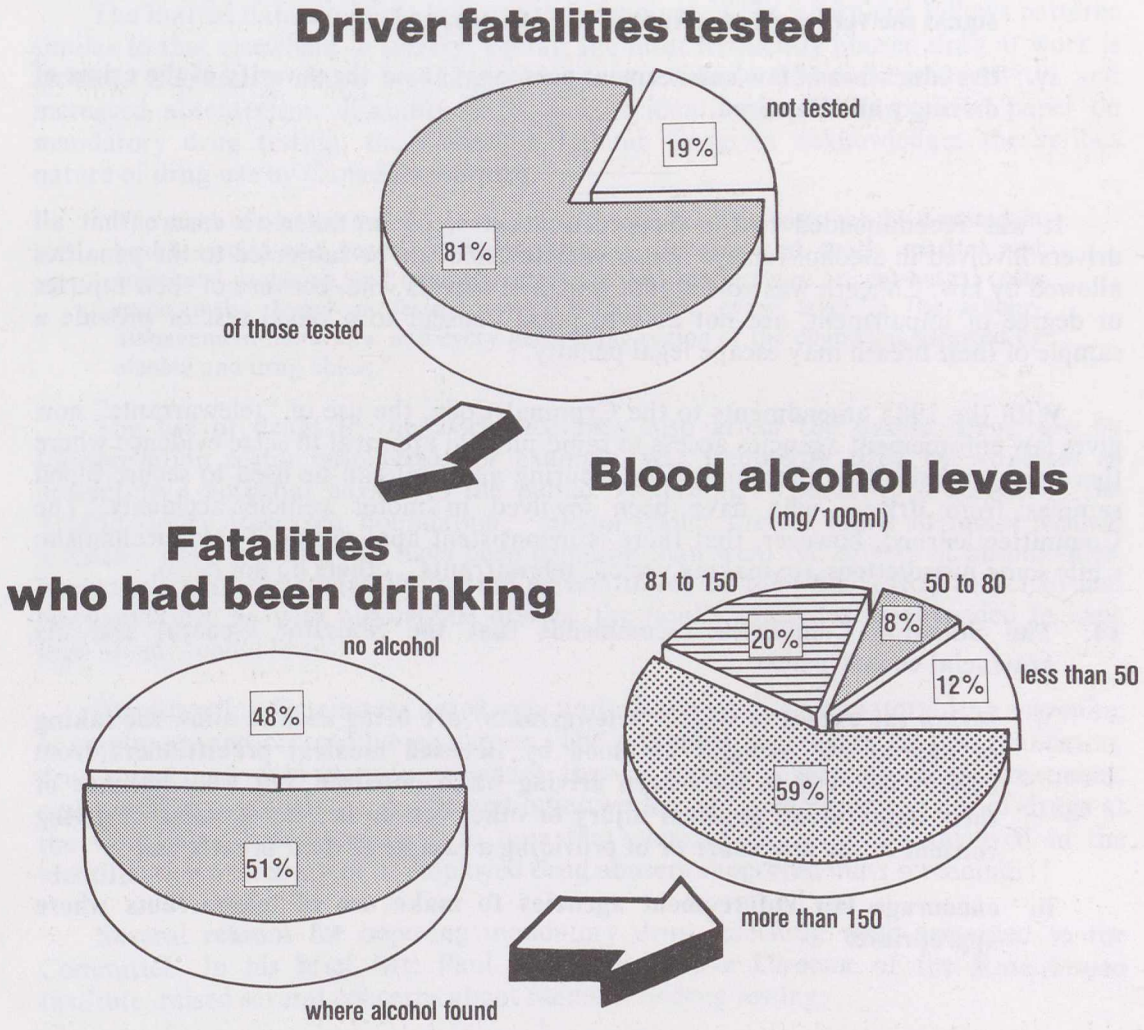
[12] British Columbia, "Liquor Policies for British Columbians", June 1987, p. 56.

Impaired driving is a contributing factor to motor vehicle accidents and resulting injury and death, and the more a driver has had to drink the greater the likelihood of mortality (see Figure 8). Legal penalties now exist for dealing with the dangerous and anti-social minority who persist in driving while impaired. The Standing Committee believes that an effective campaign to reduce impaired driving will depend on more rigorous enforcement of existing legislation; even application of penalties; increased perception by the public of the risk of apprehension; increased awareness by police, prosecutors and judges of the severity of the infraction and the need for rigorous application of law.

Figure 8:
Alcohol involvement among fatally injured drivers, 1985



Source: Traffic Injury Research Foundation

While the federal government has been primarily responsible for the development of the Criminal Code legislation creating the offences related to driving while under the influence of a drug, it has been the responsibility of the provinces to enforce this

legislation. An effective approach to reducing impaired driving must be based on an active partnership between the federal and provincial governments. An effective strategy must increase the probability that an impaired driver will be detected, and if detected, subjected to the penalties provided for under the law.

13. The Standing Committee recommends that the federal and provincial Solicitors General work jointly toward implementing a national strategy to reduce impaired driving. This strategy should include:

i. increased road-side spot checks to detect impaired drivers;

ii. the availability in all police vehicles of portable Breathalyzer equipment;

iii. a minimum penalty on second conviction for impaired driving sufficient to signal the very serious nature of the offence; and

iv. the education of law enforcement personnel about the severity of the crime of driving while impaired.

It was recommended to the Committee that steps be taken to ensure that all drivers involved in alcohol-related motor vehicle accidents be subjected to the penalties allowed by law. Concern was voiced that impaired drivers who, because of their injuries or degree of impairment, are not able to grant consent to a blood test or provide a sample of their breath may escape legal penalty.

With the 1985 amendments to the Criminal Code, the use of "telewarrants" now gives law enforcement agencies access to rapid judicial approval to seize evidence where there are grounds. This mechanism for securing approval can be used to secure blood samples from drivers who have been involved in motor vehicle accidents. The Committee learned, however, that there is inconsistent application of this mechanism; while some jurisdictions are making use of "telewarrants", others do not do so.

14. The Standing Committee recommends that the Solicitor General and his provincial counterparts:

i. review the extent to which "telewarrants" are being used to allow the taking of appropriate samples of blood by licensed medical practitioners from drivers believed to have been driving while impaired, but who, because of their impairment, physical injury or other reason are not capable of giving consent to the procedure or of providing a sample of their breath; and

ii. encourage law enforcement agencies to make use of telewarrants where appropriate.

THE WORKPLACE

There is clear evidence that drug use in the workplace occurs and that this use creates serious problems for the worker, for fellow workers and for the employer. Individuals do not leave problems at home when they go to work and workers who are experiencing difficulties with drug use at home are also likely to experience problems in the workplace.

Partly as a result of the recent publicity about mandatory drug screening in the workplace and recent action by the United States government to introduce such screening, the issue of drug use on the job has become subject to increased public scrutiny in Canada.

The limited data available indicate that drug use in the workplace follows patterns similar to that elsewhere in society. By far, the most frequently abused drug at work is alcohol. Substance abuse by employees can result in reduced productivity, and increased absenteeism, disability days, and accident rates. In its position paper on mandatory drug testing, the Canadian Labour Congress acknowledges the serious nature of drug use by Canadian workers:

> The costs of alcohol and drug use are monumental. The costs can be assessed in health, social and economic terms. Injuries, illnesses and death, marital and emotional problems, and unemployment and lost productivity are the actual costs respectively. Every profession, every occupation, every level in the labour-management hierarchy, and every geographic region of the country is affected by alcohol and drug abuse.[13]

The use of drugs in the workplace may also affect the public. Drug use by transportation sector employees, for example, was frequently cited by witnesses as presenting a potential hazard to the public. According to statistics prepared by the Traffic Injury Research Foundation,[14] tractor-trailer drivers killed in motor vehicle accidents were less likely to have been drinking than were the drivers of automobiles. Nevertheless, of the 56 fatally injured drivers tested in 1984 and 1985, 12 (21%) had been drinking. As with automobile drivers, the fatally injured drivers tended to have high blood alcohol levels.

The Standing Committee heard only limited support for mandatory drug screening of employees and prospective employees. The argument was presented that mandatory drug screening would identify substance abusers and force them to accept treatment, and would also protect the public and other workers by preventing the use of drugs at the workplace. It is interesting to note that none of the witnesses involved in the identification or treatment of employed drug abusers supported mass screening.

Several reasons for opposing mandatory drug screening were presented to the Committee. In his brief Mr. Paul Welsh, Executive Director of the Rideauwood Institute, raised several concerns about mandatory drug testing:

> Drug testing is not used to test for alcohol, the mood altering chemical causing the largest number of accidents, crime, health, social and work performance costs. A positive drug test does not indicate dependence to a drug. It may only indicate one use in the previous 4 - 6 weeks. Drug tests for legal but addictive drugs are of

[13] Canadian Labour Congress, Position paper on mandatory drug testing, December 1986, p. 1.

[14] A.C. Donelson, P.J. Walsh and G.C. Hass, "Alcohol Use by Persons Fatally Injured in Motor Vehicle Accidents: 1985", The Traffic Injury Research Foundation of Canada, December 1986.

> little use since they are medically and legally sanctioned, though potentially dangerous... Drug testing is unreliable, poorly considered and shows little usable information except in the minority of cases.

This scathing rejection of drug testing was supported by other witnesses involved with the treatment of drug abusers.

The Standing Committee was particularly disturbed at the potential for "false positives" in drug screening. False positives occur when urine samples containing no drug substances are erroneously identified as containing drugs. The probability of inaccurate test results is related to the type of urine test used.

For mass screening in the United States, some employers use immunoassay techniques. Antibodies for specific drugs are produced in laboratory animals and then introduced into urine samples from workers. If the drugs in question are present in the urine sample a reaction occurs that can be measured with the assistance of enzymes. Though these tests are less reliable than some competing methods, they are significantly less expensive, and are therefore attractive for mass screening programs.

The use of gas chromatography/mass spectrometry (gc/ms) provides a more accurate method of testing for drugs. Gas chromatography separates the compound and the mass spectrometry measures the unique profile the chemical produces. The main disadvantage of this method is its cost. Currently, a two-stage screening method in which only positive samples in immunoassay are subject to gc/ms costs approximately $35 per subject screening.

It should be recognized that laboratories in the United States using the less expensive immunoassay techniques have been shown to have an unacceptably high rate of inaccurate results. The U.S. Centers for Disease Control in collaboration with the National Institute on Drug Abuse conducted a proficiency testing program of laboratories involved in routine drug screening and found that the numbers of both false positives and false negatives were unacceptably high.[15]

In speaking of mandatory drug testing, Mr. Doug Hockley, Program Manager for the Employee Assistance Program of British Columbia Telephone Company, indicated such efforts may reduce the effectiveness of other approaches:

> As a generalized tool to be used by management, I find it [mandatory employee drug testing] abominable. It is costly. It subverts all the efforts that have gone into producing a management-labour climate that is workable between two sides... The issue of drug testing can be dealt with more effectively by informed supervisors and informed labour representatives understanding the nature of substance abuse... If that were to happen there would be no need for drug testing.

