Response to Follow Up Request from the
Standing Senate Committee on Aboriginal Peoples – 27 February 2018

Question/Request #1:

Senator Lovelace Nicholas: […]

As you know, there is **prescribed medical marijuana** and my concern, […]is that a lot of people can't afford to buy it. **So […] they wanted […] to see if there was a possibility that the marijuana that they have to use […] could be paid for.**

Ms. Gideon: At the First Nations and Inuit Health Branch, we have the Non-Insured Health Benefits Program for First Nations and Inuit that covers a broad range of supplemental health benefits, including prescribed medications, so I'll respond.

We have absolutely looked at coverage of medical marijuana. The problem is that it does not have a notice of compliance and it is not a medication, so to speak, that is dispensed in that manner, and so it is not something that we can cover within the context of the program.

There is also not a strong clinical evidence with respect to medical marijuana at this stage. **We do,** however, **cover medications that do have some of the medicinal properties of medical marijuana under the program**, and those are alternatives for elders or people suffering from chronic pain to consider.

We do have some information about this that we could provide to the committee that we have provided to First Nations that have inquired about why the program does not cover medical marijuana. I could certainly forward that on.

Answer:

The Non-Insured Health Benefits (NIHB) Program maintains a list of drugs provided as benefits to eligible First Nations and Inuit clients. Eligible drug benefits are identified and compiled on this NIHB Drug Benefit List by the NIHB Program with the advice of the pan-Canadian Common Drug Review of the Canadian Agency for Drugs and Technologies in Health and the NIHB Drugs and Therapeutics Advisory Committee (DTAC). DTAC includes practicing pharmacists and physicians, some of whom are First Nations. In their review of drugs, these Committees follow an evidence-based approach and consider current medical and scientific knowledge, current clinical practice, health care delivery and specific client health needs. It is the goal of the Program to maintain a comprehensive list of cost-effective drugs which will allow practitioners to prescribe an appropriate course of therapy to their clients. The list is updated on a regular basis.

In order for a drug to be listed on the DBL the drug must: (1) be approved by Health Canada under the *Food and Drugs Regulations*, and have a Notice of Compliance (NOC) signifying compliance with the Regulations, and have a Drug Identification

Number (DIN) signifying the product passed a review of its formulation, labelling and instructions for use and serving as a tool to help in the follow-up of the product on the market, recall of products, inspections, and quality monitoring; (2) be prescribed by a licensed practitioner and dispensed by a pharmacist; and (3) be reviewed by the Canadian Agency for Drug Technologies in Health's (CADTH) Common Drug Review process and/or NIHB's expert committee, DTAC.

Medical cannabis does not meet these requirements: there is no DIN or NOC; medical cannabis is not dispensed by a pharmacist; and neither CADTH nor DTAC would review medical cannabis for listing recommendation because of its regulatory status and the lack of quality evidence as to its safety and effectiveness. In addition there is a lack of information around its indications for use, therapeutic and toxic dosages, and knowledge of interactions with other medications.

The drug nabilone, a synthetic cannabinoid, is listed as an NIHB benefit for patients with nausea and vomiting due to chemotherapy and for use in palliative care. Requests are also considered on a case-by-case basis for a variety of conditions when supported by clinical evidence. Below are the nabilone drug products available on the NIHB Drug Benefit List.

Cannabis Legalization and Regulation Branch input (Health Canada - CLRB)

Health Canada Licensed Producers- Compassionate Programs
Under the *Access to Cannabis for Medical Purposes Regulations*, the availability, pricing and variety of cannabis strains sold for medical purposes in Canada are business decisions made by each federally licensed producer.
As of September 2017, the following licensed producers offered some form of compassionate pricing program:
ABcann
Aurora
Bedrocan
Canada's Island Garden
Canna Farms
CanniMed
CannTrust
Delta 9
Emerald Health
Green Relief
Mettrum
Organigram
Peace Naturals
Tilray
Tweed
WeedMD

Please note that these programs are subject to change, and may be “capped” and at capacity. This list does NOT include any licensed producers that offer universally low pricing (as of January 2, 2018, the prices for dried marijuana range from $4 to $17.50 per gram; the prices for cannabis oil range from $1.20 to $4.67 per milliliter) or new producers recently licensed by Health Canada.

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Question/Request #2:

Senator Patterson (Acting Chair): Is marijuana better or worse than tobacco for lungs and lung cancer?

Ms. Gideon: I'm not a medical doctor so I can't answer that question, but we can certainly forward the response based on the evidence that we have.

Answer:

The evidence of harms associated with smoking tobacco is categorical. Studies have demonstrated conclusive evidence of an association between smoking tobacco and lung diseases as well as lung cancer. Harms to the lungs from smoking tobacco include: increased airway inflammation, compromised immune status, coughing, wheezing and phlegm, accelerated lung function decline, chronic obstructive pulmonary disease (COPD), increased risk of lung infections including tuberculosis and pneumonia, and exacerbation of asthma. With respect to cancer, the evidence conclusively demonstrates that tobacco smoking causes lung cancer.

Research suggests that cannabis smokers display many of the same respiratory symptoms as tobacco smokers, including cough, wheezing, phlegm, and shortness of breath. However, studies have not demonstrated conclusive evidence of a link between smoking cannabis and lung cancer or other lung diseases such as COPD.

