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**EVIDENCE**

## Thursday, October 6, 2016

## Vice Chair

**Mr. Len Webber**

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● (0850)

[*English*]

**The Vice-Chair (Mr. Len Webber (Calgary Confederation, CPC)):** Hello, everyone. I'd like to call the meeting to order here, please. We are continuing today our study of the opioid crisis in Canada. I am going to get right into it quickly, because we have a lot of work to do today.

I'd like to introduce our panel this morning. From the British Columbia Coroners Service, we have Lisa Lapointe, the chief coroner. Thank you, Lisa, for coming.

From the British Columbia Ministry of Health, we have Bonnie Henry, the deputy provincial health officer. Thank you, Bonnie.

We also have David Juurlink from the Sunnybrook Health Sciences Centre in Toronto. David is the head of the division of clinical pharmacology and toxicology at Sunnybrook.

From the Drug Users Advocacy League, we have Sean LeBlanc, the founder and chair. Thanks, Sean. We also have Catherine Hacksel, a community organizer and research assistant. Thanks, Catherine, for coming.

Let's get right down to it here. We'll start with the British Columbia Coroners Service, and Lisa Lapointe. Thank you, Lisa.

**Ms. Lisa Lapointe (Chief Coroner, British Columbia Coroners Service):** Good morning. Thank you for having me. It will be a challenge to confine my remarks to 10 minutes, because there's so much to say about this crisis that is happening, but I will do my very best.

I'm going to tell you a little bit about the coroners service's investigation so you have a bit of an understanding of how we gather this information; some highlights from the data; information on the collaborations we've developed in B.C. in an attempt to reduce the number of deaths that are happening; and then some of the strategies we've developed moving forward.

One of the key points is the importance of thorough death investigations. If you're not doing the investigations and gathering the information, of course you don't know that you have a problem. That sounds very much like common sense, and I'll talk about that in a minute.

Then there is strategic surveillance. Again, if you're not doing the surveillance on the deaths, you don't know you have a problem. It's interesting to see across the country the different surveillance and reporting that's happening on these types of deaths.

The B.C. Coroners Service has 90 coroners across the province. The coroners actually respond to all sudden, unexpected deaths, so they go to the scene of death and do a thorough investigation, which includes an examination of the deceased, an examination of the scene, and then a collection of the medical history of the deceased. That information is critical in determining next steps. If you don't have the suspicion that this death may be linked to drug use, then you won't order the appropriate testing and you won't have the appropriate results. That sounds really like common sense, but it's really important to do a thorough scene investigation of each of these sudden, unexpected deaths.

The coroners work 24-7, and that's important. People die all over the province at different times. We have a very clear investigative protocol, which ensures that consistent information is collected on every death. Again, that is critically important if you're looking for patterns.

We also have in B.C. a dedicated research unit. Again, that seems to be a matter of common sense, but unless you make a decision to do surveillance on a type of death, you won't have the data. Across the country this varies, with every province and territory doing something different. In B.C., we decided to do some pretty focused surveillance on our drug deaths, which has resulted in the data that we now have and been able to share publicly. Those strategic decisions really can be made death investigation by death investigation and province by province, and they will vary across the country.

Something I want to talk about is how we have always heard the term “overdose”. In my coroners service we are starting to shift our terminology, because “overdose” suggests that there's a safe dose. It also has a bit of a pejorative tone, implying that perhaps if the user had used the right dose, they wouldn't have died. In fact, that's really misleading, because for many of these drugs, there is no safe dose. “Overdose” suggests that there's a safe dose; there isn't. We really want to move away from that, so our reporting from now on will no longer talk about overdose deaths. All of these illicit drugs, the opiates and the non-opiates, are manufactured in very suspect circumstances, and you never know what's in the substance that you're taking.

I also wanted to make clear that I know that the meeting today is focused on the opioid crisis, but the deaths we've been reporting are related not just to opioids. While B.C.'s reporting on illicit drug deaths includes opioids, such as heroin and fentanyl, for example, it also includes other illicit drugs, such as cocaine, MDMA or ecstasy, and methamphetamines. The high numbers of illicit drugs, which are going up month by month, include all of those substances, not just opioids. They also include prescription medications that have been diverted; there is a small market for people selling their prescription medications, but we're not seeing a lot of that in this crisis.

Again, toxicology testing is critically important. If you haven't identified that illicit drug use or any substance use may be a factor in the death, then you won't order the appropriate testing. That again speaks to the importance of the initial investigation and then the toxicology testing.

● (0855)

We have in British Columbia something called "expedited" toxicology testing, which means our provincial toxicology centre will give us results within 48 to 72 hours. That doesn't happen elsewhere in the country. I've spoken to my colleagues, chief coroners and chief medical examiners across the country, and they don't have that ability. That expedited toxicology, the ability to get information back from the lab very quickly, is really key in getting the messaging out in a timely manner.

As I think you know, British Columbia so far, to the end of August, has had 488 illicit drug-related deaths. That compares with 505 for the whole of last year. Just to give you a bit of context, in the whole of last year British Columbia had 300 motor vehicle incident fatalities. This epidemic of death is much more significant than the deaths we're seeing on our roads, which we have numerous strategies in place to try to resolve. We're seeing approximately 61 deaths a month due to illicit drugs. If that number continues to the end of the year, we'll have 732 deaths in 2016. That's quite a significant increase. The significant rise started in 2012, which is, ironically, when we first saw fentanyl appear on our horizon.

Although we're seeing deaths among all ages, the deaths we're seeing primarily are among males between the ages of 19 and 39. Most of the deaths involve those who use illicit drugs habitually, but we have seen deaths of recreational users, such as people who all use drugs at a party. We've had situations, in fact two or three in the last couple of months, where five or six people at a party "overdosed", for lack of a better term, became very ill, and were treated. In most of those cases they've all survived. although we've had one or two fatalities. Generally, then, it's the people who use drugs habitually that we're seeing among the deceased, but we are also seeing some recreational users.

As well, a number of people who use drugs quite consistently are what we would call "high-functioning users". That sounds pejorative, and I don't mean it to be, but it's people who go to work, hold steady jobs in all sorts of occupations, and routinely use illicit drugs. That's a fairly significant population as well.

Most of the deaths we're seeing involve mixed substances. Very few involve just heroin, or just fentanyl, or just cocaine. In fact we looked at 207 results recently, and 96% of those were mixed-drug deaths. Cocaine was involved in 46%, alcohol 36%, methamphetamines 34%, and heroin 30%—and that was with fentanyl.

The proportion of illicit drug deaths where fentanyl has been detected has grown substantially since 2012. We saw 5% of our illicit drug deaths in B.C. involving fentanyl in 2012. That's up to 60% in 2016. That's a significant increase. That's not to say that fentanyl is the cause of all of those deaths, but fentanyl was detected at varying levels in the toxicology results of all of those deaths. If there were no fentanyl, we don't know how many deaths we would see. If we removed all the fentanyl deaths, we would have at least 200, but our numbers for previous years suggest that it would be between 200 and 300. The involvement of fentanyl appears to be doubling the deaths we're seeing.

I won't spend any time talking about what fentanyl is. I think you know that it's a synthetic opioid traditionally used for pain management. It's become increasingly prevalent on the illicit markets, brought in from other countries, primarily Asian countries, but also manufactured in clandestine labs in B.C. When you think of a lab, you tend to think of white coats and sterile circumstances. In fact these labs are people's kitchens and people's basements. They are quite random, in a way. They're trying to measure substances appropriately, but they're blending them in juice blenders and Mixmasters. The compounds are by no means secure or safe. These labs are often, as we can see with the number of deaths, getting their mixtures wrong. The police are well aware of that. They're finding fentanyl in pill form and in liquid form. It's used in a variety of ways.

● (0900)

What we're experiencing in B.C. are deaths due to illicit drugs, including a significant percentage due to fentanyl. We're often seeing unsuspecting use. People think they're purchasing cocaine, for example, and it's laced with fentanyl. They're either becoming very ill and being treated and surviving, or they're dying.

We found a paradox with warnings. We've tried to work closely with our police community on this. The language around this epidemic is very important. We've had our law enforcement partners often wanting to go out and say "There's very strong heroin on the street", or that fentanyl is "very strong" or "powerful", but those words can be triggers.

Paradoxically, we now have people actively seeking fentanyl because of the bigger high. It's really important to remember that we should be talking about the risks and the toxic effect, but not necessarily that this is a more powerful drug or a stronger drug.

I'll wrap up. One of the really important things is the messaging. We've gone out with public messaging and talking about what to say and what not to say. In B.C., we've adopted a harm reduction approach. Shaming and blaming does not help. We want to ensure that people, if they're going to use, have medical assistance nearby. That's the biggest message that we're giving: “Don't use alone, but have somebody there who can help you out if get into trouble.”

We have a multi-sectoral partnership. If not for the collaboration of a variety of groups, we wouldn't have been able to approach this crisis the way we have. We have BC Ambulance, the health communities, the corner service, law enforcement, and the labs all working together to try to collaboratively come up with solutions.

One of the changes that BC Ambulance has adopted is a policy not to call police every time they respond to an overdose. Again, the emphasis on encouraging people to ask for help, as opposed to being afraid they're going to be arrested or that somebody is going to be in trouble. It's that the shift toward preventing deaths. Thank you.

**The Vice-Chair (Mr. Len Webber):** Thank you, Lisa.

We'll move on quickly to Dr. Bonnie Henry from the B.C. Ministry of Health. She's the deputy provincial health minister.

**Dr. Bonnie Henry (Deputy Provincial Health Officer, British Columbia, Office of the Provincial Health Officer, British Columbia):** Thank you. I'm the deputy provincial health officer, not the deputy minister.

**The Vice-Chair (Mr. Len Webber):** The officer, and not the minister.

[*Translation*]

**Dr. Bonnie Henry:** Thank you, Mr. Chair.

Thank for your this opportunity to present the work that British Columbia has done to respond to this tragedy.

[*English*]

I have a short presentation that will illustrate some of what Lisa talked about.

This response, as our coroner indicated, has been across the health sector and public safety in B.C. This is the first time that we have used the Public Health Act in B.C. to declare an emergency. The provincial health officer, Dr. Perry Kendall, declared an emergency on April 14 of this year, when we started to see the dramatic increase in the number of people who were dying from these overdoses. What that allowed us to do was to collect information that we couldn't necessarily receive without this order, and it allowed us to get information in a more timely and detailed way. One of the things we needed was to understand a little better who was being affected by this.

The data we collect on people who are surviving overdoses is really important in helping direct our programs and our response to this as well. We have started to receive data from emergency departments, from 911 calls, and from our ambulance service about people who are surviving overdoses. That has helped us look at how we can make naloxone, for example, more available. I'll talk about that in a minute.

In June, we had an overdose action summit, where we had people from public safety, law enforcement, and the health sector, as well as people with lived experience and people who use drugs. We had a lot of brainstorming about the things we can do to address the death crisis we are dealing with, but also, longer-term, to address the whole issue of over-prescribing opioids and the other factors that have led to some of the issues.

We have developed new guidelines for prescribing opioids that came out of the College of Physicians and Surgeons of British Columbia. Those are being looked at across the country.