Some witnesses before the Standing Committee did give limited support to mandatory drug testing in exceptional circumstances. There are situations in which the safety of the public or fellow workers is clearly at stake. In a series of recommendations on employee drug screening, the Addiction Research Foundation recommended that mass screening not be implemented and that drug screening be considered only for employees who show deficits in job performance *and* whose behaviour in the workplace is judged to constitute a safety risk.[16]

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[15] H.J. Hansen, S.P. Caudill and D.J. Boone, "Crisis in Drug Testing: Results of CDC Blind Study, *Journal of the American Medical Association*, 252(16): Ap 26, 1985, p. 2382-2387.

[16] Addiction Research Foundation, "Employee-Related Drug Screening: Public Health and Safety Perspective", March 1987.

The Standing Committee grappled long and hard with the difficult technical and ethical questions surrounding the issue of mandatory employee drug screening. The Standing Committee agrees with the thrust of the Addiction Research Foundation advice on the subject. The issue of mandatory employee drug testing is a public health and safety issue *only* and must be so treated.

It is the responsibility of the employer to weigh carefully the employment suitability of probationary employees, including the careful monitoring of behaviour which may indicate the need for drug testing. Mass or random screening of job applicants, however, is neither sensible nor acceptable.

15. The Standing Committee recommends that employers not introduce mass or random drug screening of either job applicants or employees. Only in exceptional cases in which drug use by employees constitutes a real risk to safety, the Standing Committee recommends that drug screening may be introduced under the following conditions:

i. there must be cause, i.e., the employee must have shown evidence of impairment or of performance difficulties;

ii. the testing procedure must provide a secure chain of evidence to ensure samples have not been tampered with or unintentionally altered;

iii. the specimen must be collected in a manner which protects the privacy and dignity of the individual;

iv. all positive test results must be confirmed by gas chromatography/mass spectrometry, or test of equal precision and specificity;

v. testing must be used to assist the employee in seeking appropriate treatment for drug abuse where warranted; test results should not be used as evidence in criminal proceedings;

vi. results of positive tests and confirmations should be conveyed to a licensed medical practitioner acceptable to both the employee and the employer. The employee will be given the opportunity to meet with the medical practitioner or to present evidence with regard to the positive finding before the medical practitioner recommends a course of action to the employee and the employer; and

vii. any limited drug testing which may be introduced must include screening for alcohol abuse.

The behaviour of the federal government, a significant employer of Canadians, directly affects the lives of hundreds of thousands of citizens and serves as a model to other employers. For the more than one half million Canadians employed by the federal government in the Public Service, in the Canadian Armed Forces, in the RCMP, and in our Crown corporations, commissions and agencies, the Standing Committee recommends a policy that will balance the well-being of the worker with the need to promote safety in the workplace.

16. The Standing Committee recommends:

i. that the policy proposed in recommendation 15 be immediately implemented

by appropriate methods for all employees of the federal government, its Crown corporations, its agencies, boards and commissions; and

ii. that the Government of Canada consider legislation to limit and control mandatory drug screening in the private sector.

The Standing Committee received evidence of more positive approaches to reducing workplace substance abuse and its damaging effects. The growth of Employee Assistance Programs and the cooperation between management and labour in assisting the troubled employee are grounds for optimism.

Employee Assistance Programs involve the development of written policies to establish procedures designed to assist workers who are experiencing substance abuse problems. These policies are aimed at identifying problems earlier and providing confidential ways for employees to seek assistance. Often developed jointly by management and labour, Employee Assistance Programs help troubled workers to find needed treatment and rehabilitation services.

The Standing Committee was told of the high rate of success of Employee Assistance Programs. These programs have reduced absenteeism, accidents and health care costs and have improved employee morale and productivity. These programs appear to have higher rates of use where they are developed by collaboration between management and labour and where employees have options with regard to the individuals available to offer counselling and referral to appropriate treatment.

On the basis of the evidence received, the Standing Committee believes Employee Assistance Programs should be made available to workers experiencing drug problems. Termination of employment should be seen as a last resort, following referral to an Employee Assistance Program and suspension without pay, if required. The Committee wishes to see Employee Assistance Programs introduced broadly in Canada with the Government of Canada taking steps to ensure that all employees under its jurisdiction have access to them.

17. The Standing Committee recommends that Employee Assistance Programs be made available to all employees under the jurisdiction of the federal government and, wherever possible, these programs be introduced as a joint effort by management and labour.

While the federal government should make Employee Assistance Programs available to its employees experiencing difficulty, in certain cases these programs should also be made available to immediate family members. This should be the case where families may live in isolated conditions because of employment, or where frequent moves may make it difficult for immediate family members to establish links with the community. Families of Canadian Armed Forces personnel, for example, should be eligible for counselling within Employee Assistance Programs.

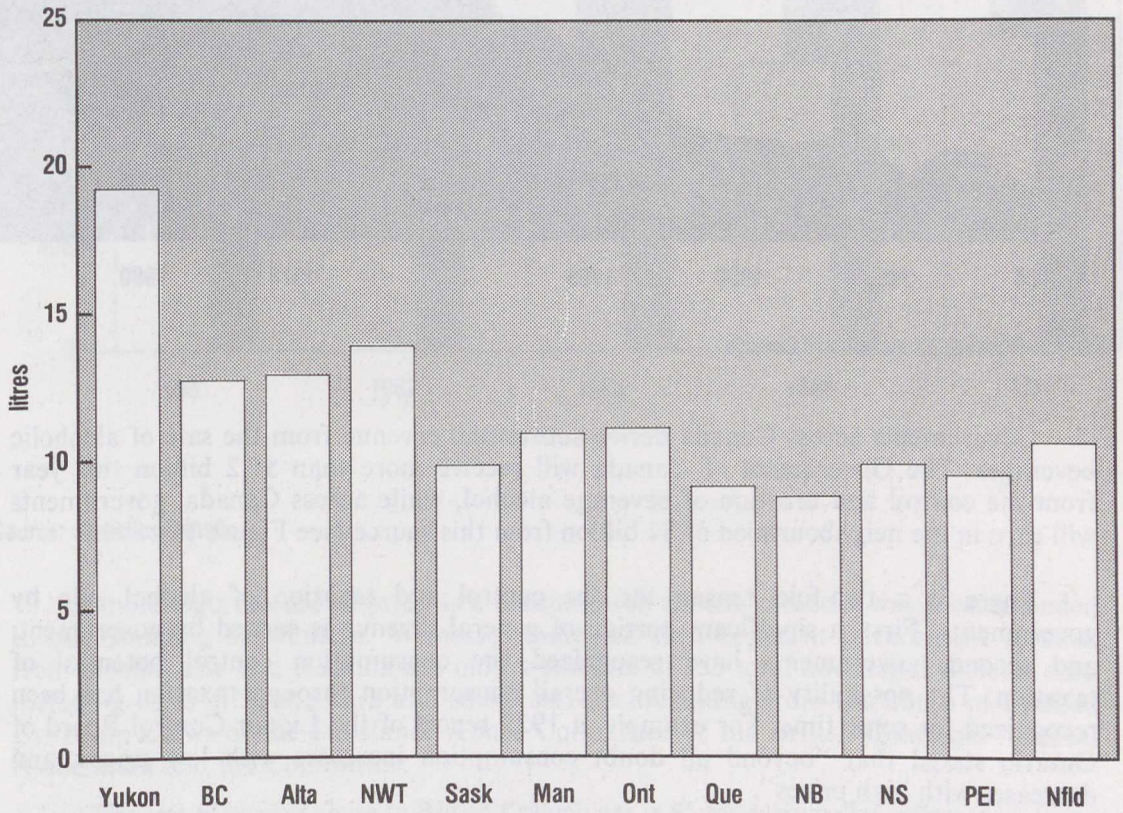
18. The Standing Committee recommends that the immediate family members of federal government employees whose employment requires frequent moves or geographic isolation be eligible for participation in Employee Assistance Programs.

BEVERAGE ALCOHOL

Alcohol holds a unique place among drugs subject to abuse. Unlike that of other drugs, its use by adults is accepted by most Canadians. More than 80% of Canadians over the age of 15 consume alcoholic beverages, and the prevalence of use by younger adults exceeds 90%. Alcohol is consumed at many social gatherings, with drinking being a part of the lifestyle of most people.

Based on 1984 sales data from Statistics Canada, Canadians consume more than 8 litres of alcohol per person per year, or approximately 11 litres for every person aged 15 and older. While rates vary from province to province, on the whole consumption levels are lowest in the Atlantic provinces and highest in the West (see Figure 9). After years of steady increase in consumption levels, since 1980 there has been a decline in the average amount of alcohol consumed (see Figure 10).

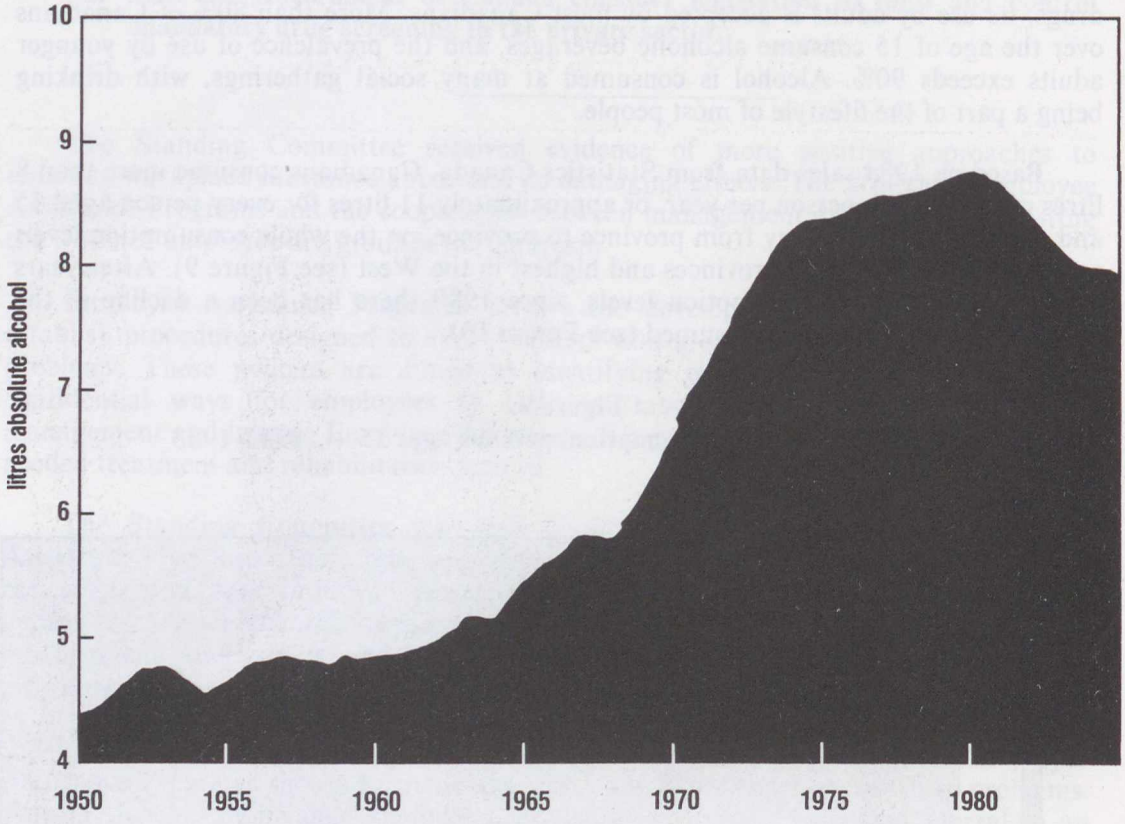
Figure 9:
Per capita alcohol consumption, persons ages 15 + , 1982-1983