Tobacco and cannabis are different substances and their patterns of use differ as well. As a result, comparing their harms is challenging. While there is ample evidence of the harms associated with tobacco smoking from decades of research, research on the association between cannabis smoking, lung diseases and lung cancer has been limited and results are conflicting. Overlapping patterns of use (i.e., some cannabis smokers may also smoke cannabis with tobacco and/or may be tobacco smokers) also pose challenges in teasing apart the risks and harms of smoking cannabis from smoking tobacco. Ongoing research is fundamental to understanding the health and safety effects of cannabis use.

Furthermore, cannabis can be consumed in many ways other than smoking that avoid many of the health risks associated with smoking. For example, the Canadian Cannabis Survey showed that cannabis edibles (which are ingested orally) are a popular method of consumption in Canada. Cannabis can also be vaporized or applied topically. The Government has committed to developing regulations to support the sale of edibles and concentrates within one year following the coming into force of the proposed Cannabis Act, if it is approved by Parliament.

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Question/Request #3:

Senator McPhedran: […]

[…] It's about the approaches to youth in particular in terms of prevention and cessation strategies. It's a question as to **whether or not you're conducting gender-based analysis when you're assessing effectiveness of the programs** in both of these areas and also whether any of the programs include elders as part of what is being delivered at the community level.

Ms. Gideon: The answer is yes on both counts. Absolutely we are, and when we did a modernization of the long-standing National Native Alcohol and Drug Abuse Program, […] (it was) identified that the program was not reaching youth effectively and also that the program lacked support services for women such as pregnant women who had substance use issues.

[…] we did leverage those resources (from the National Anti-Drug Strategy Evaluation program) in order to be able to modernize those centres and those programs in communities to be able to increase accessibility to those populations.

That is something we want to continue to build on […] So we have continued to monitor our approaches and looking for effective models specifically for youth and for women at risk.

[…]

Senator McPhedran: Could results of that analysis be shared with us?

Senator Patterson (Acting Chair): Did you hear that question? Okay, you can share results through the clerk.

Answer:

From 2007 to 2011, Health Canada worked in partnership with the Assembly of First Nations (AFN) and the National Native Addictions Partnership Foundation (NNAPF) [now Thunderbird Partnership Foundation] to carry out a comprehensive, community-driven review of substance use-related services and supports for First Nations. This review included a wide range of knowledge-gathering and consensus-building activities including regional addiction needs assessments, a national forum, a series of research papers, regional workshops, and an Indigenous knowledge forum.

A national Renewal Leadership Team was formed in 2010 to guide the implementation of the national framework at community, regional, and national levels. This Team

created a work plan, with support from AFN, NNAPF, and Health Canada, to guide renewal efforts.

In 2011, this review resulted in the development of the report, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*. This framework outlined a strength-based, systems approach to addressing substance use and associated mental health issues among First Nations people.

At the time of *Honouring our Strengths* (2011), a formal gender-based analysis process had yet to be established. However, when the Leadership Team was being created it was expected that the team would be inclusive of individuals who had been involved in policy development or service delivery at a community, regional or national level, including Elders and youth.

Notwithstanding, the lack of a formal gender-based analysis process, the *Honouring our Strengths* report found that targeted interventions for key populations, (i.e. pregnant women, youth, and LGBT2Q), needed more attention in the design and implementation of early identification and intervention strategies. The report noted there was a significant body of research demonstrating the effectiveness of prevention, outreach, early identification and intervention services targeted at youth and adolescence as a cost-effective means for reducing substance use issues later in life (e.g., youth-specific interventions such as programs for personal development, cultural ceremonies, peer education and outreach initiatives, anti-gang initiatives, and school-based early identification and intervention). http://nnadaprenewal.ca/?page_id=7

The report also noted that all of the 56 First Nations addiction treatment centres provided culturally-relevant inpatient, outpatient, and day treatment services for alcohol and other drugs. Most of these still use a number of treatment approaches—often a blend of cultural and mainstream—as well as life-skill and self-care techniques. Programs can vary in length but are usually between 29 and 42 days. At present, 10 programs provide specific programming for families while 12 are directed at youth. Nine focus mainly on solvent abuse and 17 are gender-based. These treatment centres are accessible either on an ongoing basis, or for certain clients, when needed.

While the Leadership Team for the *Honouring our Strengths* framework no longer exists, the ongoing implementation of the framework now occurs through the broader implementation of the *First Nations Mental Wellness Continuum Framework*. This implementation builds on the comprehensive, community-driven review of substance use-related services and supports for First Nations that culminated in *Honouring Our Strengths* report as a highly successful model in strengthening the system of addiction services for First Nations people.

More recently, funding has been secured to enhance the delivery of culturally appropriate addictions treatment and prevention services in First Nations communities with high needs that will continue to strengthen the system of addictions services for

First Nations people. As well, Budget 2018 resources are subject to mandatory gender-based analysis in the program formulation and implementation.

Since First Nation and Inuit addiction programs are community-driven, the question of whether Elders are consulted and incorporated into the design of the program remains a community led decision. Some communities feel it is integral to incorporate these types of cultural and spiritual supports within their programs. For example, in the Chisasibi Land-Based Healing Program, Elders develop and deliver the program in collaboration with other traditional counsellors with occasional support from Chisasibi clinical staff.