With the help of the federal government, we've made it easier for doctors to prescribe Suboxone, which is a combination opioid substitution treatment that allows people to get away from the use of illicit drugs and gives them the opportunity to take a different path.

In July, the premier appointed a joint task force with health and law enforcement that is co-chaired by Dr. Perry Kendall and Clayton Pecknold, our chief of police services in B.C.

A couple of things happened after that. As you may be aware, InSite, which is one of the only supervised injection service sites in Vancouver, a stand-alone site in Downtown Eastside, expanded its hours because of the data we were collecting, which showed peaks in overdoses and deaths around certain periods of time.

We launched a public awareness campaign, because, as indicated, it is not just about people who are using drugs on a regular basis. There are many different populations being affected, including people who are prescribed opioids for very valid reasons, but in very high doses, and who overdose on those.

One of the big successes we've had is expanding our take home naloxone program. We started that program in B.C. about three years ago, in 2012. We have now distributed over 13,000 free naloxone kits. These are for people who use drugs to help each other, and many overdoses have been survived because colleagues, friends, or family members have used naloxone. Now, thanks to the delisting and approval of nasal spray naloxone, we have police departments, fire departments, and emergency departments now providing naloxone and using it to help. Just in September, naloxone was deregulated, so now it does not need to be prescribed by a pharmacist, and we can distribute it through many of our public health distribution places across the province.

● (0905)

This slide is the data that the coroner described, from which we've seen a dramatic increase in overdose deaths in the last two or three years. The final column on this page, on the far right, is just until the end of August 2016. As you can see, we are on track to far exceed the number of deaths that we saw last year. This reflects the number of deaths; it does not reflect the fact that we're seeing hundreds of people in emergency departments across the province who are surviving their overdoses. That is a critical period of time when we can intervene, and a place where people at the very least can get naloxone and training on how to use naloxone. It's an opportunity to get connected, where they might be amenable to taking another path away from drugs.

I'm going to show a series of maps that we put together once we started collecting more detailed data on where overdoses are occurring in B.C. This is to give you a sense of why there has been such an across-government and across-province response.

This is rates by population. The darker the red, the higher the rates. This is from the distribution of illicit drug overdose deaths in British Columbia in 2016, from January to March. The comparison is with 2010. In 2010, what we used to see, and what people typically think of, were overdoses in the Downtown Eastside in Vancouver. But we're now seeing it happening across the province in communities everywhere in B.C., in the north, the interior, the Island, not just the Downtown Eastside in Vancouver. In Vancouver, it's not just in the areas that we have seen it in the past, but all around Vancouver. People are dying in public places and in their private homes.

This is some of the information that Lisa presented as well, just in a pictorial form. It shows you the percentage of these illicit drug deaths where fentanyl has been involved. It has dramatically increased from less than 5% in 2012 to over 60%, but as she indicated, these don't happen in isolation. Alcohol is very frequently a factor, and other drugs as well. It has been somewhat alarming in that most people we hear from are community members who are partners in this response, and they say there's very little heroin left in B.C. It's all illicit fentanyl. It's much more easily imported than heroin because you need such a small amount, and drug dealers are looking at maximizing their profits. It's easier for them to manufacture it and bring it in than heroin, so there's very little heroin left.

More disturbing, we are now seeing it being mixed with stimulants like cocaine. People do not necessarily expect to find a depressant, like opioids, like fentanyl, mixed with those drugs. They're not necessarily prepared and that's where we're seeing clusters of overdoses in people who are weekend users of cocaine, for example, where they don't have naloxone or the training about what to look for and how to respond.

As indicated, most of the deaths that we're seeing are of young men, many of whom had been using drugs for some time. It's really a case of roulette, if you will. If you're using on a regular basis, your chances of getting a toxic dose of fentanyl just go up that much higher. Every day that we can keep people alive is a day that they may move on a different path.

This is a description of how we have organized our response. We have a joint task force that reports up to our Minister of Public Safety and Solicitor General, and the Minister of Health. It's chaired by Dr. Kendall and Clayton Pecknold, the director of police services in B.C.

We have a large group in the middle of that pink box of people who are stakeholders in this response, from law enforcement and health to people with lived experience, including families of drug users, the drug-using community, people who use drugs. They give us very valuable advice about the issues that are happening on the street, and also about our response, what makes sense and what doesn't make sense for them. It's been an invaluable group to help us in shaping what we can do.

Then we have a number of task groups, and I'll talk about some of the things the task groups are working on. Our immediate three-month work plan has a number of specific issues.

● (0910)

One of the biggest things we wanted to initiate was to expand the reach of naloxone. Its deregulation at the federal level so that it is now a non-prescription substance has been a huge help for us, because we now have an inter-nasal formulation available. It's particularly useful for law enforcement, who didn't feel comfortable using the injectable form. Most of it is the injectable form, and we have a lot of good evidence that the injectable form works well. People can very easily learn to use it. We have some videos that we've developed for young people in particular that are entitled, “Naloxone Wakes You Up”, which tell them how to use it. We'd be happy to share those with people.

We've done a lot of work around opioid substitution treatment, making it more available and teaching physicians how to use it, particularly Suboxone, which is a much safer form of opioid substitution treatment, delinking it from the methadone programs that we've had in the past. We've also expanded its use to the nursing practice so that nurses can monitor opioid substitution treatment as well.

**The Vice-Chair (Mr. Len Webber):** Great, Bonnie.

**Dr. Bonnie Henry:** Some of the other areas that—

**The Vice-Chair (Mr. Len Webber):** Bonnie, excuse me, but I'm going to give you about another minute, if you don't mind.

**Dr. Bonnie Henry:** Yes, I'm on my last one.

Some of the other things we're expanding are around drug checking, the ability for people to check their drugs to see if there's fentanyl in them prior to taking them. There are some legislative barriers to those. We are doing monitoring and surveillance, increasing our access to supervised consumption services around the province—and again, there are some legislative barriers at the federal level, which it would be helpful to us if they were addressed.

Also, we are doing quite an extensive public education and awareness campaign around licit fentanyl and what to do about it.

This is just a graph that shows the number of naloxone kits we've distributed in the province.

To sum up, there are a couple of things that we would like to bring to your attention. The province would like support in expanding our supervised consumption services. In particular, the Respect for Communities Act has a number of barriers that are quite extreme that we would like to see reduced or eliminated. We understand there's a need to make sure that these safe consumption services are developed in a way that is safe and that has community support. We have ways of doing that which we think can meet the spirit of the bill without the extreme barriers that the bill puts in place.

We would like to work with the federal government to ensure granting of exemptions under the Controlled Drugs and Substances Act for the purpose of drug checking, which is something that we think can be an important service in helping people understand what they're taking prior to taking it.

We want to increase the availability of treatments for opioid use disorder, particularly some of the longer-acting, more effective treatments that are available south of the border. We know that some people in B.C. aren't able to access these south of the border.

Again, these are areas that, if we can get your help on, it would be appreciated.

Thank you very much for your time today.

● (0915)

**The Vice-Chair (Mr. Len Webber):** Excellent. Thank you very much for that, Bonnie.

We'll quickly move on here now to David Juurlink who's with the Sunnybrook Health Sciences Centre.

Thanks, David.

**Dr. David Juurlink (Head, Division of Clinical Pharmacology and Toxicology, Sunnybrook Health Sciences Centre):** Good morning. Thanks for the opportunity to present.

By way of introduction, I'm a physician. I specialize in internal medicine and pharmacology. I'm not a specialist in addiction. I'm not somebody with extensive public health training, but I do a fair bit of research in the field of drug safety, and over the last seven or so years this problem has become a major preoccupation of mine.

I'll just share with you some reflections on the problem as I see it. I apologize if you've heard some of these things before.

In the early 1990s, I was a pharmacist in Nova Scotia. I trained there, and during medical school and my internship I practised as a pharmacist. I worked in about three dozen pharmacies across the province. It was the case then that when patients came to the pharmacy with a prescription for morphine, they had cancer.

By the late 1990s, when I was finishing my internal medicine training, things had changed quite a lot. We saw OxyContin—a drug that is 1.5 to two times more potent than morphine—prescribed very liberally for chronic back pain, hip pain, osteoarthritis, fibromyalgia, and you name it. It was even doled out for minor ankle injuries. This happened because physicians were taught that it was safe and effective to use opioids for chronic pain.

Most physicians had no reluctance to give opioids to patients at end of life or to patients whose femur was sticking out of their leg, but the chronic-pain market was huge, and every day doctors were faced with patients with pain and we had reluctance to use the other drugs at our disposal. Acetaminophen—Tylenol—just doesn't work very well. The other drugs—anti-inflammatories—had all kinds of horrible side effects. We've all been burned by patients who had bowel problems or kidney problems as a result.

So the message that we could use these drugs, and we should use these drugs more liberally, was one we were quite happy to hear. The important thing to realize is that that message came directly and indirectly from the companies that make these drugs, and that have subsequently earned tens of billions of dollars from selling them.

They sent drug representatives to doctors' offices, but there was much more than that. Key opinion leaders in the field of pain all across North America gave talks at CME events, continuing medical education events, at fancy restaurants. I went to them myself and I was told that not only should I use these drugs, but also that if I didn't use them, I was being “opiophobic” and was depriving my patients of a proven therapy. The virtues of these drugs were extolled. The companies made their way in some instances—including at my own medical school—into the curriculum where individuals in the pay of the companies that make these drugs taught medical students for years without disclosing their conflicts and gave them overly rosy views of the utility of these drugs.

As I said before, for many of us, this was a message we were quite happy to hear. We now, however, realize with the benefit of hindsight that we should have known better. I can tell you that there are no good studies showing that opioids used in the long term improve patients' outcomes. The overarching goal when I prescribe a drug to a patient is to give more benefits than harms, and there's never ever been a study that shows that in the long term this happens.

Most of the studies, by the way, go for eight or 12 weeks. They involve very carefully selected patients who have no risk factors or as few risk factors for addiction as you can find. They're not on benzodiazepines. They have no mental health problems. They have no history of having had trauma as a child. They show that over a couple of weeks these drugs lower pain scores. The fact that there are no long-term studies didn't stop Health Canada and the FDA from approving these drugs for long-term use, and we've now seen what amounts to a 20-year experiment on the population. We've seen and we know that the beneficial effects of these drugs very often wear off, and increasing the doses doesn't solve this problem; all it does is add to the toxicity. Virtually everyone who takes these drugs daily is dependent on them, making for a self-perpetuating therapy. You can't stop these drugs. Even if the pain-reducing effects have worn off, stopping the drugs will make you sick and it will lead patients to perceive that the drugs are needed. Patients need the drugs just to feel normal.

Critically, we were taught that addiction was a rare consequence of using these drugs long term. I remember hearing these words: less than 1% of patients will become addicted. That's not true. The best estimate at the moment is somewhere in the order of about 10%. Just imagine that: hundreds of thousands of patients in Canada are on these drugs as a result of well-intentioned prescribing, and 10% of them may be spiralling into addiction.

We also know that high doses kill people. I can't tell you how often I see patients coming under my care who are on hundreds of milligrams of morphine or the equivalent. We did a study in 2015 that made it very clear that people on high doses of opioids were more likely to die from their medication than from almost anything else.