Source: Statistics Canada

For most Canadians who drink responsibly, consumption of alcoholic beverages causes no health or social problems. Witnesses told the Committee that approximately 90% of all drinkers experience no injurious effect. Canadian researchers have pointed to a possible genetic predisposition toward alcoholism. This does not mean that heredity causes alcoholism, but, rather that some people may be more susceptible to it.

Figure 10:
Per capita consumption of alcohol in Canada



Source: Brewers Association of Canada

Governments across Canada derive substantial revenue from the sale of alcoholic beverages. The Government of Canada will receive more than $1.2 billion this year from the control and taxation of beverage alcohol, while across Canada, governments will earn in the neighbourhood of $4 billion from this source (see Figure 11).

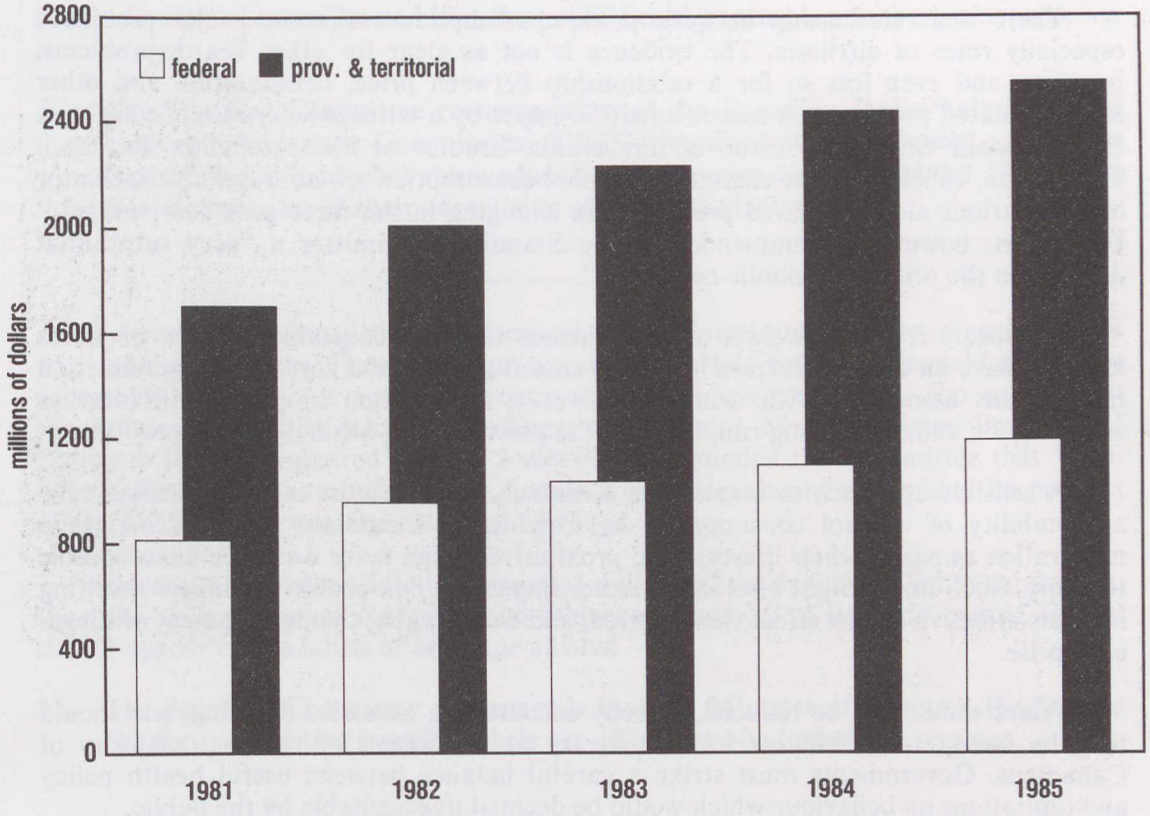
There is a two-fold reason for the control and taxation of alcohol sale by governments. First, a significant portion of general revenue is earned by government; and second, governments have recognized the consumption control potential of taxation. The possibility of reducing overall consumption through taxation has been recognized for some time. For example, a 1929 report of the Liquor Control Board of Ontario stated that "beyond all doubt consumption increases with low prices, and decreases with high prices".

There is evidence in support of the claim that levels of consumption are related to the price of beverage alcohol. While fluctuations in demand are related to changes in price, this relationship is not a perfect one. Demand for spirits, for example, may be more easily manipulated by price changes than is demand for beer.[17] In addition, an

[17] K. Makela, *et/al., Alcohol, Society, and the State: a Comparative Study of Alcohol Control*, Addiction Research Foundation, Toronto, 1981.

increase in price does not bring about an equal reduction in demand. Increases in retail prices result in lower percentage reductions in consumption.[18]

Figure 11:
Government revenue derived from alcohol



Source: Statistics Canada

A more vigorous use of price as a consumption control measure was recommended to the Standing Committee. Witnesses indicated that apparent government revenue from alcohol sale and taxation are only a fraction of the total additional societal cost, including costs of health care and social services, resulting from the abuse of alcohol. Dr. Allan Clews of the Substance Abuse Committee of the British Columbia Medical Association told the Committee:

> The cost of alcohol abuse to British Columbians is $5 for every dollar collected in taxes on alcohol. Governments can reduce the consumption of alcohol and at the same time defray some of the social costs of alcohol abuse by increasing the taxes on alcohol. The quantity of alcohol consumed in any given society... is proportional to the size of disposable income and inversely proportional to the price of alcohol. Also, for a given society, the number of alcohol-related problems is proportional to the total quantity of alcohol consumed.

[18] M.M. Horgan, M.D. Sparrow and R. Brazeau, *International Survey of Alcoholic Beverage Taxation and Control Policies*, Sixth Edition, Brewers Association of Canada, Jan. 1986.

In order to be a useful tool of public health policy, there must be a relationship between changes in the total societal consumption of alcohol, which does appear to be related to price changes, and the prevalence of alcohol-related problems. That is, while price rises may somewhat reduce the total amount of alcohol consumed by a society, this reduction must be shown to reduce problems in order to be demonstrated as an effective social policy.

There is a relationship between price, consumption and some health problems, especially rates of cirrhosis. The evidence is not as clear for other health problems, however, and even less so for a relationship between price, consumption and other alcohol-related problems. A recent scientific paper by a witness before the Committee, Dr. Reginald Smart, Director of Prevention Studies at the Addiction Research Foundation, concluded that changes in alcohol consumption are an unreliable indicator of how various alcohol-related problems are changing in the three provinces studied.[19] Dr. Smart, however, recommended to the Standing Committee a "very substantial increase in the price of alcoholic beverages".

It appears from the weight of the evidence that an acceptable increase of prices may not have an equal reduction in overall consumption and a corresponding reduction in problems associated with drinking; however, a reduction in prices will increase consumption and, in the long run, increase the prevalence of alcohol-related problems.

A sensible approach to taxation as a control measure must take into account the acceptability of alcohol consumption by Canadians. Canadians accept drinking in moderation as part of their lifestyle and prohibitively high taxes would be unacceptable to many. Such taxes might also have greater impact on non-problem drinkers resulting in a less effective health effect than desired, and encouraging the development of illegal enterprise.

Prices should not be reduced, thereby encouraging excessive drinking, nor should they be forced to prohibitive levels contrary to the wishes of the vast majority of Canadians. Governments must strike a careful balance between useful health policy and limitations on behaviour which would be deemed unacceptable by the public.

19. The Standing Committee recommends that the federal government maintain a level of beverage alcohol taxation to ensure that prices of beverage alcohol do not decline relative to real personal income.

Several witnesses have called for more control over the advertising of beverage alcohol. These individuals suggested a variety of measures ranging from greater responsibility in advertising to a total prohibition on all forms of alcohol advertising.

In Canada, concern about the misuse of alcoholic beverages has been expressed not only by the public and professionals, but by the industry itself. The Canadian brewing and distilling industries have been involved in public advertising campaigns aimed at reducing alcohol misuse. These efforts are to be commended. However, the extent of commercial advertising of alcoholic beverages far exceeds the effort placed on encouraging moderation or assisting those who have developed problems to seek help. The beverage alcohol industry must accept greater responsibility for prevention of alcohol-related problems as the price to pay for access to the Canadian market.

[19] R.G. Smart, "Changes in Alcohol Problems as a Result of Changing Alcohol Consumption: a Natural Experiment", *Drug and Alcohol Dependence*, 19, 1987, p. 91-97.

The Committee learned from Mr. Howard Greenstein, Executive Director of the Saskatchewan Alcohol and Drug Abuse Commission, that Saskatchewan has introduced regulations requiring the electronic media to give increased alcohol abuse information indexed to the rate of beverage alcohol advertising. Broadcasters in Saskatchewan are required to provide 15% of alcohol advertising time in the form of public messages. While the basic concept is sound, the Committee wishes to ensure that it is the advertiser and not the broadcaster who is responsible for carrying the costs of these educational messages and that the public health messages are aired at appropriate times of day.

20. The Standing Committee recommends that the Canadian Radio-Television and Telecommunications Commission (CRTC) require beverage alcohol advertisers to provide public alcohol abuse educational messages equal to at least 15% of the total dollar value of their advertising of beverage alcohol.

Several witnesses called on the Government of Canada to introduce warning labels on alcoholic beverages. These witnesses argued that, while beverage alcohol has socially acceptable uses, it is a potentially dangerous substance and those who consume it should be warned of its dangers. In addressing this point, Mr. John Bates, President of People to Reduce Impaired Driving Everywhere, reminded the Committee that "even ASA tablets or cold remedies must contain a warning about how to use the product safely..." This is not now the case with beverage alcohol.

Warnings about the addiction potential of alcohol, the dangers of impaired driving, the risks of fetal alcohol syndrome and other consequences of improper use of alcohol should appear on the labels of beverage alcohol.

21. The Standing Committee recommends that the Minister of National Health and Welfare ensure that warning labels are affixed to all alcoholic beverages.

SUPPLY CONTROL

While the focus of our efforts to reduce substance abuse and its consequences must be in the area of demand reduction, there is a need to maintain our efforts to reduce supply of illicit drugs. As discussed in the introduction to this report, the Committee heard from witnesses from all walks of life on the crucial importance of developing new and more effective demand reduction strategies if problems are to be significantly reduced. But witnesses also told the Committee that activities to reduce supply, to enforce the law and to make the trafficking in illicit drugs less rewarding must be augmented.

Illicit drug abuse is an international problem. Concern has been expressed worldwide and has resulted in two United Nations international conventions on drug abuse. Canada, which was a signatory to the first U.N. Convention on Narcotic Drugs, announced as part of its National Drug Strategy its intention to sign the second 1971 U.N. Convention on Psychotropic Drugs.

Drug abuse is also an international problem in that almost all illicit drugs consumed in Canada are produced in other countries. The traffic in these drugs is dominated by organized crime. For those at the highest levels, risks are minimal while the profits of international drug trafficking are substantial. In order to reduce supplies, the RCMP and Canada Customs work not only in Canada, but with producing countries and trans-shipping nations to detect and interdict illegal drugs. These efforts must be strengthened.

In testimony before the Standing Committee, witnesses from the RCMP indicated that the Force has focussed its efforts on the identification and arrest of major drug traffickers. The Committee agrees that the efforts of a national police agency should be directed at the highest levels of national and international crime. Enforcement at this level, however, is difficult and consumes significant amounts of police resources. Despite the focus on high level traffickers, of all drug-related charges laid by the RCMP, 65% were for simple possession of cannabis.[20] The Committee believes the RCMP should ensure its resources are properly utilized so that the highest priority for national enforcement will be the upper echelon of international drug trafficking.

As part of the National Drug Strategy, the Government of Canada announced new initiatives to strengthen the capability of national law enforcement and drug interdiction agencies. Additional person years have been added to the RCMP and to Canada Customs in order to strengthen drug intelligence capabilities and to detect and seize illicit drugs.

Enforcement at the local level is primarily the responsibility of provincial and local law enforcement agencies. It is important that these agencies receive cooperation from the RCMP in order that their work be more effectively carried out. Timely access to appropriate drug intelligence and the coordination of efforts are essential to ensure enforcement at the street level. Joint force operations should be encouraged to reduce duplication and maximize efficiency. The RCMP should also increase the support provided to provincial and local law enforcement agencies in the form of enhanced training on drug detection, and investigation of drug profiteering.

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[20] Canada, *RCMP National Drug Intelligence Estimate 1984/85 with Trend Indicators through 1987*, RCMP, Ottawa, 1985.

The abuse of drugs, including alcohol, has been shown to be related to non-drug crime. The Correctional Service of Canada has estimated that almost 70% of the inmates in federal penitentiaries have serious substance abuse problems. As part of the National Drug Strategy, correctional staff will be trained to recognize signs of substance abuse and to help inmates through substance abuse programs. Inmate pre-release programs and assistance on release will be provided to inmates and ex-inmates.

The profits of illicit drug trafficking

Demand in countries like Canada has produced an illegal international drug supply system which is responsible for the manufacture and illegal importation of drugs. Profits from this organized drug trafficking are significant. In his evidence, Chief Superintendent R. Stamler of the RCMP described the profitability of international traffic in illicit drugs:

> Drug trafficking generates more revenue for criminal organizations than any other type of criminal activity... The illicit opium producer may make only several thousand Canadian dollars from his annual harvest, while the organized criminal syndicates which manufacture, transport and sell heroin on the illicit markets receive billions of tax-free dollars annually.

There is a principle of Canadian law which states that criminals should not benefit from their crimes. This principle ought to be rigidly supported by laws which can remove the profit from illegal drug trafficking. According to Superintendent Stamler, this is not always the case:

> The risks involved are extremely low for the financiers and high-level international criminals, who may never come into direct contact with illicit drugs. In such circumstances, the drug trafficking syndicates can be expected to flourish and to continue supplying illicit drugs to meet the permanent demand from groups within society willing to pay the price for them.

Under the new National Drug Strategy, the Minister of Justice has introduced legislation to seize the profits of illicit drug trafficking, consistent with the advice provided to the Standing Committee from law enforcement officials across Canada. The Standing Committee is concerned, however, that the proposed legislation does not compel financial institutions operating in Canada to report large cash transactions in Canadian or in foreign currency. Such legislation would not affect legitimate commercial transactions and would merely "flag" certain cash transactions for possible scrutiny by law enforcement agents.

The Canadian Bankers Association has made it clear that Canadian banks will not assume "the task of policing criminal activity". In a statement, the Association stressed the banks' duty of confidentiality to clients, "Disclosure of account information by a bank to enforcement agencies will occur when the bank is compelled by law to do so". This Committee's concern is that such compulsion can only occur when there has already been evidence that individuals have profited from crime. The Committee is also concerned that there is no requirement for the banks to maintain the records most suitable for police investigation and in an accessible form or for a period of time appropriate for law enforcement purposes.

The Standing Committee was informed by several witnesses of the success of legislation in the United States which requires banks to maintain records of cash transactions in excess of $100 and to report cash transactions of $10,000 or more. This

system of reporting has had good results in assisting law enforcement officials and the courts in detecting and seizing the profits of drug trafficking.

While Canadian banks are required to retain records of cash transactions under the *Bank Act*, there is currently no requirement that banks report large cash transactions, or maintain records of such transactions in a particular fashion.

22. The Standing Committee recommends that the Minister of Justice table legislation requiring financial institutions operating in Canada to report to the federal government all cash transactions in Canadian or in foreign currencies of $10,000 or more, and that such records be retained by these institutions in a manner prescribed in regulations so as to facilitate the tracing of the proceeds of crime.

Drug paraphernalia

Of special concern to witnesses from law enforcement agencies and from parent groups concerned with drug abuse was the open and legal sale of drug paraphernalia. Drug paraphernalia include equipment and products used in the production and use of illicit drugs. Witnesses from these two groups were particularly concerned at the presence of "head shops" in many Canadian cities. "Head shops" are commercial enterprises whose principal business is the sale of drug paraphernalia and items which describe their use and which advocate the use of illicit drugs. Drug paraphernalia sold in "head shops" includes scales and balances for weighing drugs, kits for diluting cocaine and other drugs, hashish pipes, empty capsules to be filled with drug substances and other objects for illicit drug use.

Calls for the banning of "head shops" came from witnesses from the RCMP, the Canadian Association of Chiefs of Police, the Ontario Association of Chiefs of Police, Alcohol and Drug Concerns Inc., Parents Against Drug Abuse, the Ontario Secondary Schools Principals Council, the Ontario Association of Home and School Associations, and Youth Alcohol and Drug Community Action. According to these groups, the presence of "head shops" presents a mixed message to youth. While educators and parents discourage the use of illicit drugs, there is public tolerance of the sale of drug paraphernalia and the public display of these items. The presence of "head shops" and the display of paraphernalia are also seen by these witnesses as glamourizing drugs and their illicit use.

Assistant Commissioner D. Heaton of the RCMP told the Standing Committee:

> I think if we are really serious about the drug problem, there is probably no better place to start than to look at the drug paraphernalia. At a time when we put forth preventive education of our young people as a priority, there is an industry that thrives in this country delivering a completely contradictory message. We permit retail outlets that are called "head shops" to operate, and they distribute literature, equipment, and material to facilitate and enhance the use of illicit drugs. The paradox of such an industry is all too obvious. It relies on the message of drugs and their glamour for youth, and it delivers a message that really is directly opposite to what needs to be taught.

The development of legislation aimed at banning drug paraphernalia is a difficult task as, in most cases, items of drug paraphernalia also have legitimate and non-drug applications. The intent of legislation should be to close "head shops" and not to attack

the items themselves. The law must be carefully drafted to address those commercial enterprises which glamourize and facilitate illicit drug use.

23. The Standing Committee recommends that the Minister of Justice, in cooperative efforts with his provincial counterparts, develop legislation to close "head shops" (commercial enterprises whose principal business is the sale of drug paraphernalia and items which describe their use and which advocate the use of illicit drugs).

Prescription drugs

The Standing Committee learned of problems in the abuse of prescription drugs. The increasing number of individuals cross-addicted to alcohol and prescription drugs have concerned some witnesses about the prescribing practices of some physicians. The Standing Committee learned of the difficulty in identifying individuals who are "multiple-doctoring", whereby patients see more than one physician in order to secure multiple prescriptions for a single health problem.

Currently, the Bureau of Dangerous Drugs in the Department of National Health and Welfare is responsible for monitoring narcotic drug prescriptions in Canada. The Committee is concerned that such monitoring is far too limited in scope in that it includes only a small number of the drugs subject to abuse. The Standing Committee believes it is necessary to develop a system which will allow the monitoring of the full range of mood-altering prescription drugs.

Monitoring will provide accurate data not now available on the extent of drug use. Much of our epidemiological knowledge has been derived from survey research, rather than from observation of drug prescribing practices. A monitoring system should facilitate the identification of those patients who are receiving multiple prescriptions for their own use or for illicit diversion to others. Such a system will also assist the Colleges of Physicians and Surgeons to monitor the prescribing practices of their members, to take remedial action where appropriate, and to target their educational messages.

The Standing Committee recognizes the difficulties in developing a national system for prescription drug monitoring. Of the provinces, only Saskatchewan has developed a prescription drug monitoring system and this may serve as one model to be considered. In Alberta, the College of Physicians and Surgeons has introduced a more limited system for tracking prescriptions for ten analgesic drugs.

A national system must be designed to protect the privacy of the patient and meet the needs of physicians and pharmacists. It must provide information in a timely manner and which does not place undue burden on health care professionals. Finally, a prescription monitoring system must be affordable.

24. The Standing Committee recommends that the Minister of National Health and Welfare establish an Expert Task Group to examine the feasibility of establishing national standards for provincial systems for the monitoring of mood-altering prescription drugs and to bring forth recommendations on the establishment of such systems.