● (0920)

When we talk about addiction and death, there's a lot more to it than that. The death toll in Canada, as I'm sure you've already heard, is not known. It sounds as if B.C., with a population of about 4.7 million, is on track for about 700 deaths. That places it up there with Alabama, the worst state in the U.S. in terms of rates.

You can think about it differently. We published a paper in 2014 that looked at deaths in Ontario, and we found that one out of every eight deaths of people aged 25 to 34 involved an opioid. That's a staggering number. When you total the deaths from opioids in Ontario—remember, these are people dying in their twenties and thirties and forties who should have lived to their seventies and eighties and longer—the total years of life lost is somewhere in the order of one-thirteenth of all years lost from all cancers combined.

There are other harms here as well. People driving under the influence of opioids are at risk of collisions. We've shown that convincingly. There are falls. I see older people all the time who are on opioids for chronic pain—often not benefiting, as far as I can tell—who fall and break hips and necks and have head injuries. There is constipation. It sounds like an annoyance. I have had more than one patient die under my care from constipation caused by these drugs.

It might seem counterintuitive, but these drugs can worsen pain. As the doses go up, the pain gets worse because of the drugs. These drugs disrupt sleep. I am convinced they cause depression in some people and cause them to commit suicide, and those suicides are very often blamed on the pain rather than the drugs themselves.

There are other epidemics here like neonatal abstinence syndrome. In Ontario, from 1992 to 2011, the number of babies born dependent on drugs went up 15-fold. That's just from the prescribing. The proliferation of tablets from our well-intentioned prescribing of drugs has left every medicine cabinet in Ontario with some opioids. It's a bit of an exaggeration, but those drugs are there for people who might want to experiment, 16- or 17-year-olds who are curious and find themselves spiralling into addiction.

The epidemic has transformed over the last couple of years, as you've been told. It's not just about OxyContin and Dilaudid, and so on. It's now about fentanyl and heroin. Those drugs have been used for a long time, but a market has been created in response to our well-intentioned prescribing, a market that did not exist to anywhere near the same degree in the early 1990s.

This was a crisis that was largely created by physicians, and it has to do with the fact that opioids, once started, are hard to stop. It was exacerbated in 2012 by the reformulation of OxyContin. Purdue took off their old product, put on a new product that was tamper resistant, and we found a lot of people going to heroin and fentanyl as a result.

This can't be overstated. You can get a kilogram of fentanyl from China for $10,000 or $20,000. It fits in a shoebox and you can turn it into $20 million of profit. That's not ending up, as you've heard, just in heroin. It's ending up in fake OxyContin tablets, cocaine, meth, in fake Xanax tablets.

The scope of the problem in Canada is completely unknown. We know that in the U.S., the CDC estimates that over the last 20 years, about a quarter of a million people have died from opioids, more than half of them from prescription opioids, and about 2.1 million people in the U.S. suffer from addiction. We have no corresponding numbers in Canada. I speculate that somewhere in the order of 20,000 Canadians have died over the last 20 years from these drugs. The fact that no federal politician can tell you that number is a national embarrassment.

This is the greatest drug safety crisis of our time, and it's not hyperbole to say that every one of you knows somebody with an opioid use disorder. Whether you realize it or not, you do, and it's quite possible that you know someone who's lost a loved one to these drugs. Yet the Public Health Agency of Canada has been largely silent on this issue, despite its mandate “to promote and protect the health of Canadians through leadership, partnership, innovation and action in public health”. Go to their website, search fentanyl, and you'll find almost nothing.

Health Canada seems to have largely handed this file to CCSA, which I think is a good organization and has all kinds of potential, but it's not adequately resourced and it's not focused exclusively on opioids. It has alcohol and other drugs under its consideration. It feels very much as if no one is really in charge of this file and everyone is keen to pass the buck to someone else. Only recently we've begun to see some federal leadership on this issue with the hastening of the move of naloxone to non-prescription status; reducing barriers to safe-injection sites, which are very important; and this upcoming summit in November.

To solve this problem, I think the response needs to be collaborative, proportional to the scale of the problem, and urgent.

● (0925)

If 30 or 40 Canadians were dying every week from the Zika virus, your hair would be on fire with the scope of the problem. I mean, this is actually what's happening now. We need timely surveillance, and not just in B.C., which is the only province that is doing it in a timely fashion. We need it everywhere, and not just on deaths but on non-fatal overdoses as well.

Naloxone saves lives, and it should be everywhere. It should be in corner stores and gas stations for free.

Health Canada has good grounds to revisit its decision, its indications, for these drugs. There has never been a study, as I said, that shows that these drugs are safe and effective for chronic pain. I think that the label, the indication, should be revised, and when doctors choose to prescribe these drugs for chronic pain, they should do so off-label, without an official endorsement from our national regulator.

We can give serious thought to removing market approval for the highest-potency drugs out there: the fentanyl patches of up to 75 and 100 micrograms, OxyNEO 80, and the highest formulations of Dilaudid. The provisions under Vanessa's law give the minister the power to do exactly that.

We need to change how doctors prescribe. Doctors need to start these drugs much less readily, and escalate doses much less readily than they have. A whole generation of doctors has lost respect for these drugs. We do not see this as we did 20 years ago.

The education of physicians is important, but it is not going to solve this problem on its own. It has to be detached completely from industry, and from pain specialists who take money from these drug companies.

You'll see new prescribing guidelines for physicians coming out early next year. I'm on the steering committee for that, and I think that will be helpful. However, the fewer patients who start on these drugs the better. The patients who are on very high doses need to be de-escalated cautiously and closely.

We have a large swath of the population with addiction. I think it is very important that we perceive this as a public health problem and not a criminal one. When somebody steals from a pharmacy or holds up a store, it's not because they're a bad person, but a person who needs help.

Many of these people want out. They need rapid access to opioid substitution therapies, like Suboxone. They need access to supports. We need many more clinicians who know how to treat these people, and ready access to them. We need safe injection sites. I think the point has been made that the Respect for Communities Act poses a major barrier to the construction of these sites.

I will leave you with one last point. This is not your usual epidemic. No one has ever argued for more Ebola, more Zika, or more influenza. There are forces at play that will argue that physicians should not prescribe differently, that we need these drugs for chronic pain, which, I think, is exactly the wrong message. Those sorts of oppositional comments need to be disregarded.

I'll leave my comments there.

**The Vice-Chair (Mr. Len Webber):** Thank you very much, Doctor. It was very informative, for sure.

We now have, from the Drug Users Advocacy League, Catherine Hacksel and Sean LeBlanc.

You have 10 minutes.

**Mr. Sean LeBlanc (Founder and Chairperson, Drug Users Advocacy League):** First of all, thank you very much for inviting me.

I'd like to mention that I'm also a peer support worker in the city of Ottawa. I work pretty well first-hand and front-line with drug users, almost specifically opiate users, on a daily basis.

DUAL is a non-profit that was founded in 2010. It neither condones nor condemns drug use, but sees it as a facet of everyday society. People are going to use drugs, and we just try to best educate them about that. We have several services, some of which Catherine runs, with a couple of drop-ins. It's basically to provide a voice for people who do not have one.

I am someone who has survived an addiction to opiates. I used opiates for about 15 years. It's not a pleasant thing; it certainly isn't. Coming off of these drugs is extremely, extremely hard. I had pretty well a normal childhood and everything. The last thing I thought I would ever be was someone who would inject opiates. Unfortunately, I suffered through a few traumas during my teenage years, and I just wanted to end the pain.

That's one thing that I will give credit to opiates for: they help you to numb the pain, not in any healthy or helpful way, but for someone who's really hurting, opiates do deaden that pain.

My life pretty well spiralled after that. I ended up homeless, with not much self-worth. I guess I have kind of a stubborn streak, and thankfully, around 2010 I started to do some advocacy, and founded DUAL out of that. It was basically the lack of inclusion that really made me want to start DUAL to create a voice for people. I started being on different committees and everything like that. I'd always see some great doctors and police officers and epidemiologists, but there were never people who actually used drugs on those committees. If they were there, it was usually in a really tokenistic way.

This is why I'm so thankful to be invited here today. These offers don't usually come around. I think the best way we can get results in this crisis is by working in conjunction with each other—doctors, coroners, police officers, and, more so than anybody, people who use drugs, because they really are the experts on this.

The Oxy crisis started right around 2010 in Ontario. As my fellow panellists have alluded, it created this whole desire, this need, for fentanyl and heroin. The drugs have gotten so much stronger, and so many younger people are using them now, it's really, really scary.

I think we don't want to get too far into that, though. These drugs do play a really good role in the lives of some people, those who are really suffering from great pain. I've known people who cannot get relief from that pain through an opiate prescription because of the stigma associated with using these drugs. Again, I'm not condoning them or anything, but they do fill a role in our society. Some people need them, and I don't think we want to get too far away from that.

I'll just speak very briefly and very informally, because my fellow panellists have said everything I wanted to say on this. I alluded earlier a little bit to detoxing off the opiates. When I first started to want to get off opiates, there weren't really any substitutes out there for me. There was methadone, but there was no treatment offered. I tried to get into a treatment centre, and that was impossible. To this day it's pretty well a roll of the dice if you can get into treatment or not. We really need to increase all different types of treatment. Right now there's basically one form, and that's detox. That's it. It's not going to work for everybody. Nobody ever wants to grow up to stick a needle in their arm or use opiates, but it's a facet of society and I think we need to deal with it responsibly.

This is a medical issue, as some of my fellow panellists have pointed out, and not a criminal issue. I think we need to continue to deal with it in that way. Almost all my recommendations have already been said by my fellow panellists, but I think we really need to repeal Bill C-2, or at least different parts of it, and have supervised injection sites. The Supreme Court came out unanimously in favour of keeping InSite open in Vancouver, yet we've seen no other supervised injection sites in this country. Frankly, there should be one, if not several, in every major city. They've been shown to reduce overdoses, reduce deaths, and reduce the transmission of diseases.

● (0930)

Another thing that DUAL does is to go into schools a lot, but we're very limited in what we can say, especially in public schools. There's no harm reduction education; it's all abstinence based. And a lot of people who are starting into drugs, specifically opioids, are doing so at that age. Those teenage years are extremely important and we're not allowed to have an honest conversation with them.

I think there can be some really good benefits to getting to people while they're young and showing them that in addiction, addiction to opioids specifically, nothing positive is going to come of that.

I think we need to be educating people who are being released from jail. Right now there are a lot of overdoses among people being released. They'll get out, they'll use, and take the same dose they used before they went in and it is enough to kill them. I'm sorry I'm so emotional, but these are my friends, the people I work with, people I love. I lost my best friend to a fentanyl overdose and it really hits home. In Ottawa we see an overdose on opioids about every 10 days, and that's obviously just not acceptable.

I brought a naloxone kit here today, which has been really great. I've actually used it twice and I've seen it, basically, pull people right out of an overdose. The problem with these kits right now is that the dose of the naloxone is so low and the drugs doses are so high it isn't actually counteracting the overdoses as well as it should. I'd really like to see the dosage of naloxone, a very innocuous and harmless drug, increased so that it can meet the demand that these drugs are putting out.

I'd also like to see and develop other forms of treatment. Right now, even to get somebody into detox is difficult. I've got people approaching me every day wanting to clean up their lives per se and we can't get a bed anywhere. It's basically just the luck of the draw. If you can get somebody in, great, if you can't, then that's a....

What's most important is that we need to continue to include people with lived experience and people who use drugs in these conversations. We have a wealth of knowledge that I think we could share. As I alluded to earlier, in conjunction with scientists, doctors, and politicians, as well, obviously, we can really get to the guts of this problem. There are solutions out there. I believe that Canadians are really nurturing. We really believe in health care. This is a medical issue and I think we need to continue to treat it as such.

A statement that we use at DUAL and other drug-user groups around the country is “nothing for us, without us”. We'd just like to see more inclusion at all levels from the top to the bottom, because there are solutions to these problems. We solved a lot of things with the Oxy crisis and I think we really can do that with the fentanyl crisis. Let's just keep plugging away and I think these problems can be eradicated really quickly.

Again, I apologize for my emotion. My voice was breaking most of the time and I really appreciate the invite here. Thank you very much.

● (0935)

**The Vice-Chair (Mr. Len Webber):** Thank you, Sean. I'm really happy to see you're doing better and thank you for your presentation.

**Mr. Sean LeBlanc:** Thank you.

**The Vice-Chair (Mr. Len Webber):** Sean, you do have a minute, so may I ask you a very quick question about that naloxone kit. How easy is it for you to get that and to distribute that to your patients, to your clients?

**Mr. Sean LeBlanc:** I've now been trained as a trainer to be able to do it, but it took a lot of work to do that. We've only given out 250 kits, or I should say Public Health has only given out 250 kits in Ottawa over five years. That's less than one kit a week. Now there are a lot of pharmacies that are giving it out, which is really great. They're not training people maybe as well as they should, and a lot of pharmacies still don't realize that they're able to get rid of it.

I think someone mentioned there were 13,000 kits given out in B. C. I think we can easily approach that in other provinces too.

**The Vice-Chair (Mr. Len Webber):** Excellent. Thank you, Sean.

We'll get into our questioning round now and we're going to start with MP John Oliver.

John.

**Mr. John Oliver (Oakville, Lib.):** Thank you very much and thank you to all of you for your presentations. You showed a lot of passion.

And Sean, in particular, the sharing of your own personal story is much appreciated.

Dave, I just want to confirm that I heard from you that one out of eight deaths in Ontario involve opioids now and that the years of life lost from opioid deaths are greater than all the cancer years of life lost. Did I hear that right?

**Dr. David Juurlink:** Not quite. We published a paper a few years ago that simply looked at all of the deaths that occurred in Ontario and at the deaths that involved opioids, and we broke those up into age ranges. I think the key finding there, other than the fact that deaths involving opioids have skyrocketed over the years, which is no surprise, is that in 2010 in the age group of 25 to 34 years—

**Mr. John Oliver:** I have seven minutes, so get to the punch.

**Dr. David Juurlink:** —that's the segment of the population where one in eight young people died of an opioid and, collectively, all of the person years of life lost was about one-thirteenth that of all cancers combined.

**Mr. John Oliver:** David, I also appreciated your comment that you've seen some federal leadership coming on this.

The Minister of Health has laid out a comprehensive five-point federal strategy, including better informing Canadians about the risks of opioids, supporting better prescription practices, reducing the access to unnecessary opioids, supporting better treatment options, and improving the gathering of evidence and getting the evidence together. The naloxone capability was made possible, and the nasal sprays are now coming in from the U.S.

I heard a number of recommendations from you and from Bonnie.

From Bonnie I heard about expanding supervised consumption services, and that Bill C-2 is a major problem across Canada; establishing drug checking as a harm reduction service to make sure you can see what you're ingesting, even if it's illegal; and increasing availability of treatments for opioid use disorders.

From David I heard about prescription changes and better education of physicians to make sure that the use of opioids is better managed.

All of you referenced better surveillance, and that we need a national surveillance program for this.

I heard from John that the dosage of naloxone needs to be increased in some of these kits.

Are there any other recommendations beyond these? The minister is convening a workshop in November as a special consultation. Is there any other advice you can give us to better the situation or to give advice to the minister?

● (0940)

**Ms. Lisa Lapointe:** We would recommend more regulation of the precursors, the sorts of chemicals that combine to make these drugs, and drug regulation of those. Regulation around commercial pill presses, those—

**Mr. John Oliver:** They're on the minister's list, and they are trying to add the chemicals used to make illicit fentanyl to the Controlled Drugs and Substances Act. That's in the works.

**Ms. Lisa Lapointe:** Okay. Sorry.

The commercial pill presses need to be regulated.

We would advocate a good Samaritan law, which I believe has been introduced in the House. It's a small measure, but it will be a health response to overdoses. Police will no longer come, and that's focusing on the health as opposed to—

**Mr. John Oliver:** The author of that bill is sitting at the table.

**Dr. David Juurlink:** I said in my comments and I can't emphasize it enough that I really think Health Canada needs to revisit its grounds for the indications for using these drugs.

If you find yourself in a hole, then the first thing you have to do is stop digging. Unless we stop prescribing these drugs, as we have for 20 years, this problem is not going to go away.

**Mr. Sean LeBlanc:** I would like to see increased education, especially at the public school and high school levels.

Harm reduction, frankly, saved my life.

When it comes to needle distribution, distribution of these kits, and methadone, we can't talk right now, frankly, about drugs in a real sense, because of a lot of school boards and everything. I think loosening of those restrictions would be really great.

**Dr. Bonnie Henry:** I would like to see federal enforcement and interdiction strategies around importation of illicit drugs. Anything we can do through CBSA, the Canada Border Services Agency, to try to improve our ability to prevent these from getting in and improving relationships with other countries, particularly China, where a lot of these substances are being manufactured, would be good.

**Mr. John Oliver:** I think, Bonnie, you mentioned that you've launched social media campaigns and that you're trying to get public awareness.

When focusing on the younger population who might be looking at experimental or recreational use of these drugs versus the other sort of categories, what would be the key messages you'd deliver to younger Canadians?

**Dr. Bonnie Henry:** Number one is that these are dangerous things, so don't do them, obviously.

As our colleagues mentioned, we recognize that young people are going to try these. The messages are around how to look after each other and how to use naloxone. We have a whole campaign around "Naloxone Wakes You Up", so that people understand the use of it and understand and recognize that when their friends are overdosing, they need to call 911. We've done a lot of work with law enforcement in B.C. to make that a positive experience, so they aren't arresting people when they respond to overdoses, which has been an issue in the past.

We've involved a lot of youth in developing these tools, and having people with the lived experience involved in helping us speak frankly about these issues to children.

I would encourage people to go to Towardtheheart.com. It's a website that we've developed in B.C., a collaboration among people who use drugs, people with lived experience, and the health sector. We have a lot of tools there for young people and for all age groups around what to do, what the risks are, and how to respond.

● (0945)

**Mr. John Oliver:** I thought you gave some excellent advice as well on not using words such as "powerful". Maybe it was Dr. Lapointe who raised that point.

I have one last question for David. This epidemic of fentanyl in British Columbia has been staggering. I think the percentage of illicit drug deaths involving fentanyl went from 5% in 2012 to 62% by 2015.

Do you have any data on the incidence or presence of fentanyl in Ontario?

**Dr. David Juurlink:** In Ontario, it has roughly doubled over the last four years. In Alberta, I think fentanyl-related deaths have gone up about 5,000% over the span three or four years. That's no longer the prescription stuff; it's the illicit stuff that's coming into Canada from China, and being produced domestically to a certain extent.

I'll make a comment very quickly. There are scarier forms of fentanyl out there. In Ontario, we aren't even testing for that. I know they're around. We're not looking for them.

**The Vice-Chair (Mr. Len Webber):** Thank, Mr. Oliver. We're going to move on now to Ms. Harder.

**Ms. Rachael Harder (Lethbridge, CPC):** Thank you.

I'm going to start with a question for Ms. Henry. You talked a bit about providing naloxone. I think we would all agree that's a very positive thing to do. One of my concerns with that, though, is that we're also talking about testing for fentanyl in these drugs that are being used, and we would like to do that.

With the combination of being able to test for fentanyl and providing naloxone kits, I would imagine that some drug users would make the decision, regardless of testing for and finding fentanyl, to go ahead and use anyway because they have access to naloxone.

I am concerned about that. It feels as though that could actually perhaps perpetuate the problem rather than solve it. I would be interested in hearing your thoughts on that.

**Dr. Bonnie Henry:** You're absolutely right. As a matter of fact, some people seek out the testing. We've heard that some of the dealers are actually sending people in to have the drugs checked, because they don't want to be giving fentanyl to their cocaine users. Anyway....

I don't think it's an issue around perpetuating use. We did a pilot study at InSite, the supervised injection service site in Vancouver. Some people didn't test. People go to InSite because they don't want to die from their drug addiction. It's an opportunity for us to intervene, to treat them with respect, to give them the chance to get off that cycle they're in. We don't see it as a way of perpetuating the use or encouraging people to use. What we find is that every day they stay alive, it's an opportunity to get off that cycle.

The naloxone keeps people alive. What we're finding is that people will check their drugs, and because you have to use a bit of your drug, if it's hard to come by and you're in that situation, you might not want to do that. We're finding that people will do it after they've overdosed to see if that was the cause of it.

It's a challenge still, because with the tests that are available for drug checking, we don't know the parameters. They're not designed for drugs. They're designed for urine testing. We don't have good drug checking capabilities yet, but we're working on it.

**Ms. Rachael Harder:** Thank you.

Another thing that has been said across this table is that there is an emphasis on safe injection sites, safe use, safe consumption, if you will. There's a focus on substitution treatment. I'm not hearing much with regard to detox or therapy treatments where we would want to see people actually off illicit drugs.

I am of the belief, and I would be interested in hearing your thoughts on it, that every single person on this planet is very valuable and born with incredible potential. I'm also of the belief that this potential can only be fulfilled if that individual is given the opportunity to be healthy. It would seem reasonable for me to then believe that using illicit drugs certainly prevents that individual from being able to realize his or her full potential.

With that belief in mind, I am clearly an advocate for treatment that would help people get off illicit drugs and be able to step into their full capacity as people. So I wonder, why not focus on treatment? Why not focus on helping people overcome these addictions which most of them probably don't want anyway, and help them step into their full capacity as people and reach that potential with which they were born? Why not take that approach and put our energy and money toward that instead of these other things?

I understand that there are intermediate stages. I understand that. I just wonder why that isn't part of the conversation at this table.

Ms. Henry, I'd like to start with you.

● (0950)

**Dr. Bonnie Henry:** It is a large and very important part of our conversation. I'm sure that David will talk about this. The challenge is that we need to have immediate actions to prevent people from dying so they can get to that point. You're absolutely right. Sean just said it: nobody grows up wanting to be addicted to these drugs and wanting to die on the street from fentanyl. That is not people's aim in life. For example, we have found through InSite—where we have InSite and OnSite—that treating people with respect, getting them to the point where they are managing their addictions and not dying from them, helps them make that shift and get into treatment and off drugs.