PROFESSIONAL EDUCATION AND TRAINING

Substance abusers are disproportionately heavy consumers of health care resources. Several studies have demonstrated the high degree to which hospital admissions are related to alcohol abuse. Dr. Ken Thornton, Chief of the Department of Laboratory Medicine, Greater Victoria Hospital Society, reported to the Standing Committee the results of an "informal survey" of hospital patients in Victoria, British Columbia:

> [The survey] showed that over 20% of adult in-patients were dependent on alcohol. And that has been confirmed, of course, in the literature. They are, of course, disproportionately represented in hospital and use disproportionate amounts of medical service... and I think the out-patient representation is far larger than the in-patient representation.

Health care workers are in a critical position to assist in the prevention and treatment of drug problems as they regularly come into contact with abusers of alcohol at all stages of the disease process. In addition, the Standing Committee heard of the growing number of multiple drug users who appear in physicians' offices. Cross-addiction to alcohol and prescription drugs, most notably the minor tranquilizers, was especially singled out by witnesses.

There are several problems which can be addressed through improved training in the health professions. First, there is at times an unfortunate tendency for professionals to deny that a problem exists. This was termed a "conspiracy of silence" by Dr. Thornton, who indicated that because professionals consume alcohol themselves, they are reluctant to identify alcohol abusers in their practices. It is important for them to become aware of the significant role they can play in prevention and treatment.

Secondly, additional professional training is necessary to enhance the ability to recognize drug-related problems, especially in their early stages. Professionals must learn how to respond to drug abuse problems once they have been identified. The perception that some of these problems are intractable, the lack of a clear technological intervention, and non-compliance by some of these patients have resulted in the avoidance by some professionals of recognition and treatment.

Physicians were also said to need additional training in prescribing. Over-prescribing of psychoactive drugs and relying too heavily on these were identified as issues requiring additional attention in physician education.

Despite the significance of substance abuse in health care practice in Canada, little time is devoted to drug abuse in undergraduate, graduate or continuing medical education. While witnesses differed as to which educational level should receive the greatest emphasis, strong opinion was expressed on the need for additional training.

Mr. Marvin Burke, Executive Director of the Nova Scotia Commission on Drug Dependency, was one of the witnesses who addressed the need for additional physician training:

> Physicians have to be trained. They have to be trained to understand this problem, to understand that there are many resources in the community that are prepared to work alongside them. It is very crucial that this be considered not just in one school, but right across this country.

The Standing Committee agrees that there is a need for additional training for those studying to enter health care professions as well as those already in them.

25. The Standing Committee recommends that the Minister of National Health and Welfare convene a committee of representatives of the professional associations concerned with the training of health professionals. This Committee, in consultation with experts in substance abuse, will identify the needs for enhanced professional education, and will bring forth recommendations for curricula changes with regard to the early identification of alcohol and drug-related problems, appropriate professional interventions, and prescribing practices.

PROGRAM EVALUATION

Several witnesses before the Committee spoke of the need for program evaluation. In support of this view, Ms. Maggie Hodgson, Executive Director of the Nechi Institute on Alcohol and Drug Education, spoke forcefully on the need for major expansion of program evaluation efforts. In her own program, implementation of recommendations of a recent evaluation allowed the agency to increase its productivity by 166% while reducing costs by 12%. The Committee recognizes that evaluations, though they will not often achieve these results, can, however, provide the information necessary for better understanding and improvement of program operation.

Program evaluation will equip service providers with the information necessary to establish priorities rationally and to reallocate resources as client needs change. The most effective methods can be identified and developed while resources going to less effective techniques can be reassigned.

26. The Standing Committee recommends that all new substance abuse prevention, treatment and rehabilitation programs funded in whole or in part by the federal government include an evaluation component to monitor activities and to assess impact.

Program providers should be given the opportunity to learn the purposes and methods of evaluation research. Programs can work best where they are subject to ongoing review and modification. Service providers should be given the basic tools to allow them to monitor their own programs and clients, to analyze the impact of their efforts, and to assess the potential for change in program activities. With these skills, providers are more likely to build evaluation into the daily operation of the service.

In describing the need for evaluation competence at the provider level, Ms. Hodgson indicated that technical competence in evaluation methods is not sufficient. It is also important to have competence in community development and a sensitivity to local issues. This can be accomplished through the training of service providers and their participation in or conduct of necessary evaluation research.

27. The Standing Committee recommends that the Department of National Health and Welfare provide training in program evaluation to community groups receiving program funds from the Department.

NATIONAL CENTRE ON SUBSTANCE ABUSE

Across Canada there have been developments in prevention programming, treatment and rehabilitation methods, assessment procedures, and research. These developments have been at the provincial level in the addictions commissions and in departments of health, social services, and education. Developments have occurred both within industry in Employee Assistance Programs and health promotion programs, and in universities in applied and in pure research.

The experience, special skills and the expertise of Canadians should be regarded as a national resource. There is a pressing need to disseminate the best information available and to develop a permanent forum for addressing substance abuse issues. Our efforts in this area should be formed into a cohesive whole to be seen and used nationally.

There are many centres of distinction across Canada. For example, the Alcoholism and Drug Addiction Research Foundation, the first organization in the drug field to be designated by the World Health Organization as a "centre of excellence" and collaborating centre for research in drug dependence, has conducted biomedical, social, epidemiological research of world renown. The successes of the National Native Alcohol and Drug Abuse Program in developing culturally relevant treatment programs, of the Alberta Alcohol and Drug Commission in the production of public education materials and the Nova Scotia Commission on Drug Dependency in community development activities, all testify to the important, innovative and excellent work being conducted nationally.

The Standing Committee heard testimony from representatives of the provincial addictions commissions on the need to develop a national organization in the substance abuse area. To some extent, the Addiction Research Foundation has by default adopted a national function. But the Committee is aware that the Addiction Research Foundation does not have a national and international mandate. Recognizing this, Dr. Joan Marshman, the President of the Addiction Research Foundation, joined other heads of provincial addictions commissions in urging the Committee to consider the creation of a new national substance abuse body.

In addition to providing links among the provinces and between the provinces and the federal government, it was suggested by some witnesses that the private sector, labour, and volunteer groups could also be involved in a national substance abuse organization.

Duplication of effort must be avoided. Resources that exist across Canada for professional training, for research, for program evaluation, for prevention and public information should be brought together. A process should be developed in which the various centres of distinction can serve all Canadians.

As part of the National Drug Strategy, the Minister of National Health and Welfare has established a task group to review the means of ensuring that expertise and experience can be made available for the benefit of Canada as a whole and to ensure an ongoing commitment for the promotion of research and the prevention of substance abuse. The Standing Committee is concerned that this task group has been given tools inadequate to the task of creating and supporting a national focus on substance abuse. Under the National Drug Strategy, the government has identified only $1.4 million over the first four year period and no funds at all have been identified for the fifth and final year of the initial commitment to a National Drug Strategy.

The creation of a national organization need not be an expensive commitment; however, it will require a lasting commitment from the Government of Canada. The Standing Committee believes the Government must identify funds now for the continuing support of a national centre on substance abuse. To indicate the termination of such funding prior to the conclusion of the first five years of the National Drug Strategy provides the wrong signal to the provinces, to the private sector, to labour and to others who might participate in a national organization.

28. The Standing Committee recommends that the Government of Canada extend its announced funding of the "National Focus on Drug Abuse" to include all five years of the initial commitment to a National Drug Strategy.

29. The Standing Committee recommends that the Minister of National Health and Welfare consider the creation of a National Centre on Substance Abuse. This National Centre, with a governing body composed of representatives of the federal and provincial governments, of the private sector and labour and of volunteer organizations should:

i. conduct and promote basic and applied research on substance abuse;

ii. disseminate information about substance abuse;

iii. engage in public education and substance abuse prevention; and

iv. encourage the application of new knowledge in clinical programs, prevention programs and research.

Research priorities

The need for additional information on substance abuse is apparent. Across Canada, witnesses indicated important areas requiring additional research effort. There are gaps in our knowledge of all aspects of this complex issue. Not enough is known about the causes of substance abuse. There must be more exploration of the effectiveness of current prevention efforts and the promise of approaches being developed. There is incomplete information about the extent of the drug problem and the characteristics of the population which abuses drugs. Treatment methods need to be more carefully examined and more attention should be paid to matching patients to the treatments that are best for them.

The Standing Committee recognized in its first recommendation the need for additional research on the causes of substance abuse. Other substance abuse issues also require study as a matter of high priority.

It is important to know the prevalence of drug problems and their distribution within the population so as to better direct our prevention and treatment efforts. In addition, these data allow us to evaluate the effectiveness of current approaches. In analyzing the extent of the drug problem, however, the Standing Committee found much of the data that would be helpful to the task did not exist. Basic epidemiologic data were often either not available or inconsistently available.

In addressing the need for epidemiologic data, Dr. Harold Kalant of the Addiction Research Foundation told the Committee:

> In areas such as alcohol and drug problems, which cannot logically be seen in a local context, the national and international responsible authorities — and in the context of this hearing... the federal government — can play a very important role if they are so inclined in the support of continuing long-term research into... [epidemiologic trend analysis] which would have been impossible to do without a commitment from some source to gather data over many years in order to be able to map trends, and to do it with standardized techniques so the information from one survey is comparable to and interpretable with the data from another survey.

A number of provinces have been involved in the collection of epidemiologic data. There is, however, no generally agreed upon method for collecting these data, no regularly recurring period of collection nationally, and no consistent effort within all provinces in this type of research. As a result, statistics are limited. While we have data on the total consumption of alcohol, for example, our knowledge of the distribution of consumption by key variables such as age, is more limited. For illicit drugs, our knowledge is even more inadequate. Surveys conducted have not often used the same methods, therefore our ability to combine information or to compare over time or over geographic division is limited.

Mr. Guy Charpentier, Director General of Pavillon Jellinek, described to the Committee a school survey conducted in 1984. While acknowledging the desirability of repeating this survey so as to monitor trends, he told the Committee that the costs of a repetition do not allow this.

The Addiction Research Foundation has conducted regular cross-sectional surveys. A household survey, which was last conducted in 1984, is a random sample of people aged 15 and older. A second cross-sectional survey of Ontario high school students is conducted every two years. This same approach has now been adopted in the United States where a household survey and a school survey will be conducted periodically.

Effective approaches and efficient use of limited treatment and prevention resources demand a more comprehensive and timely data base. Effort must be appropriately targeted and their effects must be known. Amongst its responsibilities, the Standing Committee believes the new National Centre on Substance Abuse can assist this process by establishing a national data base.

30. The Standing Committee recommends that the proposed new National Centre on Substance Abuse develop a national substance abuse data base which would include results of national repeated cross-sectional household and school surveys.

Research is being conducted in every province of Canada. An efficient and truly national effort will require greater and more timely sharing of the results of this effort. For example, those who are planning school-based prevention programs should have the latest results of research on the efficacy of various program models. Treatment programs that are developing assessment tools should know about tools developed and piloted by similar programs. Increased sharing of information would make the system both more efficient and more effective.

It is important that current research findings be made more easily accessible to others. Both the production of standardized reports and the provision of information about particular research issues on request is required. The new National Centre should, among its other tasks, take major responsibility for meeting the substance abuse

information needs of health and social service professionals, educators, scientists, policy makers and government officials and the general public.

31. The Standing Committee recommends that the proposed new National Centre on Substance Abuse establish a clearinghouse for the dissemination of national and international information on alcohol and other substance abuse.

SUMMARY OF RECOMMENDATIONS

Prevention

1. The Standing Committee recommends that the Minister of National Health and Welfare through the National Health Research and Development Program support research on the causes of drug abuse.

2. The Standing Committee recommends that the Minister of National Health and Welfare, in collaboration with the provinces, introduce a new 50-50% cost sharing program with increased funding for the prevention of substance abuse.

3. The Standing Committee recommends that program funds under the proposed new cost-shared prevention program be made available to both professional and community groups through the relevant provincial bodies.

4. The Standing Committee recommends that the Department of National Health and Welfare identify children and youth as the first priority for funding under the cost-shared substance abuse prevention program.

5. The Standing Committee recommends that the Minister of National Health and Welfare negotiate with the Alcoholism and Drug Addiction Research Foundation (ARF) and with the appropriate provincial bodies the extension of the ARF Drug and Alcohol Information Line.

Treatment and rehabilitation

6. The Standing Committee recommends that the Minister of National Health and Welfare initiate discussion with the provinces aimed at developing a 50-50% federal cost-shared program within Health and Welfare Canada with increased funding for the provision of treatment and rehabilitation services for substance abusers.

7. The Standing Committee recommends that the Minister of National Health and Welfare identify children and youth as the first priority for funding under the proposed new cost-shared substance abuse treatment program.

Native alcohol and drug programs

8. The Standing Committee recommends:

   i. that the Department of National Health and Welfare establish substance abuse programs for non-status native people as a high priority for funding under the new cost-shared substance abuse treatment program; and

   ii. that *all* funding under this proposed new program be contingent on the provinces addressing the needs of non-status native peoples in their jurisdictions.

9. The Standing Committee recommends:

   i. that the National Native Alcohol and Drug Abuse Program (NNADAP) amend its objectives to allow program support for off-reserve status Indians and Inuit; and

ii. that this support be made available to appropriate community-based groups.

10. The Standing Committee recommends:

    i. that the membership of the National Native Advisory Council be more broadly representative of the aboriginal peoples of Canada;

    ii. that NNADAP and the broadened National Native Advisory Council jointly develop clear program priorities for aboriginal drug abuse programs; and

    iii. that decisions to fund projects under these new program priorities be jointly made by NNADAP and the National Native Advisory Council.

Driving while impaired

11. The Standing Committee recommends that the Minister of Transport initiate a study of the effect of various legal drinking ages on motor vehicle accident rates and related fatalities and injuries.

12. The Standing Committee recommends that the provinces consider a probationary licence system for new drivers that would make it an offence to drive a motor vehicle during this probationary license period, or to drive while below the provincial legal drinking age, with any measurable alcohol in the body.

13. The Standing Committee recommends that the federal and provincial Solicitors General work jointly toward implementing a national strategy to reduce impaired driving. This strategy should include:

    i. increased road-side spot checks to detect impaired drivers;

    ii. the availability in all police vehicles of portable Breathalyzer equipment;

    iii. a minimum penalty on second conviction for impaired driving sufficient to signal the very serious nature of the offence; and

    iv. the education of law enforcement personnel about the severity of the crime of driving while impaired.

14. The Standing Committee recommends that the Solicitor General and his provincial counterparts:

    i. review the extent to which "telewarrants" are being used to allow the taking of appropriate samples of blood by licensed medical practitioners from drivers believed to have been driving while impaired, but who, because of their impairment, physical injury or other reason are not capable of giving consent to the procedure or of providing a sample of their breath; and

    ii. encourage law enforcement agencies to make use of telewarrants where appropriate.

The workplace

15. The Standing Committee recommends that employers not introduce mass or random drug screening of either job applicants or employees. Only in exceptional cases in which drug use by employees constitutes a real risk to safety, the

Standing Committee recommends that drug screening may be introduced under the following conditions:

i. there must be cause, i.e. the employee must have shown evidence of impairment or of performance difficulties;

ii. the testing procedure must provide a secure chain of evidence to ensure samples have not been tampered with or unintentionally altered;

iii. the specimen must be collected in a manner which protects the privacy and dignity of the individual;

iv. all positive test results must be confirmed by gas chromatography/mass spectrometry, or tests of equal precision and specificity;

v. testing must be used to assist the employee in seeking appropriate treatment for drug abuse where warranted; test results should not be used as evidence in criminal proceedings;

vi. results of positive tests and confirmations should be conveyed to a licensed medical practitioner acceptable to both the employee and the employer. The employee will be given the opportunity to meet with the medical practitioner or to present evidence with regard to the positive finding before the medical practitioner recommends a course of action to the employee and the employer; and

vii. any limited drug testing which may be introduced must include screening for alcohol abuse.

16. The Standing Committee recommends:

i. that the policy proposed in recommendation 15 be immediately implemented by appropriate methods for all employees of the federal government, its Crown corporations, its agencies, boards and commissions; and

ii. that the Government of Canada consider legislation to limit and control mandatory drug screening in the private sector.

17. The Standing Committee recommends that Employee Assistance Programs be made available to all employees under the jurisdiction of the federal government and, wherever possible, these programs be introduced as a joint effort by management and labour.

18. The Standing Committee recommends that the immediate family members of federal government employees whose employment requires frequent moves or geographic isolation be eligible for participation in Employee Assistance Program.

Beverage alcohol

19. The Standing Committee recommends that the federal government maintain a level of beverage alcohol taxation to ensure that prices of beverage alcohol do not decline relative to real personal income.

20. The Standing Committee recommends that the Canadian Radio-Television and Telecommunications Commission (CRTC) require beverage alcohol advertisers to

provide public alcohol abuse educational messages equal to at least 15% of the total dollar value of their advertising of beverage alcohol.

21. The Standing Committee recommends that the Minister of National Health and Welfare ensure that warning labels are affixed to all alcoholic beverages.

Supply control

22. The Standing Committee recommends that the Minister of Justice table legislation requiring financial institutions operating in Canada to report to the federal government all cash transactions in Canadian or in foreign currencies of $10,000 or more, and that such records be retained by these institutions in a manner prescribed in regulations so as to facilitate the tracing of the proceeds of crime.

23. The Standing Committee recommends that the Minister of Justice, in cooperative efforts with his provincial counterparts, develop legislation to close "head shops" (commercial enterprises whose principal business is the sale of drug paraphernalia and items which describe their use and which advocate the use of illicit drugs).

24. The Standing Committee recommends that the Minister of National Health and Welfare establish an Expert Task Group to examine the feasibility of establishing national standards for provincial systems for the monitoring of mood-altering prescription drugs and to bring forth recommendations on the establishment of such systems.

Professional education and training

25. The Standing Committee recommends that the Minister of National Health and Welfare convene a committee of representatives of the professional associations concerned with the training of health professionals. This Committee, in consultation with experts in substance abuse, will identify the needs for enhanced professional education, and will bring forth recommendations for curricula changes with regard to the early identification of alcohol and drug-related problems, appropriate professional interventions, and prescribing practices.

Program evaluation

26. The Standing Committee recommends that all new substance abuse prevention, treatment and rehabilitation programs funded in whole or in part by the federal government include an evaluation component to monitor activities and to assess impact.

27. The Standing Committee recommends that the Department of National Health and Welfare provide training in program evaluation to community groups receiving program funds from the Department.

National Centre on Substance Abuse

28. The Standing Committee recommends that the Government of Canada extend its announced funding of the "National Focus on Drug Abuse" to include all five years of the initial commitment to a National Drug Strategy.

29. The Standing Committee recommends that the Minister of National Health and Welfare consider the creation of a National Centre on Substance Abuse. This National Centre, with a governing body composed of representatives of the federal and provincial governments, of the private sector and labour and of volunteer organizations should:

    i. conduct and promote basic and applied research on substance abuse;

    ii. disseminate information about substance abuse;

    iii. engage in public education and substance abuse prevention; and

    iv. encourage the application of new knowledge in clinical programs, prevention programs and research.

30. The Standing Committee recommends that the proposed new National Centre on Substance Abuse develop a national substance abuse data base which would include results of national repeated cross-sectional household and school surveys.

31. The Standing Committee recommends that the proposed new National Centre on Substance Abuse establish a clearinghouse for the dissemination of national and international information on alcohol and other substance abuse.

GLOSSARY OF TERMS USED IN THE REPORT

aboriginal peoples — Aboriginal peoples are the native North Americans. The term refers to native Indians, the Inuit and Métis.

addiction — For some people, the terms "addiction" and "addict" are used in a negative sense, implying moral weakness. When used by drug abuse experts the terms refer to the use of drugs when accompanied by physical dependence. Addiction is usually said to occur when the user is dependent, experiences tolerance (requires increasingly more of the substance to achieve the same drug effect) and experiences unpleasant physical withdrawal effects when the drug is removed. Because of the moral implications of the term "addiction", the World Health Organization recommends the use instead of the term "drug dependence".

alcohol (ethanol) — Although many people do not usually consider beverage alcohol to be a drug, it is a sedative drug. The most widely used and abused drug in Canada, alcohol produces central nervous system effects similar to those of other sedatives.

alcohol abuse — As with other forms of drug abuse, it is not clear what behaviours constitute alcohol abuse. Generally, it is felt that alcohol abuse occurs when the use of alcohol is engendered by physical or psychological dependence, when the use of alcohol causes physical, social or psychological problems.

blood alcohol level — Blood alcohol level is the concentration of alcohol in the user's body. Generally, where impaired driving is suspected, police measure blood alcohol level by use of the Breathalyzer. This device measures the amount of alcohol in exhaled breath and this acts as an index of the blood concentration of alcohol. In Canada, it is illegal to drive with a blood alcohol level in excess of .08 grams of alcohol per 100 millilitres of blood.

Breathalyzer — See blood alcohol level.