I think one of the challenges we have is that we're stuck in an anachronism around detox and treatment that is based on alcohol and on 28-day abstinence programs for alcohol. These do not work for opioids. The physiological dependence on opioids and what they do to your body and your mind are very different from alcohol addiction. Opioid substitution treatment is a way of getting people off illicit drug use. It is used instead of detoxing, which is something that puts people at great risk of overdosing and dying and is very traumatic and difficult. The substitution treatment is not meant to be lifelong for most people. It's a period of time that allows them to get off the illicit drugs and to then taper off the substitutes in time.

**Ms. Rachael Harder:** Sorry, in the interests of time, I'm just going to interject here quickly. I had the opportunity to go to InSite in the spring. I talked with the director there and asked him if there were any endeavours to help people get off drugs, and he said, “No.” He said the success of their program was if they could help people inject safely, full stop. So I asked if there were any partnerships with organizations—

**Dr. Bonnie Henry:** What you were talking about was the philosophy of InSite itself, the services—

**Ms. Rachael Harder:** —that might help people, because I understand that different organizations can work together in partnership to achieve that goal. He said, “No.” That's very disappointing for me because I can see the value in a safe injection site, but again, it has to be only an intermediate solution.

How is it that we can then work collaboratively between organizations to further help people.

**Dr. Bonnie Henry:** I think you have misunderstood his approach. The purpose of InSite is not to tell people they need to get off drugs; it's to help them on that day. However, there's an OnSite detox treatment program that's actually based in the same building. So InSite does have the philosophy that these are opportunities to find ways to support people to get off drugs, as well. I've visited it many times, and I know that the philosophy in the injection room is not that they're going to tell you every time you come in that you should stop doing this. It's to say, “How are you doing today? Can we help you today?” But there are definitely connections with allowing people to get off drugs, and there's an OnSite treatment program there. We are looking at the whole spectrum of how we respond.

**The Vice-Chair (Mr. Len Webber):** Thank you, Ms. Henry.

We're going to move on to MP Don Davies now.

**Mr. Don Davies (Vancouver Kingsway, NDP):** Thank you, Mr. Chair, and thank you to all of you for being here today. It's very cogent, powerful testimony.

Ms. Henry, we know that Dr. Perry Kendall, the senior medical health officer for British Columbia, has declared a public health emergency in the province. He is quoted as saying that “an effective collaboration with the federal government could really have major impact on reducing overdose deaths”.

Could you briefly explain to us what led Dr. Kendall to declare a public health emergency in British Columbia, and do you believe that we need a national public health emergency declared?

**Dr. Bonnie Henry:** That's a very good question.

I'm Dr. Kendall's deputy, and we made this decision in consultation with our colleagues in the coroners service. We have a network of people who have been watching this.

The reason we declared an emergency, as this graph shows, is that even though we had probably the best detection, monitoring, surveillance in the country for this, we were not making an impact. We had a take-home naloxone program, but people were still dying. Two people a day are dying in our province from these overdoses.

We felt we needed a much more comprehensive response, and we needed the ability to collect information that we couldn't collect under the current legislative framework in B.C. It was having more data to help us understand who was being affected, where they were being affected, and where were the programs, the points of intervention, that we could set up.

It was partly to raise awareness and partly to give us those extra powers to be able to gather more information to help us respond in a more coordinated way.

Vivek Murthy, the U.S. surgeon general, has sent out a letter to every single provider in the U.S. about the issues they're having. We are not the only ones being affected by this. Canada has the second-highest rate of prescribing of opioids in the world. The U.S. is just ahead of us. There are a number of states that are having similar—

● (0955)

**Mr. Don Davies:** Ms. Henry, do you think we need a national public health emergency—

**Dr. Bonnie Henry:** I do. As the coroner reported, we are not measuring this across the country. It is affecting our entire country. I would like us to have a national approach to this, and I think national leadership would be very helpful.

**Mr. Don Davies:** Ms. Lapointe, the Vancouver Police Department has a policy of not attending at 911 calls for overdoses, and the RCMP testified on Tuesday that they've not even considered such a policy. Should they?

**Ms. Lisa Lapointe:** Absolutely.

I heard our Minister of Public Safety say recently that we cannot arrest ourselves out of this situation. We know that approach—the shaming, blaming, and arresting of people—has not worked. It significantly has not worked. In fact, the deaths and rates of overdose have only increased. Treating this as a health problem, such that if somebody becomes ill from a drug they call an ambulance and are treated at a hospital, is the only way we are going to save lives.

In keeping with the treatment aspect as well, if you develop a terminal illness, or an illness that is potentially terminal, a cancer, for example, you expect that you will be treated and that treatment will be available. If you become addicted to drugs, treatment should be available.

**Mr. Don Davies:** Let me pick up on that, both Ms. Henry and Ms. Lapointe.

I'm going to speak bluntly here. There seems to be a division in this room and with this government on Bill C-2. The government seems to stubbornly refuse to acknowledge that it needs to make any changes to Bill C-2 .

Ms. Henry, the words you used were that Bill C-2 contains extreme barriers. Hon. Hedy Fry, when she was the Liberal Health critic, said that Bill C-2 was designed to avoid the opening of safe consumption sites. I think Dr. Perry Kendall has said that too.

I'm going to ask you directly. The Liberal government seems to suggest that the problem isn't with Bill C-2. It's just explaining the requirements to groups, and if we can facilitate that, we can get more safe injection sites.

The facts are that we have two injection sites in the country, InSite and the Dr. Peter Centre. There is not a single site that has opened in this country in the last year and a half. We have one application currently, and that's from the City of Montreal. With the Toronto Board of Health, everybody is telling me that with the barriers, it takes months and hundreds of hours to get an application in.

My question is, what are the barriers in Bill C-2 that you think are unnecessary?

**Dr. Bonnie Henry:** I could talk for a long time on that. Some of them are outlined in the written report that we sent in.

There are about 25 different pieces of Bill C-2 that I find are barriers. One of the key ones is requirement for opinions from neighbourhoods that are not necessarily based on fact, and the types of opinions that need to come in. It's a challenge to get those, because it reopens questioning around supervised consumption services and their worth. It's a challenging part.

The other part that is just ridiculous is that you have to name every single person who will work in the facility, and none of them can have a criminal record. People like Sean would be excluded from working in a site, which we think is ridiculous, because peer support is really important and it helps.

There are a whole variety of them that I can certainly list for you.

● (1000)

**Mr. Don Davies:** Thanks. Maybe you could send those to the committee, all the barriers that you see—

**Dr. Bonnie Henry:** We can do that.

**Mr. Don Davies:** —because what jogged me was this connection of it being a health issue, not a policing issue. You have to get the approval of the local chief of police. What other medical or health service do we have in this country that you have to get the chief of police to sign? Shouldn't that be a medical decision, not a criminal decision?

**Dr. Bonnie Henry:** I believe so, and it's the opinion of the chief of police. I will say that we have had a lot of positive response from the policing services in B.C., including the RCMP E Division.

Through the minister, Health Canada has expressed interest in working with us on trying to overcome some of these barriers, but we do still feel that repeal or an extensive revision of Bill C-2 would be most appropriate.

**Mr. Don Davies:** Dr. Juurlink, I want to give you a chance. You've talked about there being no national system of surveillance in Canada. Even the number of Canadians who die annually from opioids is unknown. You've talked about the CCSA. You've called that an inadequately resourced non-governmental organization. They've made 58 recommendations that you say have not been prioritized or implemented. What can you tell us about those recommendations? Have they been implemented? Which ones do you think ought to be implemented?

**Dr. David Juurlink:** I think some of them have. I'd have to direct you back to the CCSA itself for the status of the various recommendations.

I guess my point in making that comment earlier was that of those 58 recommendations, by definition some of them are more important than others. I have one in front of me here:

> Improve and promote access to treatment, which should include:
>
> i. Pharmacological interventions;
>
> ii. Psychosocial support and counselling; and
>
> iii. Withdrawal management programs.

The proposed leads there are health care institutions. That can't happen fast enough. This is a three and half year-old document. It should be happening everywhere now. That's why I think that the assigning of priority was something that should have happened and did not.

**Mr. Don Davies:** Thank you, Doctor.

**The Vice-Chair (Mr. Len Webber):** Next is MP Sonia Sidhu.

**Ms. Sonia Sidhu (Brampton South, Lib.):** Thank you to all the presenters.

Dr. Juurlink, you mentioned opiate prescription by physicians. What kind of restrictions need to be placed on the doctors who are prescribing opioids?

**Dr. David Juurlink:** What kinds of prescriptions should be implemented for physicians? You'll get very different—

**Ms. Sonia Sidhu:** What kind of restrictions need to be—

**Dr. David Juurlink:** Restrictions?

**Ms. Sonia Sidhu:** Yes, on the physicians when they prescribe—

**Dr. David Juurlink:** Are you asking what restrictions I would advise?

**Ms. Sonia Sidhu:** No, can you talk about any preventative measures? You said that one in eight deaths of those aged 25 to 34 in Ontario are due to opioid overdoses, so what kinds of preventative measures are you thinking of, such as physicians not being allowed to prescribe higher opioid doses?

**Dr. David Juurlink:** I think there are certainly different constructs, but from the prescribing perspective, I think as a physician I am conditioned to want to help my patient. I see pain all the time, and I'm scared of the other drugs, and I've become comfortable with opioids because of what we've been taught, much of which is untrue. What I'm saying is that I think physicians need to be re-educated—de-educated—about these drugs.

**Ms. Sonia Sidhu:** What kind of education do you think needs to be utilized.

**Dr. David Juurlink:** Education should focus on the fact that the goals of a drug are to impart more benefit than harm, and opioids very frequently don't do that. They can be beneficial to some patients in the long term, but the higher the dose goes the less likely that will happen. That's why I think doctors shouldn't be allowed to prescribe ridiculous doses of 200 milligrams or 300 milligrams. It's inconceivable that someone is benefiting from that.

I also think that when these high-dose formulations are used as directed, like the OxyNEO 80 and the high-dose fentanyl patches, you are exceeding the threshold dose from the old Canadian guidelines—a dose above which it's very likely that harms exceed benefits. It shouldn't be happening, yet it still is. It's a cultural thing now. We've been doing it for 20 years, and we have to stop doing it.

**Ms. Sonia Sidhu:** Mr. LeBlanc, you said that we need to educate our kids about harm reduction. At what age does this need to be taught? Is it in elementary school or middle school?

**Mr. Sean LeBlanc:** I see, at least in Ottawa, children as young as 13 even getting into fentanyl. There seems to be no progression. When I was young, people would start with marijuana, then alcohol, and kind of progress their way up. They're starting at fentanyl and these hard-core opiates at a really young age, so yes, I would say that education about it should start in junior high school, at grade 7 and 8.

**Ms. Sonia Sidhu:** Thank you.

Ms. Lapointe, you referred to language. Is there any strong language with respect to heroin that would have an impact on the crisis? Is there a great impact with the language? Can you outline any other example of how language and definition have impacted the crisis in B.C.?

● (1005)

**Ms. Lisa Lapointe:** Before I answer that, I'd like to emphasize that we have a dearth of research in this area. We do not have evidence across the country as to exactly who's dying, when they're dying, and why they're dying. We don't know, for example, how many people who are currently dying were prescribed opiates. If you're going to implement evidence-based solutions, you need evidence, and we do not have that. I would certainly call on this committee to seek some investment in the research.

To answer your questions, one of the things we hear anecdotally from the people are working with illicit drug users is that the language around stronger drugs, more powerful drugs, will cause a certain segment of the drug-using population to seek out those drugs. We're talking about people who are now actively seeking fentanyl because it's a better high, because it's stronger than the heroin they've been using, for example.

I also want to be clear that the drug deaths that we're seeing in B. C. are not just from opiates. Cocaine is also often involved. Alcohol is often involved. We are starting to do the research to pull out the different substances, but without knowing exactly what substances are killing people and how they started to use those substances, I would argue that we really can't implement any meaningful solutions.

**Ms. Sonia Sidhu:** I want to pass my time to Mr. Sarai.

**Mr. Randeep Sarai (Surrey Centre, Lib.):** Thank you all for coming. I have sat in on several committee meetings and I would say to anybody who is aged 19 to 39, or to a parent, that if they have to watch any committee meeting, the two hours they spend on this would will probably be most valuable time they have ever spent, in hearing a range of testimony from people who deal with those who are overdosing, to the people who prescribe these drugs, to the people who see the health emergency in British Columbia and, unfortunately, to the people who see them die. This is probably the most profound panel I've seen on this issue, so I want to commend you on that.

Dr. Juurlink, what are the benefits of a supervised consumption service site in avoiding this opioid crisis?

**Dr. David Juurlink:** It's invaluable. People are always going to use drugs. Not everybody who has an addiction wants to keep using. Many of them want out, and they should be given the opportunity to get out. But it's simply a fact that people do not die in safe injection sites. I agree with Sean that there should be one in every community in this country. The barriers are there, and as the wheels turn to try to get approval, people are dying in public bathrooms. It shouldn't be happening.

**Mr. Randeep Sarai:** Dr. Henry, in British Columbia what percentage of the people dying from this opioid crisis are dying because of prescription-based addictions versus recreational-based addictions? Do we have any data—even preliminary?

**Dr. Bonnie Henry:** We don't have data on that, though I can say that the crisis in B.C. has evolved, and it's slightly different from what they're seeing in Ontario right now. It's generally not prescription opioids that we're seeing as the issue; it's illicit opioids that people are buying on the street. It may have started with some diversion of illicit fentanyl, but clearly the issues right now are around illicit fentanyl that's mostly being manufactured offshore and imported into B.C.

**Mr. Randeep Sarai:** If somebody went to a safe consumption site and wanted to test the product that they're using, are there any detection devices that can see the level of fentanyl or if it is laced? Is there any technology like that out there that would be helpful to have in places such as safe consumption sites so that people can test their product really quickly to make sure they won't be overdosing afterward?

**Dr. Bonnie Henry:** The short answer is “kind of.” There are ticket tests that we've done a pilot of at InSite. They're like those pregnancy tests—those little bars—but they can only detect fentanyl, not some of the other illicit opioids that we're seeing out there, and we don't know how well they work. This was just a pilot.

Some of the challenges we're having under the Controlled Drugs and Substances Act are that the people who work at InSite cannot handle the drugs, so the people themselves have to test their own drug. It's a bit tricky and complicated, and they need some help.

There are some mass spectrometer machines that can do a better job at detecting what is in substances, but again, they have to be used by somebody. That's where we think we can get helpful exemptions under the Controlled Drugs and Substances Act to allow that service to be available more widely in places. It is illegal for me to test someone's drug for them at the moment.

● (1010)

**Mr. Randeep Sarai:** Thank you.

**The Vice-Chair (Mr. Len Webber):** Thank you, Randeep.

Okay, we'll move to our second round. You have five minutes each.

We'll start with MP Dr. Colin Carrie.

**Mr. Colin Carrie (Oshawa, CPC):** Thank you very much, Mr. Chair.

I did want to bring something to the attention of Ms. Lapointe and Ms. Henry. You mentioned the pill presses and the precursors for fentanyl. I know that one of our colleagues in the Senate, Vern White, has actually had two private members' bills moving forward, and I think he's had discussions with the minister. I think we're trying to expedite moving that forward.

I'm going to take a contrarian view. It may not be popular with this panel, but similar to Vern White, who comes to the issue and takes into account the public safety point of view, as well as focusing on treatment.

Maybe I'll start with Madam Henry.

We talked about how we don't have good statistics and that even the statistics at InSite are the questionnaire type of statistics. From its website, they say that only 7% of users of InSite actually go on to OnSite, and their statistics show that only 50% stay with the treatment. So, from their own statistics, only 3.5% go into treatment. Then we have no idea how many of them actually continue on afterwards.

You're calling for the repeal of the Respect for Communities Act. I think the situation in Vancouver is very unique, an extreme situation, including before InSite. I have visited InSite and I still find the situation there to be very extreme and very sad when you move through that area. But when you talked about communities, shouldn't they have an opinion?

I want to quote somebody who takes a different viewpoint. His name is Bill Blair. When he was a police officer—now he's a politician—he said that “They have been doing [this] in Vancouver for some years and there have been [some] issues that have arisen there. I don’t know of any place in Toronto where that couldn’t have a significant negative impact on the communities.” In discussing the education part of it, he also referred to what he called “the ambiguous messaging that comes out from a society that says you can’t use these drugs, they’re against the law—but if you do [it], we’ll provide a place for you to do it.”

Do you actually think that communities shouldn't have an opinion, shouldn't have a say? I would think that if the community doesn't support a supervised injection site, it won't be successful. Calling for the repeal of that, is that really what you think?

**Dr. Bonnie Henry:** I think communities absolutely have to have an opinion, but it needs to be an informed opinion, and informed on the evidence. There is a lot of evidence about InSite and its effectiveness, not just at saving people's lives but also its impact on crime, the impact on the community. You're absolutely right that the Downtown Eastside in Vancouver is a community like no other, thankfully, in this country. There are many challenges in that community.

I think the model of InSite as a stand-alone safe injection site is not what we're looking at in many communities. What we're looking at are what we're calling “safe consumption services”, meaning the ability of people to use it in an environment where they can obtain the health care they need if they need it. But I think we miss the very first part of our message, that this is dangerous and you shouldn't do it. As Dr. Juurlink says, people are going to use drugs, and what we have to do is to provide the opportunity for them to stay alive long enough to reach their potential in life.

I think safe consumption services do that, but they need to be integrated into the health service system. The Dr. Peter Centre is another good example of this, where they're working very quietly within the provision of other health services. It's been a very effective service. We've done a lot of work with our law enforcement colleagues in B.C., and they have talked to the Vancouver Police Department about how well this is working. People's ideas have changed, and what they need to be is informed—

**Mr. Colin Carrie:** I agree with that, but if—

**Dr. Bonnie Henry:** —about the effectiveness of these services and how they benefit communities.

● (1015)

**Mr. Colin Carrie:** That's what I'm talking about—informed and good data—and we just said that we didn't have it. But InSite keeps being held up as if this is where we want to go, or that this is the flagship for Canada. I looked at the literature, and it seems that it's written by one or two different guys who keep quoting each other. There's a guy named Kerr; there's a guy, I believe, whose name is Montaner. When you're looking at it from a government standpoint, it seems that injection sites are an effort to put all the eggs into one basket. I believe the police association president was saying on CTV that as a result InSite, they've had to divert 100 officers to police and make sure that area is safe for people who are down there. If you look at the costs, at $100,000 per officer, that's $10 million per year. If you look at treatment beds, that money could treat over 1,000 people in 90-day treatment programs.

**The Vice-Chair (Mr. Len Webber):** Dr. Carrie, your time is up.

**Mr. Colin Carrie:** I just want to make sure if there are any informed and good statistics out there.

**Dr. Bonnie Henry:** I think there is some very rigorous research that was done around InSite. Dr. Kerr is one of the lead researchers in that. Those are independent research grants that he received.

As I mentioned, there are many different models that we are looking at around safe consumption that are integrated into health services and the continuum of services for people, including treatment options.

**The Vice-Chair (Mr. Len Webber):** Thank you.

We'll now go to MP Dr. Doug Eyolfson.

You have five minutes.

**Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.):** Thank you, Mr. Chair.

Thank you all for coming. This is very valuable.

As background to some of my questioning, I'm an emergency physician. My entire career was in emergency medicine, with the last eight years spent in the inner city of Winnipeg. This kind of subject has been near and dear to my heart, as it has occupied a great deal of my professional time.

Dr. Juurlink, I really appreciated the comments you made about physician prescribing practices. I see people who come in, and we get a computer readout of what they have been prescribed. It astonishes me what people are being prescribed, and when they run out of their medications, they come to the emergency department because they've run out, and they say, “My doctor's office is closed”, or worse, “My doctor is refusing to prescribe these anymore, can you do it?”

We have tried to get interventions from the College of Physicians and Surgeons of Manitoba to have some sort of prescribing guidelines and restrictions as to how prescribing practices can be more controlled. They have more or less turned a blind eye to it. They say, “Well, no, we're not in the business of just micromanaging how physicians practise medicine.”

Would you think that the colleges, the regulatory agencies in each provinces, could have a greater role in helping to change physician behaviour in prescribing?

**Dr. David Juurlink:** Yes, I do. I think B.C. has already done that. In fact, the CDC in the U.S. introduced prescribing guidelines earlier this year, and I think B.C. has mandated their use.

There is some danger in that, because those guidelines don't deal with the people on hundreds of milligrams a day. Those people, when cut off suddenly, will go to the street and they'll die because they get something with fentanyl in it, for example.

As someone on the steering committee of the new Canadian prescribing guidelines for chronic pain, I think it's important that every provincial and territorial regulatory agency strongly encourages, if not actually mandates, that the guidelines to come out in early 2017 be followed.

**Mr. Doug Eyolfson:** Thank you. That is what I always thought should be the case. It's nice hearing a voice supporting it.

Ms. Henry, one of things we talked about was alluded to by Mr. LeBlanc, who I thank for his courage in showing up today and sharing his story. We talked about the justice system. Many people who use drugs are in the justice system, and the justice system has woefully inadequate treatment facilities. Would you agree that we need better drug rehab in our correctional system?

**Dr. Bonnie Henry:** Absolutely, and one of our partners, in our response, is our correctional services, the provincial and federal correctional services. We've started with naloxone, and making it available in our provincial corrections facilities. Treatment availability is being worked on. These are really important issues.

We do see, as was mentioned, a critical period when people get out of a correctional facility. They have not had regular access to drugs in the facility, and they are at a high risk of dying from an overdose in that period of time, and so supporting them around that period of time is important.

We also hear in the correctional facilities themselves that because drugs apparently come in quite regularly, people need to use them all up very quickly prior to their being detected. As a result, there's a high rate of overdoses happening in our facilities now. How to manage those appropriately, to encourage people, and to provide the opportunity for opioid substitution and treatment while in prison is something that we think is really important.

● (1020)

**Mr. Doug Eyolfson:** Thank you.

I have one minute left, and I want to go further into that.