Canada Assistance Plan (CAP) — Canada Assistance Plan is a program of the federal government which provides assistance and welfare services. The program is cost-shared with the provinces. In 1987-88, the federal government will provide more than $4 billion to 2.5 million needy Canadians under CAP. A small amount of funding for alcohol abuse programs is available under CAP.

cannabis — Cannabis is a plant producing a psychoactive drug substance. The main mood-altering ingredient in cannabis is called "delta-9- tetrahydrocannabinol" or "THC". Marijuana is composed of the leaves of the dried cannabis plant. Hashish is the dried resin produced from the leaves. The drug can be smoked or ingested. Cannabis users seek the common short-term effect of euphoria. In higher doses, the drug can cause perceptual distortion, disorganized thought and hallucinations.

cocaine — Cocaine is extracted from the leaves of the coca plant which grows in South America. The drug is a powerful central nervous system stimulant. In Canada, cocaine is usually inhaled, but "crack", a cocaine derivative, is usually smoked. Cocaine can also be taken intravenously. In addition to the stimulant effects of cocaine, the drug often induces euphoria in users. Cocaine use increases the pulse rate, blood pressure, and the rate of respiration, reduces appetite and interferes with sleep. Psychological dependence on cocaine can occur. Cocaine has been implicated in sudden, unpredictable death in users.

cost-shared program — In this report, the term "cost-shared program" refers to a funding program in which 50% of the eligible costs of a provincial activity are provided by the federal government.

cross-sectional survey — A survey providing information at a given point in time. A survey which provides information concerning more than one point in time is called a "longitudinal survey".

demand reduction — This term refers to strategies aimed at decreasing the desire of individuals or groups to use drugs. Demand reduction includes prevention of drug use and the treatment of drug users.

drug abuse — There is no one generally agreed upon definition of "drug abuse". Drug abuse may be said to occur when the use of a drug is the result of the development of physical or psychological dependence on it, is damaging to the user's health, or creates social or psychological harm.

drug paraphernalia — Drug paraphernalia are items which are used to assist or enable illicit drug use. Drug paraphernalia consist of items which almost always have legitimate uses as well and may include such diverse items as balance scales for weighing drugs, water pipes for smoking hashish, mirrors and razor blades in "cocaine kits" and other items.

drug testing — Drug testing usually refers to the analysis of urine samples for the purpose of detecting illicit drug products. Drug testing has become a political issue with certain groups advocating its mandatory use in workplaces as a way of detecting and reducing illicit drug use.

Employee Assistance Programs — Employee Assistance Programs involve the development of written policies and procedures designed to assist workers who are experiencing substance abuse problems and other personal problems. Increasingly developed jointly by management and labour, Employee Assistance Programs help troubled workers to find needed treatment and rehabilitation.

epidemiology — Epidemiology is the study of the occurrence, distribution and causes of illness in human populations.

head shop — "Head shops" are commercial enterprises whose principal business is the sale of drug paraphernalia and items which describe their use and which advocate the use of illicit drugs. "Head shops" sell such drug paraphernalia as scales and balances for weighing drugs, kits for diluting cocaine and other drugs, hashish pipes, empty capsules to be filled with drug substances and other objects for illicit drug use along with informational material on the use of paraphernalia in the use of illicit drugs.

heroin — Heroin, one of the narcotic drugs, is a central nervous system depressant. Heroin has an analgesic effect, but is abused because of its euphoric effect on the user. Heroin abusers usually inject the drug, although it can also be inhaled or ingested. The drug can produce withdrawal distress. Heroin is not widely used in Canada.

Inuit — Inuit are one of the original aboriginal peoples in North America. Inuit, meaning "the people" were one of the original groups to settle the North. Inuit were at one time known to European settlers by the derogatory term "Eskimos".

Métis — The term "Métis" refers to people of mixed native North American Indian and European descent.

mood-altering drugs — Mood-altering drugs, or psychoactive drugs, affect the way the drug user thinks or feels. Such drugs include a wide variety of stimulants, depressants and hallucinogens.

multiple-doctoring — Multiple-doctoring is the use of more than one physician so as to secure additional prescriptions for drugs. Multiple doctoring may be done in order to secure additional drugs for the individual's own use or for illicit resale.

National Drug Strategy — The National Drug Strategy is a newly announced series of initiatives by the Government of Canada aimed at reducing substance abuse. The National Drug Strategy will provide an additional $210 million over five years to combat substance abuse.

National Native Alcohol and Drug Abuse Program (NNADAP) — NNADAP is a program within Health and Welfare Canada to provide support to substance abuse programs for on-reserve status Indians and Inuit. The program will contribute approximately $52 million in 1987-88.

National Native Advisory Council — This group acts as an advisory body to the National Native Alcohol and Drug Abuse Program and to the Minister of Health.

Native peoples — The term "native peoples" is often used interchangeably with "aboriginal peoples" to refer to the Indian, Inuit and Métis.

Person-year — A person-year is a measure of human resources, and refers to the employment of one person for one full year, or its equivalent, for example, two persons for six months each.

prescription drugs — Prescription drugs include all drugs requiring written order from a licensed medical practitioner.

prevalence — Prevalence is the total number of cases of a specific disease or condition in existence in a specified population at a specified period of time.

prevention — In the health care field, prevention may be said to be either "primary", "secondary", or "tertiary". Action taken before the onset of the problem is said to be primary prevention. Intervention taken when the symptoms or signs of the problem become known is termed secondary prevention. Tertiary prevention is treatment and rehabilitation aimed at minimizing the harmful effects of a condition. School-based drug abuse programs are examples of primary prevention in the area of substance abuse. A program aimed at assisting drug users to withdraw from drug use is an example of secondary prevention. Detoxification of chronic alcohol abusers is an example of tertiary prevention. In this report the term "prevention" generally refers to primary prevention.

program evaluation — Program evaluation is the application of social science methods to social and health programs in order to monitor activities, identify outcomes, analyze the relative costs and impacts of competing programs or models of service, and other studies to improve knowledge of the effects of programs.

solvents — Solvents are chemicals used in commercial and household preparations. They are highly volatile organic chemicals. Contained in such items as nail polish remover, glues, and gasoline, solvents can be inhaled so as to cause lightheadedness, exhilaration and excitation. Solvents can also cause disorientation, unconsciousness and seizures. Long-term effects can include weight loss, liver and kidney problems, irritability and depression.

substance abuse — Substance abuse includes the abuse of all mood-altering substances, including alcohol, solvents, prescription and non-prescription drugs. As with the term "drug abuse", there is no one generally agreed upon definition of "substance abuse". It may be said to occur when the use of a drug results in the development of physical or psychological dependence on it, is damaging to the user's health, or creates social or psychological harm.

supply reduction — Supply reduction refers to strategies aimed at decreasing the availability of drugs. Supply reduction includes the detection of illicit drugs, drug interdiction and drug law enforcement.

tranquilizers — Tranquilizers are a group of central nervous system depressants which can be taken either orally or by injection. These are the most frequently prescribed drugs in Canada. Now usually called "anxiolytics" or anti-anxiety drugs, these drugs have abuse potential. Effects of the use of these drugs include feelings of relaxation and well-being. Even at normal dosages, the drugs can reduce intellectual and perceptual functioning. Chronic users risk dependence on these drugs.

Vocational Rehabilitation for Disabled Persons (VRDP) — Vocational Rehabilitation for Disabled Persons is a federal government program providing financial assistance to the provinces in support of programs for disabled Canadians. The program is cost-shared. In 1987-88, the federal government will provide $95 million in support of provincial programs. It is estimated that $20 million of this will be in support of alcohol and drug abuse programs.

APPENDIX "A"

WITNESSES AND SUBMISSIONS

Issue No.	Date	Organizations and Witnesses
3	Thursday, December 11, 1986	**Carleton University**
		Dr. M. Parkes, Director of Research Resources Development Research Centre
		Peter Appleton, Director of Administration Resources Development Research Centre
		Dr. A. Sweeny, Research Associate Resources Development Research Centre
3	Thursday, January 22, 1987	**Royal Canadian Mounted Police**
		Chief Superintendent R.T. Stamler Director, Drug Enforcement
		Donald H. Heaton, Assistant Commissioner Commanding Officer of "F" Division
4	Monday, January 26, 1987	**Meadow Creek Addiction Treatment Centre (Royal Ottawa Hospital)**
		Dr. Allen Wilson, Director
		Dr. Douglas Tate, Program Coordinator
6	Thursday, February 5, 1987	**Individual**
		Norman Panzica, Independent Counselor Toronto, Ontario
		Department of Revenue Canada, Customs and Excise
		W.C. McKissock, Chief, Narcotics Interdiction and Intelligence Division

7	Monday, February 16, 1987	**Royal Canadian Mounted Police** Sergeant Michel Pelletier Drug Awareness and Education Program Westmount, Quebec **Saskatchewan Alcohol and Drug Abuse Commission** Howard Greenstein, Executive Director
8	Thursday, March 5, 1987	**University of Toronto** Dr. H. Kalant Department of Pharmacology Faculty of Medicine **Addiction Research Foundation** Dr. R.G. Smart, Director Prevention Studies
9	Monday, March 9, 1987	**Department of National Health and Welfare** Dr. Peter Glynn, Assistant Deputy Minister Health Services and Promotion Branch Lavada Pinder, Acting Director General Health Promotion Branch Dr. Irving Rootman, Acting Director Program Resources Division Health Promotion Branch Ron Dykeman, Policy Analyst Health Protection Branch
10	Tuesday, March 10, 1987	**CanCare Canada** Peter A. Lea, President Bill Graham, Vice-President **Rideauwood Institute** Paul Welsh, Executive Director

11	Tuesday, March 17, 1987	**Canadian Association of Chiefs of Police**
		D.N. Cassidy, Executive Director
		R.T. Stamler, Vice-Chairman Drug Abuse Committee
		Jacques Duchesneau, Director Montreal Urban Community Police
		Lawrence Hovey, Staff Sergeant Metropolitan Toronto Police
		Council on Drug Abuse
		Norman Panzica, Senior Consultant Independent Counselor, Toronto
12	Thursday, March 19, 1987	**Nova Scotia Commission on Drug Dependency**
		Marvin Burke, Executive Director
		Alberta Alcohol and Drug Abuse Commission
		Greg Stevens, Chairman
		Brian Kearns, Executive Director Program Services
13	Tuesday, March 24, 1987	**Alcohol and Drugs Program of British Columbia**
		David Gilbert
		Alcoholism and Drug Dependancy Commission of New Brunswick
		Joseph E. McIntyre, Executive Director
16	Monday, April 27, 1987	**Minister of National Health and Welfare**
		The Honourable Jake Epp
		Department of National Health and Welfare
		Dr. A.J. Liston, Assistant Deputy Minister Health Protection Branch