One of the benefits of a program like InSite, in addition to preventing overdoses, of course, is that users are provided with clean supplies and clean needles. That means that you're also decreasing the rates of blood-borne disease transmission, such as HIV and hepatitis.

Several months ago, it was brought up in the news that they are refusing to have anything like needle exchange programs in prisons because of a “zero tolerance”. Would you agree that a harm reduction program needs to be introduced in our correctional system?

**Dr. Bonnie Henry:** Absolutely. That's something we've been advocating for some time. We think harm reduction is one of the important pillars in this response, and it should be in our correctional facilities as well.

**Mr. Doug Eyolfson:** Thank you very much. I only have five seconds.

**The Vice-Chair (Mr. Len Webber):** You have five seconds, I'm sorry, Doctor. If you could spit a question out in five seconds, I would be impressed.

We're going to move back to the Conservatives, to Dr. Carrie.

You have five minutes.

**Mr. Colin Carrie:** I'm going to split my time with Madam Harder. I'll take ask question.

Dr. Juurlink, I think you hit the nail on the head about one of the real challenges, but you've said some controversial things. I'm going to be the contrarian, because normally we have different viewpoints on a panel, and I'm going to try to give you a hard time. I don't think you'll have a hard time with it.

You said that the crisis is created by physicians, that we basically have to stop prescribing these drugs because physicians are conditioned to help. I think that's a really good thing and there have been studies that actually show that. You mentioned the opioids on the market. When we were in government, we were heavily criticized by the former Liberal health minister in Ontario, Deb Matthews, and American governors, when we said we should take a federal approach to make all of these opioids tamper-resistant, because, if they are going to be prescribed, make it so that it's a very small population that should do that.

I believe she also said that in one of her first nation communities, 78% of the people were addicted to opioids. The comment that really scared the living daylights out of people was when the chief said that the drug pusher in his community wore a white coat.

What do you think about this whole issue if they're going to be prescribed, as Mr. LeBlanc said, for some conditions? I've had people come to my office to say, “Fentanyl kind of makes me be able to function in my day-to-day when it's prescribed appropriately”. We can argue about that. Should these drugs—the entire class—be made more difficult to access, both tamper-resistant and more restrictive for physicians to prescribe?

**Dr. David Juurlink:** I just want to correct that. I think you cited me as saying that these drugs shouldn't be prescribed. I didn't say that: they do have a role.

I think abuse-deterrent formulations are a good thing generally. You can crush them, and you can chew them, and you can get a much higher level in your blood than you would by taking them intact, but you can't powderize them, inject them, or snort them, but it is a mistake to think this is the way out of this problem. These products tend to materialize on the market as the patent on the original product expires, so a cynic might wonder if this is primarily a business decision. I'm just saying that.

The fact is that the primary route by which opioids are abused is oral. I know for a fact that physicians, when they hear about these abuse-deterrent formulations, think that these are somehow impervious to abuse. They are totally abusable. If you could snap your fingers and have them all be abuse deterred, great. It is not a major part of the solution to this problem, in my view.

**Mr. Colin Carrie:** Ms. Harder, go ahead.

**Ms. Rachael Harder:** I just want to create a framework for this epidemic that we're seeing, so I'm wondering, Ms. Lapointe, if you might be the best one to answer this question.

Can you comment on the demographic that we're looking at? I know that more males than females are involved, but are we seeing a specific ethnicity involved in this at a higher percentage? That would be question number one.

● (1025)

**Ms. Lisa Lapointe:** We don't collect data around ethnicity, so I can't tell you that. We have started collecting data for the First Nations Health Authority in British Columbia, so we will be able to report at some point about the number of first nations people or indigenous people who are dying. The demographic is, for the most part, as you said, male and aged 29 to 49—sometimes a little bit older—and from all walks of life. Primarily we're talking about people who have used illicit drugs for a long time.

I want to be clear: our criteria only includes illicit drugs; prescribed drugs are not included in these deaths.

**Ms. Rachael Harder:** Thank you.

**Dr. Bonnie Henry:** Because we have been collecting data on people who are surviving overdoses, the picture that we're seeing of those who have survived overdoses is different, at least in some parts of the province. As well, we're seeing geographic differences. In some parts of the province, it's more equally weighted between boys and girls, men and women, and those who survive overdoses are more often not the long-time users, but people who are more recreational users and often in private homes rather than in public places. There is a difference, and that's why this data is so helpful for us in looking at points where we can intervene to prevent ongoing drug use by people.

**Ms. Rachael Harder:** Perhaps you could answer this question between the two of you. There are two parts to it.

One, I'm wondering why the province of B.C. is so hard hit. Perhaps you could reflect on that a bit. B.C. seems to have exponential numbers in comparison with other provinces.

Second, as part of that, why has there been such a drastic increase in the last five years? When I look at that map up there, when you show me the colours, that really hits home for me. I really would love to understand why this has become such an epidemic in the last five years.

**Ms. Lisa Lapointe:** You only have a problem if you know you have a problem. That's my first response. The B.C. Coroners Service has adopted a fairly risk-tolerant approach to reporting this data. We get the data within 48 to 72 hours, and we are reporting these deaths monthly. You will not see that across the other provinces or territories. They do not collect the information the same, and if they do, they're not reporting it the same. The surveillance we're doing is letting us know there's a problem. We may find that out in other parts of the country months or years from now, when the data is rolled out.

In terms of the increasing number of deaths we're seeing, fentanyl is driving that hugely. I would say, because we are on the coast, and a great deal of this product is coming from China, that it's hitting our ports and moving into our communities that way. I think that's also why you see it in B.C. and Alberta.

If I may, I want to mention something else. You talked about treatment a few minutes ago. I didn't want to leave that, because I do want to advocate for treatment. We see, from the families we talk to who have lost their loved ones, that they banged their heads against brick walls for months, if not years, trying to get appropriate treatment for their loved ones. Sean may be able to talk about this better than I can, but there is a time when someone who is using wants treatment, wants to get off. That window is small. If that treatment is not there when they are ready for it, then they will go back and they will die, or they will continue to use. The window is lost.

So you're absolutely right that treatment is a critical piece of this. It has to be available for people and it has to be at no cost. We also know that families have spent tens of thousands of dollars, if not hundreds of thousands, trying to access treatment for their loved ones. Not everybody has that kind of money, so that's a very good point.

**The Vice-Chair (Mr. Len Webber):** We'll move on now to MP Darshan Kang for five minutes.

**Mr. Darshan Singh Kang (Calgary Skyview, Lib.):** Thanks to the panel members.

We were talking about prevention and education. I know an organization in Calgary called Drug Awareness Foundation Calgary that has been doing open houses and trying to educate people against drugs. But every time they have an open house, there is concern that when they're trying to educate people not to use drugs, that may encourage young people to try drugs. It becomes a kind of double-edged sword.

Do you think we're doing prevention and education in a proper way so that we don't encourage youth to get into drugs?

● (1030)

**Dr. Bonnie Henry:** We can look at this in terms of other things we've done. We can look at how we've educated children around alcohol use. From studies we've done in B.C., alcohol use is actually decreasing in teenagers. Around cigarette use, smoking is just not done anymore in that age group.

We've talked to students about these things. We've talked to them about marijuana, for example, and we've talked to them about drugs. They say, “Oh, we never hear anything. Since we don't get information in a formal way in school, we hear about it on the streets. We hear untruths, and that's what makes it tempting to us.”

I think we do need to talk to people in a very forthright and open way about drugs, about their uses, their benefits, and their harms, so they can make those informed decisions. When we do it right, we've seen that it works.

**Mr. Darshan Singh Kang:** Is there enough getting done? It took five years to come to this fentanyl crisis. Couldn't we have seen it back then, when the crisis was brewing?

As well, is there another drug on the horizon that you think could be after this one? Are we being vigilant about any other drugs?

**Dr. Bonnie Henry:** You'll notice there was a peak in the 1990s, and that was when crack came into B.C. We've been looking at that for some time, and that peak was mainly confined to the Downtown Eastside. We were seeing a lot of people dying.

The response was quite different. We have a partnership in B.C. that has been looking at this data, the coroner's office and others, for a number of years. We did see things coming up.

We finally reached the point that we declared the emergency because all of our usual measures to try to intervene, to increase awareness on the street, to make sure that people know what's happening, via a number of campaigns, weren't going anywhere. We needed a much broader partnership to try to address these crises as the deaths were coming up.

**Mr. Darshan Singh Kang:** Why is it right across the province? That's mind-boggling.

**Dr. Bonnie Henry:** A variety of factors have led to increased use. We've seen issues related to economic conditions in certain parts of the province. I think our understanding that it was no longer confined to, or just a problem in, one part of the province was one of the reasons we declared an emergency to address it.

**Mr. Darshan Singh Kang:** We've been talking about Bill C-2. I think the Minister of Health is going to look at the barriers in Bill C-2.

Dr. Juurlink, you said something about doctors prescribing medications. I know some people will go from doctor to doctor to get OxyContin, for example. They will get it, and sell it too.

How can we control the medications? Is there some kind of mechanism in place, so the doctor knows that—

**Dr. David Juurlink:** [*Inaudible—Editor*] to stop that problem, but we can take lessons, again, from B.C., which in the mid-1990s began a program called PharmaNet. Almost overnight, every doctor, and every pharmacist had access to real-time data. If you got a prescription in Richmond and the following day you got a prescription in Burnaby, the person looking at the prescription profile would know.

We showed some years ago that this was associated with a very rapid and dramatic drop in double-doctoring for both opioids and benzodiazepines. That sort of model that tracks all drugs prescribed to all people should exist in every province and territory in Canada. There's no good argument against it.

**The Vice-Chair (Mr. Len Webber):** Thank you, Doctor.

Our final questioner today is Mr. Davies. You've got three minutes.

● (1035)

**Mr. Don Davies:** A few years ago, the public safety committee did a study on the rate of addiction and mental illness in the federal correctional system. The conclusion we came to was that 80% of inmates in the federal system had an addiction.

Would an increased use of drug courts and treatment diversion programs in the justice system be a positive measure to help people entering prison have a chance of dealing with their addiction?

**Ms. Lisa Lapointe:** That's a very good question. There's a drug treatment court in Vancouver, and I haven't seen the data coming out of that. I know anecdotally from those who work in that field that they believe it's very successful.

I can tell you, I have worked in the provincial correction system, and at the time I was there around 2006, 2007, and 2008, we found the same, that 63% of those in jail had either a substance abuse and/or mental health disorder, and generally both.

It's very challenging treating those with substance abuse or mental health disorders in jail. It's not an optimal place for people. Again, if you want to adopt a health approach, if somebody has an illness, putting them in jail isn't the best way to treat them.

Absolutely, we need to be looking at novel ways of treating populations that really are just going to cycle back through the jail.

**Mr. Don Davies:** Mr. LeBlanc, in your experience and that of people you know, if people were facing a criminal charge and had an addiction, if they were given the opportunity to avoid the corrections system and go into treatment, would that be something people would choose?

**Mr. Sean LeBlanc:** I think so for the most part. I think it needs a bit of tailoring, though. The drug court right now is pretty well abstinence-based. When people are failing, they're still being punished for their original crimes. In a lot of cases, though, it's worked really well for people. There are a lot of limitations though. People can't work when they're on it, and people are unable to attend school while they're on it because of the time commitment involved. I think if we could make a couple of adjustments, it would be even more successful.

**Mr. Don Davies:** Dr. Juurlink, I want to come back to you. You said there was no national system of surveillance in Canada and even the number of Canadians who die annually from opioids is unknown. How do we fix that? Who should be collecting the data and how do we do that?

**Dr. David Juurlink:** You need data on deaths and data on non-fatal overdoses. The data on deaths should come from the regional coroners, who should be empowered to collect data in real time and report it in real time. You can't fix what you're not even measuring. The information on non-fatal overdoses should come, I think, primarily from CIHI, which contains national records on emergency department and hospital visits. Those two things together, I think, will give you a pretty clear picture of the problem.

Do you want to add to that?

**Dr. Bonnie Henry:** The challenge would be that CIHI doesn't have timely data, and emergency department data is not universal across the country, but it's a start.

**Mr. Don Davies:** I know there's a summit in November, but it sounds to me as though the joint task force in British Columbia has come up with some great recommendations. Do we need a national joint task force made up of the federal government and all the provinces and territories to get a handle on this Canadian issue?

**Dr. David Juurlink:** Yes.

**Dr. Bonnie Henry:** Yes.

**Ms. Lisa Lapointe:** Yes. First of all, and I don't want to harp on this, but we need to establish criteria, because we don't even know if we're talking about the same thing across the country. Is the data that Ontario is collecting around fatalities the same data that B.C. is collecting and the same as Nova Scotia is collecting?

**Mr. Don Davies:** We need standardization.

**Ms. Lisa Lapointe:** We need a definition that is standard, and I think it will require federal leadership to say here's the definition for the information we want to collect, and then the provinces and territories will start to collect it.

**Mr. Don Davies:** Thank you.

**Dr. David Juurlink:** Every hospital in the country could have a person who is empowered to report each week the number of drug overdoses that came to their emergency department. That would be easy. They report all kinds of other things that are far less important. It would not be hard to do.

**Ms. Lisa Lapointe:** Again, I would say that we need to have a definition. What is a drug overdose? Is it a prescribed overdose? Is it an illicit opioid overdose? Is it a cocaine overdose, a stimulant overdose? Those are all different substances and they have different solutions.

**Dr. David Juurlink:** I agree.

**Mr. Don Davies:** Mr. Chair, I think we have our joint task force sitting at the table here. That's the truth.

**The Vice-Chair (Mr. Len Webber):** Unfortunately we have to end our witness session here. I want to thank you all sincerely for being here today. You were most informative. Thank you so much.

We have to move on to some committee business. You're welcome to sit through that. It's quite related to the topic here today. So you're welcome to stay if you wish.

Ms. Sidhu, at the last meeting, tabled a motion and she wants to move it now, from what I understand.

Would you like to read your motion again, Ms. Sidhu?

**Ms. Sonia Sidhu:** Yes. Thank you, Mr. Chair.

As I gave notice of my motion last meeting, today I am moving my motion.

This motion reflects what we have heard from witnesses.

● (1040)

**The Vice-Chair (Mr. Len Webber):** Ms. Sidhu, can I just interrupt you? We have a bit of a commotion here right now. Perhaps we will restart this in about a minute or two.

● (1040)

(Pause)

● (1040)

**The Vice-Chair (Mr. Len Webber):** I would like to call the meeting back to order, please.

Again, MP Sidhu, I'm sorry for interrupting, but we will get back to your motion again. So please, if you can, continue.

**Ms. Sonia Sidhu:** Thank you, Mr. Chair.

As I gave notice of my motion last meeting, today I'm moving my motion:

> That, pursuant to Standing Order 108(2), the Committee call upon the Minister of Health to move as quickly as possible to conduct a review of the laws and regulations in place with regard to safe injection sites. This review should have as an end goal to improve the health and safety of Canadians, using a strong evidence-based approach.

**The Vice-Chair (Mr. Len Webber):** MP Sidhu, I'll let Dr. Carrie talk first here.

**Mr. Colin Carrie:** Mr. Chair, I find this motion quite unusual because the minister can already do this at her discretion. I would have thought that she's already reviewed the files she is responsible for.

Call me old-fashioned, but the comment here was “safe injection site”. I don't like that term “safe”. I think we've heard that there's no way to safely inject street heroin. Heroin could be laced with whatever off the street. It could be kerosene in your veins. It's not something that's safe.

I would like to propose a friendly amendment, if we are going to go this route.

The minister can do it anyway.

After the second sentence, where it reads, “This review should”, I'd like to add the words, “be reported back to committee and” have an end goal to improve the health and safety of Canadians, using a strong evidence-based approach. If the committee is asking her for this, then it would make sense to me that we get a report from the minister so that we can see what she said.

I'd like to also add the words, “that strengthens consultations with communities who will be affected” after the words “evidence-based approach”, because I think it's really important. If you want to have some success, then you have to have communities that are supportive.

That would be my attempt at improvement.

● (1045)

**The Vice-Chair (Mr. Len Webber):** You've put forward an amendment to the motion to change the wording in here.

**Mr. Colin Carrie:** Sorry, I have other thing to suggest. Instead of “safe injection sites”, could we say “consumption sites” or something like? I would like to change that wording, because there's nothing safe about it.

**The Vice-Chair (Mr. Len Webber):** All right.

We'll go to Mr. Davies.

**Mr. Don Davies:** For the latter, sometimes we use the words “supervised consumption sites”. That's also an adjective that we can use.

The other amendment I think that ought to be made is to strike out the words “and safety”. We're the health committee. If we said, “This review should have as an end goal to improve the health of Canadians”, absent the words “and safety”, that would be the point of this. I think we've heard our witnesses testify over and over again that the point of this bill is to make this a health decision and not one that's diverted into issues of criminality or safety. To be honest, I think the concept of health embraces safety.

I would strike the words “and safety”.

**The Vice-Chair (Mr. Len Webber):** Okay. Mr. Davies, we were going to go to Mr. Carrie's amendment first, and vote on it.

Mr. Carrie, do you...?

**Mr. Colin Carrie:** As a point, we had health officials here, and the mandate of the minister is the health and safety of Canadians.

To remove “and safety” doesn't make sense to me without first asking the minister.

**The Vice-Chair (Mr. Len Webber):** All right.

Mr. McKinnon, on the amendment to the motion.

**Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.):** I think we have three separate amendments here. I would suggest that we raise them as three separate things.

**The Vice-Chair (Mr. Len Webber):** Yes. Absolutely. We do have 10 minutes, so let's deal with the first amendment.

**Mr. Ron McKinnon:** I would suggest that the first amendment you're proposing would be to replace the words “safe injection sites” with something such as “supervised consumption sites”.

**The Vice-Chair (Mr. Len Webber):** That's what you indicated?

**Mr. Colin Carrie:** That's fine. I'm fine with that if you guys are fine with that.

**The Vice-Chair (Mr. Len Webber):** Then, at the end, you wanted—

**Mr. Colin Carrie:** The next one would be to report back to committee.

**The Vice-Chair (Mr. Len Webber):** To report back to committee. That's the second change there.

What is the third?

**Mr. Colin Carrie:** The third one is to add the words, “that strengthens consultations with communities who will be affected”, because once you have an injection site in a community, it can change that community forever. I think it's important that they have an opinion and a say in this.

**The Vice-Chair (Mr. Len Webber):** Are there any comments on the amendment?

**Mr. Don Davies:** I'm sorry. What is that amendment? I'm a little bit behind.

We would use the wording, “supervised consumption site”, and then, Colin, you wanted to have a report back?

**Mr. Colin Carrie:** That would be the second amendment.

**Mr. Don Davies:** Okay, and what's the third?

**Mr. Colin Carrie:** At the very end, it would say, “that strengthens consultations with communities who will be affected”.

**The Vice-Chair (Mr. Len Webber):** Mr. McKinnon, you have a subamendment to the amendment?

**Mr. Ron McKinnon:** Am I to understand this is one amendment to make those three changes?

**Mr. Colin Carrie:** Maybe to quickly get through it, because we're —

**Mr. Ron McKinnon:** It would be nice.

**Mr. Colin Carrie:** —over time already, and I have another thing to go to.

My first one, if it's unanimous, is that I'd just like to scratch “safe injection sites” and put “supervised consumption sites”, which is Don's wording.

Is everybody okay with that?

**Mr. Ron McKinnon:** If that's a separate amendment, I support it.

**The Vice-Chair (Mr. Len Webber):** Can we have a vote on that one amendment then?

**Mr. Don Davies:** Yes.

**Mr. Colin Carrie:** Do you know what? I'm going to have it just as one amendment. Let's just vote on it.

**The Vice-Chair (Mr. Len Webber):** Absolutely.

**Mr. Doug Eyolfson:** That's one amendment. In the two amendments there are parts that are very different. We need to vote on it.

**Mr. Colin Carrie:** I put the amendment forward originally and, Mr. Chair, unfortunately we are overdue. I have another—

● (1050)

**The Vice-Chair (Mr. Len Webber):** We'll vote on the amendment and the three changes in the amendments, the “supervised consumption sites”, and the addition of it being reported back to the committee, and third, that—

**Mr. Colin Carrie:** The last line would read, “that strengthens consultations with communities who will be affected”.

**The Vice-Chair (Mr. Len Webber):** We're going to vote on that amendment to the motion.

(Amendment negatived)

**The Vice-Chair (Mr. Len Webber):** Mr. McKinnon.

**Mr. Ron McKinnon:** I'd like to move an amendment that “safe injection sites” be changed to “supervised consumption sites”.

**The Vice-Chair (Mr. Len Webber):** All right, we will vote on that amendment to the motion.

(Amendment agreed to)

**The Vice-Chair (Mr. Len Webber):** That change will be made.

Mr. Davies.

**Mr. Don Davies:** I would like to move that we add the words,“and that the Minister be obligated to report back to the Committee on the result of her review”.

**The Vice-Chair (Mr. Len Webber):** Okay, is there any discussion on that?

**Mr. Don Davies:** By the way, I don't mean her personally. I just mean that we get that from the minister's office.

**The Vice-Chair (Mr. Len Webber):** All right, then I guess we're prepared to vote on your amendment to the motion.

(Amendment agreed to)

(Motion as amended agreed to [See *Minutes of Proceedings*])

**The Vice-Chair (Mr. Len Webber):** All right, the motion put forward by Ms. Sidhu as amended is passed. Thank you.

We don't have time to go in camera now, but we will have to find a time to discuss our future meetings.

Actually, we have a list of presenters here prepared for our next meeting. We will invite them to be here, and at that time we will discuss our future meetings down the road.

**Mr. Don Davies:** Perhaps, Mr. Chair, we've been circulating a list among the members of the subcommittee on agenda and priorities, and we could continue the discussion of that at that level as well.

**The Vice-Chair (Mr. Len Webber):** Fantastic.

Mr. McKinnon.

**Mr. Ron McKinnon:** At some point, I wanted to suggest a couple of witnesses for you. I can do that off-line if you prefer.

**The Vice-Chair (Mr. Len Webber):** Certainly, if you can just bring that to the clerk we'll put it on the list. Thank you.

The meeting is adjourned.

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