		Dr. D.E.L. Maasland Assistant Deputy Minister Income Security
19	Thursday, May 21, 1987	**Addiction Research Foundation**
		Dr. Joan Marshman, Director
		William Becks Treatment Services Consultant Community Services Division
		Garth Martin, Head Sociobehavioural Treatment Services
		Bruce Cunningham Employee Assistance Program
		Dr. Donald Meeks, Training
		Dr. Michael Goodstadt, Head Education Research Programme
		Henry Schankula, Director Education Resources Division
		Council on Drug Abuse
		Fred Burford, President
		Michael Harrison, Executive Vice-President
		Ottawa Board of Education
		Don Smyth Drug and Alcohol Abuse Consultant
20	Friday, May 22, 1987	**Alcohol and Drug Concerns Inc.**
		Alan Staig, Chairman Social Action and Legislative Committee
		Karl N. Burden, Executive Director
		Toc Alpha
		Michael DeGagné, Youth Coordinator
		Parents Against Drugs
		Joan Gitelman, Executive Director
		Walter Cebrynsky, Chairman

		John Garcia, Board Member
		Ontario Association of Chiefs of Police
		Superintendent Sefrin H. Ginther Officer in Charge Drug Enforcement Branch, Toronto
		Ontario Secondary Schools Principals Council
		George W. Peck, Chairman Drug Education Committee
		People to Reduce Impaired Drive Everywhere
		John Bates, President
		Canadian Institute for Guardianship
		Dr. D.V. Anderson
		Ontario Federation of Home and School Association
		Norma McGuire, Substance Abuse Chairman
		Central Toronto Youth Services
		Grant Lowery, Executive Director
21	Monday, May 25, 1987	**Native Council of Canada**
		Christopher McCormick, Vice-President
		Gail Graham, Second Vice-President of the Native Council, Price Edward Island
		Bob Groves, Special Advisor
		Individual
		Dr. Donald Morison Smith Former Chairman, United Nations Commission on Narcotic Drugs

Individual

John Jansen, Member of the Legislative Assembly of British Columbia
Chairman, Liquor Policy Review Committee

Victoria Police Department

William Snowden, Chief Constable

Douglas E. Richardson, Superintendent
Officer in Charge of Operations

Victoria Life Enrichment Society

Dr. C.H. Aharan, Director

Task Force on Alcohol and Drug Abuse in the Workplace

James M. Ryan, Chairman

Dr. Douglas Graham, M.D.
Technical Advisor

Images UnLtd.

Ludmyla Glover
Personal Development Consultant

Justis Chase
Personal Development Consultant

Individual

Donald W. Munro
Former Member of Parliament

Breakthrough Productions and the Society for Exploring Television with Children and Youth (ETC)

Joy Simons, Director

Hilary Jones-Farrow, Director

Evan Adams, Youth Participant

Daniella Sorentino, Youth Participant

Drug and Alcohol Rehabilitation Society of Greater Victoria

Dr. Ken Thornton, Board Member

		John Cantelon, Administrator
		Dr. Maureen Piercey, Consulting Physician
		British Columbia Medical Association
		Dr. Allan G. Clews, Chairman Committee on Substance Abuse
		Dr. Douglas Graham
		British Columbia Ministry of Health
		David Gilbert, Alcohol and Drug Programs
23	Wednesday, June 3, 1987	**Kaiser Substance Abuse Foundation**
		Ross Ramsey, President
		Alternatives Program for the Prevention of Chemical Dependencies
		Alan A.W. Podsadowski, Executive Director
		Alkali Lake Reserve
		Anastasia Nelson Alcohol and Drug Counselor
		National Native Alcohol and Drug Abuse Program (NNADAP)
		Phil Hall, Chairman National and Regional Board
		Horizon Institute
		Jon-Lee Kootnekoff, President and Director
		Individual
		Reta Felling
		British Colombia Ministry of Health
		Dr. Carl Stroh, Regional Manager Alcohol and Drug Programs
		Alcohol-Drug Education Service

		Art Steinmann, Executive Director
		Colin Mangham, Program Director
		British Columbia Telephone Company
		Doug Hockley, Programme Manager Employee Assistance
		University of British Columbia, Family Practice Unit
		Dr. Peter Grantham
24	Thursday, June 4, 1987	**Nechi Institute on Alcohol and Drug Education**
		Maggie Hodgson, Executive Director
		Alcohol and Drug Association of Alberta
		Douglas H. Russell, Director
		Alberta Alcohol and Drug Abuse Commission
		Dr. Stewart Clark Medical Pharmacology Consultant
		Federation of Saskatchewan Indian Nations
		Chief Paul Poitras, Chairman, Regional Board, National Native Alcohol and Drug Abuse Program
		Chief Melvin Isnana
		Poundmakers Lodge
		Pat Shirt, Executive Director
25	Monday, June 22, 1987	**Department of National Health and Welfare**
		J.D. Nicholson, Assistant Deputy Minister Medical Services Branch
		Richard Jock, Program Manager National Native Alcohol and Drug Abuse Program

		National Native Advisory Council on Alcohol and Drug Abuse
		Louise Mayo, Executive Director
		Poundmakers Lodge
		Pat Shirt, Director
		Union of Ontario Indians
		R.K. (Joe) Miskokomon Grand Council Chief of Anishinabek Nation
26	Tuesday, June 23, 1987	**University of Western Ontario**
		Professor Robert Solomon Faculty of Law
27	Monday June 29, 1987	**Department of Justice**
		Richard G. Mosley, General Council Criminal Law Policy and Amendments Section
		Ministry of the Solicitor General
		Kim Johnston, Policy Advisor R.C.M.P. Policy and Programs

APPENDIX "B"

OTHER REPRESENTATIONS SUBMITTED TO THE COMMITTEE

Brawner, Patricia

Cartier Manor

Drug Education Coordinating Council

Lévesque, Denis

Stonehenge Institute

Pursuant to Standing Order 99(2), the Committee requests that the Government table a comprehensive response to this Report within one hundred and fifty (150) days.

A copy of the relevant Minutes of Proceedings and Evidence of the Standing Committee on National Health and Welfare (*Issue No. 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, 26 and 27 of the Second Session of the Thirty-Third Parliament, which includes this report*) is tabled.

Respectfully submitted,

Bruce Halliday, M.P.
Chairman

MINUTES OF PROCEEDINGS

TUESDAY, AUGUST 4, 1987
(39)

The Standing Committee on National Health and Welfare met *in camera*, at 9:10 o'clock a.m., at the O'Brien House, Meech Lake, this day, the Chairman Bruce Halliday presiding.

Members of the Committee present: Sheila Copps, Bruce Halliday, Paul McCrossan, Howard McCurdy, Barry Turner, Brian White.

Other Member Present: Gilles Grondin.

In attendance: *From the Library of Parliament*: Paul D. Rosenbaum, Research Officer.

The Committee resumed consideration of the Order of Reference pursuant to Standing Order 96(2) relating to the mandate of the Department of National Health and Welfare with regard to the study of alcohol and drug abuse in Canada.

The Committee commenced consideration of a draft report to the House of Commons.

By unanimous consent, it was agreed, — That the Committee authorize the expenditure of funds from the Committee budget to pay the costs incurred for the two-day working session held at Meech Lake.

At 12:00 o'clock p.m., the sitting was suspended.

At 1:30 o'clock p.m., the sitting resumed.

At 5:30 o'clock p.m., the sitting was suspended.

At 6:30 o'clock p.m., the sitting resumed.

At 8:30 o'clock p.m., the Committee adjourned to the call of the Chair.

WEDNESDAY, AUGUST 5, 1987
(40)

The Standing Committee on National Health and Welfare met *in camera*, at 9:00 o'clock a.m., at the O'Brien House, Meech Lake, this day, the Chairman Bruce Halliday presiding.

Members of the Committee present: Sheila Copps, Bruce Halliday, Paul McCrossan, Howard McCurdy, Barry Turner, Brian White.

In attendance: *From the Library of Parliament*: Paul D. Rosenbaum, Research Officer.

The Committee resumed consideration of the Order of Reference pursuant to Standing Order 96(2) relating to the mandate of the Department of National Health and Welfare with regard to the study of alcohol and drug abuse in Canada.

The Committee resumed consideration of a draft report to the House of Commons.

At 1:00 o'clock p.m., the Committee adjourned to the call of the Chair.

TUESDAY, SEPTEMBER 1, 1987
(41)

The Standing Committee on National Health and Welfare met *in camera*, at 9:14 o'clock a.m., in Room 306 of the West Block, this day, the Chairman Bruce Halliday presiding.

Members of the Committee present: Sheila Copps, Bruce Halliday, Howard McCurdy, Barry Turner, Brian White.

In attendance: *From the Library of Parliament*: Paul D. Rosenbaum, Research Officer.

The Committee resumed consideration of the Order of Reference pursuant to Standing Order 96(2) relating to the mandate of the Department of National Health and Welfare with regard to the study of alcohol and drug abuse in Canada.

The Committee resumed consideration of a draft report to the House of Commons.

At 12:47 o'clock p.m., the sitting was suspended.

At 3:40 o'clock p.m., the sitting resumed.

At 4:24 o'clock p.m., the sitting was suspended.

At 5:00 o'clock p.m., the sitting resumed.

At 5:55 o'clock p.m., the Committee adjourned to the call of the Chair.

THURSDAY, SEPTEMBER 17, 1987
(42)

The Standing Committee on National Health and Welfare met *in camera* at 3:27 o'clock p.m., in Room 371 of the West Block, this day, the Chairman Bruce Halliday presiding.

Members of the Committee present: Sheila Copps, Bruce Halliday, Howard McCurdy, Barry Turner, Brian White.

In attendance: *From the Library of Parliament*: Paul D. Rosenbaum, Research Officer.

The Committee resumed consideration of its Orders of Reference pursuant to Standing Order 96(2) relating to the mandate of the Department of National Health and Welfare with regard to the study of alcohol and drug abuse in Canada.

The Committee resumed consideration of a draft report to the House of Commons.

By unanimous consent, it was agreed, — That the Committee authorize the expenditure of funds from the Committee budget to pay the costs incurred for the preparation of graphs and of a distinctive cover for use in the printing of the Committee's First Report to the House.

By unanimous consent, it was agreed, — That the Committee print 5,000 copies of its First Report to the House in tumble bilingual format with a distinctive cover.

By unanimous consent, it was agreed, — That the title for the Committee's First Report to the House shall be: "Booze, Pills and Dope — Reducing Substance Abuse in Canada".

By unanimous consent, it was agreed, — That the Committee authorize the expenditure of funds necessary for engaging the services of an editor for the First Report to the House.

By unanimous consent, it was agreed, — That the draft report, as amended, be adopted as the Committee's First Report to the House and that the Chairman be authorized to make such typographical and editorial changes as may be necessary without changing the substance of the report and that the Chairman be instructed to present the said report to the House.

By unanimous consent, it was agreed, — That pursuant to Standing Order 99(2) the Committee request that the Government table a comprehensive response to its First Report.

At 5:10 o'clock p.m., the Committee adjourned to the call of the Chair.

Patricia Russell
Clerk of the Committee